Perry Multi-County Juvenile Facility

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Policy and Procedure Manual

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O.A.C.	**5139-36-02(A)(N)(M); 5139-36-17(B)**
A.C.A.	**3-JCRF-1A-01 1A-03 1A-05 1A-06 1A-07 1A-10**
P.R.E.A.	**None**

1.0 Purpose

To establish the facility's goals, objectives, and standard operating procedures including a system of regular review.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to providing youth the opportunity to live, learn, and grow in an environment that is supportive of cognitive-based treatment. This shall be accomplished by facility staff working in partnership with the resident, family, committing courts, and community.

4.0 Definitions/Documents

Appendix: Staff Review of Policies and Procedures

5.0 Responsibility

5.1 All Employees are responsible for maintaining a positive and supportive environment.

5.2 The Director is responsible for working with the Ohio Department of Youth Services in setting long range goals and objective as well as obtaining and displaying the approval certificate

5.3 Resident Care Workers are responsible for facilitating programs, participating in staff meetings, and reviewing, understanding and implementing policies and procedures.

5.4 The Compliance Coordinator is responsible for ensuring policies and procedures are reviewed annually by employees and approved by the facility governing board.

5.5 Case Manager is responsible for coordinating all referral information, intake assessments, admissions, ongoing treatment plan reviews, inviting the probation officer of each resident to a monthly team meeting, facilitating the team meeting, and providing a monthly progress report to the courts.

6.0 Procedures

6.1 The Perry Multi-County Juvenile Facility (hereafter referred to as "PMCJF") shall be sanctioned to operate as a public community corrections facility following the standards established by the Ohio Administrative Code, the American Correctional Association, and the federal government.

6.2 PMCJF shall operate under the Ohio Department of Youth Services (hereafter referred to as "ODYS") complying with all applicable licensing requirements of the jurisdiction in which it is located.

6.3 The Director shall demonstrate licensing requirements by obtaining and displaying the approval certificate awarded by the Ohio Department of Youth Services

6.4 The Director shall set long-range goals and objectives based upon criteria established by the Ohio Department of Youth Services and the mission of the facility. The goals shall be reviewed annually and submitted to ODYS in an annual report.

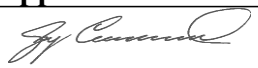
6.5 Employees shall be actively involved in the integrated delivery of services to residents and families by maintaining positive and supportive attitudes while engaging residents in cognitive behavioral therapy through daily interactions including facilitating programs, participating in staff meetings, and providing specific guidance to residents assigned for staffing.

6.6 Employees shall participate in the formation of policies and procedures by reading, understanding, and demonstrating compliance in implementing policies and procedures while providing feedback through staff meetings, email, and policy and procedure review.

6.7 PMCJF shall communicate and collaborate with juvenile justice and service agencies in information gathering, exchange and standardization among the eight core counties which consist of Coshocton, Delaware, Fairfield, Knox, Licking, Morgan, Muskingum and Perry County as well as any committing court within Ohio.

6.8 The Case Manager shall coordinate all referral information, intake assessments, admissions, and ongoing treatment plan reviews. The probation officer of each resident shall be invited to a monthly treatment team meeting and provided a monthly progress report.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: A	**General Administration**
Subject: 1.1	**Governing Authority Meetings and Community Advisory Board**
Related Standards:	
O.A.C.	**5139-36-03 (D)(1)(2)(3)(F)(L)(O)(1)(2)(3)(4)(5)(6)**
A.C.A.	**3-JCRF-1A-04 and 1A-11**
P.R.E.A.	**None**

1.0 Purpose

To establish a system of governing authority review of the administrator and appropriate staff, establish policy, and ensure conformity to legal and fiscal requirements while linking the program with the community.

2.0 Persons Affected

Facility Director, Governing Board, and ODYS.

3.0 Policy

The Perry Multi-County Juvenile Facility Director shall facilitate communication, establish policy, and ensure conformity to legal and fiscal requirements by conducting quarterly meetings with the governing authority and appropriate staff. The Director shall hold bi-annual meetings with an advisory board comprised of community members.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for providing notice for each and conducting the following:

a. Quarterly Governing Board meetings
b. Annual ODYS and Governing Authority meetings
c. Bi-Annual Community Advisory Board meetings

5.2 The Director is responsible for controlling, managing, operating, and having general charge of the facility and program as well as custody of its property, files and records.

5.3 Juvenile court judges of the eight core counties are responsible for performing their duties on the governing board in their official capacity or appointing temporary replacements to serve as their representative at scheduled governing board meetings.

5.4 The Perry Multi-County Juvenile Facility Governing Board is responsible for the following:

a. Appointing and fixing the compensation of the director of the facility and program and other professional, technical and clerical employees.
b. Supervising the Director
c. Reviewing, revising and approving policies and procedures, criteria used to admit youth to the facility, governing board by-laws, the operating budget of the facility, and any funding applications to the ODYS.
e. Deciding admission appeals.
f. Maintain compliance with rules under Chapters 5139-36 of the Administrative Code.

6.0 Procedures

6.1 The ODYS representatives and the governing authority of the facility will meet annually with the director and appropriate staff as designated. The meeting may serve as an annual review of the policies and procedures, the programs, and conformity to legal and fiscal requirements.

6.2 The Governing Board shall consist of the juvenile judges of each participating county. Each juvenile judge may appoint a temporary replacement to serve as their representative at a scheduled governing board meeting. The juvenile judges shall perform their duties on the board in their official capacity.

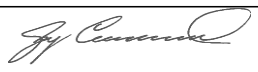
6.3 The Governing Board shall appoint and fix the compensation of the Director of the facility and program and other professional, technical, and clerical employees who are necessary to properly maintain and operate the facility and program. The Director, under the supervision of the Executive Board and subject to the ODYS grant agreement and administrative rules, shall control, manage, operate, and have general charge of the facility and program, and shall have the custody of its property, files and records.

6.4 The Governing Board shall review, revise and approve policies and procedures set forth in a facility policy and procedure manual, the criteria used to admit youth to the facility, governing board by-laws, the operating budget of the facility, and any funding applications to the ODYS. The Governing Board shall decide appeals of "refusal to admit" youth to the facility by a majority vote of the participating counties at a scheduled meeting and maintain requirements of established rules under Chapters 5139-36 of the Administrative Code.

6.5 The Director shall discuss an annual report of all legal activities with the facility Governing Board, send the report to ODYS, and make the annual report available to the public upon request.

6.6 The facility advisory board shall be comprised of representatives of the community in which it is located. PMCJF shall conduct bi-annual advisory board meetings. The advisory board shall be open to community members as well as representatives from law enforcement, prosecuting attorney offices, board of education, local mental health providers and local substance abuse rehabilitation centers. Notice shall be given to each representative prior to the meeting or published in area media sources.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: A	**General Administration**
Subject: 1.2	**Single Administrative Officer & Qualification of Facility Administrator**
Related Standards:	
O.A.C.	**5139-36-02 (D)(1)(2)(3)**
A.C.A.	**3-JCRF-1A-06 and 1A-07 (Rev. 2003)**
P.R.E.A.	**28 CFR §115.311 (a)(b)(c) & §115.313 (d)(1)(2)(3)(4)**

1.0 Purpose

To ensure a qualified person is hired with the control and authority necessary to operate the Perry Multi-County Juvenile Facility in accordance with all minimum standards.

2.0 Persons Affected

Governing Board, Director, and Compliance Coordinator

3.0 Policy

The facility shall be managed by a single administrative officer qualified for the position. The single administrative officer shall ensure all minimal standards of local, state, and federal compliance are maintained including mandating zero tolerance toward all forms of sexual abuse and sexual harassment within the facility. The facility is a single community corrections facility with an appointed PREA coordinator.

4.0 Definitions/Documents

Attachment: 1) Director Job Description 2) Compliance Coordinator Job Description

5.0 Responsibility

5.1 The Perry Multi-County Juvenile Facility Governing Board is responsible for notifying the public of position vacancy, interviewing and hiring the facility director.

5.2 The Director shall have the authority and responsibility to do the following:

a. Manage the facility structure, grounds, property, files and records, personnel, programs, procedures, and practices.
b. Ensure compliance with local, state, and federal standards including the Ohio Administrative Code, the Prison Rape Elimination Act, and the American Correctional Association standards.
c. Mandate zero tolerance toward all forms of sexual abuse and sexual harassment.

5.3 The Compliance Coordinator shall hold the role of PREA Coordinator and shall coordinate the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment.

6.0 Procedures

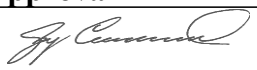
6.1 The facility and its programs are managed by a single administrative officer with the position title of Director. The qualifications for the Director's position include, at a minimum, the following: a bachelor's degree in an appropriate discipline; five years of related administrative experience; and demonstrated administrative ability and leadership. The degree requirement may be satisfied by completing a career development program that includes work-related experience, training, or college credits at a level of achievement equivalent to the bachelor's degree.

6.2 All facility structure, grounds, property, files and records, personnel, programs, procedures, and practices are under the sole authority and responsibility of the Director. The staffing plan, staffing patterns, deployment of video monitoring systems and other monitoring technology, and resources available to commit to adherence to the staffing plan shall be assessed, determined and documented annually noting any adjustments.

6.3 The Director shall ensure compliance with the Ohio Administrative Code and the Prison Rape Elimination Act (hereafter referred to as "PREA") by developing, implementing and overseeing facility efforts to comply with all minimal standards. The Director shall mandate zero tolerance toward all forms of sexual abuse and sexual harassment. The Compliance Coordinator shall be appointed by the Director and serve as the PREA Coordinator with sufficient time and authority to coordinate the facility's efforts to prevent, detect and respond to such conduct.

6.4 The Perry Multi-County Juvenile Facility Governing Board has the responsibility of hiring a director. Notification of vacancy in the director position will be given to area newspapers. Candidates meeting the above qualifications may be recruited and interviewed.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: A	**General Administration**
Subject: 1.3	**Policy and Procedure Manual & New and Revised Policies and Procedures**
Related Standards:	
O.A.C.	**5139-36-08 (B)(K)**
A.C.A.	**3-JCRF-1A-12 and 1A-13**
P.R.E.A.	**None**

1.0 Purpose

To establish written instructions concerning the operating and maintaining of the facility in a policy and procedure manual that is accessible to all employees and the public. The manual shall be revised as needed with revisions communicated to designated employees.

2.0 Persons Affected

All employees

3.0 Policy

The instructions for operating and maintaining the Perry Multi-County Juvenile Facility shall be written in a policy and procedure manual that is accessible to all employees and the public. The manual shall be revised as needed with revisions communicated to designated employees.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Perry Multi-County Juvenile Facility Governing Board shall be responsible for the annual approval of the policy and procedure manual and the employee handbook.

5.2 The Compliance Coordinator shall annually review, write, and recommend policies and procedures for operations and personnel.

5.3 All employees are responsible for the following:

a. Participating in the formation of policies and procedures through input at staff meetings and annual policy and procedure reviews.
b. Reading, understanding, and applying policies and procedures.
c. Signing an acknowledgement of the duty to apply policies and procedures contained within the manual.
d. Signing a receipt for the employee handbook acknowledging accountability for all policies, procedures and practices within the handbook.

6.0 Procedures

6.1 PMCJF shall have a facility policy and procedure manual that contains philosophy, goals and purpose, services of the facility, and approved methods of implementation.

6.2 The PMCJF Policy and Procedure Manual shall be updated as needed with annual revisions approved by the governing board.

6.3 The policies and procedures manual will be available to all staff on the computer and in printed form at Central Control. The manual is available to the public on the facility website.

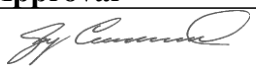
6.4 Revisions will be added to the manual as needed. New or revised policies and procedures shall be communicated to all staff through email at Central Control or via the shift information review.

6.5 All staff shall be required to read the policies and procedures manual during orientation. The manual must be reviewed annually. Staff shall sign an acknowledgement of their duty to apply all policies and procedures contained within the manual. The acknowledgement shall be placed in the employee's file.

6.6 PMCJF shall adopt the Perry County Personnel Policy Handbook with specific facility addendums attached when applicable. The Personnel Handbook will be comprehensive in design to address all foreseeable employee conduct standards and employment information. The handbook shall be reviewed and revised as deemed necessary with annual PMCJF Governing Board approval.

6.7 A copy of the approved Perry County Personnel Policy Handbook shall be distributed to all employees. Each employee shall be required to sign a receipt for the handbook and shall be held accountable to all policy, procedures and practices within the handbook. The receipt shall be placed in the employee's file.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: A	**General Administration**
Subject: 1.4	**Administration and Staff Meetings, Monitoring and Assessment**
Related Standards:	
O.A.C.	**5139-36-02 (E)**
A.C.A.	**3-JCRF-1A-14 and 1A-15**
P.R.E.A.	**None**

1.0 Purpose

To ensure open communication channels and quality programs through a system of internal monitoring, inspection and review.

2.0 Persons Affected

All employee

3.0 Policy

The Perry Multi-County Juvenile Facility provides quality programs by establishing a system of internal monitoring, inspections and reviews conducted by the administrator or designated staff. The administrator and key staff members will have regular meetings at a minimum of every month to communicate and coordinate facility efforts.

4.0 Definitions/Documents

4.1 Administrative Treatment Team: Members of administration including the Supervisors, Clinical Coordinator, Compliance Coordinator, Case Manager and the Director.

5.0 Responsibility

5.1 The Director shall be responsible for the following:

a. Facilitating monthly supervisory meetings with the Food Service Supervisor, the Maintenance Supervisor, the Resident Care Worker Supervisors, Compliance Coordinator, Case Manager, and others as necessary.
b. Regular attendance at Administrative Treatment Team Meetings.
c. Recording and maintaining supervisory meeting minutes for three years.
d. Attending annual inspection of training curriculum manual by the programming team.

5.2 The Supervisors shall be responsible for the following:

a. Facilitating daily shift review meetings with Resident Care Workers.
b. Facilitating weekly staff meetings with resident care workers.
c. Attending weekly Administrative Treatment Team Meetings
d. Attending monthly Supervisory Meetings
e. Attending Quarterly Mandatory Staff Meetings
f. Conducting and recording discussions with Resident Care Workers on areas of concern, competence or resolution.
g. Attending annual inspection of training curriculum manual by the programming team.

5.3 The Compliance Coordinator shall be responsible for the following:

a. Reading the weekly Administrative Treatment Team Meeting minutes
b. Attending the monthly Supervisory Meetings
c. Conducting and providing the Director with an annual resident program and staff survey.
d. Maintaining administrative treatment team meeting minutes for three years.

5.4 The Clinical Coordinator shall be responsible for the following:
a. Quarterly Observations of all groups with written feedback provided on group observation forms to the group facilitator.
b. Monthly inspection of facilitator group logs.
c. Conducting programming meetings as needed to assist staff in providing continuous quality programming.
d. Attending the weekly Administrative Treatment Team Meetings.
e. Facilitating a monthly review with the Case Manager.
f. Attending a monthly review with the Director.
g. Facilitating an annual inspection of training curriculum manuals by the programming team including Director, Case Manager, Clinical Coordinator, Supervisors, and cognitive-behavioral training coach.

5.5 The Case Manager shall be responsible for the following:
a. Attending and recording minutes for the weekly Administrative Treatment Team Meetings, obtaining progress review information on residents, and approvals for visitation and phases.
b. Attending monthly review meetings with the Clinical Coordinator.
c. Attending Quarterly Mandatory Staff Meetings.
d. Attending annual inspection of training curriculum manual.

5.6 Food Service Manager and Maintenance Supervisor shall be responsible for attending all monthly Supervisory Meetings.

5.7 Resident Care Workers shall be responsible for the following:
a. Participating in the daily shift review meetings.
b. Participating in weekly staff meetings.
c. Keeping accurate and up-to-date group log information.
d. Attending programming meetings as needed.

6.0 Procedures

6.1 Regular meetings with open lines of communication shall be established at various levels between the administrator and key staff members. Regular meetings include the following:

- Daily shift reviews between Supervisor(s) and Resident Care Workers to review resident progress and provide continuity of care.
- Weekly staff meetings between Supervisors and Resident Care Workers to review resident progress, process and make recommendations on phase change requests, and discuss areas of concern or competence.
- Weekly administrative treatment team meetings between the Director, Case Manager, Clinical Coordinator, and Supervisors to provide oversight and review of resident progress, make phase change decisions, discuss areas of concern or competence, and follow-up on treatment issues.
- Monthly supervisory meeting between the Director, Case Manager, Compliance Coordinator, Supervisors, Food Service Manager, Maintenance Supervisor, and others as necessary to delegate authority, assign responsibility, supervise work, and coordinate efforts.

- Quarterly mandatory staff meetings between the Director, Supervisors, and Resident Care Workers with other staff as deemed necessary to ensure open channels of communication as well as opportunities for education and training.
- Communication meetings as needed between the Director and Food Service Assistants, facility nurse, educational staff and Resident Care Workers.

6.2 Program monitoring, inspections, and reviews shall be conducted as follows:

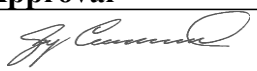
- Monthly inspections of group logs by the Clinical Coordinator.
- Quarterly group observations reviews by the Clinical Coordinator with written documentation provided to facilitators on group observation logs.
- Annual resident program and staff survey feedback provided to the Director by the Compliance Coordinator.
- Annual inspection of training curriculum manuals by the programming team including Director, Case Manager, Clinical Coordinator, Supervisors, and cognitive-behavioral training coach.
- Programming meetings as needed to assist staff in providing continuous quality programming.

6.3 Meetings may be individual or group and shall be recorded by date, personnel attending and topic. Any further documentation shall be at the discretion of the Director.

6.4 Meeting records shall be maintained for three years and shall be available for review.

6.5 Any meeting that has information that is mission critical shall be brought to the Director's attention in a timely manner.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: A	**General Administration**
Subject: 1.5	**Public Interaction, Information and Media Access to the Facility**
Related Standards:	
O.A.C.	**5139-36-08 (G)**
A.C.A.	**3-JCRF-1A-16 1A-17 1A-18**
P.R.E.A.	**None**

1.0 Purpose

To establish a plan for media relations that encourages interaction with the public and maintains confidentiality and security rights of residents at the facility.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to fostering community involvement and support for the facility through open communication with public and news media. Representatives of the media will be granted access to the facility consistent with the juveniles' rights to confidentiality and privacy and the maintenance of order and security of the facility. The facility has established the agency's commitment to informing the public and the media of events within the agency's area of responsibility. Procedures address emergency and non-emergency responses to the media and, at a minimum, include the following:

- Identification of areas of the facility accessible to media representatives
- Routine requests for information
- Identification of data and information protected by federal and state privacy laws or federal and state freedom of information laws
- Facility tours
- Special events coverage
- News release policy
- Designation of individuals or positions within the agency authorized to speak with the media on behalf of the agency

4.0 Definitions/Documents

Appendix: Facility Tour Sign-in Sheet

5.0 Responsibility

5.1 The Director or designee shall be responsible for the following:

a. Making all decisions concerning granting physical access to facility and releasing information to the public including news media.

b. Ensuring confidentiality by obtaining signatures on a facility tour sign-in sheet which includes a confidentiality agreement.

c. Complying with public records requests and freedom of information laws as allowed within a reasonable time frame.

d. Approving articles submitted by the facility to media outlets.

5.2 Facility staff shall be aware of procedures concerning providing information to media outlets. All facility staff may answer routine requests for general program information.

6.0 Procedures

Non-Emergency

6.1 Access to the facility shall be with the permission of the Director to all areas open to the public. This includes all areas in front of the double doors. Areas behind the double doors will be accessed as able to preserve resident confidentiality. Resident living areas may be accessed by the media when not in use.

6.2 All staff may answer routine requests for general program information. All other requests for information should be forwarded to the Director or designee.

6.3 Resident confidential information is protected by federal and state privacy laws. All medical information concerning staff and residents shall remain confidential. Freedom of information laws will be consulted as needed when requests for public records are made. All requests for public records will be granted as allowed within a reasonable amount of time.

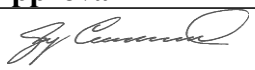
6.4 Requests by media, community agencies and other organizations for special tours will be met as able. All students from area colleges interested in learning about the facility and the residents are encouraged to participate in a practicum field of study. A facility tour sign-in sheet including confidentiality agreement should be signed prior to the tour.

6.5 Articles concerning community service activities or special interests of the facility shall be submitted to area newspapers by the Director or designee. All public relations events, activities, or articles shall be documented.

Emergency

6.6 The Director or designee shall be in charge of approving news releases or speaking with media on behalf of the agency concerning all emergency or non-emergency inquiries.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: A	**General Administration**
Subject: 1.6	**Campaigning, Lobbying, Political Practices & Ethics**
Related Standards:	
O.A.C.	**5139-36-08(J)(1)(2)(3)(4)(5)(6) 5139-36-05 (G) 5139-36-09 (A)(22)(23)**
A.C.A.	**3-JCRF-1A-20 1A-21 1B-17**
P.R.E.A.	**28 CFR §115.317 (f)**

1.0 Purpose

To establish a comprehensive employee code of ethics.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to establishing a code of ethics to guide its employees in the governmental statutes, regulations, and standards of conduct expected as an employee. This code shall include guidelines in the following:

a. Conflicts of interest including favoritism, inappropriate conduct with residents, and entering into a business relationship with residents and their families.
b. Campaigning, lobbying, and political practices
c. Contact with juveniles outside the facility
d. Employee behavior and reporting disciplinary action.

4.0 Definitions/Documents

4.1 Conflict of Interest means any employee action that adversely affects the interest of the agency. Outside concerns may bring undue pressure upon the employee in his/her effort to make decisions concerning official duties.

5.0 Responsibility

5.1 All Employees are responsible for the following:

a. Recognizing the permitted and prohibited activities in partisan politics for classified employees and asking the director for clarification if needed.
b. Being fair and impartial in interactions with residents.
c. Not trading, bartering or exchanging any personal items of value or engaging in a business relationship for any reason with residents or their families or close associates while confined at the facility or after for a period of one year after released or as long as the resident remains under court supervision.
d. Having no contact with a resident in an unofficial capacity while the resident is confined or for a period of one year after release and as long as the resident remains under court supervision. This includes all forms of social media such as Facebook, Twitter, Snapchat, and Instagram.
e. Documenting resident contact in the resident contact log.
f. Conducting oneself in a manner that does not bring discredit upon the facility, both on and off duty. Avoiding misconduct, and the appearance of misconduct.
g. Reporting any indictment or formal charging of any felony or misdemeanor charge to an immediate supervisor or to the Director within twenty-four (24) hours or the next working day.

h. Disclosing prior or current misconduct of sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution, convictions of engaging or attempting to engage in sexual activity in the community by force, overt or implied, or coercion, or if the victim did not consent or was unable to consent or refuse, and civil or administrative adjudications to have engaged in any of the above listed activities.
i. Reporting any Code of Ethics violations.

5.2 The Director is responsible for the following:
a. Disciplining employees for code of ethics violations, documenting disciplinary actions in the employee files.
b. Notifying the O.D.Y.S. community correctional facility liaison of code of conduct violations and disciplinary action taken within two business days.

5.3 The Compliance Coordinator is responsible for conducting thorough investigations into complaints of favoritism, documenting findings, and reporting violations to the director for disciplinary action.

6.0 Procedures

6.1 The Ohio Revised Code prohibits classified employees from engaging in partisan political activity.

6.2 Prohibited Political Activity is identified as follows:

- Running for a public office in a partisan election
- Running for a non-partisan election if the nomination to the candidacy was obtained in a partisan primary or by circulating nominating petitions identified with a political party
- Filing petitions that meet statutory requirements for partisan candidacy for elected office
- Circulating official nominating petitions for any candidate participating in a partisan election.
- Serving in an elected or appointed office in any partisan political organization
- Accepting a party-sponsored appointment normally filled by a partisan election
- Campaigning by writing in publications, by distributing political material or by writing or making speeches on behalf of a candidate for partisan elective office, when such activities are directed toward partisan success
- Soliciting either directly or indirectly, any assessment, contribution, or subscription, either monetary or in-kind, for any political party or political candidate.
- Soliciting or selling political party tickets
- Engaging in partisan activities at the election polls, such as soliciting votes for partisan candidates or partisan issues
- Serving as a witness or challenger for any party or partisan committee
- Participating in political caucuses of a partisan nature
- Participating in a political action committee that supports partisan activity

6.3 Permitted Political Activity is identified as follows:

- Registering and Voting. The facility encourages all employees to exercise their right to vote.
- Expressing opinions, either orally or in writing
- Making voluntary financial contributions to political candidates or organizations
- Circulating non-partisan petitions or petitions stating views on legislation
- Attending political rallies
- Signing nominating petitions in support of individuals
- Displaying political material in the employee's home and on the employee's property
- Wearing political badges, buttons and stickers, and displaying political stickers on their private vehicles
- Serving as precinct election official under Ohio Revised Code section 3501.22

6.4 Any questions regarding permissible or prohibited political activity should be presented to the Director prior to engaging in the activity.

Favoritism

6.5 Favoritism of any group or individual is impermissible. Any allegation of discrimination or preferential treatment shall be investigated thoroughly by the Director or designee and appropriate disciplinary action will be taken.

Inappropriate Conduct with Residents

6.6 Residents, staff and residents, and residents and volunteers shall not trade, barter or exchange any personal items of value for any reason. Any violations or attempted violations of these restrictions must be reported to the Director.

6.7 Employees are not permitted to accept or give any gifts to residents, their families or close associates for a period of one year after the child is released or transferred from the facility and as long as the juveniles is under court supervision.

Entering into a Business Relationship with Juveniles

6.8 PMCJF employees shall not enter into any business or contractual relationship with any juvenile, their family or close associate for a period of one year after the child is released or transferred from the facility and as long as the juvenile is under supervision.

Contact with Juveniles Outside the Facility

6.9 PMCJF employees shall not purposefully initiate any unofficial contact with juveniles and their family or close associates, for a period of one year after the juvenile is released or transferred from the facility, and as long as the juvenile is under court supervision except for those activities which are an approved, integral part of the center program and a part of the employee's job description. This includes all forms of social media such as Facebook, Twitter, Snapchat, and Instagram.

6.10 Any unsolicited contact with a juvenile is to be documented in the Resident Contact Log by the staff member who had outside contact with the juvenile. The log shall contain the name of the juvenile, the date of contact and the nature of the contact.

6.11 Employees shall exercise extreme caution in providing any advice or guidance to ex-residents and limit such advice or guidance to referring the juvenile to the appropriate agency or authority for assistance.

6.12 Any staff member who resides in close proximity to a juvenile in which daily contact is virtually impossible shall not be required to document every contact with an ex-resident, unless the contact was for guidance or advice or of a professional nature. The employee shall be required to document such contact.

Employee Behavior

6.13 All PMCJF employees shall be required to conduct themselves in a manner that does not bring discredit upon the facility, both on and off duty. Any criminal behavior is prohibited and any felony conviction shall be grounds for immediate dismissal.

6.14 All PMCJF employees shall be required to report any indictment or formal charging of any felony or misdemeanor charge to their immediate supervisor or to the Director within twenty-four (24) hours or the next working day. Failure to report the filing of formal charges on an employee shall be grounds for immediate dismissal.

6.15 Each employee and contractor has a continuing affirmative duty to disclose prior or current misconduct of sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution, convictions of engaging or attempting to engage in sexual activity in the community by force, overt or implied, or coercion, or if the victim did not consent or was unable to consent or refuse, and civil or administrative adjudications to have engaged in any of the above listed activities.

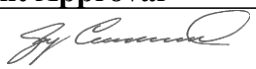
Disciplinary Action

6.16 All disciplinary action shall be documented in the employee file.

6.17 If the disciplinary action is a result of the violation of the standards of employee conduct, a copy of the disciplinary action shall be forwarded to the juvenile community correctional facility liaison from the O.D.Y.S. within two business days.

6.18 Failure to report any violation or attempt to violate policy shall result in disciplinary action.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-28-15 Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 10-20-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 06-30-15; 07-17-18; 10-20-0; 07-21-21
Date Revised: 07-19-22

Chapter: 1.0	**Administration and Management**
Section: A	**General Administration**
Subject: 1.0	**Institutional Pet Program**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	**None**

1.0 Purpose

To establish the facility's goals, objectives, and standard operating procedures for the maintenance of a facility pet program.

2.0 Persons Affected

All Employees and Residents involved directly and/or indirectly in the pet program.

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to providing youth with the opportunity to develop a better understand of responsibility, discipline and empathy through pet socialization.

4.0 Definitions/Documents

a. Primary Dog Handler is the volunteer resident screened and selected to be the primary caretaker of the animal.

b. Secondary Dog Handler is the volunteer resident who will be secondary caretaker and may replace the primary caretaker if removed or released from the program. The secondary dog handler may be in charge of the dog at times when the primary handler is unavailable including going off grounds for any length of time for visits, community service, and/or appointments.

5.0 Responsibility

5.1 Employees are responsible for knowing the program rules, knowing and supporting the training plan using basic commands taught to the facility pet, supervising resident interactions, and documenting and reporting any animal abuse or concerns.

5.2 The Director is responsible for the following:

a. Reporting on the progress, status, and any concerns related to the facility pet program to the PMCJF Governing Board and Ohio Department of Youth Services.
b. Development and approval of the facility pet program to include program rules, animal training plan, emergency plan, and the screening and selection process of resident dog handlers.
c. Screening and Selection of resident dog handlers
d. Removal or suspension of resident dog handlers for disciplinary reasons or inadequacy
e. Handler responsibilities and behavioral specific commands for obedience and socialization.
f. Locations in the building accessible/inaccessible for the facility pet.
g. Specific instructions for facility lockdown periods and emergency procedures.

6.0 Procedures

6.1 The facility pet program will teach residents how to interact with a dog that shall remain at the facility acting as a therapeutic dog.

6.2 Employees and resident handlers shall know and demonstrate support of Facility Pet Program Rules and Animal Training Plan by following the rules and using the basic commands.

6.3 Program Rules are identified as follows:

- Volunteers and community partnerships shall be developed and implemented by the Director or with the Director's approval.
- The dog shall be leashed at all times when outside the enclosed facility.
- The Primary Resident Handler shall act as the dog's caretaker.
- The Secondary Resident Handler may be the backup caretaker and may replace the primary handler if removed or released from the program. The secondary handler must be prepared to step in at any time to care for the dog.
- The dog must be accompanied by her handler when located outside her assigned unit/areas. Staff may be incorporated into the obedience training and introduced as handlers.
- All staff may enter the dog's assigned unit to interact with her at times when she is left by her primary and/or secondary handler.
- Residents shall not interact with dog without the presence of the Primary and/or Secondary Handler.
- Staff shall supervise residents with the dog, document and report any incidents of animal cruelty or neglect and other violations that would threaten the health and safety of staff, youth, visitors and/or the dog.
- The Primary Handler shall secure the dog in his room for the night and will train the dog to stay off his bed.
- The Primary Handler shall be responsible for hygiene and grooming of the dog.
- The dog shall not be permitted to sit or lay on facility furniture except as permitted
- The dog shall not be permitted in the dining area, kitchen, any facility bathrooms, Unit C or any resident room except for the Primary Resident Handler's room and the Secondary Handler during a transition period.
- During lockdown situations, the dog shall promptly be removed by the Primary Handler to his room.
- During any drills or emergency situations such as fires or storms, the Primary Resident Handler may accompany the dog to the appropriate area.
- Disciplinary action resulting in removal or suspicion of the Primary Resident Handler participating in the trial pet program shall occur by order of the Director or under emergency circumstances only.

6.4 The Animal Training Plan shall be implemented by the Primary Resident Handler and will consist of the following:

- The dog shall be groomed and exercised daily.
- A morning walk should occur in the outside recreation area prior to regular scheduled resident wake up or as needed and should be followed by the giving of food and water.

- All dog excrement shall be scooped and bagged daily. The container shall need emptied every three days into an approved area in the woods behind the facility.
- The dog shall be fed daily in the amount as appropriate. Water will be available at all times.
- Commands shall be taught through positive reinforcement: there shall be no striking, kicking, or any abusive action.
- Basic commands shall include come, sit, hold (remain in position), rest (dog laying down), and rest in hold position.
- The dog shall be trained to walk properly on a leash.
- When the dog does an action that is not permitted such as jumping on someone, biting, attempting to climb on furniture, or getting into the trash then she is to be told "no" in a firm voice.
- The water bowl shall be washed daily and the food bowl shall be washed a minimum of once per week.
- The animal living space shall be cleaned daily.

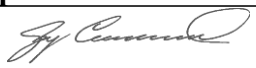
6.5 The Emergency Plan shall consist of the following:

- Masterson's Vet Clinic shall be contacted at (740) 743-1426 and will provide veterinarian care and emergency animal care at 300 North Drive, Somerset, Ohio.

6.6 Residents and Staff with allergies shall be housed and staffed in areas away from the dog. Unit C shall be utilized as a pet free zone.

6.7 Liability insurance shall be provided through the County Risk Sharing Agency (CORSA).

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: B	**Fiscal Management**
Subject: 1.0	**Fiscal Policies and Procedures, Control, Commissary & Juvenile Funds**
Related Standards:	
O.A.C.	**5139-36-05 (A)(C)(E)(F)**
A.C.A.	**3-JCRF-1B-01 1B-02 1B-08 1B-15 1B-18 1B-19**
P.R.E.A.	**None**

1.0 Purpose

To establish the facility's fiscal planning, budgeting, and accounting procedures and provide a system of regular review.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility Director shall manage and control fiscal planning, budgeting, and accountability procedures for the following:

a. Internal Controls
b. Petty Cash
c. Bonding
d. Signature Control on Checks
e. Resident Funds
f. Employee Expense Reimbursement
g. Emergency financial assistance.

The Director may delegate management of specific fiscal operations to a designated staff person. All monies collected at the facility are placed daily in an officially designated and secure location.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Managing and controlling all fiscal planning, budgeting, and accountability procedures.
b. Delegating management of specific fiscal operations to a designated staff person.

5.2 The Director or designee is responsible for the following:

a. Receiving and depositing checks or money orders collected at the facility in accordance with procedures.
b. Employee expense reimbursement

5.3 All Employees are responsible for the following:

a. Obtaining pre-approval from the director for expenditures.
b. Providing written receipts for checks or money orders for the facility as needed.

c. Submitting requests for reimbursement on the designated form while providing documentation that the expense was a legitimate expenditure incurred in the course of assigned duties including original receipts, certificates of attendance and any other requirement determined to be necessary.
d. Maintaining the original, itemized receipt of items purchased for the resident and submitting the reimbursement request in a timely manner.

6.0 Procedures

Internal Controls/Signature Control on Checks

6.1 PMCJF will operate on a "cash free" income system. All monies received into the facility shall be through check or money order.

6.2 Director or other designee shall immediately provide a written receipt to the party submitting the monies.

6.3 Money orders and checks greater than three hundred dollars collected at the facility shall be deposited within twenty-four (24) hours or the next business day to the appropriate banking institution or Auditor's office depending on the type of income. Money orders and checks for less than three hundred dollars may be held for up to seventy-two (72) hours prior to depositing. A staff member who is not responsible for the written receipt will transport and deposit funds into the appropriate accounts.

6.4 PMCJF disks are available for purchase by staff. The disks may be exchanged for facility meals.

6.5 All monies collected at the facility are placed daily in an officially designated and secure location. Until deposited, money orders and checks will be kept in the desk drawer of a locked office.

6.6 All facility payroll and account checks shall be printed and signed by the Perry County Auditor.

Petty Cash

6.7 PMCJF will not operate a petty cash fund.

Bonding

6.8 PMCJF is enrolled in the Perry County Liability Insurance Plan which provides comprehensive property and liability insurance and risk management services. The county plan is bonded under County Risk Sharing Administration (CORSA). CORSA contracts with Alternative Services Concepts (ASC), a third-party claims administrator located in Dublin, Ohio. The bond has been approved by the Perry County Prosecuting Attorney, Perry County Commissioners and the Perry County Auditor.

6.9 PMCJF shall not enter into any bond agreement without the written consent of the Ohio Department of Youth Services, Perry County Prosecuting Attorney, Perry County Commissioners, Perry County Auditor and PMCJF Governing Board.

Resident Funds

6.10 PMCJF will not accept resident funds or maintain individual resident accounts. Residents that may earn money in the facility are assisted in obtaining their own banking accounts.

Resident Financial Assistance

6.11 The facility will meet all basic needs of the residents in the event that families are unable to provide financial assistance. These needs include basic hygiene, clothing, communication, and shelter. The resident may put in a written request for indigent assistance.

6.12 Information for obtaining assistance shall be provided upon written request when emergency financial assistance is needed by the family. Referrals may be given to other county agencies or organizations.

Employee Expense Reimbursement

6.13 All expenses must be approved by the Director or designee. The employee must submit the request for reimbursement on the facility Reimbursement Request Form. The employee must provide documentation that the expense was a legitimate expenditure incurred in the course of assigned duties. This will include original receipts, certificates of attendance and any other requirement determined to be necessary by the Director.

6.14 Employees making expenditures on behalf of a resident shall maintain the original, itemized receipt of items purchased for the resident. Unavoidable expenses directly related to the outing such as movie tickets shall be reimbursed with proof of expenditure. Reimbursement forms shall be completed and submitted to the Director in a timely manner. Staff accompanying residents on reward outings will not be reimbursed for personal food expenses.

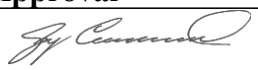
Director Responsibility

6.15 The Director is responsible for all fiscal policy, management and control. The Director may assign fiscal duties to qualified staff in order to maintain maximum efficiency and implement an internal system of checks and balances. Such duties will be outlined in staff job descriptions and written documentation will be maintained on file in accordance with applicable Federal, State or Local policy and procedure.

6.16 The Director will review all fiscal policies and procedures when necessary to ensure that all are consistent with applicable Ohio Administrative Code rules, ODYS rules and all procedures set forth by the Perry County Auditor. Any necessary amendments will be submitted to the PMCJF governing board for approval at the next meeting. Upon approval, the amendments will be forwarded to the ODYS.

6.17 The Director will develop a fiscal system that accounts for all income and expenditures. This system shall be updated on a monthly basis and quarterly reports shall be generated and disbursed to the Governing Board and the Department of Youth Services. The Director participates in all budget reviews conducted by the governing board or ODYS.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: B	**Fiscal Management**
Subject: 1.1	**Annual Budget, Review, Procedures, Monitoring, Community Services & Position Control**
Related Standards:	
O.A.C.	**5139-36-03 (B)**
A.C.A.	**3-JCRF-1B-03 1B-04 1B-05 1B-06 1B-09 1B-10 (Rev. 2001) 1B-13 1B-14**
P.R.E.A.	**28 CFR §115.318 (a) (b)**

1.0 Purpose

To establish a process for the fiscal budget.

2.0 Persons Affected

Director and Governing Board Budget Review Committee

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to anticipating revenues and expenditures by preparing an annual budget approved by the Ohio Department of Youth Services. Budget revisions and reviews shall be presented by the director to the governing board and shall include income and expenditure statements, funding source financial reports and independent audit reports. To ensure fiscal responsibility, an internal audit will be performed a minimum of once every three years.

The facility shall regulate position control regarding position allocation, budget authorization, personnel records and payroll.

4.0 Definitions/Documents

4.1 Budget committee includes the director and selected members of the facility governing board.

4.2 Fiscal Year is from July 1st through June 30th.

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Drafting and preparing quarterly budget reports and the annual operating budget.
b. Reviewing the annual operating budget with the governing board budget committee.
c. Presenting the annual operating budget to ODYS by the end of the third quarter.
d. Preparing closing income and expenditure reports at the end of each fiscal year.
e. Preparing and coordinating records for the internal fiscal audit.
f. Meeting as needed with the Clinical Coordinator to review and discuss programing requirements.
g. Planning for Capital Improvement Projects including justifying the expenditures, prioritizing the projects, and providing a timeline for completion.
h. Considering the effect of the design, acquisition, expansion, or modification upon the facility's ability to protect residents from sexual abuse when proposing designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities.

5.2 The governing board budget committee is responsible for the following:
   a. Reviewing the operating budget prior to the fourth quarter.
   b. Approving and forwarding the budget to ODYS, the Perry County Budget Commission, and Perry County Auditor.
   c. Meeting as required to review and approve the fiscal budget.

6.0 Procedures

6.1 Prior to the end of the third quarter, the Director will draft an annual operating budget including anticipated expenditures. The PMCJF Governing Board Budget Committee shall review and approve the operating budget which will include any changes deemed necessary. Copies of the operating budget shall then be presented to the ODYS to assist the department in determining overall ODYS budget requirements.

6.2 Upon approval by the ODYS, the budget shall be the operating budget for the facility. A copy of the budget and the estimates for the next fiscal year shall be presented to the Perry County Budget Commission or designated agency for approval.

6.3 Upon approval by the Perry County Budget Committee, the budget shall be presented to the Perry County Auditor to be utilized as the facility's local operating budget.

6.4 The copies shall be submitted in accordance with the deadlines given by both the ODYS and the Perry County Budget Commission.

6.5 The Director will work with designated staff on all quarterly reports and annual reviews.

6.6 If a budget revision is needed, it will be prepared according to ODYS and/or county requirements and submitted to the appropriate agency.

6.7 Upon approval, copies will be submitted to the Auditor's Office for their implementation.

6.8 The Director or designee will prepare closing income and expenditure reports at the end of each fiscal year for the Governing Board and the ODYS within the specified time requested by each entity.

6.9 Independent Audit Reports are prepared by the ODYS. These reports will be given to any agency or individual upon written request to the Director. A nominal fee may be charged for such service. The financial audit of the facility follows ODYS timeline for completion but occurs at least every three years.

6.10 The Director shall meet with the Clinical Coordinator as needed to review and discuss programming needs. The cost of any specific materials or training requirements for group leaders will be implemented into the budget and presented to the Governing Board for approval.

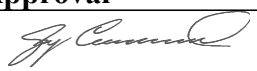
6.11 When community services are needed to supplement existing programs and services, funds are available to purchase those services.

6.12 The fiscal office shall have information on the number and types of positions filled and vacant available upon request. The fiscal office shall verify all payroll positions shall be authorized in the budget, all persons on the payroll are legally employed, attendance records support the payroll, and needed funds are available. The payroll shall be based on timekeeping records.

Capital Improvement Plan

6.13 Capital projects shall be ranked in order of preference. Justification for the projects, a plan for financing the projects, and a timeline of completion of the projects should be documented. The facility shall consider the effect of the design, acquisition, expansion, or modification upon the facility's ability to protect residents from sexual abuse when proposing designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities. When installing or updating a video monitoring system, or other monitoring technology, consideration should be given to how technology may enhance the facility's ability to protect residents from sexual abuse.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: B	**Fiscal Management**
Subject: 1.2	**Inventory and Purchasing**
Related Standards:	
O.A.C.	**5139-36-03 (D)(L)(1)**
A.C.A.	**3-JCRF-1B-11 1B-12** (Deleted 2005)
P.R.E.A.	**None**

1.0 Purpose

To establish a method for property inventory and control.

2.0 Persons Affected

Director and All Staff

3.0 Policy

The Perry Multi-County Juvenile Facility shall provide for property inventory and control and for purchasing and requisitioning supplies and equipment.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Director is responsible for the following:

a. Maintaining copies of inventory on file and forwarding to the Perry County Auditor's Office and/or the Perry County Auditor as applicable.
b. Receiving and approving purchase requests.

5.2 Director or designee is responsible for the following:

a. Completing an annual inventory of facility structure and grounds which includes any item exceeding five hundred ($500) dollars or is determined to be mission critical by the director.
b. Reviewing and revising the inventory including details on documentation of date of purchase and cost; source of funds; current value if applicable; unit and locations to which assigned and the current condition of the item.

5.3 All staff are responsible for completing purchase requests as needed and submitting to the Director.

6.0 Procedures

Inventory

6.1 PMCJF shall conduct an annual inventory of the facility structure and grounds. Any item with a total value exceeding five hundred dollars ($500.00) shall be included in the facility inventory lists. Any item valued less than $500.00 that is determined to be mission critical by the Director shall be included in the inventory.

6.2 The inventory shall be reviewed and revised annually. The inventory shall be conducted by the Directory or designee with the participation of all available staff. Copies of the inventory shall be maintained on file and copies shall be forwarded to the ODYS and/or Perry County Auditor's Office as applicable.

6.3 The inventory process shall include: documentation of date of purchase and cost; source of funds; current value if applicable; unit and locations to which assigned and the current condition of the item.

Requisitioning and Purchasing for Basic Operations Purchases Under $250

6.4 All basic operations purchases will be conducted through a purchase request system documented upon the purchase request form and presented to the Director for review. The Director will determine if the purchase is necessary and if sufficient funds area available. The Director or designee shall then make the purchase as necessary and ensure all expenditures are processed for payment and budget reconciliation.

The Facility Maintenance Supervisor and Food Service Manager have authorization to make basic operations purchases under two hundred fifty dollars ($250). Receipts for all purchases shall be maintained and presented to the Director within 30 days.

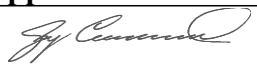
Requisitioning and Purchasing for Basic Operations Purchases Over $250

6.5 Any purchase request exceeding two hundred and fifty dollars or which is not for basic operations shall be reviewed by the Director for approval. If approved, the Director or designee will make the purchase and ensure all expenditures are processed for payment and budget reconciliation.

6.6 Any purchase over $5,000 must have approval of the governing board.

6.7 In accordance with Perry County Standards of Competitive Bidding, any purchase over twenty-five thousand dollars ($25,000.00) will be opened for competitive bidding or state purchasing can be utilized.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-10-14 Prior Effective Date: 07-01-15; 07-21-20 Date Revised: 10-20-20	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: C	**Personnel**
Subject: 1.0	**Personnel Manual, Contents of Manual & Equal Employment Opportunities**
Related Standards:	
O.A.C.	**5139-36-09 (A)(D)(1)(2)(3)(4)(5)(6)(7)(8)(9)(12)(13)(14)(15)(16)(17)(18)(19)(20)(21)(22)(23)**
A.C.A.	**3-JCRF-1C-01 1C-02 1C-03 (Rev. 1995)**
P.R.E.A.	**None**

1.0 Purpose

To establish the facility's commitment to fair and just personnel practices.

2.0 Persons Affected

All Staff

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to ensuring fair and just personnel practices that provide equal employment opportunities for all positions. The personnel practices shall be openly published in an employee manual available to the general public. The employee manual shall be comprehensive in design and will cover all the following topics:

a. Organizational Chart
b. Staff development
c. Recruitment and selection
d. Promotion
e. Job Qualifications and Job Descriptions
f. Affirmative Action
g. Sexual Harassment
h. Grievance and Appeal Procedures
i. Orientation
j. Employee Evaluation
k. Personnel Records
l. Employee Benefits
m. Holidays
n. Employee Leave
o. Hours of Work
p. Compensation
q. Travel
r. Disciplinary Procedures
s. Termination and Resignation

When deficiencies exist regarding the employment of minority groups and women, the facility shall implement an affirmative action program that is approved by the governing board. The Director shall review the internal personnel policies and the affirmative action plan annually and submit relevant recommended changes to the Governing Board.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for conducting an annual review of internal personnel policies and the affirmative action plan and submitting relevant recommended changes to the governing board for approval.

5.2 The Compliance Coordinator will review the Perry County Personnel Handbook annually and make recommendations for revisions to the Director.

5.3 All staff is responsible for the following:

a. Receiving and signing an employee handbook receipt during orientation.
b. Reporting criminal charges, criminal convictions, and moving traffic violations.
c. Participating in shift information reviews and reading emails to ensure awareness of any relevant changes.
d. Completing an annual review of all policies and procedures.

6.0 Procedures

6.1 PMCJF will have an employee handbook reflecting its management philosophy and addressing all areas relevant to the welfare of personnel and the facility. In addition to the above areas, the handbook will contain information on the probationary period of employment, the employee code of ethics, mission statement, and details concerning conflicts of interest.

6.2 The handbook shall require employees to report criminal charges, criminal convictions, and moving traffic violations. Failure to report shall be considered cause for progressive discipline including separation from employment.

6.3 Each employee will be given a copy of the handbook during their orientation period and shall be required to sign a receipt for the handbook.

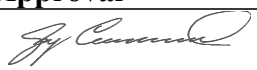
6.4 A copy of the employee handbook shall be maintained on the network drive and in the administrative offices and will be accessible to all staff, visitors and the general public.

6.5 The handbook shall be reviewed annually by the facility administrator, or as needed, and revisions shall be made as deemed necessary. Relevant revisions shall be presented to the PMCJF Governing Board for approval. New or revised policies and procedures shall be communicated to all staff through email at Central Control and via the shift information review sheet. Recommended changes relevant to the Ohio Department of Youth Services shall be communicated through the Director as needed.

6.6 PMCJF is an equal opportunity employer. All qualified persons are able to compete equally for entry into and promotion from within the facility. Reprimands, demotions, terminations, transfers and layoffs will be decided by the Director based upon job requirements and employee performance.

6.7 All federal guidelines concerning employee rights are posted in the staff lounge as well as contact information. Information is also available in the employee handbook. Complaints may be filed internally or externally.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-10-14	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 07-07-15; 07-18-17	
Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: C	**Personnel**
Subject: 1.1	**New Employee Screening, Qualifications, Certifications, Probationary Term, Confidentiality, Conduct, Sexual Harassment, Drug-Free Workplace, and Termination**
Related Standards:	
O.A.C.	**5139-36-09 (A)(10)(11) (B) (D)(2) (E) (K) (N)(1)(2)(3)(4)(5)**
A.C.A.	**3-JCRF-1C-04 1C-05 1C-10 (Rev. 2007) 1C-11 1C-12 1C-13 1C-17**
P.R.E.A.	**28 CFR §115.317 (a)(1)(2)(3) (b) (c)(1)(2)(3) (d) (e) (f) (g) (h)**

1.0 Purpose

To establish a systematic review of qualifications for employment including standards prohibiting sexual harassment and promoting a drug-free workplace.

2.0 Persons Affected

All Employees, Consultants, and Contract Personnel

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to hiring and maintaining a qualified workforce, prohibiting sexual harassment and supporting a drug-free workplace. This shall be accomplished by the following as established in procedures:

a. Ensuring the passing of a criminal background check.
b. Conducting a urine screen.
c. Administering the Diana Screen.
d. Consulting the child abuse registry.
e. Investigating into former employers, schools, references, and others prior to hiring.
f. Asking all applicants and employees who may have contact with residents directly about previous sexual misconduct in written applications or interviews.
g. Requiring appropriate physician examination statements.
h. Obtaining written commitments to abide by confidentiality requirements.
i. Completing a probationary period of 6 months to one year after which involuntary termination or demotion shall be permitted only for a good cause and subsequent to a formal hearing, if requested, on specific charges.
j. Requiring annual criminal records testing for at least ten percent of all employees and contract workers at a minimum of once every five years.
k. Maintaining an affirmative duty for employees to report current or prior sexual misconduct on written self-evaluations and during promotion opportunities.
l. Annually reviewing drug-free workplace policy which includes prohibition of the use of illegal drugs, prohibition of possession of any illegal drug except in the performance of official duties, procedures to be used to ensure compliance, opportunities available for treatment and/or counseling for drug abuse, and penalties for violation of policy.
m. Randomly conducting annual drug testing of a minimum of five percent of the facility workforce.
n. Ensuring that all employees or contract personnel required by law to possess professional licensure or certification are so licensed or certified.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director shall be responsible for the following:

a. Ensuring all new employees, contract personnel, consultants, permanent volunteers, intermittent volunteers, practicum students, and interns who work with residents read, review, agree to abide by and sign a confidentiality statement which will be kept in the appropriate personnel file.

b. Administering the Diana Screen to all new employees, consultants, permanent volunteers, practicum students, interns and/or contract personnel who work with residents shall be given the Diana Screen prior to employment.

c. Ensuring criminal background checks are conducted, passed and filed for each prospective employee, permanent volunteer, practicum student, intern, and contractor who may have contact with residents on a minimally supervised basis prior to enlisting services.

d. Submitting all persons subject to hiring to pre-employment drug screens.

e. Using reasonable efforts to prevent perspective new employees or contractors with a history of sexual misconduct from being hired at the facility including the following:

1. Obtaining a liability waiver and investigating into former employers, schools, references, and others.
2. Consulting any child abuse registry maintained by the state or in the locality on which the employee would work
3. Making best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of allegation of sexual abuse.
4. Directly asking about previous sexual misconduct during interviews or on applications.

f. Forwarding suspect information on matters with potential terrorism connections on a desirable applicant to the local Joint Terrorism Task Force (JTTF) or another similar agency.

g. Including an obligation to adopt and comply with PREA standards on any new contracts and contract renewals.

h. Asking about previous or current sexual misconduct including sexual harassment during interviews and written evaluations for all applicants for promotion and taking such incidents into consideration when making hiring and promotion determinations.

i. Ensuring written job applications directly ask about previous sexual misconduct.

j. Ensuring subsequent annual record checks for at least ten percent of all employees and contract workers at a minimum of once every five years.

k. Randomly conducting annual drug testing of a minimum of five percent of the facility workforce.

l. Maintaining current licensure and/or professional certification in personnel files.

5.2 Training Coordinator is responsible for maintaining an orientation manual that includes a section on sexual harassment and drug-free workplace policies and procedures.

5.3 All Employees are required to do the following:

a. Attend the Perry County Annual Safety Day Training which includes information on sexual harassment and drug-free workplace.
b. Read the orientation manual and sign an acknowledgment that they read the manual.
c. Provide written notification to the director of any on-going prescription medication taken into the facility.
d. Report to work fit for duty.
e. Accurately complete all medication sign-out procedures.
f. Maintain an affirmative duty to report current or prior sexual misconduct.

5.4 Supervisors are responsible for the following:

a. Conducting written evaluations of new resident care workers at 30 days, 90 days, and 180 days.
b. Making written recommendations at the end of the six months probationary period to terminate the employee, continue the probationary period for six additional months, or grant the employee a satisfactory rating.

5.5 All contractors have a continuing affirmative duty to disclose prior or current sexual abuse or sexual misconduct and to adopt and comply with PREA standards on any new contracts and contract renewals.

6.0 Procedures

Confidentiality Statement

6.1 All new employees, consultants, permanent volunteers, intermittent volunteers, practicum students, interns and/or contract personnel who work with residents are required to sign a confidentiality statement which will be kept in the appropriate employee personnel file.

Diana Screen

6.2 All new employees, consultants, permanent volunteers, practicum students, interns and/or contract personnel who work with residents shall be given the Diana Screen prior to employment. The Diana Screen is a sexual risk screening test designed to help screen candidates for positions with youth and within the facility. Failure to complete the Diana Screen or notice of fail status will result in denial of employment and/or involvement in the facility.

Criminal Record Check

6.3 Criminal background checks shall be conducted and filed for each prospective employee, permanent volunteer, practicum student, intern, and contractor who may have contact with residents on a minimally supervised basis.

6.4 Prospective employees shall be informed on the job application that as a precondition to employment, he/she must have a BCII criminal record check that includes fingerprints. This record will include comprehensive identifier information to be collected and run against law enforcement indices. If suspect information on matters with potential terrorism connections is returned on a desirable applicant, it is forwarded to the local Joint Terrorism Task Force (JTTF) or another similar agency.

6.5 Prior to employment, perspective employees and contractors who might have contact with residents, will be required to submit information and fingerprints for a criminal background check. An FBI background check shall be required if the prospective employee does not present proof of residency in Ohio for the five-year period immediately prior to the date upon which the criminal records check is requested or does not provide evidence that within that five-year period, BCII has requested information about the person from the FBI in a criminal records check. The facility may request a BCII or FBI background check on any prospective employee.

6.6 PMCJF shall require subsequent annual record checks for at least ten percent of all employees. Employees will be selected at random taking into consideration the amount of time since their last record check with all employees and contract workers with contact with residents being tested a minimum of once every 5 years.

6.7 Citizens intermittently involved with the facility having minimal and/or supervised contact with residents shall not be required to submit to a criminal record check.

Background Investigations and Institutional Duty to Inform

6.8 The facility shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who has engaged in sexual abuse in a prison jail, lockup, community confinement facility, juvenile facility or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described above.

6.9 In investigating backgrounds, the facility shall use reasonable efforts to prevent perspective new employees or contractors with a history of sexual misconduct from being hired at the facility. The facility employment application authorizes investigation and includes a liability waiver for former employers, schools, references, and others. The facility shall consult any child abuse registry maintained by the state or in the locality on which the employee would work, make best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse, and perform criminal background checks prior to enlisting services.

6.10 The facility shall ask all applicants and employees who may have contact with residents directly about previous sexual misconduct in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations as conducted as part of reviews of current employees.

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

Physical Examination

6.12 Prospective employees whose responsibilities include supervision or direct contact with residents will have a physical examination to ensure that they can carry out their assignments effectively. The basic health status of all employees shall be evaluated against the specific requirements of their assignments. The new employee will be required to obtain a physical examination at their expense from a doctor certifying their ability to perform the functions of the job as documented on their job description. Failure to provide the necessary certification will result in the prospective employee not being employed by the agency.

Probationary Term

6.13 The facility will evaluate a new employee after their first thirty days, again after ninety days and after six months of employment. Employees will be given sufficient opportunity to discuss their evaluations.

6.14 PMCJF may terminate the new employee for any reason during the probationary period including but not limited to personality conflicts, failure to use reasonable caution in safety and security procedures, inability to exercise control over residents, lack of initiative in learning more about the program, poor attendance record, repeatedly making the same errors in procedures, lack of anger management skills, poor attitude toward residents, and inability to communicate.

6.15 At the end of the six months probationary period, PMCJF has the right to terminate the employee, continue the probationary period for six additional months, or grant the employee a satisfactory rating. If an employee is given a satisfactory rating, their probationary period will end and the employee will be treated as any employee operating under the facility policies and procedures and the rights under the employee handbook.

Termination or Demotion

6.16 After the probationary period, involuntary termination or demotion will be permitted for cause in accordance with the disciplinary guidelines listed in the employee handbook.

6.17 Each employee and contractor has a continuing affirmative duty to disclose prior or current misconduct of sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution, convictions of engaging or attempting to engage in sexual activity in the community by force, overt or implied, or coercion, or if the victim did not consent or was unable to consent or refuse, and civil or administrative adjudications to have engaged in any of the above listed activities. Material omission regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Contractors and Contract Renewals

6.18 Any new contracts and contract renewals shall include the contracting entity's obligation to adopt and comply with the PREA standards.

Sexual Harassment

6.19 Perry County provides annual training on sexual harassment. All employees at the facility are required to attend the training.

6.20 The employee orientation manual includes a section on sexual harassment. All new employees will sign an acknowledgement that they read the manual. This will be kept in the employee training files.

6.21 It is against facility policy for any employee to sexually harass another employee by making unwelcome sexual flirtations, advances, requests or propositions or by creating an intimidating, hostile or offensive work environment through verbal abuse or physical conduct of a sexual nature. If at any time an employee feels uncomfortable with another employee and indicates that their behavior, verbiage or written material is offensive and/or unwelcome, the continuation of such activities constitutes sexual harassment. All such behavior should be reported to a supervisor or the Director.

6.22 The facility shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with residents.

Drug-Free Workplace

6.23 PMCJF prohibits the use and/or possession of any illegal drug except in the performance of official duties. Any medication or drug possessed by an employee on facility grounds is prohibited without an authentic prescription. Employees are required to provide written notification to the Director of any on-going prescription medication taken into the facility. Perry County provides annual training on drug-free workplace policy. All employees at the facility are required to attend the training.

6.24 The employee orientation manual includes a section on drug-free workplace policy. All new employees will sign an acknowledgement that they read the manual. This will be kept in the employee training files.

Ensuring Compliance

6.25 All prospective employees shall submit to a pre-employment drug test.

6.26 All PMCJF employees are subject to random drug testing. A minimum of five percent of the facility workforce shall be tested annually. Employees will be required to submit to drug testing in response to any allegations of substance abuse.

6.27 Staff is prohibited from using alcohol while reporting for duty, on duty or on facility grounds. If a staff member reports for duty smelling of alcohol or displaying signs of intoxication, the shift supervisor and the Director should be immediately notified. If the supervisor or Director has a reasonable belief that the employee is impaired, they shall request that the employee complete a drug screening/breathalyzer. If the employee refuses or tests positive, the employee will be sent home and disciplinary proceedings will resume the next working day. If the employee drove to work, the employee will be asked to make alternative arrangements to go home. If a ride is unavailable, the supervisor may make arrangements for the employee to be transported home. If the ride is refused, the Perry County Sheriff's Department will be called and told that an employee just left the facility smelling of alcohol and/or displaying the signs of intoxication. A description of the vehicle will be given.

6.28 Any employee who is in possession of medication that is to be dispensed to a juvenile shall be required to complete all medication sign out procedures accurately. Periodic prescription medication inventories will be taken by the nurse, supervisors or staff and documented in the prescription medication log.

Treatment and Counseling

6.29 Voluntarily disclosure is interpreted as admitting to a substance abuse problem prior to any violations.

6.30 Any employee who voluntarily discloses substance abuse problems shall be given one opportunity to enter into a substance abuse treatment and prevention program. The cost of this program shall be the responsibility of the employee. If the treatment program requires in-patient treatment, the employee will be given the opportunity to return to work after the successful completion of the program. If the employee's treatment plan requires outpatient treatment, the employee shall be required to provide PMCJF a copy of the treatment plan.

6.31 Failure to successfully complete the in-patient and/or outpatient program will result in termination.

6.32 All employees who are required to complete a substance abuse program shall be required to submit to monthly drug tests for a period of one year after the successful completion of a substance abuse program.

Disciplinary Action

6.33 Any employee who voluntarily discloses a substance abuse problem shall have the information documented in the employee's personnel record and shall be required to provide written documentation of the successful completion of a substance abuse treatment program. This documentation shall be placed in the employee's file as well.

6.34 Any employee who violated the PMCJF drug-free workplace policy, and has been determined to be in violation through any method other than self-disclosure, may be terminated. Any violation that constitutes a criminal action shall be referred to law enforcement for investigation.

6.35 Any employee terminated from employment will be forever barred from future employment with the facility.

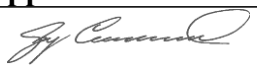
6.36 The offending employee will be held civilly liable for any lost funds resulting from any failure to report any drug-related conviction.

License and Certification

6.37 The Perry Multi-County Juvenile Facility shall ensure that all employees or contract personnel who are required by law to possess professional licensure or certification are so licensed or certified.

6.38 Copies of current licensure shall be kept on file.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 07-09-15; 07-21-20	
Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: C	**Personnel**
Subject: 1.2	**Reasonable Accommodation for Disability**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-1C-03-1** (Added Aug. 1995)
P.R.E.A.	**None**

1.0 Purpose

To establish guidelines for compliance with the American Disabilities Act.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to ensuring a mechanism to process requests for reasonable accommodation to the known physical and/or mental impairments of a qualified individual with a disability, either an applicant or an employee. The accommodation need not be granted if it would impose an undue hardship or direct threat.

4.0 Definitions/Documents

4.1 Undue hardship is based under current considerations of the nature and cost of the accommodation needed, the overall financial resources of the facility making the reasonable accommodation, the number of persons employed at the facility, the effect on the expenses and resources of the facility, the overall financial resources, size number of employees and type and location of facilities of the employer, the type of operation of the employer including the structure and functions of the workforce, the geographic separateness, and the administrative or fiscal relationship of the facility involved in making the accommodation to the employer

5.0 Responsibility

5.1 The Director is responsible for ensuring all hiring and employment decisions are made in accordance with the American Disabilities Act including making reasonable accommodations to known physical and/or mental impairments as long as accommodations do not present an undue hardship or direct threat.

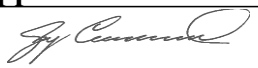
6.0 Procedures

6.1 Reasonable modifications or adjustments will be made to enable qualified applicants with disabilities entry into employment or which enable qualified employees with disabilities to perform the essential functions of the job and enjoy the same terms, conditions, and privileges of employment that are available to persons without disabilities. Terms, conditions, and privileges of employment include the following: recruitment, selection, and hiring; salary and compensation; benefits, holidays, leave, and work hours; promotion and advancement; staff development, including in-service training; retirement, resignation, and termination.

6.2 No accommodation can be made if the accommodation will present an undue hardship on the facility through difficulty or expense.

6.3 No accommodation can be made if there is a direct threat of significant risk of substantial harm to the health and safety of any person, including the applicant.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 07-19-11 Date Revised: 07-07-15	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: C	**Personnel**
Subject: 1.3	**Job Descriptions, Compensation, Merit & Qualification, & Promotions & Performance Reviews**
Related Standards:	
O.A.C.	**5139-36-09 (C)**
A.C.A.	**3-JCRF-1C-06 1C-07 1C-08 1C-09 1C-16**
P.R.E.A.	**28 CFR §115.317 (b)**

1.0 Purpose

To ensure that each facility employee has a job description that includes information necessary to perform the essential duties and responsibilities of their position.

2.0 Persons Affected

All employees

3.0 Policy

There are written job descriptions and job qualifications for all positions in the facility. Each job description includes the job title, responsibilities of the position, required minimum experiences, and education. Compensation and benefit levels for all personnel are comparable to similar occupational groups in the community. All personnel at the facility is selected, retained, and promoted on the basis of merit and specified qualifications. New employees receive credit for their prior training. Promotional opportunities may be provided within the program at the facility and from other sources. Each employee shall have an annual written performance review based on defined criteria with results discussed with the employee.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director shall be responsible for the following:

a. Review job descriptions as needed to ensure that a written job description exists for each position in the facility and includes a job title, responsibilities of the position, required minimum experience, and education.
b. Hiring, retaining, and promoting employees based upon merit, specific qualifications, and employment interests taking into consideration performance reviews and incidents of sexual harassment.
c. Periodically reviewing the Perry County Employee Handbook in order to offer similar benefits and compare compensation levels with similar occupations.

5.2 Shift Supervisors shall be responsible for the following:

a. Providing verbal and written feedback to new employees after 30 days, 90 days and 180 days of employment.
b. Ensuring employees at 180 days have requirements completed and are removed from probation or that the probationary period is extended for specific reasons.
c. Completing and reviewing annual employee evaluations with assigned staff ensuring each staff is asked directly about any sexual misconduct.

6.0 Procedures

6.1 A written job description exists for each position in the facility. Each description includes the job title, responsibilities of the position, required minimum experience, and education. All job descriptions will be available upon request.

6.2 The Director or designee will periodically review the Perry County Employee Handbook in order to offer similar benefits if it is within the budget. Phone calls may be made to compare compensation levels with similar occupational groups.

6.3 PMCJF is an equal opportunity employer. All new employees will be hired based on merit and qualifications. New employees with prior training and experience will receive a higher starting pay than those without prior training and experience.

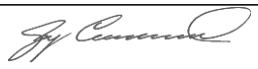
6.4 All employees will be retained and promoted on the basis of merit, specified qualifications, and interest in obtaining a promotion. Annual performance reviews will be one factor used in determining merit.

6.5 Anyone with required education, experience, and background will be eligible for consideration for a position at the level for which he/she is qualified. This includes provisions for lateral entry into the facility to enable the program to obtain the best qualified persons for positions even though the program's personnel policies may emphasize promotion from within.

6.6 The facility shall consider incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor who may have contact with residents.

6.7 Performance reviews are on-going. All employees who may have contact with residents shall be asked directly about sexual misconduct in written applications, interviews for hiring or promotions, and in any interviews or written self-evaluations as conducted as part of reviews. Written evaluations based upon criteria contained within the employee job duties will be completed at least annually.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 07-01-15; 07-18-17; 07-17-18
Date Revised: 07-21-20

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: C	**Personnel**
Subject: 1.4	**Personnel Records and Challenging Personnel Information**
Related Standards:	
O.A.C.	**5139-36-09 (F)(G)**
A.C.A.	**3-JCRF-1C-14** (Rev.1995 & 2010) **1C-15**
P.R.E.A.	**None**

1.0 Purpose

To establish a system for the creation and maintenance of personnel records.

2.0 Persons Affected

All employees

3.0 Policy

The facility maintains a current, accurate, confidential personnel record on each employee except where state statutes require open public records and the personnel record cannot be maintained confidentially. Information obtained as part of a required medical examination or inquiry regarding the medical condition or history of applicants and employees are collected and maintained on separate forms and in separate medical files and treated as confidential medical records. Employees may challenge any information in their personnel file. The information is corrected or removed, if proved inaccurate.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Director is responsible for maintaining a system for the current, accurate, confidential personnel record on each employee.

6.0 Procedures

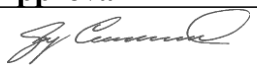
6.1 The personnel records for each employee shall contain a minimum of the following: initial application and/or resume, reference letters, results of employment investigations, verification of training and experience, wage and salary information, job performance evaluations, incident reports, if any, and commendations and disciplinary actions, if any.

6.2 Personnel files are considered public records and must be made available for inspection upon request. Employee medical records will be kept separate from their personnel files.

6.3 Current law requires that every public office that receives a request for information must provide copies of all public records at cost within a reasonable amount of time following the request.

6.4 Employees may review their personnel file at any time. The employee may challenge any information in their personnel file by following the grievance procedure. If proven inaccurate or not current, the discrepancy shall be corrected and the information removed.

7.0 Document Approval

Signature: 

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Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: C	**Personnel**
Subject: 1.5	**Employee Assistance Program, Legal Assistance and the Grievance Procedure**
Related Standards:	
O.A.C.	**5139-36-09 (A)(H)**
A.C.A.	**3-JCRF-1C-19 1A-19**
P.R.E.A.	**None**

1.0 Purpose

To establish employee assistance in identifying problems and locating sources of treatment or help.

2.0 Persons Affected

All employees

3.0 Policy

Perry Multi-County Juvenile Facility provides for an employee assistance program that is approved by the facility administrator. Legal assistance is available to facility staff as required in the performance of their duties. There is a written employee grievance procedure that is available to all employees.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Approving the employee assistance program recommended for the facility.
b. Reviewing grievances in accordance with employee grievance policies and procedures.
c. Interviewing witnesses as needed and making determination of grievance merit and whether any action should be taken.
d. Providing the employee and supervisor with a written finding of fact and determination of any action to be taking within five (5) days.
e. Maintain all employee grievances on file.
f. Making referrals to the County Risk Sharing Authority (CORSA) legal helpline.
g. Making referrals to the Perry County Prosecutor or designee for provision of legal assistance to staff as required in the performance of their duties.

5.2 The Shift Supervisors will be responsible for addressing, documenting, and responding to Resident Care Worker concerns and grievances.

5.3 The Compliance Coordinator is responsible for the following:

a. Ensuring employee assistance program information including contact numbers is posted in the administrative hallway or equivalent visible location.
b. Review grievances in accordance with employee grievance policies and procedures.
c. Make determination of grievance merit, whether any action should be taken, and providing written response to the grievance to the employee and supervisor within 5 working days.

6.0 Procedures

Employee Assistance Program

6.1 The United Way of Muskingum, Perry and Morgan Counties will provide information to any employee regarding a need for help or access to the following:

- Basic human services including food, clothing, shelter, rental or utility assistance.
- Physical and mental health resources including medical information, crisis intervention, support groups, counseling, drug and alcohol treatment, Medicaid and Medicare, maternal health, and children's health insurance
- Employment support services including unemployment benefits, financial assistance, job training, transportation assistance, and education programs
- Support for seniors and persons with disabilities including home health care, adult day care, meal services, respite care, transportation, and homemaker services
- Programs for children, youth, and families including childcare, after school programs, Head Start, family resource centers, recreation programs, mentoring, tutoring, and protective services
- Volunteer opportunities
- Support for community crisis or disaster recovery

6.2 Information including contact numbers is available posted in the administrative hallway on the bulletin board.

Legal Assistance

6.3 The County Risk Sharing Authority (CORSA) provides a legal helpline for all county employers.

6.4 The Perry County Prosecutor or designee will provide legal assistance to staff as required in the performance of their duties.

Employee Grievance Procedure

6.5 Any employee who believes they have a legitimate grievance shall address their concern with their immediate supervisor. The supervisor shall document the concern and respond to the employee.

6.6 If the supervisor fails to address the concern, the employee shall present the Compliance Coordinator with a written notice of grievance. The Compliance Coordinator will determine if the grievance has merit and whether any action should be taken. The Compliance Coordinator shall have five working days to provide the employee with a written response to the grievance.

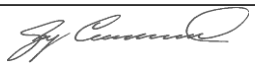
6.7 If the employee is unsatisfied with the Compliance Coordinator's response, the employee shall provide a written notice of grievance to the Director within 10 working days. The grievance shall contain the original grievance, the steps taken to correct the concern, and a copy of the Compliance Coordinator's response.

6.8 The Director shall review the information and schedule interviews with all involved parties as necessary. Within five working days, the Director shall provide the employee and the supervisor with a written finding of fact and determination of any action to be taken. The Director shall maintain all grievances on file.

6.9 If the employee reports directly to the Director, they should speak verbally about their concern and permit five working days for response. If they are not satisfied with the Director response, they should present their concern in writing to the Director. The Director will review the information and schedule interviews with all involved parties before submitting a written finding of fact and making a determination of any action to be taken.

6.10 In the event that the employee is not satisfied with the Director's decision, the employee may submit their grievance to the PMCJF Governing Board, in writing, within fourteen days of the Director's decision. The PMCJF Governing Board shall provide a written response to the employee within thirty days.

7.0 Document Approval

Signature: 

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Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: D	**Training and Staff Development**
Subject: 1.0	**Program Coordination and Supervision**
Related Standards:	
O.A.C.	**5139-36-10 (A)(B)**
A.C.A.	**3-JCRF-1D-01 1D-02**
P.R.E.A.	**None**

1.0 Purpose

To establish the facility's training and staff development program

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to staff development. The training program is reviewed annually, planned, coordinated, and supervised by a qualified employee who has completed TOT (Training of Trainers) or its equivalent.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Training Coordinator is responsible for the following:

a. Obtaining Training of Trainers certification
b. Reviewing all written training instructions as well as receiving twenty hours training in supervisory responsibilities
c. Creating and obtaining approval for an annual training plan for all personnel for the facility ensuring mandatory trainings are scheduled for all required subject areas.
d. Conducting an annual staff training needs survey
e. Tracking staff participation in mandatory meetings
f. Ensuring that staff training hours are updated quarterly and available for staff viewing g. Tracking all employee training hours and/or ensuring that such hours are documented h. Scheduling all facility required training with director approval.

5.2 Director is responsible for approving the annual training plan and approving all scheduled trainings.

5.3 Employees are responsible for the following:

a. Knowing and meeting the training requirements for the position
b. Attending mandatory trainings as required
c. Ensuring the documentation of personal training hours in the individual electronic training file is updated and accurate.
d. Submitting requests for outside trainings accompanying requests for time off. When outside trainings are approved, submitting proof of attendance in accordance with employee reimbursement procedures.

6.0 Procedures

6.1 The facility shall designate one staff member the training coordinator responsible for staff development through the planning, coordination, and implementation of the facility training program.

6.2 Training of Trainers certification or its equivalent is required for the training coordinator. The training coordinator will be responsible for obtaining certification and viewing all written training instructions during their orientation period as well as receiving twenty hours training in supervisory responsibilities.

6.3 The training coordinator is responsible for creating and obtaining Director approval for an annual training plan for personnel ensuring mandatory trainings are scheduled for all required subject areas.

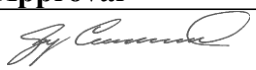
6.4. The coordinator will conduct an annual staff training needs survey. The training plan shall be developed, evaluated, and updated based on an annual assessment that identifies current job-related training needs. The annual needs assessment may utilize information from many sources: observation of job components, staff surveys regarding training needs, reviews of facility operations, resident feedback, staff reports, and evaluations and findings from sources within and outside the jurisdiction.

6.5 Facility trainings shall be scheduled by the training coordinator with the approval of the director.

6.6 The training coordinator shall maintain a training documentation sheet tracking employee training participation ensuring that staff training hours are updated quarterly and available for staff viewing.

6.7 Employees are responsible for knowing and meeting the training requirements for their positions, attending mandatory trainings as required, ensuring the documentation of personal training hours in their individual electronic training file is updated and accurate and submitting requests for outside trainings with accompanying requests for time off. When outside trainings are approved, submitting proof of attendance in accordance with employee reimbursement procedures.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: D	**Training and Staff Development**
Subject: 1.1	**Training Plan, Orientation and Job Position Training Requirements**
Related Standards:	
O.A.C.	**5139-36-05 (B)(C)(D)(F)(G)(H)(I) 5139-36-06 (B)(4)**
A.C.A.	**3-JCRF-1D-03 1D-09** (Rev. Aug. 2000) **1D-10** (Rev.1994 & 2005) **1D-10-1** (Added Aug. 2005) **3-JCRF-1D-11 1D-12 1D-13**
P.R.E.A.	**28 CFR §115.315 (f) §115.331 (a)(1)(2)(3)(4)(5)(6)(7)(8)(9)(10)(11)(b)(c)(d) 28 CFR §115.332 (a)(b)(c) §115.335 (a)(1)(2)(3)(4)(b)(c)(d)**

1.0 Purpose

To establish the facility's training and staff development programs, including training requirements for all categories of personnel.

2.0 Persons Affected

All employees

3.0 Policy

All juvenile care workers receive at least 40 hours of annual training. This training shall include a minimum of standards of conduct/ethics, security/safety/fire/medical/emergency procedures, supervision of offenders including training on sexual abuse and assault, and response to resistance regulations. Additional topics shall be included based upon a needs assessment of both staff and institutional requirements. The facility provides initial orientation for all new employees during their first week of employment. Administrative, managerial, and professional staff, support employees, part-time staff and volunteers shall all receive training hours commensurate with their needs and requirements.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Training Coordinator is responsible for the following:

a. Obtaining 40 annual training hours relevant to the position including all mandatory trainings
b. Providing training information accessible to employees on the computer.
c. Documenting the training, the date and location of training, subject matter, trainer's name, hours of training provided, and the names and positions of staff trained.
d. Overseeing orientation of new employees ensuring minimum first week orientation requirements are met and appropriate training documentation is obtained including reviewing written emergency plans and conducting Central Control testing.
e. Updating contents of the Employee Orientation Manual assuring it is meeting required standards.
f. Documenting policy and procedure review training for new employees including the location of the manual and how to use it to ensure adherence to policies and procedures.
g. Collecting employee job shadowing diaries and training records recording hours on the training records.
h. Coordinating training of employees with Supervisors to address training needs.
i. Ensuring all employees receive PREA training during orientation and annually thereafter.

5.2 Supervisors are responsible for the following:

a. Obtaining 40 orientation training hours and 40 annual training hours relevant to the position each year thereafter including all mandatory trainings.
b. Writing performance reviews every 30 days, 90 days, 180 days, and annually thereafter for all Resident Care Workers or employees under their supervision
c. Addressing deficits of training on employee evaluations and check sheets.
d. Understanding PREA requirements including training staff in how to conduct pat-down searches, cross-gender pat-down searches and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible consistent with security needs.
e. Annually reading, reviewing, implementing and instructing staff in the implementation of policies and procedures.

5.3 Resident Care Workers (RCWs) are responsible for the following:

a. Obtaining the required amount of training hours annually.
    1. Full-time RCWs must obtain 120 initial and 40 annual training hours.
    2. Part-time/On-call/and Contingent RCWs must obtain formal orientation training appropriate to their assignments and additional training as needed including mandatory trainings.
b. Annually reading, reviewing, and implementing policies and procedures making recommendations and asking questions as needed.
c. Attending all mandatory trainings.
d. Providing documentation of any trainings held outside the facility.
e. Providing documentation of any internal trainings including job shadowing training
f. Demonstrating wise use of the time available in order to advance knowledge of juvenile corrections.

5.4 New Employee(s) are responsible for the following:

a. Completing all initial paperwork for the assigned position
b. Completing and maintaining documentation for all orientation training including reviewing any orientation manual, policies and procedures manual, the employee handbook, PREA testing, and job shadowing requirements.
c. Obtaining the required amount of training hours as specified for your position

5.5 Administrative, Managerial, Professional Staff, Medical and Mental Health Care staff will be responsible for the following:

a. Obtaining 40 hours of training in addition to their orientation training during the first year of employment and 40 hours of training relevant to the position every year thereafter.
b. Maintaining up-to-date PREA training as specified for their position.
c. Annually reading, reviewing, and implementing policies and procedures making recommendations as needed.

5.6 Support Employees with regular or daily contact with resident are responsible for obtaining 40 hours of training in addition to orientation training during their first year of employment and 40 hours of training each year thereafter including basic training in supervision and security as well as specialized training in their field as it relates to the facility setting.

5.7 Volunteers and Contract Personnel are required to receive formal orientation appropriate to their assignments, PREA training, and additional training as needed based on the services they provide and level of contact they have with residents.

6.0 Procedures

6.1 Training for staff is responsive to position requirements, professional development needs, current issues, and new theories, techniques, and technology.

6.2 Annual performance reviews may include a permanent improvement plan requiring training in certain areas. The trainings may be provided through videos, books, and instructors including employees with demonstrated competencies in specified areas. Trainings may be provided at the facility or outside the facility.

6.3 The staff training coordinator will provide training log information accessible on the computer. Documentation of staff training shall include the date and location of training, specific subject matter, trainer's name, hours of training provided, and the name(s) and position of the staff trained.

Orientation and New Employee Training

6.4 Orientation training includes, at a minimum, a historical perspective of the facility, facility goals and objectives, program rules and regulations, job responsibilities, personnel policies, resident supervision, and report preparation. The employee signs and dates a statement indicating that orientation has been received. Supervisory personnel discussions and staff job shadowing will be the primary methods used to familiarize all newly employed personnel with facility policies and procedures.

6.5 During the first week of orientation, a new employee will be given ample opportunity to read the contents of the Orientation Manual which includes the following topics: Historical perspective of the facility, facility goals and objectives, employee handbook, code of ethics, program rules and regulations, job responsibilities, supervision of residents, report writing, and orientation to thinking patterns and how they are used. Employees are expected to ask questions if they do not understand the material read.

6.6 The employee also must be familiar with the policy and procedure manual. They should either know policy and procedures or be aware of where to find policies and procedures for various topics.

6.7 All new employees will be trained in the implementation of written emergency plans and annually thereafter. They will also receive training and must pass a test on Central Control operations and responsibilities.

New Juvenile Resident Care Worker Training

6.8 All new resident care workers receive an added 120 hours of training during their first year of employment and an added 40 hours of training each subsequent year. At a minimum, the training covers security and safety procedures, emergency and fire procedures, supervision of residents, suicide intervention/prevention, use-of-force regulations, resident rights, rules and regulations, and responsibilities, key control, interpersonal relations, communication skills, standards of conduct, cultural awareness/diversity, sexual abuse/assault intervention, code of ethics, first aid/cardiopulmonary resuscitation (CPR), crisis intervention, legal issues, sexual harassment, and Prison Rape Elimination Act standards.

6.9 Training for resident care workers will be comprehensive during their orientation year. All training areas will be identified on the Probationary Evaluations or training check sheets. Supervisors shall be responsible for identifying training deficits on the evaluations and working with the training coordinator to address these issues.

6.10 Additional training will include emergency medical procedures, blood-borne pathogens, and safe method of response to resistance, and child development and growth.

6.11 The facility shall also train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible consistent with security needs. Residents identifying themselves as transgender or intersex upon intake shall be asked which gender they are more comfortable with for purposes of pat-down searches. The facility shall act in a professional and respectful manner congruent with the resident's comfort and self-identification.

6.12 Employees are expected to wisely use the time available to them in order to advance their knowledge of juvenile corrections.

6.13 On-going training during subsequent years will be provided to enable employees to sharpen their skills and keep abreast with changes in operational procedures.

Employee PREA Training

6.14 All employees who may have contact with residents shall be trained on the following: (1) Zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' rights to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities; (6) The common reactions of juvenile victims of sexual abuse and sexual harassment; (7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; (10) How to comply with relevant laws related to mandatory reporting of sexual

abuse to outside authorities; and (11) The facility shall also train in relevant laws regarding the applicable age of consent. Such training will be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

6.15 All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the facility shall provide refresher information on current sexual abuse and sexual harassment policies.

6.16 All PREA training shall be documented through employee signature or electronic verification that the employees understand the training they have received.

Part-Time Staff and On-Call Staff

6.17 All part-time staff receives formal orientation appropriate to their assignments and additional training as needed. Part-time and on-call staff will be given basic orientation training. They may immediately assume duties as identified as appropriate. Additional training will be given as needed in order to expand their assignments. Part-time and on-call staff may primarily be utilized at the Central Control position due to their training status and experience.

Volunteers and Contract Personnel

6.18 All volunteers and contract personnel receive formal orientation appropriate to their assignments and additional training as needed. They may immediately assume duties as identified as appropriate.

6.19 Volunteers and contract staff who may have contact with residents will be given basic orientation training including training in responsibilities under the facility's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents shall be notified of the facility's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

6.20 The facility shall maintain documentation confirming the volunteers and contractors understand the training they have received.

Administrative, Managerial, and Professional Staff

6.21 Administrative, managerial and professional staff will receive 40 hours of training in addition to their orientation training during their first year of employment. After their first year of employment they will receive 40 hours of training relevant to their position.

Basic Support Employees

6.22 All support employees who have regular or daily contact with residents receive 40 hours of training in addition to orientation training during their first year of employment and 40 hours of training each year thereafter. They will be required to receive basic training in supervision and security as well as specialized training in their field as it relates to the facility setting.

6.23 Support personal will be familiar with policies and procedures of the facility and with basic rules of resident supervision and security. They may be required to attend some mandatory training including basic first aid and CPR.

Clerical Support

6.24 All clerical support employees who have minimal or no contact with residents, receive an additional 16 hours of training in addition to orientation during the first year of employment and 16 hours of training each year thereafter.

6.25 Clerical and support personnel who are not in continuous contact with residents will be given orientation to the policies, organization, structure, programs, and regulations of the facility and parent agency, as well as task orientation relative to their particular job assignments.

Medical and Mental Health Care

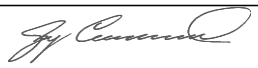
6.26 The facility shall ensure that all full and part-time medical and mental health care practitioners who work regularly in the facility have been trained in (1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and (4) How and whom to report allegations or suspicions of sexual abuse and sexual harassment.

6.27 Medical and mental health care professionals shall also receive the training mandated for employees under §115.331 or for contractors and volunteers under §115.332, depending upon the practitioner's status at the facility.

6.28 The facility shall maintain documentation that medical and mental health practitioners have received the PREA training either from the facility or elsewhere.

6.29 Medical staff employed by the facility will not be expected to conduct forensic medical examinations.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section: D	**Training and Staff Development**
Subject: 1.2	**Training Resources, Qualified Trainers, Library Reference Services, Space & Equipment and Reimbursement**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-1D-04 1D-05 1D-06 1D-07 1D-08**
P.R.E.A.	**None**

1.0 Purpose

To establish the resources necessary for a comprehensive training program.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to encouraging staff development by providing administrative leave and/or reimbursement for attending approved educational programs, professional meetings, seminars, or similar work-related activities. The training and staff development program shall use resources available from the community to enhance staff education. All trainings will be conducted by persons who are qualified in the subject matters in which they train. Library and reference services are available to complement the training and staff development program. The necessary space and equipment for the training and staff development program are readily available.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Training Coordinator is responsible for ensuring that the tools necessary for staff development are available at the facility including sufficient trainings to meet training needs.

5.2 Employees are responsible for the following:

a. Knowing and meeting the training requirements for their position.
b. Attending mandatory trainings as required.
c. Utilizing available resources to meet individual training needs or goals.
d. Submitting proof of attendance and certificates to the training coordinator for personnel files.

6.0 Procedures

6.1 The facility will have a variety of resources available to meet training needs.

6.2 The National Institute of Corrections maintains a large online educational library of relevant trainings for correctional workers and support staff in a variety of positions. The NIC online catalog is available in a binder in the staff lounge. Each training has testing with certification available to document competency.

6.3 There are many training opportunities available offsite including those provided by the Department of Youth Services. Prior authorization is needed in order to attend offsite training activities. Staff must submit a time off request and receive approval prior to attendance.

6.4 There is ample space in the building for staff trainings. The conference room, school classroom, unoccupied resident unit, and the gymnasium are available for staff use at various times.

6.5 All training programs shall be presented by qualified trainers. Qualified trainers must have experience, education, training, and/or demonstrated abilities in the areas in which they conduct trainings. Area instructors from colleges, private businesses, and community agencies may assist in providing training for the staff.

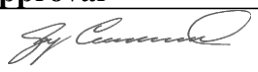
6.6 Any trainer hired by the facility will be expected to offer proof of their credentials in training in the topics discussed.

6.7 The facility will have a vast amount of reference material available to staff for training and staff development purposes. These resources include videos, books, and pamphlets. Other resources may be obtained from the local library at the request of staff.

6.8 Staff development is encouraged by the facility. Administrative leaves may be granted at the discretion of the Director if the leave does not affect the operation of the program and will benefit the facility in some manner. Reimbursement may be granted for attending approved professional meetings, seminars, educational programs, or other work-related activities.

6.9 Hocking College, Ohio University, and Ohio State University gives a few free credits per year to facilities and organizations that permit practicum positions for their students. Staff is encouraged to use these free credits for their own development and to meet their training requirements in the facility.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section:	**Juvenile Records**
Subject:	**Case Record Management**
Related Standards:	
O.A.C.	**5139-36-12 (A)(1)(2)(3)(4)(B)(C)(1)(2)(3)(4)(5)(6)(7)(8)(9)(10)(11)**
Ohio Revised Code	**§149.43**
A.C.A.	**3-JCRF-1E-01 1E-02 1E-03 1E-04 1E-05 1E-06 1E-07 1E-08 3-JCRF-5A-05 5B-10**
P.R.E.A.	**None**

1.0 Purpose

To establish the facility's management of case records, including security, right of access, and release of information.

2.0 Persons Affected

All employees

3.0 Policy

Perry Multi-County Juvenile Facility has rules governing case record management including the establishment, use, and content of resident records; right to privacy; secure placement and preservation of records; and schedule for retiring or destroying inactive records. Records will be audited monthly to ensure appropriate and accurate material is being entered. Case records containing relevant treatment information shall be transferred with the resident and all transfers or removals from the facility shall follow due process and allow for resident appeal. Policies and procedures are reviewed annually.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Case Manager is responsible for the following:

a. Establishing a file/record for all residents accepted into the facility for staff member access with the following contents added per procedures:

- Initial Intake Information/Referral form
- Case Information from referral source, if available
- Case history/social history
- Medical Record, when available
- Individual plan or program
- Signed release of information forms
- Evaluation and progress reports
- Current employment data
- Program Rules and disciplinary policy signed by the resident
- Documented legal authority to accept the resident
- Grievance and disciplinary record
- Referrals to other agencies
- Final discharge report

b. Adding records to the file as scheduled.
c. Writing a letter to the referring source stating the specific reasons for not being accepted into the program. Placing a copy of the letter in a file established for the purpose of documenting denial of admission to the facility.

5.2 Central Control Operator
a. Maintaining a file/record for all residents
b. Reviewing random records monthly to ensure that the appropriate and accurate material is being entered as scheduled and documenting monthly reviews. Monthly record audits will include checks for dates and names of person entering information into the master record.
d. Scanning documentation and placing it in the resident electronic file as needed throughout their stay.
e. At resident discharge, scanning the contents of the resident file into electronic format for preservation following record retention policy.

6.0 Procedures

Establishment of File

6.1 Upon acceptance into the facility, the Case Manager will establish a file in the name of the resident.

6.2 If a juvenile is not accepted, a letter shall be written and provided to the referring source stating the specific reasons for not being accepted into the program. A copy of this letter shall be placed in a file established for the purpose of documenting denial of admission to the facility.

Content of the File

6.3 At the time of admission, the following information shall be placed into the resident's file: Initial intake information/referral form, case history/social history from referral source, case history/social history, medical record, when available, signed release of information forms, current employment data, documented legal authority to accept the juvenile, pre-sentence investigation, and medical consent forms.

6.4 During the first 30 days in the facility, the following shall be added to the file: Program rules and disciplinary policy signed by the resident, receipt of handbook signed by the resident, individual plan or program, evaluation and/or progress reports, grievance and disciplinary record, and referrals to other agencies.

6.5 A discharge plan shall be created and on file within 30 days of discharge. This plan shall include a tentative discharge date and information regarding the person(s) to whom the resident will be discharged.

Rights to Privacy

6.6 Each file will be kept in an area separated from residents and the public. Access to files shall be granted only to those employees, practicum students or volunteers who have signed confidentiality statements, the sending courts, the Department of Youth Services, medical personnel in the course of treatment of the residents, and outside agencies providing care or treatment.

6.7 Computerized systems shall be maintained at the facility and are not accessible to the public. Confidential information shared over the internet is with approved agencies or organizations only. Any work on files outside the facility shall be with permission of the Director. Confidential resident files shall remain at the facility.

Secure Placement and Preservation of Files

6.8 All records will be kept in designated areas. All resident records, excluding medical records and confidential counseling records shall be kept at the Central Control Area or on the network drive. These areas are not accessible to the general public and are accessible only with permission. All manual records will be marked confidential.

6.9 When a resident leaves the facility, the file is placed in the administrative office area or stored in the Supervisor's Office. The files are then purged as scheduled and will be placed in a locked storage room or container.

Monthly Audit

6.10 Records will randomly be reviewed monthly by the Central Control Operator to ensure that appropriate and accurate material is being entered.

6.11 Monthly record audits will include checks for dates and names of person entering information into the master record. This procedure will enable staff members who use this information to assess the relevance of the entries evaluating the resident's progress. It also ensures that the persons who make the entries are accountable for them.

Schedule for Retiring or Destroying Records

6.12 Resident records will be cleared of all unnecessary information and placed in locked storage upon discharge. The facility will follow the approved record retention procedures including the transfer of paper records to electronic storage. Records will be accessed only with permission from the Director.

6.13 All case records associated with claims of sexual abuse and/or assault, including incident reports, investigative reports, juvenile information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be maintained in accordance with an established record retention policy.

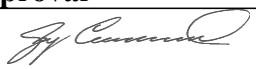
Transfer of Records

6.14 A cumulative case file will be sent with a resident upon transfer to another facility. If the case file is not prepared at the time of transfer, the contents of the file will be communicated via mail, fax or other means of transport to the new facility within 72 hours. Transfers or removals from the facility shall follow due process and allow for resident appeal.

Consent Forms

6.15 The facility shall utilize a release of information form that is signed by the parent/guardian of the resident prior to releasing information. A copy of this consent form shall be maintained in the resident's records.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-10-14	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 07-02-15; 07-18-17; 07-21-21	
Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section:	**Information Systems and Research**
Subject:	**Information System, Cooperation, Evaluation, Security & Results**
Related Standards:	
O.A.C.	**5139-36-22 (A)(1)(2)(3)(4) (B) 5139-36-16 (H)**
A.C.A.	**3-JCRF-1F-01 1F-02 1F-03 1F-04 1F-05 1F-06 1F-07 1F-08 1F-09**
P.R.E.A.	**None**

1.0 Purpose

To establish the facility's program for information storage and retrieval, master indexes, daily reports, evaluation, and research.

2.0 Persons Affected

All employees

3.0 Policy

Perry Multi-County Juvenile Facility has rules governing the security of the information and data collections system, including verification, access to data, and protection of privacy of residents under the jurisdiction of the facility. The facility or parent agency cooperates with other juvenile justice agencies in information gathering, exchange, and standardization. The facility provides for an annual evaluation of information systems and research operations and progress toward goals and objectives. The facility or parent agency supports, engages, and uses research activities relevant to its programs, services, and operations. The Director reviews and approves all research projects prior to implementation to ensure conformity with the policies of the parent agency. All research results are made available to the facility administrator for review and comment prior to publication or dissemination.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Central Control Operator shall be responsible for providing all the necessary data to ODYS including the weekly and monthly population reports.

6.0 Procedures

6.1 Information will be provided and used as needed for storage, retrieval, reporting and review. The information is on-site and governed by each department manager. All information will be kept confidential.

ODYS Management Information System

6.2 All residents that receive program services must be entered into a management information system authorized by the Ohio Department of Youth Services.

6.3 The Training Coordinator shall be responsible for providing all the necessary data to ODYS including the weekly and monthly population reports.

6.4 A random sample of case records shall be reviewed annually by the ODYS representative to ensure that data in case records corresponds with that in the MIS.

6.5 An annual report is submitted to ODYS detailing research operations and progress toward goals and objectives.

6.6 The data collection system is in the administrative offices. The Director will have primary access to the data collection system. Limited access may be granted to administrative staff with approval of the facility administrator.

6.7 Data will be verified with log entries made by staff prior to entering it in the system.

Program Review

6.8 A program review is conducted annually. The annual program review may use information gathered from resident and staff surveys, the risk/needs assessment tools, and recidivism rates to continuously improve the quality of the facility programs, services, and operations.

6.9 Based on the information gathered, programs may be continued, eliminated, altered, or supplemented to provide quality facility services.

Research Projects

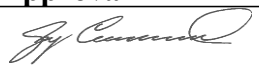
6.10 All research projects must receive approval from the facility Director prior to implementation. If the research project is conducted within the facility, the approval will be given in writing for documentation purposes.

6.11 PMCJF will comply with all state and federal guidelines for the use and dissemination of research findings.

6.12 Any results from research projects within the facility or from the parent agency are made available to facility administrator for review and comment prior to publication or dissemination.

6.13 The facility will allow voluntary participation of residents in non-medical, non-pharmaceutical, and non-cosmetic research programs. Residents and parents/guardians will give signed permission in order to participate in research programs. Research programs will be approved by the Perry Multi-County Juvenile Facility Governing Board and the Ohio Department of Youth Services.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 07-19-11
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Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 1.0	**Administration and Management**
Section:	**Citizen Involvement and Volunteers**
Subject:	**Program Coordination, Organization, Recruitment, Confidentiality & Orientation**
Related Standards:	
O.A.C.	**5139-36-06 (B)(1)(3)(4)(5)(6)**
A.C.A.	**3-JCRF-1G-01** (deleted 2007) **1G-02** (Rev. 2007) **1G-03 1G-04 1G-05 1G-06 1G-07 3-JCRF-1G-08 1G-09**
P.R.E.A.	**28 CFR §115.332 (a)(b)(c)**

1.0 Purpose

To establish the screening, training, and operating procedures for a citizen involvement and volunteer service program for the benefit of juveniles.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to operating a citizen involvement and volunteer service program with lines of authority, responsibility, and accountability specified on an organizational chart that can be found in the volunteer handbook.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Coordination including interviewing, approving, and training of the citizen involvement and volunteer service program
b. Designating volunteer supervision and training as appropriate
c. Designating volunteers as intermittent volunteers or contractors with minimal resident contact.
d. Ensuring intermittent volunteers and contractors review and sign the Citizen's Involvement pamphlet including the confidentiality statement and PREA information.
e. Ensuring completion of the Diana Screen and the background check as required.
f. Providing a copy of the volunteer handbook with designated lines of authority.

6.0 Procedures

6.1 The Director will be in charge of coordination of the citizen involvement and volunteer service program. Coordination may consist of interviewing, approving, training, and assigning the volunteer to a PMCJF employee for additional supervision and/or training after being informed of referral as appropriate.

6.2 Intermittent volunteers and contractors with minimal resident contact and/or supervised resident contact shall be permitted at the facility following the review of the Citizen's Involvement pamphlet and signing of the agreement which includes a confidentiality statement and PREA information on the facility's zero-tolerance policies for sexual harassment and abuse.

6.3 Regular volunteers with resident contact must have a background check completed or have a copy of a completed background check which has been conducted within the past year prior to acceptance as a volunteer. This document will be kept on file. They will also take the Diana Screen as a precondition to volunteering.

6.4 Each volunteer will receive a copy of the volunteer handbook that will designate the line of authority. A receipt of handbook will also be signed and kept on file. An organizational chart is included in every volunteer handbook with lines of authority clearly drawn. Each volunteer will be verbally assigned to a supervisor or department head and they will be accountable to that person.

Screening and Selection

6.5 If volunteers are used, the facility will set procedures for citizen-involvement programming, including roles as advisors, liaison between the program and public, direct service roles, and cooperative endeavors with the residents.

6.6 Volunteers shall be recruited based upon facility interests and needs encouraging participation from all cultural and socioeconomic levels of the community. If there is an area of programming that we would like to supplement with volunteer help, staff becomes a resource in finding a person or an organization interested in volunteering. We accept volunteers from the local college on an on-going basis. Notification of volunteer recruitment may also be distributed to the community through use of civic organizations, schools, governmental agencies and individuals.

6.7 When a person indicates they wish to volunteer, they may be given a formal or informal interview to determine interests and skills if this is unknown. The process is kept as simple as possible to encourage volunteerism.

6.8 When a volunteer indicates they are no longer interested in their work, they are asked to give some feedback on their experience.

Orientation

6.9 Each volunteer completes an appropriate, documented orientation and/or training program prior to assignment. Volunteers will receive a basic orientation suitable to their roles. Included in every orientation will be a review of the confidentiality agreement and a review of safety and security issues in the facility. These are signed and kept in their files. Zero-tolerance regarding the facility's sexual abuse and harassment prevention, detection, and response policies and procedures shall be reviewed for all volunteers working with residents. Documentation confirming volunteers understand the training received shall be maintained. A review of the emergency procedures including exits, a basic overview of the facility program and goals, and a clear line of authority is also presented. A staff member may conduct the orientation. Volunteers agree in writing to abide by facility policies, particularly those relating to the security and confidentiality of information.

6.10 There is an official registration and identification system for volunteers. Volunteers sign into the building at the front desk. The person assigned to supervise the volunteer will identify the volunteer or leave instructions to another employee who is able to make the

identification. A record is kept for each volunteer that consists of photo identification, address, current telephone number and other relevant information.

Professional Services

6.11 Volunteers will not perform professional services.

6.12 Professional services requiring a certificate or license shall be performed by employees of the facility or through a contract or service agreement. Personnel in charge of delivering a service that requires a license will provide a copy of that license for their file. Attempts will be made to verify certifications and licensure.

Termination

6.13 The Volunteer Handbook indicates that volunteers work at the discretion of the Director. When there is a substantial reason for curtailing, postponing, or terminating the services of a volunteer or volunteer organization, the Director will give notification to the affected party or parties.

Suggestions

6.14 There is provision for volunteers to contribute suggestions regarding the establishment of policy and procedure for the volunteer service program. The volunteer handbook discusses the manner in which volunteers may contribute suggestions regarding the facility, volunteer policies and procedures, and individual resident treatment.

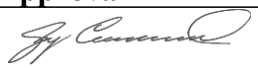
Practicum Students

6.15 Students recruited and selected for practicum coursework at the facility will be interviewed by the Director. Upon approval, practicum students will be required to pass a urine screen and background check prior to having contact with residents. Each practicum student will be given a brief orientation to the facility. All practicum students will be supervised by qualified personnel as assigned based upon their interests and the needs of the facility.

Liability Insurance

6.17 All volunteers shall be covered under the Perry County Liability Insurance Plan. However, injury or destruction of property that is caused by the volunteer's disregard for PMCJF policy and procedure shall be the responsibility of the volunteer.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-21-20	

Perry Multi-County Juvenile Facility	
Chapter: 2.0	**Physical Plant**
Section:	**Building and Safety Codes**
Subject:	**Building Codes, Zoning Ordinances & Alternative Power Source**
Related Standards:	
O.A.C.	**5139-36-13 (A)(B)(D)(6)(E)**
A.C.A.	**3-JCRF-2A-01** Corrected August 1998 Non-mandatory Standard **2A-02**
P.R.E.A.	**None**

1.0 Purpose

To comply with professional zoning, building, and fire safety codes help to ensure the safety of all persons within the facility.

2.0 Persons Affected

Director and Maintenance Supervisor

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to ensuring the safety of all persons within the facility by conforming to all laws, building codes, and zoning ordinances. If an inspection reveals an area not in compliance, the facility shall attempt to comply with or change the laws within a reasonable time frame.

4.0 Definitions/Documents

None

5.0 Responsibility

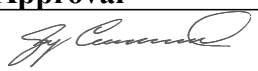
5.1 Facility Maintenance Supervisor shall be responsible for the scheduling of building inspections and working with the Director to quickly correct any areas revealed out of compliance.

6.0 Procedures

6.1 The facility conforms to all applicable state and local building codes, applicable zoning laws, codes and ordinances.

6.2 An alternative power source is available. The lighting, heating and kitchen appliances will operate using an emergency generator located outside of the building in the event of an emergency.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 07-02-15; 07-18-17	
Date Revised: 07-17-18	

Perry Multi-County Juvenile Facility	
Chapter: 2.0	**Physical Plant**
Section:	**Size, Location, and Organization**
Subject:	**Staff and Juvenile Interaction**
Related Standards:	
O.A.C.	**5139-36-13 (G)(H)(I)**
A.C.A.	**3-JCRF-2B-01 2B-02** (Rev. 2006) **2B-02-1** (Added 2006) **2B-03 2B-04**
P.R.E.A.	**None**

1.0 Purpose

To establish a facility sized and designed to encourage flexibility, creativity and innovation in meeting the concerns for effective programming, safety, and quality of life.

2.0 Persons Affected

All Employees, Residents, and their families.

3.0 Policy

The Perry Multi-County Juvenile Facility was designed to meet the treatment needs of a maximum of twenty residents and their families. The facility is located among eight core counties to enable the residents to maintain continued contact with their families. The size of the facility encourages interaction between residents and staff. The number of residents does not exceed the facility's rated bed capacity and no more than eight residents are housed in each living unit in the facility.

4.0 Definitions/Documents

None

5.0 Responsibility

None

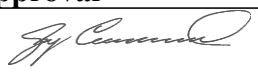
6.0 Procedures

6.1 Staff is always available to the residents in the living units. The majority of staff offices are located in the hallway adjacent to the classrooms and dayrooms.

6.2 The facility is equipped with twenty beds with no more than twenty juveniles housed at one time. At night during sleeping hours, there are no more than eight residents in each living unit.

6.3 The facility was constructed in 2000 and opened in July 2002. The facility serves residents from the surrounding eight core counties. Residents may be accepted from any county in Ohio. Attempts are made to accommodate the families of residents that identify location as an issue.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 2.0	**Physical Plant**
Section:	**Juvenile Housing**
Subject:	**Sleeping Areas, Dayrooms, Decorations, Toilets, Showers, Washbasins and Laundry**
Related Standards:	
O.A.C.	**5139-36-13 (J)(1)(a)(b)(c)(2)(3)(5)(6)(N)(O)(P)(Q)(S)(T)**
A.C.A.	**3-JCRF-2C-01** (Rev. Aug. 1997 Correction Jan. 2002 does not apply to JCRF) **3-JCRF-2C-02 2C-03 2C-04 2C-05** (Rev. 1995) **2C-06 2C-07**
P.R.E.A.	**None**

1.0 Purpose

To establish housing that promotes safety and well-being of both juveniles and staff by maintaining the appearance of regular homes and living conditions.

2.0 Persons Affected

All Employees

3.0 Policy

The facility will balance the need for safety and security with the desire to simulate the privacy and comfort of home. Each sleeping room has some degree of privacy for the resident with access to all the necessities twenty-four hours a day. The facility permits residents to decorate their living and sleeping quarters with personal possessions depending on phase and privileges. Regulations concerning the rules are available to all residents and staff. The rules are reviewed annually and revised if indicated. Tables are available for varied activities as well as a separate seating area with chairs. The temperatures in the unit wash basins and showers are thermostatically controlled. The facility supplies an adequate number of toilets and washbasins as well as two operable washers and dryers.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Maintenance Supervisor is responsible for the following:

a. Taking and documenting monthly water temperature checks.
b. Taking and documenting monthly air temperature checks.
c. Responding to maintenance requests in a timely manner.

5.2 Shift supervisors are responsible for the following:

a. Annually reviewing resident rules making revisions when necessary.
b. Ensuring that rules remain posted on the doors of resident sleeping rooms.
c. Ensuring maintenance issues are communicated to the maintenance supervisor.

6.0 Procedures

6.1 Each living unit is designed for single occupancy sleeping rooms. Each of the sleeping rooms has an intercom with communication linkage to staff at the Central Control desk to permit access to toilets and washbasin with hot and cold running water. Resident rooms are 70 square feet when unencumbered. All rooms all encumbered with a bed, mattress, pillow, locker, desk and stool. The rooms contain 44.5 square feet when holding all permitted items. Writing and seating space is provided in the dayroom.

6.2 Natural light is provided in the living units, sleeping rooms, gymnasium, and dining area. Temperatures are computer controlled.

6.3 There is a minimum of 60 square feet of unencumbered floor space in each living area. There is space for varied resident activities. The dayroom provides 78.424 square feet of space per resident for the maximum number of residents (10) expected to use the dayroom at one time.

6.4 Each dayroom provides sufficient seating and writing surfaces for every resident using the dayroom. Dayroom furnishings are consistent with the security needs of the residents assigned.

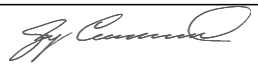
6.5 Dayrooms with space for varied resident activities are situated immediately adjacent to the sleeping areas, but are separated from them by a floor-to-ceiling wall. Dayrooms provide a minimum of thirty-five square feet of space per resident (exclusive of lavatories, showers, and toilets) for the maximum number expected to use the dayroom at one time. Residents are permitted to decorate their day rooms and sleeping quarters according to the program phase. Rules may be posted on the doors of sleeping rooms. The rules are reviewed annually and revised when necessary.

6.6 The facility has two operable toilets and washbasins with hot and cold running water for every eight residents. Two operable showers with thermostatically controlled temperature ranging from 100 degrees Fahrenheit to 120 degrees Fahrenheit for every eight residents are also available. Monthly water temperature checks are taken to ensure thermostat is accurate.

6.7 The facility has two operable washers and dryers for every twenty residents.

6.8 Any issues with facility toilets, washbasins, showers, washers and dryers, lighting, temperature controls, and intercoms should be communicated to the Maintenance Supervisor on safety request forms which are available in the staff lounge.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 10-16-16; 07-18-17	
Date Revised: 07-17-18	

Perry Multi-County Juvenile Facility	
Chapter: 2.0	**Physical Plant**
Section:	**Juvenile Housing**
Subject:	**Housing, Integrated Programming and Assistance for Disabled Juveniles**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-2C-08** (Rev. Aug. 1995) **2C-09** (Added Jan. 2002) **2C-10** (Added Aug. 2002) **2F-02**
P.R.E.A.	**None**

1.0 Purpose

To ensure facility accessibility for all persons

2.0 Persons Affected

All persons

3.0 Policy

The facility shall be designed to be handicapped accessible. Residents with disabilities shall be housed in a manner that provides for their safety and security and provides integration with other residents including programs and services. Appropriately trained individuals may be assigned to assist disabled residents who cannot otherwise perform basic life functions. Education, equipment and facilities, and the support necessary for residents with disabilities to perform self-care and personal hygiene shall be provided in a reasonably private environment.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Director shall be responsible for ensuring accommodations are implemented as needed.

6.0 Procedures

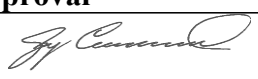
6.1 Reasonable accommodation is made to ensure that all parts of the facility that are accessible to the public are accessible and usable by staff and visitors with disabilities.

6.2 All residents with disabilities will be housed in a manner that provides for their safety and security. Housing used by residents with disabilities is designed for their use and provides integration with other residents. Programs and services are accessible to residents with disabilities who reside in the facility.

6.3 All rooms are wheelchair accessible. Toilets, rooms, and showers are equipped for wheelchair accessibility and handrails. Additional accommodations for disabled residents may be implemented as necessary. Residents have the facilities to perform self-care and personal hygiene in a reasonably private environment.

6.4 Necessary accommodations will be made when residents need assistance including having appropriately trained individuals appointed to assist disabled residents who cannot otherwise perform basic life functions.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 2.0	**Physical Plant**
Section:	**Environmental Conditions**
Subject:	**Housing Area & Heating and Cooling**
Related Standards:	
O.A.C.	**5139-36-13 (J)(4)(Y)**
A.C.A.	**3-JCRF-2D-01** (Rev. Aug. 2002 Interpreted Aug. 2002 Rev. Jan. 2008 **2D-02** (Rev. Aug 2006)
P.R.E.A.	**None**

1.0 Purpose

To ensure the preservation of the health and well-being of juveniles and staff members by establishing standards for lighting, air quality, temperature, and noise levels

2.0 Persons Affected

All employees, residents, and facility visitors.

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to establishing standards for lighting, air quality, temperature, and noise levels to preserve the health and well-being of residents and staff members. All sleeping quarters in the facility shall be well lighted and properly ventilated. Natural lighting should be provided wherever possible. Documentation shall be provided by a qualified source that lighting is at least 20 foot-candles at desk level and air circulation is at least 15 cubic feet of outside or re-circulated filtered air per minute per occupant for rooms, housing areas, staff stations, and dining areas. Air and light levels should be checked at least once per accreditation cycle or not less than once within the past three years. Temperatures in indoor living and work areas are appropriate to Summer and Winter comfort zones.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Maintenance Supervisor will schedule an inspection of the lighting and air circulation a minimum of every three years to verify adherence to local health code for proper lighting and ventilation and document monthly air temperatures.

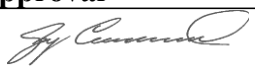
6.0 Procedures

6.1 An inspection will be conducted a minimum of every three years to verify adherence to local health codes for proper lighting and ventilation.

6.2 The facility contains air conditioning and an appropriate heat source. Temperatures in indoor living and work areas are tested monthly to ensure they are appropriate to the Summer and Winter comfort zones.

6.3 Natural lighting is provided throughout the facility.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-21-10 Prior Effective Date: 06-24-15; 07-18-17 Date Revised: 07-17-18	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 2.0	**Physical Plant**
Section:	**Program and Service Area**
Subject:	**Program and Counseling Space, Visiting, Kitchen Sanitation and Hygiene & Janitorial Supplies**
Related Standards:	
O.A.C.	**5139-36-13 (R)(1)(2)(4)(U)(Z)(BB)(4)**
A.C.A.	**3-JCRF-2E-01 2E-02 2E-03** (Rev. Jan. 2005) **2E-04 2E-05 2E-06 2E-07**
P.R.E.A.	**None**

1.0 Purpose

To ensure adequate space is available for the various program and service functions conducted as determined by a careful assessment of how, when, and how many juveniles use a specific area.

2.0 Persons Affected

All employees

3.0 Policy

Adequate space and furnishings to accommodate activities, such as group meetings of the residents, are provided in the facility as well as adequate private counseling space and appropriate areas for visiting and recreation programs. Adequate dining space is provided for residents. The kitchen, dining, and food storage areas are properly ventilated, properly furnished, and clean. Toilet and washbasin facilities are available to food service personnel and residents in close proximity of the food preparation area. Adequate space is provided for janitorial supplies, which is accessible to the living and activity areas.

4.0 Definitions/Documents

None

5.0 Responsibility

None

6.0 Procedures

6.1 The facility has space in the living area for groups. There is also space available in the school classrooms and the conference room.

6.2 There are offices available for private individual and family counseling.

6.3 The gymnasium is designated as the visiting area. There is adequate space provided.

6.4 The gymnasium is also the designated area for recreation programs. Recreation can also be held in the outside recreation area. Non-physical recreation can be performed in the living units.

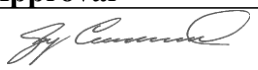
6.5 The dining area is 347 square feet. There is 17.35 square feet of floor space per resident for those occupying the dining room or dining area. The kitchen, dining and food storage areas are ventilated through the heating and cooling system. The dining area is equipped with dining tables. Kitchen and dining areas are cleaned daily.

6.6 The staff restroom facilities are located just outside the food preparation area. A toilet and washbasin is provided for both male and female staff. There are also four sinks in the food preparation areas.

6.7 A restroom with a toilet and washbasin for resident use is located in each living unit, down the hallway from the dining area.

6.8 Closets for storage of cleaning supplies and equipment are located in each principal area and are well ventilated.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-29-15	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effected Date: 06-24-15; 07-17-17	
Date Revised: 07-16-19	

Perry Multi-County Juvenile Facility	
Chapter: 2.0	**Physical Plant**
Section:	**Program and Service Area**
Subject:	**Clothing, Supplies and Personal Property**
Related Standards:	
O.A.C.	**5139-36-08 (BB)(1)(2)(3)(4)**
A.C.A.	**3-JCRF-2E-08 2E-09**
P.R.E.A.	**None**

1.0 Purpose

To establish adequate space requirements for clothing, supplies and personal property.

2.0 Persons Affected

All Employees

3.0 Policy

Space is provided in the facility to store and issue clothing, bedding, cleaning supplies, and other items required for daily operations. Adequate space is provided for storing the personal property of residents.

4.0 Definitions/Documents

None

5.0 Responsibility

None

6.0 Procedures

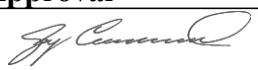
6.1 Clothing and bedding storage is located in the room connected to the laundry room. Cleaning supplies are stored in the mechanical room or the shed behind the building.

6.2 Storage is also available in the room next to the medical room and in the shed behind the building.

6.3 Personal items are stored in the room inside the Supervisor Office in the resident storage room. Each resident has a personal storage bin labeled with their corresponding room letter and number.

6.4 Operational and administrative supplies are available in the storage area located in the administrative office hallway.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 11-24-09
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Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Operations Manual, Staffing Patterns and Responsibility**
Related Standards:	
O.A.C.	**5139-36-10 (E)(6) 5139-36-04 (I)(1(3) 5139-36-08 (K)(L)**
A.C.A.	**3-JCRF-3A-01 3A-03 3A-04 3A-05 3A-10 3A-11**
P.R.E.A.	**28 CFR §115.313 (a)(1)(2)(3)(4)(5)(6)(7)(8)(9)(10)(b)(c)**

1.0 Purpose

To establish a combination of supervision, inspection, accountability, and policies and procedures to promote safe and orderly operations.

2.0 Persons Affected

All employees

3.0 Policy

There is a manual containing all procedures for facility supervision, with detailed instructions for implementing them. The manual is available to all staff and is reviewed annually and updated when necessary. There is at least one staff person on the premises twenty-four hours a day who is readily available and responsible to resident needs. The staffing pattern concentrates staff when most residents are in the facility. No resident or group of residents is in a position of control or authority over other residents. The sleeping rooms shall be single occupancy only.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Maintaining a policies and procedures manual.
b. Presenting changes in policies and procedures to the governing board as needed.
c. Approving the staffing plan and schedule concentrating staff when most residents are in the facility.

5.2. The Compliance Coordinator is responsible for the following:

a. Reviewing the policy and procedure manual annually making recommendations for changes as needed.
b. Conducting an annual staff review of policies and procedures.
c. Ensuring the policy and procedure manual is available to all staff.

6.0 Procedures

6.1 There is a policy and procedure manual available at Central Control and on the facility network drive. The policies and procedures are reviewed annually and revised as necessary with final approval of the governing board.

6.2 The facility staffing plan provides for a minimum of two staff persons on the premises twenty-four hours a day. The staffing plan takes into consideration generally accepted secure residential practices, any judicial, federal, or internal or external oversight findings of inadequacy, all components of the facility's physical plant including blind spots or areas where staff or residents may be isolated, the composition of the resident population, the number and placement of supervisory staff, institution programs occurring on a particular shift, any state or local laws, regulations, or standards, the prevalence of substantiated or unsubstantiated incidents of sexual abuse and any other relevant factors.

6.3 Staffing patterns concentrate staff when most residents are in the facility and active. Staff ratios shall be a minimum of 1:8 during resident waking hours. Staffing is at a minimum level during resident sleeping hours at a ratio of 1:16. Only security staff shall be included in staffing ratios.

6.4 The facility shall comply with the staffing plan except during limited and discrete exigent circumstances as approved by the Director. Staff shall fully document any deviations from the staffing plan.

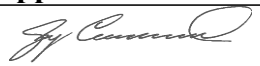
6.5 After lights out, one staff member will remain in Central Control and be readily available to respond to all resident needs. Staff shall carry a radio when leaving the Central Control area and personal protection pouches equipped with a cutdown tool when performing resident headcounts. At no time should one staff member be away from the Central Control area for over fifteen minutes without checking in with Central Control. Staff must communicate with each other to ensure resident headcounts are performed randomly at intervals not to exceed thirty minutes.

6.6 After residents are secured in their rooms for the night, only one cell door shall be opened at a time for the protection of residents and staff with the exception of monthly fire drills and other emergency situations. All resident movement and contact after lights out shall be documented. While staff is performing head counts, resident contact shall be limited to that which is deemed necessary. Residents are not permitted to be out of the units after lights out unless two or more staff is present and the contact occurs in full view of the video monitoring systems.

6.7 Residents are never permitted to be in a position of control or authority over other residents. Residents may be asked or selected to lead groups or activities with staff supervision and guidance. No resident will be given permission to enter the room of another resident at any time.

6.8 The facility will only house one resident per sleeping room. The facility provides sleeping rooms for a maximum of twenty residents. This facility houses only male residents.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-29-15 Prior Effective Date: 06-24-15; 07-18-17; 07-17-18 Date Revised: 07-21-20	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Response to Resistance**
Related Standards:	
O.A.C.	**5139-36-10(A)(B)(1)(2)(3)(C)(1)(2)**
A.C.A.	**3-JCRF-3A-02 Revised August 2000 (Mandatory)**
P.R.E.A.	**None**

1.0 Purpose

To establish guidelines for employee response to resident resistance.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to providing an appropriate, and limited response to resident resistance as follows:

a. Response to resistance shall be restricted to instances of justifiable self-defense, protections of the resident or others, protection of property, prevention of escapes, and to maintain or regain control, and then only as a last resort and in accordance with appropriate statutory authority.
b. In no event is physical force justifiable as punishment.
c. Justification for every physical response to resident resistance shall be documented in an incident report and submitted to administrative staff for review.

The use of prone restraint is prohibited across all state systems. Prone restraint is defined as all items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face down position for an extended period of time. Prone restraint includes physical or mechanical restraints.

4.0 Definitions/Documents

Attachment Appendix C: General Guide for Response to Resistance

5.0 Responsibility

5.1 All Resident Care Workers are responsible for the following:

a. Knowing, understanding, and practicing the skills necessary to deescalate residents during crisis situations.
b. Maintaining the ability to physically intervene in crisis situations
c. Obtaining Managing Youth Resistance certification and recertification on an annual basis.
d. Writing and submitting detailed response to resistance reports including the specific information necessary to determine the appropriateness of the response
e. Notifying the Director as soon as possible following any incident involving restraint of a resident including any reported injuries or continued refusal of the resident to cooperate with staff.

5.2 The Supervisor on duty during a response to resistance incident is responsible for reviewing response to resistance reports and providing guidance in adhering to policies and procedures.

5.3 The Compliance Coordinator shall review the appropriateness of the response and resistance documentation.

submit findings to all Response to Re

6.0 Procedures

Response

6.1 The response of staff should be reasonable and consistent to the resistance offered by the resident(s) using the least restrictive response likely to be effective under the circumstances to gain control of the resident.

6.2 When assessing the situation and determining the level or response needed, staff must consider the following factors:

a. Level of response needed including seriousness of the incident, size, age, weight and mental state of resident
b. Apparent physical ability of the resident(s) involved
c. Number of residents present who are involved or may become involved
d. Any weapon, known history of violence, and the presence of potential victims.
e. Factors to consider in determining staff response including size, physical ability, defensive tactics and expertise of staff
f. Number of staff present or available to assist
g. Immediacy of reaction needed to a sudden attack
h. Restraint devices available
i. Location of resident(s)
j. Agency policy.

6.3 As a resident increases resistance, staff may increase their response until the resistance decreases and staff is able to control the resident. As soon as the resident is compliant, staff shall decrease their response level to that which is necessary to maintain control.

6.4 When using mechanical restraints, staff must set the lock on handcuffs and shackles to ensure these items are unable to tighten when left on a resident. The Director must approve of use of mechanical restraint devices after 15 minutes. Residents should be placed on their side in the recover position as soon as possible after restraint. The use of prone restraint is prohibited.

Medical Assistance

6.5 When a resident or staff person involved in a response to resistance incident suffers physical injury, complains of injury, or requests medical assistance the facility will provide for and document any examination or treatment by facility medical personnel or outside emergency medical services.

Notification

6.6 The Director should be notified as soon as possible following any incident involving restraint of a resident including any reported injuries or continued refusal of the resident to cooperate with staff.

Training

6.7 Managing Youth Resistance and Cognitive Behavioral Therapy trainings including crisis de-escalation shall be offered annually and as needed.

6.8 Staff shall demonstrate awareness, understanding, and proficiency in applying the principles of least restrictive response as indicated on the general guide chart meant to aid staff in understanding and selecting effective, reasonable, and legal response options in a verbal or physical encounter.

Documentation

6.9 Instances of physical resistance shall be clearly documented on a Resident Restraint Incident Report by all staff present at the time of the incident including information on the following:

a. Name of all people witnessing or directly involved in the incident
b. Justification for a physical response including protecting themselves, protecting residents or others, protecting property, preventing escapes, and maintaining or regaining control as a last resort to prevent imminent and physical harm. Justification for use must be clearly documented in the report.
c. The response to resistance that was used.
d. Mechanical restraint use and proper setting of the lock on handcuffs and shackles
e. Injuries, examination and treatment provided to staff or resident suffering or complaining of injury or requesting medical assistance.

6.10 Response to Resistance Reports shall be submitted to a supervisor for review prior staff clocking out and leaving the facility

6.11 The Compliance Coordinator shall review all Response to Resistance Incident Reports with findings added to the resident files.

Watch Room Instructions

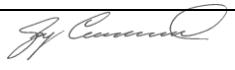
6.12 If a resident is in the watch room, staff shall intervene only if the resident is committing serious bodily injury or threatening to commit serious bodily injury with availability to immediately follow through on their threat. In situations where residents are committing self-injury by hitting or kicking walls, staff shall not place their own safety in jeopardy by intervening. When the resident is calm, staff should assess the resident's injury.

6.13 Residents isolated in the watch room should not have on shoes, glasses, or other items. If a resident is escorted or restrained and placed into the watch room with such items, staff should seek the resident's cooperation in removing the items. If a resident refuses to relinquish the items and the items are not being used in a manner to harm self or preparing to harm others, staff shall observe resident until such time that the resident cooperates with staff and relinquishes control of the items.

6.14 When staff uses physical force including guiding touch in response to resident resistance, the policies and procedures in place for involuntary seclusion or seclusion following an act of violence, depending on the incident, should be followed.

6.15 A resident remaining in the watch room for the night may be permitted to have a book to read and to take a shower when no residents are in the unit based upon their behavior and willingness to cooperate with staff.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Room Restriction, Seclusion and Watch Room Usage**
Related Standards:	
O.A.C.	**5139-36-16 (C)(I)(M)**
A.C.A.	**3-JCRF-3C-11 3C-13 3C-14**
P.R.E.A.	**None**

1.0 Purpose

To ensure that residents are humanely treated balancing individual treatment needs with the need to provide for the safety and security of the facility population.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to balancing the individual resident need for treatment with the need to provide for the safety and security of the facility population. Room restriction and restraint shall be used as follows:

Use of room restriction and/or restraint shall be limited to times when verbal and behavioral interventions are ineffective and the resident presents a danger to himself or others requiring removal from the general population. Room restriction shall be used as a cooling off period. The resident shall assist in determining the end of the restriction period and the room restriction shall be discontinued at the point the resident is able to successfully demonstrate that he has regained composure and is safely able to return to the population.

Room restriction shall occur in the area specified by the type of isolation and shall not exceed two hours without review. During room restriction, visual and verbal contact by staff with the resident shall be made at least randomly every ten minutes. Visual contact may be documented when a resident is sleeping. This contact is recorded and retained by staff. All instances of room restriction, privilege suspension, and facility restriction are recorded, dated and signed by staff. The record is reviewed and signed by a supervisory staff member daily.

Use of the watch room shall have the prior approval of the Ohio Department of Youth Services and, if revised, shall be resubmitted for approval.

4.0 Definitions/Documents

4.1 Voluntary Room Confinement/Time Out: Room restriction initiated by resident request or staff suggestion to assist the resident in de-escalating disruptive behaviors.

4.2 Involuntary Room Restriction: Room restriction initiated by staff order when the resident presents a danger to himself or others only when less restrictive intervention has failed.

4.3 Seclusion Following an Act of Violence: Room restriction based upon a resident act of violence, a direct threat to commit an act of violence verbally or in writing, a documented reasonable suspicion based upon conduct that an act of violence is imminent, or resident behavior that is substantially disruptive to other residents and staff ability to maintain order and control within the facility.

4.4 Administrative Treatment Team Members: Supervisors, Clinical Coordinator, Compliance Coordinator, Case Manager, and the Director.

4.5 Director Designee: Personnel that the Director has assigned to complete a specified task in lieu of the Director.

5.0 Responsibility

5.1 Resident Care Workers are responsible for the following:

a. Attending mandatory trainings for Managing Youth Resistance and Emergency Response Training.
b. Encouraging residents in the development of coping skills to deal with emotions.
c. Addressing resident failure to use coping skills and/or failing to respect the rights of others in accordance with the general guide to response to resistance found in Appendix A and in accordance to the procedures listed below.
d. Assisting or seeking the assistance of co-workers, supervisors, and/or Administrative Treatment Team Members to try to de-escalate the situation and calling for resident lockdown as appropriate.
e. Informing the Supervisor and/or Director of involuntary room restriction in accordance with policies and procedures.
f. Documenting the incident on the appropriate forms.

5.2 Central Control Operator is responsible for the following:

a. Documenting voluntary room restriction/time out on a general observation form including verbal responses and conduct displayed.
b. Speaking to the resident in voluntary room restriction/time out after fifteen (15) minutes to determine if composure is regained. If resident indicates to staff that he does not wish to return to the normal activity, permitting fifteen (15) additional minutes to regain composure. After thirty (30) minutes if resident conduct does not show composure or the resident indicates he wishes to remain in voluntary room restriction/time out a member of the administrative treatment team should be notified when present in the facility so they may meet with the resident to assess the situation. If no member of the Administrative Treatment Team is in the facility and the resident is verbally expressing, he wishes to extend his time then this shall be permitted up to one hour without requiring additional supervisory notification.
c. Demonstrating sound judgement and documenting reasoning including verbal comments and conduct when making determination extending resident room restriction changing the status to involuntary room restriction. A risk assessment must be performed and the director must be notified. The resident may be placed on special watch.
d. Following all documentation requirements for voluntary and involuntary room restriction.

5.3 Shift Supervisor(s) are responsible for the following:

a. Ensuring that policies and procedures are followed and documentation is accurately completed.
b. Ensuring that after an hour of voluntary room restriction, the resident is either released from room restriction, or given a risk assessment and placed on special watch with the status being extended voluntary room restriction or involuntary room restriction based on conduct.
c. Checking on a resident who has been confined for involuntary room restriction for one (1) hour and ensuring a risk assessment is conducted if that resident has not been able to demonstrate fifteen (15) minutes of composure or if they are still unwilling to follow rules.
d. Informing the director of all special watches and/or resident involuntary room restrictions.
e. Reviewing room restriction every two hours while documenting the review on the special watch form.
f. Updating the shift information review sheet daily
g. Reviewing all room restrictions, privilege suspensions and facility restrictions.

6.0 Procedures

Voluntary Room Restriction/Time Out

6.1 Residents shall be encouraged to take responsibility for their actions and respect others. When they recognize that they are failing to use coping skills to deal with their emotions and/or failing to respect the rights of others, they may initiate time out or take a time out at the suggestion of staff. The voluntary room restriction will take place in the watch room, unoccupied unit, or resident room as directed by staff and shall last no longer than fifteen minutes. Residents initiating a time out shall be permitted to read during their isolation.

6.2 Documentation of voluntary room restriction shall be performed by Central Control staff on the general observation form. After fifteen minutes (15), residents will be expected to demonstrate an ability to regain their composure. Residents will be permitted to immediately return to the activity they abandoned prior to taking a time out.

6.3 If the resident is unable to demonstrate the ability to regain his composure after fifteen (15) minutes or indicates to staff that he does not yet wish to return to the activity, Central Control staff shall continue general observation log documentation noting resident verbal response and the conduct. The resident will be given an additional fifteen (15) minutes to regain his composure. After this time if the resident verbally states that he does not wish to return to the activity and/or demonstrates conduct that indicates the resident has not yet regained his composure, the Central Control Operator shall be permitted to extend time up to one (1) hour without requiring additional supervisory notification. After one hour, if the Central Control member wishes to extend the time of voluntary room restriction based on verbal comments or conduct, the room restriction shall then be considered involuntary. A risk assessment must be performed, the resident will be placed on special watch and the director shall be notified.

6.4 When the resident leaves the time out area after an extended time out, the resident will automatically not earn the points of the activity.

Involuntary Room Restriction

6.5 Involuntary room restriction is initiated by staff order when a resident presents a danger to himself or others only when less restrictive intervention has failed and shall be for the least amount of time needed for the resident to demonstrate the ability to regain his composure. Criteria that may to be considered includes but is not limited to the following:

- Threats of immediate harm to self or others
- Out-of-control behavior and lack of reasoning as demonstrated by failure to respond to staff interventions and failure to recognize the out-of-control conduct is infringing upon the rights of others.
- Activity that encourages riots or resident uprising
- Chronic, repeated behaviors that demonstrate resident inability to function with others

6.6 A resident may not be confined involuntarily in a room for punishment, harassment, or retaliation for resident misconduct.

6.7 Staff ordering a resident to room restriction shall seek to avoid a power struggle and attempt to keep the resident focused on his own issues by encouraging the resident to make a responsible choice. Staff shall seek assistance of co-workers, supervisors, and/or the Administrative Treatment Team Members to try to de-escalate the situation. The goal is to de-escalate the resident so that he will go into the watch room without the need for physical intervention.

6.8 Staff shall follow the chart listed for response to resistance meant as a general guide for staff control or physical response. Lockdown should be called to eliminate the presence of the resident population and enable the resisting resident to respond positively to staff intervention attempts without risking being seen as weak by the other residents.

6.9 Appropriate involuntary room restriction location shall be either the resident bedroom or the watch room as decided by the team leader of the intervention in accordance with the response to resistance staff general guide continuum. The confinement area shall be secured.

6.10 Documentation of involuntary room restriction shall be performed by Central Control staff on the general observation form or on a special watch form following a risk assessment as determined by staff. The staff initiating the room restriction shall include the behavior and conduct justifying the need for room restriction on the form. A supervisor or another member of the administrative treatment team shall be notified if present and must notify the director if room restriction exceeds an hour. If no members of the administrative treatment team are present, the director or designee shall be notified

6.11 All involuntary room restrictions shall result in a Class III incident report. The supervisor or lead staff member shall complete an Administrative Conference Notice Form. This form will be processed with the resident before returning to the general population.

6.12 While a resident is in involuntary room restriction, staff must visually and verbally contact, monitor and randomly document resident behavior a minimum of every ten minutes on the appropriate form. A staff member shall interact with the resident in an effort solve problems and determine release time. The documentation of contact shall be retained by staff. The goal is for involuntary isolation to be as short in duration as needed for the resident to regain and maintain composure.

6.13 The resident assists in determining the time needed to stay in the watch area first by demonstrating an ability to regain and maintain composure for fifteen minutes. Indicators of compliance include ability to sit or move quietly in the watch area, speaking in a controlled and respectful voice, answering questions of staff when asked, and following rules including not staring out the window. After fifteen (15) minutes of composure staff may ask the resident if they are willing to follow the rules and ready to leave the watch area. If they indicate that they are willing to follow the rules and ready to leave the watch area, they may be permitted to rejoin the general population after signing the administrative conference form. A resident may stay in the watch area for one (1) hour.

6.14 After one (1) hour in the watch area, if the resident has been unable to demonstrate fifteen (15) minutes of composure or if they still are unwilling to follow rules, then a risk assessment must be conducted and the resident shall be placed on special watch. Staff will document reasoning for any resident confinement extension and shall continue documentation randomly a minimum of every ten minutes until the resident is removed from watch. The supervisor must be notified of the special watch if present as well as the director.

6.15 Resident room restriction shall be reviewed a minimum of every two waking hours by an administrative treatment team member until the resident is determined to be appropriate to return to the general population. The review shall be documented on the watch form. If no administrative treatment team member is present, the director shall be apprised of the situation a minimum of once every eight hours which shall be documented on the watch form. The resident shall remain on special watch in accordance with procedures until removed.

6.16 The resident shall not earn the points of any activity missed during involuntary room restriction.

Room Restriction Following an Act of Violence

6.17 Room restriction shall be used when a resident commits an act of violence, directly threatens to commit an act of violence verbally or in writing, staff is able to document reasonable suspicion based upon conduct that an act of violence is imminent, or resident behavior is substantially disruptive to other residents and staff ability to maintain order and control within the facility.

6.18 When a resident is isolated from the general population following an act of violence, the room restriction will occur in the watch room with the confinement area secured. The resident shall be placed on special watch.

6.19 The supervisor or another member of the administrative treatment team shall be notified if present in the facility as well as the director. If no other member of the administrative treatment team is present, the director shall be notified.

6.20 If the resident escalated to Behavioral Level 3 and mechanical restraints were used, restraints shall remain in place until the resident is compliant to staff instructions. Mechanical restraints used in excess of fifteen minutes shall occur only with the approval of the Director and must be noted on the report.

6.21 The resident assists in determining the time needed to stay in the watch area by demonstrating an ability to regain and maintain composure and to make positive choices reflective of clearer thinking. The resident must demonstrate a minimum of one (1) hour of composed behavior by sitting or moving quietly in the watch area, speaking in a controlled and respectful voice, answering questions of staff when asked, and following rules including not staring out the window. If the resident remains on seclusion, the behavioral expectation for release to the general population shall be specified on the watch form.

6.22 Room restriction following an act of violence shall follow the same review procedures as listed in involuntary room restriction at 6.15: review must be conducted every two hours and documentation noted on the watch form.

6.23 A watch/isolation renewal form shall be completed each shift by the Central Control Operator.

6.24 A resident risk assessment shall be completed each morning that a resident remains on special watch.

6.25 An administrative treatment team member or staff designated by the director must meet daily with any youth in room restriction following an act of violence. The meeting must be documented on the watch log.

6.26 The Director must be notified and approve of return to the general population following an act of violence seclusion.

6.27 All room restriction, Suicide Watch and/or Special Watch documentation papers shall be kept together in the designated folder until the resident has been removed from all special observations. At this time, staff shall scan the documentation into the watch incidents file.

Administrative Treatment Team Review

6.28 The Administrative Treatment Team shall conduct a treatment plan review during their weekly meeting on any resident that is involuntarily placed on room restriction or after an act of violence. Resident room restriction beyond seventy-two (72) hours in a rolling thirty (30) day period shall be monitored, tracked, and reviewed. Changes on the treatment plan should be reviewed and initialed by the resident.

Resident Rights

6.29 Residents that are placed on room restriction from the general population shall be afforded living conditions and privileges approximating those available to the general population. Exceptions must be justified by clear and substantiated evidence.

6.30 During any period of isolation, the facility shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

6.31 When isolated from the general population, the facility shall clearly document the basis for the concern for the resident's safety and the reason why no alternative means of separation can be arranged.

General Room Restriction Guidelines

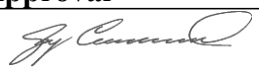
6.32 Resident behavior and comments will determine if restrictions are eased by permitting the resident to eat at a desk with staff, have reading and writing utensils, and take a shower when the living units are empty or after other residents are in bed.

6.33 If more than one resident requires room restriction they can be restricted to a sleeping room once all materials, clothing and bedding is removed from the room.

Reintegration with the General Populating following Involuntary Room Restriction

6.34 If a resident is placed on room restriction, a watch/isolation renewal form must be completed every eight hours and prior to reintegration with the general population. The review should be conducted by supervisory staff, staff with a rapport with the resident or a senior staff member. The Director will make a decision on resident reintegration with others. All room restrictions should be indicated on the shift information sheet daily until removed.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 07-17-18; 07-02-15; 07-16-19; 07-21-20	
Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Permanent Log**
Related Standards:	
O.A.C.	**5139-36-15 (E)(9)**
A.C.A.	**3-JCRF-3A-06**
P.R.E.A.	**None**

1.0 Purpose

To establish systems of communication.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to effective communication to promote continuity of care. The system of communication shall record routine information, emergency situations, and unusual incidents that occur in the facility. This shall include shift reports and shift information reviews

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Shift Supervisors are responsible for the following:

a. Completing a Shift Information Review form daily containing relevant information to be communicated to all Resident Care Workers.
b. Reviewing facility records ensuring that Resident Care Workers are completing documentation properly in order to facilitate effective communication.

5.2 Resident Care Workers are responsible for the following:

a. Logging onto computer and reading facility email daily
b. Reviewing the Shift Information Review form daily. Indicating the form has been read by signing and dating the form.
c. Recording routine information on the unit specific documentation forms as well as resident point sheets.
d. Recording emergency situations and unusual incidents on incident reports, and/or response to resistance forms.
e. Ensuring each entry is dated and contains identifying information of the author of the report.

5.3 Dayshift Central Control Operator is responsible for creating a Shift Information Review sheet in the absence of the shift supervisor.

5.4 All Staff is responsible for logging onto the computer, reading facility email, and responding as appropriate.

6.0 Procedures

6.1 Accurate and efficient documentation is vital in carrying out the mission of the facility. To ensure effective communication, all staff is responsible for logging onto the computer, reading facility email, and responding as appropriate.

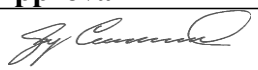
6.2 Resident Care Workers shall maintain a permanent log that records all routine information, emergency situations, and incident reports. Deviations from the schedule shall be documented including reasons for schedule changes. Names of residents in staffs' charge shall be listed each shift with all pertinent information documented.

6.3 If something occurs on one shift that has the foreseeable consequence of affecting another shift, then documentation should occur in a manner that identifies the issue, who was affected, and any actions taken. Such documentation is a key component in communication, keeping all staff aware of potential issues and aiding in resident treatment.

6.4 Each log entry should contain the date and identifying information of the author of the report.

6.5 The daily log and resident daily point sheets are passed to the on-coming shift.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 07-19-11 Prior Effective Date: 07-02-15 Date Revised: 07-17-18	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Inspections to Deter and Detect Staff Sexual Abuse and Reporting of Health, Safety and Sanitation Issues**
Related Standards:	
O.A.C.	**5139-36-08 (EE) 5139-36-10 (E)(20)**
A.C.A.	**3-JCRF-3A-07** (Revised August 1997)
P.R.E.A.	**28 CFR §115.311 (a) and 28 CFR §115.313 (e)**

1.0 Purpose

To establish guidelines supporting inspections of the facility that promote safety, security and cleanliness.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to the health, safety and sanitation. The facility supports daily inspections, including holidays and weekends, of all areas occupied by residents for identification of health, safety and sanitation issues. A daily written report is submitted to the facility administrator or designee. Unoccupied areas are to be inspected weekly. Intermediate or higher-level supervisors will conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Policy prohibits staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Resident Care Workers are responsible for the following:

a. Conducting daily checks within the building on all areas occupied by residents.
b. Reporting and/or remedying safety hazards and unsanitary conditions via maintenance request.
c. Nightshift RCW inspects the facility and documents on a daily report posted on the Director's door. Unoccupied areas are inspected once per week with safety and security concerns reported as needed.

5.2 Maintenance Supervisor performs weekly inspections throughout the interior and exterior buildings. When there is noted equipment deterioration, safety hazards and unsanitary conditions, notations are made and the situations are remedied or the Director is notified.

5.3 Compliance Coordinator will view and document quarterly random video checks and/or conduct inspections or view and document findings from randomly selected video clips from all shifts in all areas of the building to identify and deter staff sexual abuse and harassment. Such videos may also be used for staff training and commented upon in staff evaluations.

6.0 Procedures

6.1 Staff is responsible for conducting daily checks within the building including holidays and weekends of all areas occupied by residents. Any noticeable equipment deterioration, safety hazards and unsanitary conditions should be reported and/or remedied by staff immediately. A maintenance request should be made for any issue that is not able to be corrected by staff or under staff direction.

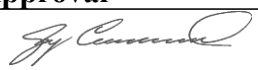
6.2 Nightshift inspects the facility and documents on a daily report posted on the Director's office door. Unoccupied areas shall be inspected by staff a minimum of once per week. Any safety and security concerns will be reported as needed.

6.3 The Maintenance Supervisor performs weekly inspections throughout the interior and exterior buildings. When there is noted equipment deterioration, safety hazards and unsanitary conditions, notations are made and the situations are remedied. If the problem is something outside the expertise of the Maintenance Supervisor, the Director will be notified and arrangements made to contract for needed services.

6.4 Due to proximity of intermediate and higher-level supervisors to the staff and residents, supervisor observation of staff is random. The facility supervisors directly oversee staff and may enter all areas of the building including areas inaccessible to other staff. Intermediate or higher-level supervisors occasionally view and document findings from randomly selected video clips from all shifts in all areas of the building to identify and deter staff sexual abuse and harassment. Such videos may also be used for staff training and commented upon in staff evaluations.

6.5 The Director or designee conducts and documents random unannounced rounds for all shifts on a quarterly basis to identify and deter staff sexual abuse and sexual harassment.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 03-11-14 Prior Effective Date: 05-11-17; 07-18-17 Date Revised: 07-20-21	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Resident Movement, Absence without Leave, and Escape Accountability**
Related Standards:	
O.A.C.	**5139-36-14 (G)(1)(a)(b)(c)(d)(2)(a)(b)(c)**
A.C.A.	**3-JCRF-3A-08 3A-09**
P.R.E.A.	**None**

1.0 Purpose

To ensure that residents are safe and accounted for both inside and outside the building.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to ensuring the safety of the community. No resident shall be unaccounted for while in or out of the facility. Staff shall monitor resident movement including the movement of residents into and out of the facility to detect any residents attempting to escape/run.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Resident Care Workers shall be responsible for the following:

a. Conducting headcounts in assigned unit at the beginning and end of each shift.
b. Notifying the Director of missing residents.
c. Conducting head counts at random intervals a minimum of every thirty minutes when a resident is in their room.
d. The staff on duty will also have provisions for random verification of residents on authorized leave from the facility. The Director shall be notified thirty minutes after a resident fails to return to the facility.
e. Ensuring residents are secured in their unit and their rooms in accordance with policies and procedures.

5.2 Central Control Operator will be responsible for the following:

a. Conducting resident head counts at random intervals a minimum of every two hours when able to visually observe residents or population counts verified by the staff supervising the residents when unable to visually observe residents.
b. Monitoring all resident movement into and out of the facility in a resident movement log.
c. Supervising resident movement in all common areas.

6.0 Procedures

6.1 To prevent absconders (residents trying to escape facility control), staff on duty will conduct regular population counts of residents in the facility. Headcounts will be conducted in the unit at the beginning and end of each shift. Central Control will conduct resident headcounts at random intervals a minimum of every two hours when able to visually observe residents. If visual observation is not possible, then Central Control shall conduct population counts verified by the staff supervising the residents. The time at which the count is taken and person doing the count are documented. In cases of scheduled or random population counts, immediate Director notification is required when a resident is missing.

6.2 While residents are in their sleeping rooms, headcounts shall be performed at random intervals a minimum every thirty minutes. This documentation can be done in the Central Control Log when residents are in their sleeping rooms for afternoon and dayshifts. Nightshift may maintain a more detailed accounting on their log documentation form.

6.3 The staff on duty will also have provisions for random verification of residents on authorized leave from the facility. No residents shall be unaccounted for while in or out of the facility.

6.4 To further aid detection of absconders, should any verification process indicate a resident's absence, the staff on duty shall immediately attempt to locate the individual by searching the facility and calling parents, guardians, friends, employers and the last destination indicated on the movement log or other itinerary sheet.

6.5 In event contact is made with the resident within an hour of the expected time of return, the resident shall be instructed to return to the facility immediately. An agreed upon deadline shall be established for the resident's return, not to exceed one hour or the minimum amount of time necessary to return to the facility.

6.6 Any resident that fails to return, or where indication exists that the resident will not return, will be declared an absconder. The Director shall be notified after thirty minutes when there is a failure to return to the facility. The Director will determine when to notify the authorities and any other necessary notifications.

6.7 Staff monitors all resident movement. Resident movement into and out of the facility is documented in the resident movement log and may also be located on the master sign out sheet. Residents are supervised in all common areas. Prior to letting a resident move into a secured hallway, staff shall ensure the direct supervision of the resident.

6.8 When there are only two staff members in the building, during night shift and early morning hours while residents are asleep, residents are not permitted out of their units. Staff shall keep the unit doors locked and minimize resident contact to that necessary to perform job duties. All residents should be secured in their rooms during nightly head counts. Only one resident at a time should be permitted out of their room for bathroom, emergency purposes, or chore duties. The secured unit door shall only be opened when two staff are present or no residents are unsecured. Both staff should be wearing or within reach of two-way communications devices.

6.9 The Central Control Operator is responsible for the overall safety and security of the building and must be observant at all times. Under situations that demand unusual or immediate action, the Central Control Operator can leave the secured position such as assistance in providing mechanical restraints. Such circumstances shall require an incident report. Keys are available in the staff lounge key box to unlock the Central Control door.

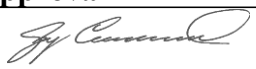
Transportation

6.10 If a resident absconds during transportation, staff shall immediately call 911. Staff shall then notify the Director.

Facility Lockdown Status

6.11 Upon verification of absconder status, the facility should immediately be placed in lock down. No residents shall be permitted to leave the facility until approved by the Director or designee.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 08-08-14 Prior Effective Date: 06-25-15; 07-18-17; 07-21-20 Date Revised: 07-20-21	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Resident Transportation**
Related Standards:	
O.A.C.	**5139-36-10 (E)(18)**
A.C.A.	**None**
P.R.E.A.	**None**

1.0 Purpose

To ensure staff, resident and community safety during resident transportation outside of the facility.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility recognizes the legitimate interest in protection of persons and property while establishing the necessity of mechanical restraints during resident transports. When the facility is responsible for the transportation of residents, decisions regarding mode of transportation shall be made on an individual basis.

4.0 Definitions/Documents

4.1 ***Mechanical Restraints:*** Any device used to restrict resident movement including handcuffs, chains, ankle shackles, and waist belt.

4.2 ***Court Authorization:*** Authorization granted by the committing court and/or court representatives.

5.0 Responsibility

5.1 Resident Care Workers are responsible for the following:

a. Ensuring residents that are not being mechanically restrained have court permission to be out of the facility.
b. Matching security classification to the procedures followed.
c. Securing residents in accordance with transportation procedures in vehicles equipped with partitioning between the front and back seat or obtaining director permission if transporting a resident in a vehicle that does not have appropriate partitioning.
d. Ensuring that a communication device is taken during the transportation: Staff may take their own personal cell phone or ensure that they are carrying the facility cell phone.
e. Requiring all passengers to wear seatbelts.

5.2 Central Control Operator is responsible for ensuring all tool and/or security risk items used in transport are signed out in the mechanical restraint log for transportation and signed in when returned.

6.0 Procedures

6.1 The Perry Multi-County Juvenile Facility shall handcuff all residents during transportation when the resident has not received court permission to be out of the facility for visits and/or community service.

6.2 Factors to be considered include the following:

- Age
- Resident record of contacts with the court system
- Possibility of escape
- History of lack of compliance with law enforcement, court personnel, probation officers, corrections officers, and parole.
- Danger presented to self or others
- Resident conduct during current incarceration
- Mental Health history
- History of escape and/or escape attempts
- Propensity towards violence

6.3 Other considerations include the decorum and dignity afforded to the resident in the perspective surroundings, maturity level of the resident, purpose of transportation, phase level, and the availability of less intrusive methods of security.

6.4 Residents shall be transported in the vehicles equipped with a protective barrier between the front and back seat.

6.5 The vehicle(s) equipped with 4-wheel drive may be used for transportation of residents at the discretion of the director.

Security Classification Rating

6.6 The facility shall establish three levels of security based upon the security classification rating system. Residents may be rated low, medium, or high risk.

Low Risk Security Classification

6.7 Low risk residents shall not require mechanical restraints in public settings. The resident may be transported in any vehicle while seated in the back seat furthest away from the driver. Handcuffs and waist belt may be removed at transportation destination.

Medium Risk Security Classification

6.8 Medium risk residents may require resident hands to be cuffed to the waist belt. The resident may be transported in any vehicle while seated in the back seat furthest away from the driver. Handcuffs and waist belt may remain on at transportation destination. Staff shall maintain continual sight and/or sound presence.

High Risk Security Classification

6.9 High risk residents shall require all mechanical restraints. Resident hands shall be cuffed to the waist belt and the ankles shall be shackled. The resident shall be transported in the partitioned/caged vehicle. Mechanical restraints shall remain in place at all times. Staff shall maintain continual sight and/or sound presence.

Transportation Procedures

6.10 All residents shall be transported based upon their security classification level. The level may be revised throughout the program as appropriate.

a. Residents shall be frisk searched prior to transportation to ensure that a weapon or other contraband has not been secured.
b. The vehicle shall be searched for contraband prior to transportation.
c. Mechanical restraints shall be applied as indicated by security level. Handcuffs and shackles shall be double-locked to prevent tightening and the possibility of picking the locks. If the resident complains that the cuffs are too tight, staff shall inspect the cuffs and make adjustments as needed.
d. All passengers shall be required to wear seatbelts.
e. Staff shall have the appropriate means of communication available: personal cell phones or the facility cell phone is required during transportation.

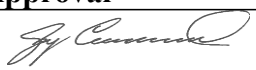
6.11 Staff may use the radio at an appropriate volume. Windows may be rolled down if desired.

6.12 Residents shall remain seated and shall not attempt to enter or exit the vehicle without staff permission. Residents shall keep their voices at an appropriate level.

Emergency Procedures

6.13 If a resident is being transported for medical care, staff may receive permission from the Director or Supervisor to make adjustments to mechanical restraints regardless of security level.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 05-12-15	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 07-02-15; 07-18-17; 07-17-18	
Date Revised: 07-20-21	

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Control of Contraband**
Related Standards:	
O.A.C.	**5139-36-10 (E)(10)(11)(12)**
A.C.A.	**3-JCRF-3A-12**
P.R.E.A.	**28 CFR §115.315 (a) (b) (c) (e)**

1.0 Purpose

To ensure the safety of residents, staff and the community by providing searches in an effort to control contraband within the facility.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to controlling contraband by providing for searches to control contraband and its disposition at a level commensurate with security needs. This policy is made available to staff and residents. Body cavity searches are not allowed in the facility.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Shift Supervisors are responsible for the following:

a. Demonstrating understanding of search policies and procedures.
b. Training all staff on proper frisk search procedures including modifications for professional cross-gender frisk search, transgender and intersex searches.
c. Conducting or designating staff to conduct and document weekly resident room searches including all resident rooms a minimum of once per month completing the appropriate documentation.
d. Notifying the maintenance supervisor of any issues discovered in resident rooms.

5.2 Resident Care Workers are responsible for the following:

a. Attending annual PREA training which includes training in proper frisk search procedures.
b. Demonstrating understanding of the modifications for professional cross-gender frisk search, transgender and intersex searches.
c. Conducting weekly room searches in accordance with supervisory instructions. Completing a room search incident report when finding contraband.
d. Conducting strip searches and completing documentation in accordance with policies and procedures.
e. Documenting frisk searches on unit specific documentation log.
f. Visually inspecting all areas of the facility occupied by residents each night.
g. Conducting a weekly inspection of all areas in the facility unoccupied by residents.
h. Completing the documentation for daily and weekly visual inspections located on the director's door by initialing and dating the inspection report form.

5.3 Compliance Coordinator is responsible for annually reviewing contraband policies and procedures making revisions as necessary.

6.0 Procedures

6.1 The facility will use the least intrusive method of search consistent with the safety and security of the facility.

6.2 The policy regarding searches for the control of contraband is published, made available to staff and residents, and reviewed at least annually and updated if necessary. Personal jewelry is not permitted at the facility and is considered contraband. Any item that is not approved for the area in which it is located or being used in a manner contrary to intended use may be considered contraband.

Room Searches

6.3 Supervisors are in charge of conducting or designating staff to conduct room searches randomly a minimum of once a week to aid in the control of contraband. Each room should be searched no less than once per month. Residents designated as higher risk may have their rooms searched regularly. Additional room searches may be conducted to locate missing items or when there is a suspicion of contraband. If contraband is found, a room search incident report shall be completed.

6.4 Resident Care Workers are responsible for conducting a nightly visual inspection all areas of the facility occupied by residents and a weekly inspection of all areas of the facility unoccupied by residents. A sheet for daily and weekly visual inspections is located on director's door. The documentation on must be dated and signed daily.

Pat-down Searches

6.5 Pat-down searches may be conducted without specific authorization upon entry to the Perry Multi-County Juvenile Facility and at all times when based upon a reasonable belief that the resident is carrying contraband. Pat-down searches may be conducted after visit, counseling, following the dispensing of medication, at any time when a resident is returning from outside the building, prior to resident transportation, and with specific authorization from supervisory staff.

6.6 The facility shall not conduct cross-gender pat-down searches except in exigent circumstances. Any exigent circumstances resulting in cross-gender pat-down searches shall have Director approval and be fully documented and justified in an incident report which shall include details of the circumstances as well as contact initiated, time and approval from director. Resident(s) requiring search should be isolated during exigent circumstances until such approval is granted. Female staff is prohibited from performing cross-gender strip searches or cross-gender visual body cavity searches.

Visitors

6.7 Resident visitors shall be subject to metal detection, frisk and/or wand search prior to visitation. Refusal to consent to a search shall be grounds for removal from the premises. Visitors shall not be permitted to bring any gifts, packages, food or other items into the facility without prior written consent from facility administration. Any approved item shall be inspected before it shall be taken into the secure area of the facility.

Strip Search

6.8 Prior to intake, each resident shall be assessed using the Strip Search Authorization Form. Strip searches shall be conducted in accordance with the form.

6.9 Residents identifying themselves as transgender or intersex upon intake shall be asked which gender they are more comfortable with for purposes of pat-down and strip searches. The facility shall act in a professional and respectful manner congruent with the resident's comfort and self-identification.

6.10 All residents shall receive a pat-down search at intake. Residents will be asked to empty their pockets and proceed to the intake area. Based upon the risk determination on the Strip Search Authorization Form, residents shall remove their clothing in front of male staff or in the shower area. All residents shall take a shower using the delousing formula prior to changing into institutional clothing.

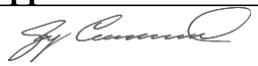
6.11 Two male staff will be present when conducting strip searches of male residents. Strip searches are conducted without any physical contact with the resident. Strip searches shall not be conducted for the sole purpose of determining a resident's genital status.

6.12 If a strip search reveals evidence that contraband is being secured in a body cavity, medical personnel outside of the facility may perform the search. Body cavity searches are prohibited in the facility.

6.13 The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

6.14 Strip searches may be performed with authorization at all times when based upon a reasonable belief that the resident is carrying contraband. The reasonable belief must be documented on an incident report and the strip search must be authorized by the Director or Designee.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 05-12-15 Prior Effective Date: 07-02-15; 07-24-17; 07-18-17 Date Revised: 07-17-18	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Tools, Equipment, and Keys**
Related Standards:	
O.A.C.	**5139-36-10 (E)(7)(14)(16)(a)(b)(c)(d)(e)(f)(g)(17)(18)**
A.C.A.	**3-JCRF-3A-13** (Revised January 2001 Mandatory)
P.R.E.A.	**None**

1.0 Purpose

To ensure the safety and security of the premises by controlling the use of tools, equipment and keys throughout the facility.

2.0 Persons Affected

All employees

3.0 Policy

Perry Multi-County Juvenile Facility has rules governing the control and use of tools, equipment, and keys. All items identified as tools shall be documented and counted daily. If a tool is in use, means should be available to track the tool until it is returned to its proper location. Items identified as equipment shall be checked daily and use should be documented. Keys are to be identified and secured at all times.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 All Employees are responsible for adhering to proper procedures for care and handling of keys.

5.2 Resident Care Workers are responsible for the following:

a. Using limited access codes to obtain and return security keys.
b. Conducting and documenting nightly key checks on the key checklist.
c. Reporting missing, broken or malfunctioning keys and tools to the Maintenance Supervisor.
d. Conducting daily tool inventories while maintaining safety and accountability by returning tools to their appropriate locations behind locked doors as stored.

5.3 Central Control Operator is responsible for the inventory and documenting accountability of the security risk items kept at Central Control including mechanical restraints.

5.4 Maintenance Supervisor is responsible for the following:

a. Conducting daily tool inventory in the garage, mechanical room and cleaning cart.
b. Conducting inventory in the community service building as used a minimum of once per month when not in use.
c. Maintaining the operational function of the locks throughout the facility and notifying the director of issues.
d. Responding to staff issues of broken or malfunctioning keys and tools

5.5 Kitchen Staff are responsible for the following:
   a. Completing the daily food safety checklists
   b. Documenting daily accountability of security risk items including the knife cabinet, stainless steel drawer and meat slicer, janitor closet, and pots and pans.

6.0 Procedures

Security Keys

6.1 Security keys shall be secured by staff at all times. When a security key is not in use it shall be kept in the Morse Watchman Box, a locked key safe, or otherwise accounted.

6.2 Any employee leaving the facility with a key ring shall return it immediately upon realizing the mistake and when instructed by the facility. An employee who loses, misplaces, or otherwise cannot account for a key or key ring shall immediately alert the shift supervisor and submit a written report. If a key breaks inside a lock, the employee should promptly report the issue to the maintenance supervisor and alert the Central Control Operator so they can remain vigilant monitoring the location of the broken key.

6.3 If a key is broken or malfunctioning, it is reported to the Maintenance Supervisor and/or the Facility Director. The key can be replaced by a duplicate key or ordered if necessary. A duplicate set of keys is available in the Director's office.

6.4 Employees shall not refer to key numbers or other means of key identification within earshot of a detainee.

6.5 Emergency keys and keys to control security are clearly marked for staff.

Key Box #1

6.6 The combination to the key safe is given to Administrative, Kitchen and Supervisory Staff. Key(s) removed or returned to the key box are documented on the key log located in the box and inventoried monthly by a Shift Supervisor.

6.7 The key to unlock the Morse Watchman Box is located in Key Box #1.

Morse Watchman Box

6.8 Keys in the key box shall be identified and inventoried daily by the computer. Each staff is given an access password and granted access to keys specified by their positions.

6.9 The Central Control Center Key is available to all staff as well as the facility vehicles.

Mechanical Tool Control

6.10 Control of tools will consist of shadow boards and sign in and out sheets. All tools shall be inventoried and logged. When in use away from the inventory area, the tools will be signed out and returned as noted on the sheets.

6.11 Tools brought into the facility for use in the facility shall be inventoried upon entrance and exit or kept in areas not accessible by residents.

6.12 Handcuffs, belts and shackles are mechanical restraints and shall be considered tools. These tools are to be inventoried daily. Any use of mechanical restraints is to be documented.

6.13 There are forms available for all broken tools. Staff may also email the Assistant Director.

Kitchen Tool Control

6.14 Residents are not permitted in the kitchen without direct supervision or approval from the Director. All knives are kept in a locked cabinet when not in use along with instruments with sharp edges such as thermometers. Knives and culinary equipment are checked and documentation is performed daily.

6.15 Eating utensils are accounted for and documentation is completed after each meal. The utensils are kept behind a locked door that is checked daily.

6.16 Forms are available for all broken tools and equipment.

Medical Equipment Control

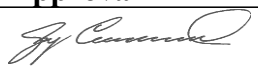
6.17 All medical equipment is locked and secured in the nurse station. No residents are permitted in the nurse's office without staff supervision.

6.18 A defibrillator is in a secured cabinet with an alarm in the hallway.

6.19 All prescription and non-prescription medication is stored behind two locks inside the medication cart at Central Control. When medication is taken from the cart, documentation is kept showing the staff person removing the medication and the person that requested the medication.

6.20 Surplus supplies and non-prescription medication is kept in the nurse/intake office behind a locked door.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Investigation into Allegations of Misconduct and Preservation of Physical Evidence**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-3A-14** (Added new subtitle January 1995)
P.R.E.A.	**28 CFR §115.321 (a) §115.364 (a)(1)(2)(3)(4)(b)**

1.0 Purpose

To ensure planned response for allegations of misconduct and in the preservation, control and disposition of physical evidence in connection with a violation of law and/or facility regulation.

2.0 Persons Affected

All employees

3.0 Policy

Perry Multi-County Juvenile Facility ensures that allegations of misconduct are immediately addressed by staff commensurate to the seriousness of the allegation and the ability to prevent or alleviate harm. Staff shall take immediate actions to implement a coordinated response to reports of sexual misconduct.

The facility provides for the preservation, control, and disposition of all physical evidence obtained in connection with a violation of law and/or facility regulations. At a minimum, the procedures shall address chain of custody, evidence handling and location and storage requirements.

4.0 Definitions/Documents

Commensurate means corresponding in size or degree; proportional.

5.0 Responsibility

5.1 Director is responsible for approving contact with law enforcement for investigation.

5.2 Shift Supervisors are responsible for the following:

a. Ordering lockdown of the facility any time a major crime takes place or is alleged where an immediately investigation is necessary in accordance with procedures.
b. Securing the crime scene and notifying the director of law enforcement referral request.
c. Separating residents when allegations of serious misconduct have occurred as well as procuring written statements from residents for Class III allegations.
d. Ensuring staff is following procedures in documentation, supervision, and separation of the accuser and accused in consideration to the seriousness of the allegation.
e. Collecting and securing evidence

5.3 Resident Care Workers are responsible for the following:

a. Contacting shift supervisors and/or ordering lockdowns when a major crime takes place or is alleged.
b. Conducting and documenting resident head counts during lockdowns.
c. Immediately addressing allegation of misconduct commensurate to the seriousness of the allegation and the ability to prevent or alleviate harm
d. Providing documentation on the allegation, separating the accused and accuser, and maintaining proper supervision to prevent any further issues.
e. Following first responder duties as listed for the prison rape elimination act.

6.0 Procedures

Allegations of Resident Misconduct

6.1 Staff has the duty to provide for the safety and well-being of each resident.

6.2 Upon hearing an allegation of misconduct, staff first priority shall be taking action to alleviate or prevent harm based upon the seriousness of the allegation involved.

6.3 Staff shall immediately separate the accuser and the accused. The distance of the separation shall depend on the seriousness of the allegation. Residents shall not be placed in close proximity for twenty-four (24) hours without staff monitoring their interactions.

6.4 The second priority shall be in determining whether the allegation is true or false, accurate or inaccurate, and whether the allegation is serious or not.

6.5 Staff shall obtain and document the basic information from the accuser and the accused. Basic information includes details such as who was involved, what happened, where it happened, and when it happened. Witnesses may also be questioned.

6.6 If the allegation involves a Class III incident or serious threat, the residents shall be isolated away from each other so that their stories and any witnesses do not have the opportunity to communicate with each other. Written statement forms are available at Central Control. The resident statements shall be documented.

6.7 If the allegation involved a Class I offense, the event should be discussed with the involved residents. Descriptions of the allegation shall be documented including staff response to the allegation. Residents should be encouraged to be honest and respectful to each other. Any inappropriate responses should be documented with appropriate consequences given.

6.8 If staff witnessed the event, staff should document what they saw or heard. Staff shall document any deviations from the accuser and the accused descriptions and make any determinations of truth or falsehood.

6.9 If staff did not witness the event, they shall try to make a determination of truth based upon the information they have gathered. If they are not reasonably certain about what occurred, they shall document the information they have gathered in an informational incident report.

6.10 Discipline shall match the severity of the allegation. It shall be firm, fair and consistent. Discipline shall be inescapable with resident unable to manipulate their way out of the consequences or bargain for lesser consequences. The consequences shall be relevantly related to the offense as able.

Allegations of Sexual Misconduct

6.11 Staff shall follow first responder duties as listed in Part 6: PREA policies and procedures.

Physical Evidence Major Crime

6.12 The goal of the facility is to follow uniform evidence protocol to maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

6.13 Any time a major crime takes place or an allegation of a major crime is made, the area in which the incident occurred shall be sealed, the facility shall be placed in lock-down status, and the Director shall be called to approve law enforcement referral. Such crimes include any death at the facility, murder, attempted murder, rape, sexual assault, sexual abuse, or escape.

6.14 The Perry County Sheriff's Office shall be in charge of conducting the investigation and evidence collection of any major crime listed in 6.2.

6.15 While the Perry County Sheriff's Office is conducting the investigation and preserving evidence, resident head counts shall occur and be documented every fifteen minutes. Residents shall not be permitted out of lock-down until specific orders are given from the Director and/or law enforcement.

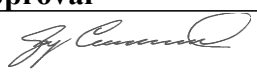
Physical Evidence Facility Violation

6.16 All other physical evidence obtained in connection with a violation of law and/or facility regulation and not a part of a major crime shall be documented in an incident log. The evidence shall be turned in to a Supervisor and then forwarded to the Director.

6.17 If possible, blood and body fluid evidence should be secured in a sealed plastic cup and placed in a paper bag using universal precautions. Other evidence can be secured in a plastic bag. The Supervisor or Resident Care Worker should seal the bag shut with a white label. The label should include the signature of person securing the evidence, any witness to the evidence being placed in the bag, the date, and the time. The evidence may then be placed in the double locked nurse's office if the Director's Office is unavailable.

6.18 Any contraband which may require a law enforcement referral will require Director notification prior to further investigation. The crime scene should be secured until appropriate steps can be taken to collect any evidence.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 07-02-15; 7-18-17
Date Revised: 07-17-20

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Safety and Emergency Procedures**
Subject:	**Fire Safety Codes, Regulations, and Procedures**
Related Standards:	
O.A.C.	**5139-36-08 (A)(B)(C)(D)(1)(2)(3)(4)(5)(E) 5139-36-10 (E)(19)**
A.C.A.	**3-JCRF-2A-03 3B-01 3B-02 3B-03 3B-04 3B-05 3B-06 3B-07 3B-08 3B-09**
Mandatory	**3-JCRF-3B-10 3B-11**
P.R.E.A.	**None**

1.0 Purpose

The Perry Multi-County Juvenile Facility is committed to adhering to all applicable safety and fire codes and has the necessary equipment and procedures in place in the event of a major emergency.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall comply with the regulations of the state or local fire safety authority to ensure the safety of staff, residents and visitors. Care shall be taken to ensure equipment availability with all inspection and testing is conducted on facility equipment at least quarterly with furnishings evaluated for fire safety prior to purchase. Prevention measures are taken to ensure accurate fire safety procedures including annual inspections by qualified personnel, emergency plan training and fire drills conducted monthly with evacuation plans posted throughout the facility. Provisions have been made for fire protection service. The facility is smoke-free with a noncombustible receptacle provided at the entrance to the building. Care in control and usage shall be required for flammable, toxic and caustic materials.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Maintenance Supervisor is responsible for the following:

a. Arranging quarterly and annual fire inspections and accompanying the fire inspector during the testing.
b. Ensuring emergency exit plans are posted in listed places throughout the building
c. Keeping files and providing documentation of all testing and inspections to the director and compliance coordinator.
d. Ensuring care in control and usage for flammable, toxic and caustic materials. This includes ensuring chemicals are properly labeled, inventoried and stored with available of Safety Data Sheets (SDS) in areas of usage with a complete SDS binder in the chemical storage area.
e. Approving requests on the chemical exception form ensuring SDS sheets are available.
f. Posting evacuation plans throughout the building and keeping a written copy of the location of all publicly posted plans.
g. Obtaining annual safety inspections for all facility vehicles.

5.2 The Shift Supervisors are responsible for the following:
   a. Overseeing and/or conducting monthly fire drills for each shift varying times and locations of the drills.
   b. Ensuring receptacles inside the facility are emptied daily by residents and/or staff.

5.3 The Compliance Coordinator is responsible for ensuring fire evacuation plans are annually disseminated to the New Lexington Sheriff Department and the New Lexington Fire Department.

5.4 The Director or designee is responsible for ensuring facility furnishing in living units, exit areas and places for public assembly are evaluated for fire safety prior to purchase.

6.0 Procedures

Exits and Exit Plans

6.1 The state fire marshal or an authority having jurisdiction inspects exits in the facility. Documentation is maintained indicating compliance.

6.2 The facility shall have posted in all areas, emergency exit plans that are properly positioned, clear, distinct and permanently marked in order to ensure the timely evacuation of residents, staff and visitors in the event of fire or other emergencies. Posted exit plans shall include clearly marked exits, location of fire extinguishers, first aid kits, pull stations and other essential life-safety equipment.

Testing

6.3 All facility fire equipment is tested a minimum of four times yearly and inspected by the local authority once annually. All documentation of inspections, findings, and changes is kept on file.

Fire Safety

6.4 The New Lexington Fire Department is located less than two miles from the facility and would respond in case of a fire. The fire department typically visits once annually for a walk through of the facility.

6.5 Fire drills are performed once monthly at all facility areas. Qualified and certified personnel inspect systems quarterly throughout the year. The state certified fire inspector approves systems annually. Protection equipment is located throughout the facility.

Fire Safe Furnishings

6.6 Facility furnishings that meet fire safety performance requirements will be selected for purchase.

6.7 There is documentation by a qualified source that the interior finishing materials in resident living areas, exit areas, and places of public assembly are in accordance with recognized codes.

Smoking

6.8 The facility is smoke-free. Smoking is permitted in personal vehicles only.

6.9 A noncombustible receptacle is placed outside of the facility for refuse.

6.10 Special containers provided for flammable liquids are located in the storage shed behind the building. Only materials that can be disposed of immediately after use will be provided in storage shed for use with flammable liquids.

6.11 All receptacles and containers located inside the facility are emptied and cleaned daily.

Flammable, Toxic and Caustic Materials

6.12 Any product that is flammable, toxic, and/or caustic will be stored in locked areas and have appropriate labels affixed indicating the danger with current Material Safety Data Sheets.

6.13 Chemicals will be inventoried in the areas in which they are stored. Flammable, toxic and caustic materials shall be stored in the kitchen storage closet, the maintenance room, and the garage in the storage cage.

6.14 Whenever a chemical is removed from a storage area, it shall be signed out and documented when returned.

6.15 Chemicals may be brought to the facility for use in rigorous cleaning by completing a request to the Facility Maintenance Supervisor or Director. These chemicals are not to be kept in the facility and must be removed by the time and date specified on the form. MSDS sheets should accompany any product brought to the facility.

6.16 Chemicals kept in the living units shall not be flammable, toxic or caustic. The facility shall minimize resident contact with flammable, toxic, and caustic materials by purchasing products that have low hazard ratings.

6.17 Residents will not use products that are listed as flammable, toxic, and caustic without strict supervision.

Evacuation Plans

6.18 Written emergency evacuation plans are posted throughout the building. These plans show the building floor plan and the exits with directional arrows for traffic flow. A master plan shall show the locations of all posted evacuation plans.

6.19 Monthly fire drills are conducted in all facility locations to ensure residents know the emergency plan. The drills are scheduled on a rotating basis for all shifts. All drills are documented.

6.20 The Maintenance Supervisor is responsible for posting plans throughout the building and keeping a written copy of the location of all publicly posted plans. The emergency plans are submitted annually via the mail or signed by the local fire department and may include an invitation to view the Perry Multi-County Juvenile Facility in person with the accompaniment of other firefighters.

6.21 An independent outside inspector trained in the application of national fire safety codes approves the emergency evacuation plan annually. The plans are updated as needed.

Dissemination of Emergency Plans

6.22 Emergency plans are posted throughout the building, including the entry area to the building. All plans include directions to and the locations of exits, fire extinguishers, first aid equipment, and other emergency equipment.

6.23 Plans are disseminated to the fire department and the sheriff's department.

Training

6.24 All fire, storm, evacuation and other emergency plans are posted. The emergency plans are communicated to all employees and residents during their orientation. The emergency plans are reviewed and updated annually for all employees.

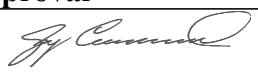
Fire Alarm System

6.25 The facility has a fire alarm system with automatic detection. All parts are tested four times a year with annual inspections and approval by the state certified fire inspector.

Safety Inspections of Mass-Transport Vehicles

6.26 Agency vehicles may be given annual safety inspections. Immediate completion of any safety violation will be kept on file.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 05-12-15 Prior Effective Date: 07-02-15; 07-17-18 Date Revised: 07-21-20	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Safety and Emergency Procedures**
Subject:	**Continuous Facility Operations**
Related Standards:	
O.A.C.	**5139-36-04 (J)**
A.C.A.	**3-JCRF-3B-12 1C-18**
P.R.E.A.	**None**

1.0 Purpose

To establish a written plan for continuous facility operation.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to maintaining continuous facility operation in the event of employee work stoppage or other job action. Copies of a written plan for continuous operation are available to all supervisory personnel who are required to familiarize themselves with its content.

4.0 Definitions/Documents

None

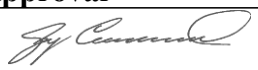
5.0 Responsibility

5.1 The director is responsible for establishing a plan for continuous facility operation.

6.0 Procedures

6.1 Full-time and/or part-time provisional appointments may be obtained from local law enforcement agencies, juvenile courts, and current job applicants during times of severe emergency. These appointments will not be considered permanent replacements for permanent personnel.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-17-18	

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Safety and Emergency Procedures**
Subject:	**Critical Incidents**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-3B-13** (Added January 2003)
P.R.E.A.	**None**

1.0 Purpose

To ensure the wellbeing of staff, residents and the facility following a critical incident.

2.0 Persons Affected

All employees

3.0 Policy

Critical incidents for the facility provide for a debriefing to be conducted after each such incident. The debriefing process includes coordination and feedback about the incident with designated staff of the facility as soon as possible after the incident. A debriefing includes a review of staff and resident actions during the incident, review of the incident's impact on staff and residents, review of corrective actions taken and still needed and plans for improvement to avoid another incident

4.0 Definitions/Documents

4.1 Critical incidents include any death of an individual identified with the facility, suicide attempts, life threatening injuries requiring emergency treatment or hospitalization, group disturbances that result in injury or disruption of established facility activities such as a hunger strike hunger strike or program stoppage, sexual misconduct by a youth with another youth, staff, visitor, volunteer or contract personnel, any incident jeopardizing the safety and security of facility operations such as a bomb threat, hostage situation, fire or natural disasters that impair the facility, escape attempts or actual escapes, and finding major contraband such as a knife, firearm or controlled substance.

5.0 Responsibility

5.1 Resident Care Workers are responsible for identifying a critical incident, immediately notifying supervisors and/or the director, checking on the wellbeing of residents in their charge and documenting the incident on an incident report.

5.2 Shift Supervisors are responsible for the immediately notification of the director during a critical incident, writing a critical incident report, and providing a debriefing to staff on duty at the time of the incident.

5.3 Treatment Team Member(s)s are responsible for conducting a review of staff and residents' actions during the incident, review of the incident's impact on staff and residents, review of corrective actions taken and still needed and plans for improvement to avoid another incident.

6.0 Procedures

6.1 An incident shall be considered a critical incident if it is an unusual event that could be classified as a crisis event. A crisis event will typically be sudden, powerful and outside the normal range of ordinary human experience.

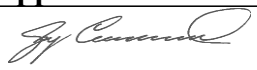
6.2 Critical incidents shall include any death of an individual identified with the facility, actual suicide attempts, life threatening injuries requiring emergency treatment or hospitalization, group disturbances that result in injury or disruption of established facility activities such as a hunger strike or program stoppage, sexual misconduct by a youth with another youth, staff, visitor, volunteer or contract personnel, any incident jeopardizing the safety and security of facility operations such as a bomb threat, hostage situation, fire or natural disasters that impair the facility, escape attempts or actual escapes, and finding major contraband such as a knife, firearm or controlled substance. Each of these situations requires documentation by the staff involved on an incident report as well as immediate notification of the Director. A critical incident report should also be completed by the supervisor on duty.

6.3 A staff debriefing will occur as soon as possible after a critical incident with the supervisor on duty at the time of the incident. Treatment team member(s) are responsible for conducting a review of staff and resident actions during the incident, review of the incident's impact on staff and residents, review of corrective actions taken and still needed and plans for improvement to avoid another incident at the next scheduled shift change or staffing meeting.

6.4 A resident debriefing may occur as soon as possible after a critical incident with a member of the treatment team. The resident debriefing will focus on the emotional impact of the incident on each resident.

6.5 All critical incidents are reviewed by the administration, which may include health services and security personnel including any information not available at the time of the original incident to review the validity and appropriateness of all policies, plans, and information used during the critical incident and immediately after. Other factors examined may include who was involved in the incident, precipitating factors to the incident, responses of staff and residents, communications used during the incident and immediately following, impact of the incident on others, a review of any corrective actions taken and still needed, and plans for improvement.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Safety and Emergency Procedures**
Subject:	**Weather Emergencies**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	**None**

1.0 Purpose

To ensure staff and residents are prepared for weather related emergencies.

2.0 Persons Affected

All employees

3.0 Policy

Emergency preparation shall be made in the event of weather-related emergencies such as tornadoes. Residents and staff shall be familiar with the plan and take steps to activate the plan during weather emergencies.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Central Control Operator is responsible for the following:

a. Ensuring the facility cell phone is available for emergency use.
b. Ensuring the availability of emergency weather information during tornado watches.
c. Alerting staff in the building of tornado warnings and the need to take shelter.
d. Notifying staff in the storm shelter when tornado warning has been lifted.
e. Coordinating with shift supervisors and contacting parents possibly traveling to the facility of cancellation of visits and other scheduled activities due to the weather during Level 3 snow emergencies.

5.2 The Shift Supervisors are responsible for the following:

a. Notifying the Central Control Operator when a Level 3 snow emergency occurs in Perry County requiring visitation to be cancelled and organizing the notification of parents.
b. Preparing staff to follow emergency shelter plan when Perry County is under a tornado watch with conditions right for a tornado.
c. Approving the exit of the storm shelter following a tornado warning.
d. Postponing movement outside the facility in emergency situations.
e. Ensuring staff is conducting monthly storm drills.

5.3 Resident Care Workers are responsible for the following:

a. Knowing the emergency plans.
b. Escorting residents to the storm shelter.
c. Ensuring a radio is available in the storm shelter.
d. Conducting monthly storm shelter drills.

6.0 Procedures

Level 3 Snow Emergencies

6.1 Activities at the facility shall be cancelled. Attempts should be made to notify all parents possibly traveling to the facility that activities have been cancelled due to the weather. Residents should not be transported out of the facility unless emergency circumstances warrant the transport.

Tornadoes

6.2 Seasonal activity will necessitate the use of the emergency tornado shelter for residents and staff. Staff shall be aware of seasonal activity and may use a radio at Central Control tuned to 105.9 or 102.5 for emergency notification.

6.3 During times of tornado watches, conditions are right for the formation of tornadoes. Staff should be notified that there are watches in the county via the "All Page" system or informally calling the staff in the building. Tornado policy may be reviewed with the residents under staff care.

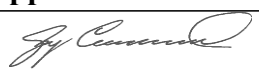
6.4 If there is a warning in the county, the residents should walk in an orderly fashion to the facility shelter located in the medical office including the intake bathroom and shower. Residents and staff may take the radio into the shelter. Everyone should remain in the shelter until the warning has been lifted.

6.5 Staff may also contact the local Sheriff's Department for specific weather information. The Perry County tornado siren will sound for all warnings in the county.

6.6 Movement and activities outside the building should be postponed in emergency situations.

6.7 A facility cell phone shall be located at Central Control for emergency use.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 07-02-15; 07-18-17; 07-17-18; 07-20-21
Date Revised:07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Safety and Emergency Procedures**
Subject:	**Suicide Prevention and Intervention Program**
Related Standards:	
O.A.C.	**5139-36-18 (G)**
A.C.A.	**3-JCRF-4C-06** (Revised August 1994 Mandatory)
P.R.E.A.	**None**

1.0 Purpose

To establish a system of assessment and review of residents exhibiting high risk behaviors in order for staff to intervene prior to any self-injurious acts or suicidal attempts.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to providing for the safety and security of the residents in our care. There is a written suicide prevention and intervention program reviewed and approved by qualified medical or mental health professionals. All staff with responsibility for resident supervision shall be trained in the implementation of the suicide intervention and prevention plan. The plan includes specific procedures for intake screening, identification, and supervision of suicide-prone residents.

4.0 Definitions/Documents

4.1 Suicide Risk Assessment
4.2 Suicide Watch Cover Sheet
4.3 Suicide Watch Log
4.4 Special Watch Cover Sheet
4.5 Special Watch Log
4.6 Risk Assessment Form
4.7 Watch/Isolation Renewal Form
4.8 General Observation Documentation

5.0 Responsibility

5.1 The Health Care Authority shall review and approve the suicide prevention and intervention plan.

5.2 Training Coordinator is responsible for conducting an annual suicide prevention and intervention training, documenting staff training hours, and providing information of training compliance or lack of compliance to the director on an annual basis.

5.3 Shift Supervisors are responsible for the following:

a. Completing a Shift Information Review Log Daily
b. Ensuring that staff on duty are signing the Shift Information Review Log.
c. Knowing and understanding how to implement the suicide prevention and intervention plan.
d. Ensuring the documentation provided by staff during any watch is accurate and complete according to policies and procedures.

5.4 The Clinical Coordinator is responsible for the following:

a. Reviewing and approving the suicide prevention and intervention plan.
b. Completing resident intake screening by reviewing resident intake information, interviewing the resident and completing a suicide risk assessment making a determination on watch status including renewal, removal or changing to a suicide watch.
c. Communicating the mental health status of each intake resident to the appropriate staff
d. Communicating on-going mental health concerns to appropriate staff
e. Advising staff in the care and treatment of individuals displaying suicidal indicators
f. Assisting the training coordinator in annual suicide prevention and intervention training.
g. Providing daily contact and completing daily risk assessments of all residents on any watch when working at the facility.
h. Making determinations of watch status including renewal, removal, increasing status or decreasing status.
i. Providing documentation of resident removal from suicide watch and why the decision was made including a date, time and mental health professional qualifications.
j. Ensuring all suicide watches are downgraded to a special watch prior to removal of watch status.

5.5 Resident Care Worker are responsible for the following:

a. Daily reading and signing of the Shift Information Review Log to keep informed about any unusual incidents, behaviors, or medical conditions that exist with any resident.
b. Creating a Shift Information Review Log in the absence of the shift supervisor.
c. Knowing and understanding how to implement the suicide prevention and intervention plan.
d. Ability to identify early warning signs and suicidal indicators of residents.
e. Immediately informing the Clinical Coordinator and/or Director when a resident is displaying suicidal indicators so an assessment can be conducted and/or a suicide or special watch ordered.
f. Placing a resident on suicide watch and completing a risk assessment any time a resident threatens to harm himself.
g. Performing a risk assessment for a resident in the absence of the clinical coordinator when a resident demonstrates potential for violent behavior, potential for flight, questionable mental health status, or any other reason determined by the clinical coordinator, mental health professional or administration.
h. Ordering a special watch when indicated on the risk assessment
i. Possessing and demonstrating the ability to appropriately intervene in crisis situations
j. Communicating information concerning resident behaviors, comments and actions that could alert co-workers and mental health staff of potential issues.
k. Making and documenting observations at random intervals not to exceed ten minutes on the appropriate suicide watch log, special watch log, or general observation form.
l. Ensuring each resident is wearing the clothing specified and in the locations appropriate for their watch status.
m. Offering the suicide gown and blanket in the watch room at night, maintaining a direct line of sight while viewing the camera from Central Control.
n. Maintaining direct line of sight of a suicidal resident while documenting suicidal resident behavior/attitude and interactions with other staff and residents.

o. Attending and completing annual suicide prevention and intervention training.
p. Documenting annual review of policies and procedures.
q. Ensuring that no shaving instruments are used during any resident watch.
r. Immediately informing the director of all watches and completing the appropriate documentation
s. Observing and documenting residents that are isolated from the general population due to illness a minimum of once every fifteen minutes including the reason for isolation on the general observation form.
t. Observing and documenting residents that are taking a time out in the watch room on the general observation form.
u. Talking to the resident and completing a watch/isolation renewal form prior to making any decisions about reintegrating a resident with the general population when a resident is on special watch, suicide watch, or is restricted to a room isolated from the general population due to behavior for longer than 2 hours.

6.0 Procedures

Shift Information Review Log

6.1 Resident Care Workers shall read and sign the shift information review log to keep informed about any unusual incidents, behaviors or medical conditions that exist with any resident at the beginning of each shift. If a resident has been placed on any type of watch, this information shall be documented on an incident report as well as on the shift information review log. Shift supervisors shall be responsible for writing the log with a senior staff member assuming this duty in the absence of a shift supervisor.

Intake Screening

6.2 Each resident that is admitted into the facility will be placed on a special watch until the resident is interviewed by the Clinical Coordinator and a suicide risk assessment is completed. The resident will be observed and documentation of the resident behaviors will be noted in the special watch log. The documentation must occur randomly a minimum of every ten minutes.

6.3 Each new resident shall answer questions concerning a history of mental health issues including any suicidal ideation, thoughts, gestures, statements and records. A social history shall include information concerning previous hospitalizations, medications and mental health treatment. This information will also be asked of the resident's parents and caregivers on the date of admission, prior to the resident's admission to the facility, or as soon as possible after admission. Providing records documenting prior mental health issues will be the responsibility of the court or county that admitted the resident.

6.4 Prior to the resident being released from the intake precautionary special watch, the clinical coordinator shall review all the records kept during the watch and conduct an interview with the resident. Using the interview and records, the Clinical Coordinator shall complete a suicide risk assessment and make a determination on watch status including renewal, removal or upgrading the status to a suicide watch.

6.5 The Clinical Coordinator shall communicate the mental health status of each intake resident to the shift supervisor or other appropriate staff following the suicide risk assessment.

Suicide Awareness/Suicide Watch

6.6 Every staff member will be required to attend annual suicide prevention and intervention training as well as complete a documented policy and procedure review on the suicide prevention and intervention plan. All staff will be given training on identifying the warning signs of suicide that include but are not limited to the following:

- Feelings of hopelessness
- Feelings of worthlessness, shame, and/or guilt
- Symptoms of withdrawal, irritability, "no one cares" statements or attitude, or prone to angry outbursts, fear of losing control or thoughts of harming self and others
- Feelings of loss of self-control or powerlessness
- Resident becomes sad, withdrawn, tired, apathetic, anxious, and irritable
- Declining work performance in school, groups, or phase work
- Decline in otherwise identified interested activities such as recreation or friends
- Poor personal hygiene
- Change in eating habits or sleeping patterns
- Loss of energy
- Previous history of suicide attempts, suicide ideations, statements, gestures or history of self-harm
- Development of a suicide plan
- Self-inflicted injuries such as cuts, burns or head banging
- Reckless behaviors
- Giving away of possessions
- Inability or unwillingness to contract for personal safety
- Recent significant family crisis; death of a family member, infidelity, major illness or divorce
- Dramatic shifts in emotional expression or mood; depression to elation, agitated to calm, or being in early stages or recovering from severe depression

Suicide Watch Procedures and Documentation

6.7 If the staff notes that a resident is displaying suicidal indicators then the Clinical Coordinator and Director should be immediately informed so an assessment can be conducted and/or a suicide or special watch ordered. If the Clinical Coordinator is unavailable, the risk assessment must be completed by staff and communicated to the director.

6.8 Staff shall order a suicide watch and complete a risk assessment any time a resident verbalizes a threat to harm himself.

6.9 Staff shall complete a risk assessment and order a suicide watch in the absence of the Clinical Coordinator when a resident is displaying suicidal indicators. If staff is concerned for the safety of the resident, but doesn't feel the risk assessment demonstrated suicidal indicators they may follow the procedures and order a special watch.

6.10 During the suicide watch, the resident must have constant direct supervision. Documentation of time of observation, behavior and/or attitude should be performed at random intervals not to exceed ten minutes. The observation must be noted on the suicide watch form.

Suicide Watch Clothing and Location

6.11 If the suicide watch occurs during the daytime, the resident will be clothed in underwear, shorts, a t-shirt, and shower clogs. Sweatpants and a sweatshirt may be used dependent upon the temperature. Regular shoes may be provided for recreation and removed when recreation has been completed.

6.12 During the night, the resident will be permitted to have a mattress in the watch room with the door closed and locked. A direct line of sight shall be maintained by requesting the resident to lay with his head on the bench on the side with the window. The watch room shall be viewed on camera from Central Control. Staff will request that the resident remove all clothing and will offer a suicide gown and suicide blanket for covering. If the resident complains that the temperature of the watch room is too cold, a wool blanket may be given to provide additional warmth. If the resident refuses to remove their clothing, staff shall contact the Director for further instructions.

Hygiene

6.13 No resident shall be permitted to shave during any watch status. Showering may be permitted at the discretion of staff based upon resident behaviors. If permitted, staff shall maintain direct observation of the resident to ensure resident safety. The resident legs shall be visible under the door when dressing and undressing and under the shower curtain as observed from the doorway.

Suicide Precaution Removal

6.14 The Clinical Coordinator shall provide daily contact and perform a daily suicide risk assessment for all residents on a suicide watch when working at the facility. In the absence of the Clinical Coordinator, an Administrative Treatment Team member shall provide daily contact and perform a daily risk assessment for all residents on suicide watch.

6.15 A suicide watch shall be removed only by the order of the Clinical Coordinator. Following an interview and suicide risk assessment of the resident, the Clinical Coordinator will make a determination concerning the suicide watch. If the resident is determined not to be a threat to self, the suicide watch will be discontinued and the watch will be downgraded to a special watch. If the resident is determined to be a threat to self, the suicide watch will continue.

6.16 The Clinical Coordinator shall document resident removal from suicide watch and why the decision was made on the suicide risk assessment form. This documentation should include a date, time and the mental health professional qualifications. If a resident is determined to remain on suicide watch, then the resident will continue on the watch until another interview is conducted.

Special Watch Procedures and Documentation

6.17 A risk assessment should be performed by staff when a resident demonstrates one or more of the following behaviors:

- Potential for violent behavior through speech, gestures, posturing, written threats or other verifiable behaviors
- Potential for flight through speech, gestures, posturing, written threats or other verifiable behaviors

- Questionable mental health status which has not been diagnosed or determined, but the professional opinion is that the resident could become at risk
- Any other reason determined by the counselor(s), mental health professionals or administration

6.18 Any staff member may order a special watch. The staff ordering the special watch must sign the special watch log and notate the reason for the special watch and type of watch being ordered. If the watch has been ordered by a counselor or administrative staff via the telephone, the staff member who received the instructions shall document the name of the person ordering the watch in the watch log and write their own initials near the documented name.

6.19 If a resident is on special watch, direct care staff shall observe the resident and document on the special watch log at random intervals not to exceed ten minutes.

Special Watch Clothing and Location

6.20 The resident on special watch will be clothed in underwear, shorts, a t-shirt, and shower clogs. Sweatpants and a sweatshirt may be used dependent upon the temperature. Regular shoes may be provided for recreation and removed when recreation has been completed. No resident shall not be permitted to shave during any watch status. Showering may be permitted at the discretion of staff based upon resident behaviors.

6.21 During the night, the resident will be placed in the watch room with the door closed. Residents on special watch may have their bedding including mattress, pillow, fitted sheet, flat sheet, blanket and pillowcase. All other items should be removed from the watch room. The watch room shall be viewed on camera from Central Control.

6.22 If more than one resident is on a watch, then additional residents may be placed in their rooms with all items removed except for the approved clothing and bedding.

Removal from Special Watch

6.23 The Clinical Coordinator, or an Administrative Treatment Team member in the absence of the Clinical Coordinator, shall provide daily contact and perform a daily risk assessment for all residents on a special watch.

6.24 The Clinical Coordinator or a qualified mental health professional will be responsible for making the decision of removing the special watch based upon reduction of risk. On weekends when the responsible parties may not be present in the building, designated staff may perform a risk assessment that can be reviewed via telephone with the Director to assist in determining resident removal from special watch.

General Observation

6.25 Staff must observe residents that are isolated from the general population due to illness or other documented reasons a minimum of once every fifteen minutes. Documentation will include the reason for isolation on the general observation log.

6.26 Residents taking timeouts in isolation shall be observed more frequently to better monitor resident affect, behavior and mood during their isolation period.

6.27 Observation documentation will end when the isolation is concluded.

Watch/Isolation Renewal Form

6.28 When a resident is on special watch, suicide watch, or is restricted to a room isolated from the general population due to behavior for longer than 2 hours, a watch/isolation renewal form should be completed by staff prior to making any decisions about reintegrating a resident with the general population.

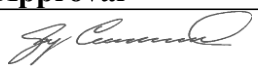
6.29 The Shift Supervisor, staff with rapport with resident or staff with most experience shall talk with youth and document reasons for permitting youth to rejoin population or necessity of continuing to isolate from others. For suicide and special watches, the interview should take place at the earliest time each day, preferably while other residents are still in bed. For residents isolated from the general population for over two hours due to behavior, the interview should take place prior to reintegration with the group and a risk assessment may be performed.

6.30 All watches must be evaluated for renewal every twenty-four hours.

Notification

6.31 The Director should be notified of all resident watches.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Safety and Emergency Procedures**
Subject:	**Firearms and Weapons**
Related Standards:	
O.A.C.	**5139-36-09 (E)(13)**
A.C.A.	**3-JCRF-1A-22**
P.R.E.A.	**None**

1.0 Purpose

To ensure the safety and wellbeing of every person in the facility by strictly limiting the circumstances in which weapons are brought into the facility.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to providing safety and security. Firearms are not permitted in the facility with the exception of situations that are declared an emergency in which law enforcement shall have the authorization to take action to secure the facility.

4.0 Definitions/Documents

None

5.0 Responsibility

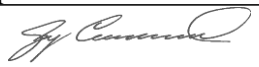
5.1 The Director or Designee shall be responsible for making the determine in declaring an emergency situation in which law enforcement is authorized to take action to secure the facility with weapons.

6.0 Procedures

6.1 Firearms, chemical agents and any other object that can reasonably be described as a weapon shall be prohibited in the facility structure. A weapons locker has been located in the lobby of the facility for law enforcement personnel to secure their weapon prior to entering the secure area of the facility.

6.2 Firearms shall only be permitted in the secure area of the facility when the Director, or in his/her absence, a designated person, or the board, has declared an emergency situation in which law enforcement shall be authorized to take action to secure the facility.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Safety and Emergency Procedures**
Subject:	**Threat to the Facility**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	**None**

1.0 Purpose

To ensure a speedy and coordinated response to threats to the facility.

2.0 Persons Affected

All employees

3.0 Policy

Threats to the facility and/or staff will be taken seriously. Procedures shall be in place for bomb threats as well as threats of physical violence.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Central Control Operator is responsible for the following:

a. Responding to an eminent threat to the facility using the "All Page" System and two-way radios to notify everyone in the building that it must be immediately evacuated taking the facility cell phone with them as they exit building leaving all doors unlocked.
b. Calling 911 and informing the Sheriff's Department of the threat and evacuation and notifying the director as soon as possible.
c. Placing the facility in lockdown following procedures when someone is under and eminent threat of bodily harm.
d. Maintaining video monitoring during any threatening situation to assist staff in providing backup and notification of director and emergency authorities as needed.

5.2 All Staff are responsible for being vigilant as all times. This includes being alert to unusual situations and the potential of violence, documenting such situations and communicating with other staff to increase awareness.

6.0 Procedures

Bomb Threats

6.1 Staff shall use the "All Page" system and two-way radios to notify everyone in the building that it must be immediately evacuated. Staff at Central Control shall take the cell phone with them as they exit the building. 911 shall be called informing the Sheriff's Department of the threat and the evacuation. The Director shall be notified as soon as possible about the situation.

Eminent Threat of Bodily Harm

6.2 Staff under threat of eminent bodily harm from visitors to the facility shall call 911 immediately while following the steps for response to resistance as needed. The facility shall be locked down as able with all available staff assisting in securing the facility. Visitors shall be asked to exit the building or to remain in a secure location until the situation can be handled. The Director shall be notified as soon as possible about the situation.

Verbal Threat of Bodily Harm or Future Threats to the Facility or Persons in the Facility

6.3 The person making the threat shall be asked to leave the premises immediately. Assistance should be called if needed in escorting the person from the building. The Director shall be called and informed of the nature of the threat and response to the threat. The Director may notify authorities or direct staff to notify authorities. The facility may be placed on lock down.

Facility Fights

6.4 Staff should be aware of the warning signs that the climate may be right for a fight to occur. A few signals include increased whispering, residents may stop talking to staff, increasing number of complaints about treatment, the program, food, medical treatment, and visiting or mail privileges, increased tension and nervousness, racial disputes, excessive noise, lack of consideration for rules of conduct and lack of respect to others.

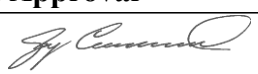
6.5 Staff shall document any warning signs and inform their supervisor immediately. The supervisor should attempt to assess the situation and rectify legitimate complaints and resolve issues. If resident behavior indicates a need for counseling, the mental health professional should be notified when present in the facility. If the mental health professional is not present and the supervisor believes there is an eminent threat, the Director should be notified.

6.6 If a fight breaks out, staff should be aware of their personal safety and the safety of any bystanders. Staff must make attempts to control the situation by getting assistance, isolating the situation, and using distracting tactics such as yelling and/or attempting a verbal intervention. If these tactics are insufficient to stop the fight, staff should assess the situation and plan a physical intervention.

6.7 If possible, staff should try to identify the aggressor and isolate this person. If verbal taunts are being used and the situation is getting worse, the person making the taunts can be the aggressor.

6.8 Staff should never underestimate the people involved in the fight.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Safety and Emergency Procedures**
Subject:	**Critical Illness or Death of Family Member**
Related Standards:	
O.A.C.	**5139-36-15 (A)(3)**
A.C.A.	**3-JCRF-5G-08** (Added August 2003)
P.R.E.A.	**None**

1.0 Purpose

To promote family communication while encouraging empathy and support.

2.0 Persons Affected

All employees

3.0 Policy

A resident shall be informed in a timely manner of the verifiable death or critical illness of an immediate family member. In case of the critical illness of an immediate family member, the resident is allowed, whenever statutes and circumstances allow, to go to the bedside under escort or alone.

4.0 Definitions/Documents

None

5.0 Responsibility

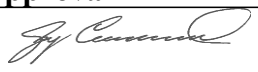
5.1 The Director is responsible for verifying death or critical illness of the immediate family member of a resident and approving all special visits.

6.0 Procedures

6.1 All residents are informed in a timely manner of the verifiable death or critical illness of an immediate family member in conformity with family wishes. Special visits may also be arranged for the purpose of informing the resident of the death. If possible, in the event that a special visit is not an option, counseling staff will directly speak to the resident or be made available to the resident to discuss the death or critical illness.

6.2 Special permission to go to the bedside of an immediate family member may be permitted in the case of critical illness with approval of the Director and/or sending court. The resident may be required to be escorted in shackles and handcuffs as required by procedure.

7.0 Document Approval

Signature: 

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Date Revised: 07-16-19

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Juvenile Rights**
Subject:	**Reporting Child Abuse**
Related Standards:	
O.A.C.	**5139-36-15 (D)**
A.C.A.	**3-JCRF-3D-05 3D-04-1** (deleted Jan. 2013)
P.R.E.A.	**28 CFR §115.361 (b)**

1.0 Purpose

To ensure the continued safety of the youth entrusted in the care of the facility.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility is committed to reporting of all instances of child abuse and/or neglect consistent with appropriate state or local laws.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 All staff is responsible for knowing the requirements of being a mandated reporter. All incidents of reported child abuse, neglect, sexual abuse or sexual harassment shall immediately be reported to the director.

5.2 The Director or Designee shall make necessary referrals to the Perry County Children Services, the Perry County Sheriff's Department, and/or the resident probation officer and committing court as needed.

6.0 Procedures

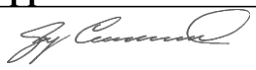
6.1 The staff and supervisors are required to immediately report to the Director any knowledge, suspicion, or information they receive regarding an incident of child abuse and neglect, sexual abuse or sexual harassment, retaliation against residents or staff who reported such an incident and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation that occurred in an agency, whether or not it is part of the facility.

6.2 The Director or designee will make necessary referrals to Perry County Children Services and the Perry County Sheriff's Department as needed. The Director will keep the reporting staff informed on the status of any investigations into the alleged child abuse and neglect, sexual abuse, or sexual harassment.

6.3 The facility shall cooperate with Perry County Children Services and the Perry County Sheriff's Department during an investigation of suspected or alleged resident abuse or neglect. Cooperation shall include, but not be limited to, permitting access to the following:

- The alleged juvenile victim
- The alleged perpetrator
- Witnesses
- Staff
- Incident report or logs
- Medical and dental records
- Personnel records
- Training records
- Procedural records
- Photographs, video documentation
- Other records, which relate to the investigation of alleged juvenile abuse or neglect

7.0 Document Approval

Signature: 

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Prior Effective Dates: 10-18-16; 07-02-15
Date Revised: 07-18-17

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Rules and Discipline**
Subject:	**Rule Violations, Handbook, Incident Reports & Class Offenses**
Related Standards:	
O.A.C.	**5139-36-16 (I)(J)(K)**
A.C.A.	**3-JCRF-3C-01 3C-02 3C-03 3C-04 3C-05**
P.R.E.A.	**None**

1.0 Purpose

To establish the facility's rules of conduct, sanctions and procedures for violations in writing and ensure they are communicated to all residents and staff. Disciplinary procedures are carried out promptly and with respect for residents.

2.0 Persons Affected

All employees

3.0 Policy

Program rules and regulations pertaining to residents are included in a handbook that is accessible to all residents and staff. When literacy or communication problem exists, a staff member shall assist the resident in understanding the materials in the handbook. The disciplinary regulations are reviewed annually and updated when necessary. Employees shall prepare an incident report when they have a reasonable belief that a resident has committed a Class II or higher violation of facility rules. A resident charged with a Class III violation of facility rules is given a written copy of the alleged rule violations within twenty-four hours of the infraction. A hearing may be held within twenty-four hours with the resident's written consent. There are informal resolutions for Class I infractions of facility rules made by residents.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Clinical Coordinator is responsible for conducting the Resident Vulnerability Assessment and communicating special accommodations needed to the Shift Supervisors.

5.2 Shift Supervisors are responsible for the following:

a. Providing resident orientation by proving each resident with a resident handbook, reviewing resident rules, and documenting the completion or orientation in the resident training log.
b. Overseeing the resident handbook testing in order to pass a resident from Orientation to Phase I.
c. Communicating with the Clinical Coordinator when resident literacy problems exist and reviewing rules or designating a staff member to review rules with the resident.
d. Overseeing resident discipline including resident action, staff response, classification of incident, disciplinary action taken, and documentation provided.

5.3 Compliance Coordinator is responsible for the following:
   a. Facilitating an annual resident handbook review providing updates if necessary.
   b. Assisting supervisors with issues involving resident discipline in accordance with the handbook and applicable standards. Collaborating with supervisors in administering resident discipline for issues not addressed in the resident handbook.

6.0 Procedures

Resident Handbook

6.1 Each resident is given a handbook upon entry into the facility. The handbook includes written rules and regulations as well as discipline for violations of rules. Residents are given a rules test in order to pass from Orientation to Phase I. Parent(s) or guardian(s) of the resident are also provided with a resident handbook.

6.2 Staff members are given a resident handbook on their orientation. During their orientation period, they are instructed on the rules and implementation of the rules.

6.3 The handbook is reviewed annually and updated if necessary.

Literacy Problems

6.4 When a literacy or communication problem exists, a staff member orally reviews the rules and assigns a high phase resident in the unit to review the rules with the new resident. The handbook test may be waived or read out loud in cases where literacy is an identifiable problem.

Incident Reports

6.5 All Class II and III rule violations shall be reported by staff through an incident report. In cases of repeated Class I offenses (a Class II offense), the resident's staffing person shall be told so that the behavior may be addressed during staffing and/or treatment team meetings and clear directions may be given about response to the behavior.

6.6 The incident reports shall be reviewed by the Shift Supervisor and/or designated staff. The legitimacy of the report shall be examined as well as the nature of the offense. Staff is expected to make meaningful disciplinary decisions related to the resident violations as permitted in the resident handbook. Judgment shall be made in levying additional consequences.

6.7 When a rule infraction results in privilege suspension, the staff member fills out an incident report. If the infraction is part of an issue already reported on an incident or an additional sanction, the privilege suspension may be noted by Supervisory Staff or the Case Manager on the Supervisor Overview Sheet. When giving a restriction or privilege suspension, each resident is informed of the reasons for the consequence being given. The incident report is filed in the resident's case record. No suspension will last longer than one month without review.

Class I Rule Violations

6.8 Minor infractions of facility rules shall be handled through the resident point system. If a minor infraction is committed, a point or points may be deducted. The deduction and reason for the deduction will be written.

6.9 Additional sanctions are available for Class I rule violations. These sanctions are listed in the resident handbook and include denial or removal from non-required recreation or free time, extra work detail for a day, writing sentences, victim damage sheets, and/or letters of apology, writing papers or completing additional assignments, and oral apologies to the offended party.

Class II Rule Violations

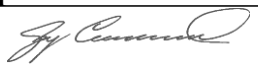
6.10 Staff shall stabilize the situation and assign a Class I consequence for the behavior, comment, or action(s). In cases of repeated Class I offenses, staff shall discuss the repeated offenses with the resident's staffing person so that it may be addressed during staffing and/or treatment team meetings. All other Class II offenses shall be clearly documented on an incident report.

6.11 Additional sanctions are available for Class II rule violations. These sanctions are listed in the resident handbook and include any combination of Class I sanctions as well as extra work detail for one week, and denial or removal from non-required recreation and/or free time for up to a week. A disciplinary team may decide on demotion by one phase, notification of the court and filing criminal charges as applicable.

Class III Rule Violations

6.12 An Administrative Conference Notice will be given to a resident for any major rule violation within twenty-four hours of the alleged rule violation with an explanation of the violation. Rule violations will be handled according to the resident handbook. Class III rule violations may be referred to the resident's court for a hearing.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Rules and Discipline**
Subject:	**Resident Hearing Time and Notice Requirements, Procedures, Waivers & Appeals**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-3C-06** (Rev. Jan. 2008) **3C-07 3C-09 3C-10 3C-15 3C-16**
P.R.E.A.	**None**

1.0 Purpose

To ensure that the facility's disciplinary procedures occur in a prompt and uniform manner with adequate resident notifications, waivers, and appeals.

2.0 Persons Affected

All employees

3.0 Policy

Residents charged with Class III violations are scheduled for a hearing no later than seven days, excluding weekends and holidays, after the alleged violation. Residents shall be notified of the time and place of the hearing at least twenty-four hours in advance of the hearing. A resident may waive the right to a hearing, provided that the waiver is documented and reviewed by the facility administrator or designee. Postponement or continuance of the disciplinary hearing may be permitted for a reasonable period of time. Disciplinary decisions shall be based solely on information obtained in the hearing process, including staff reports, the statement of the resident charged, and evidence derived from witnesses and documents. A written record shall be made of the disciplinary hearing decision and the supporting reasons with a copy provided to the resident. The hearing record and the supporting documents shall be maintained in the resident's file. The facility shall grant residents the right to appeal disciplinary decisions to the facility administrator or designee. Residents have up to fifteen days of receipt of the decision to submit an appeal. The appeal shall be decided within thirty days of its receipt, and the resident is promptly notified in writing of the results.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Shift Supervisors are responsible for the following:

a. Supervising and conducting the resident disciplinary procedures.
b. Ensuring residents are provided notifications within twenty-four (24) hours of an incident, or the discovery of an incident, involving a major rule violation including the time and place of a hearing.
c. Reviewing all hearing waivers.
d. Notifying the resident of postponement of a hearing including granting a continuance.
e. Meeting with each resident receiving a Class III incident report within seven (7) days.

f. Documenting hearing attendance and basing decisions using only the information obtained from staff reports, the statements of the resident charged, and evidence derived from witnesses, videos and documents may be used to make the disciplinary decision.
g. Providing each resident a written record of the hearing decision.

5.2 The Resident Care Worker is responsible for the following:
a. Knowing and demonstrating knowledge through enforcement of resident handbook rules.
b. Writing incident reports with classifications based upon resident handbook instructions.
c. Providing residents with writing notices of a hearing involving a major rule violation within twenty-four (24) hours after a Class III incident report is documented.

5.3 The Compliance Coordinator is responsible for the following:
a. Oversight of the resident disciplinary procedures.
b. Processing resident appeals in accordance with the grievance process.

6.0 Procedures

Hearing Notice

6.1 There will be a hearing scheduled as soon as possible but not longer than seven days excluding weekends and holidays if a resident is charged with a major rule violation. The resident will be informed of the time and place of the hearing at least twenty-four hours in advance of the hearing.

6.2 The Shift Supervisors or designated persons will be in charge of dispensing hearing notices to residents for Class III violations.

Waiver

6.3 After being given a hearing notice, a resident may waive his right to a hearing by signing a waiver. The facility administrator or designee will review the waiver.

Postponement of a Hearing

6.4 When circumstances arise which prevent the completion of a disciplinary hearing within seven days, a continuance can be granted for a reasonable amount of time. Circumstances may include but are not limited to pre-planned vacations, illness and inability of witness to attend

Basis of Hearing Decisions

6.5 Only the information obtained from staff reports, the statements of the resident charged, and evidence derived from witnesses, videos and documents may be used to make the disciplinary decision.

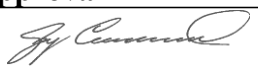
Written Record of Hearing

6.6 There must be a written record of the disciplinary hearing decision and the supporting reasons. The resident will be given a copy and a copy will be maintained in the resident file.

Appeal

6.7 Residents shall be permitted to appeal all offenses and sanctions through the grievance process. The resident will have the right to appeal the disciplinary decision to the Director or designee within fifteen days of receipt of the decision. The appeal will be decided within thirty days of its receipt. The resident will be promptly notified in writing of the results.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 07-19-11	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
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Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Rules and Discipline**
Subject:	**Facility Restriction, Privilege Suspension, Observation, Review & the Watch Room**
Related Standards:	
O.A.C.	**5139-36-16 (A)(D)(N)**
A.C.A.	**3-JCRF-3C-08 3C-12 3C-14**
P.R.E.A.	**None**

1.0 Purpose

To ensure that disciplinary treatment of residents that results in privilege suspension or facility restriction impartially reviewed and documented.

2.0 Persons Affected

All employees

3.0 Policy

Before a resident is placed on facility restriction for more than forty-eight hours, there shall be an administrative hearing by a person or panel of staff who are not directly involved in the incident leading to restriction. A written, signed, and dated report shall be completed and submitted to the facility administrator. Before facility restriction or privilege suspension, the reason(s) for the restriction is discussed, and the resident shall have the opportunity to explain the behavior. All instances of room restriction, privilege suspension, and facility restriction shall be recorded, dated, and signed by staff. The record is reviewed and signed by a supervisory staff member daily.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for making decisions regarding facility restrictions lasting more than forty-eight (48) hours. Parents and courts will be informed of restrictions affecting off-ground visits.

5.2 Shift Supervisors are responsible for the following:

a. Ensuring a written, signed and dated report is completed and submitted to the facility administrator for all incidents leading to facility restrictions.
b. Conducting a daily review of resident privilege suspensions.

6.0 Procedures

Facility Restriction

6.1 All residents are restricted to the facility until they reach the appropriate phase where off-grounds activities or privileges are permitted.

6.2 Once a resident has off-grounds privileges, they will be restricted to the facility for more than forty-eight hours only when the resident does not maintain the standards of behavior required for the phase. At this time, he is notified on his point sheet, via the percentage, or through an internal or external review hearing. An incident report may also be written.

6.3 An administrative panel of staff who are not directly involved in the incident leading to restriction may include the Compliance Coordinator, Clinical Coordinator, Mental Health Professionals, Counselors, Supervisors, Case Manager, and the Director to review resident facility restriction. At this time, the reasons for the restriction are reviewed via incident report or log notes and length of time the restrictions will apply are discussed. Decisions are noted on the follow up to the incident report or in the pass down log and submitted to the Director. Parents and courts are informed of the restrictions and alternative visit arrangements are made when necessary.

6.4 When a rule infraction results in privilege suspension, the staff member fills out an incident report. When giving a restriction or privilege suspension, each resident is informed of the reasons for the consequence being given and has the opportunity to explain their behavior. The incident report is filed in the resident's case record. No privilege suspension will last longer than one month without review. Resident behavior and comments after being placed on restriction will assist in determining the end of the restriction period.

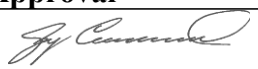
6.5 All instances of room restriction, privilege suspension and facility restriction are recorded, dated and signed by staff.

Watch Room

6.6 The watch room shall be used for special watches, suicide watches, illnesses, resident time-out and other safety and security purposes. When residents are in the watch room, they will be observed. These observations shall be periodically documented in the appropriate log.

6.7 DYS has either suggested or granted approval for all of the above purposes.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 03-24-14 Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
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Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Juvenile Rights**
Subject:	**Access to Courts and Counsel**
Related Standards:	
O.A.C.	**5139-36-16 (C)**
A.C.A.	**3-JCRF-3D-01 3D-02**
P.R.E.A.	**None**

1.0 Purpose

The facility protects the safety and constitutional rights of juveniles and seeks a balance between individual rights and preservation of order.

2.0 Persons Affected

All employees

3.0 Policy

Each resident has the right to access to the courts. The facility ensures and facilitates resident access to counsel and assists residents in making confidential contact with attorneys and their authorized representatives. Such contact includes, but is not limited to, telephone communications, uncensored correspondence, and visits.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Resident Care Workers shall submit resident requests for access with counsel to the Central Control Operator or Case Manager who will facilitate resident access.

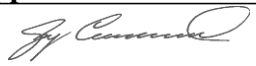
6.0 Procedures

6.1 All residents at the facility will have access to their courts. Any contacts with the courts will be documented in writing.

6.2 Residents who wish to have access with counsel will submit a written request to a Resident Care Worker who will forward it to the Central Control Operator or the resident may place a request in the Case Manager's mailbox. The Central Control Operator or Case Manager will assist residents in making confidential contact with attorneys and their authorized representatives. Such contact includes, but is not limited to telephone communications, uncensored correspondence, and visits.

6.3 Residents' families will be responsible for any cost associated with residents who utilize legal counsel.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Juvenile Rights**
Subject:	**Protection from Harm, Specific Rights, Conflicting Rights, Photos & Discipline**
Related Standards:	
O.A.C.	**5139-36-16 (B)(1)(2)(3)(4)(5)(E)(G)(1)(2)(J)(1-14)(L)**
A.C.A.	**3-JCRF-3D-04**
P.R.E.A.	**28 CFR §115.315 (d)**

1.0 Purpose

To ensure residents are treated respectfully with consideration for their basic rights.

2.0 Persons Affected

All employees

3.0 Policy

Residents shall be treated with respect. They shall not be subjected to corporal or unusual punishment, humiliation, mental abuse, or punitive interference with the daily functions of living, such as eating or sleeping. Discipline shall only be delegated to employees of the facility. The facility will protect the resident rights to a reasonable amount of privacy, to have an opinion heard and be included when any decisions are being made which affect the resident's life, to receive adequate and appropriate food, clothing, and housing and to his own money and personal property in accordance with the resident's case plan and to participate in an appropriate educational and/or vocational program. Photographing and audio or audio-visual recordings of residents in facility custody shall require written consent of the juvenile and the juvenile's parent(s) or guardian when used for fundraising or program publicity purposes. All photographs and recordings shall be used in a manner which respects the dignity and confidentiality of the juvenile.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Resident Care Workers are responsible for the following:

a. Role modeling appropriate behaviors for the residents.
b. Enforcing rules ensuring positive conduct is encouraged and negative conduct is deterred with construction and educational discipline. Rewards should outweigh punishments at a 4:1 ratio.
c. Locking resident sleeping rooms at night.
d. All staff should announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. Female staff should announce their presence when first entering the unit.
e. Infringing on resident rights only in the event of an emergency or as required to maintain safety and security.
f. Ensuring no audio or video devices are used with residents without their permission.

5.2 Central Control Operator/Training Coordinator is responsible for ensuring the waivers for photographs and video recording have been signed and are inside resident files.

6.0 Procedures

Protection from Harm

6.1 The facility promotes role modeling from staff to resident to improve the social skills and ability each resident has to interact in society.

6.2 Discipline at the facility is both constructive and educational. Consequences are related to the rule violation(s) made by the resident. Resident discipline is carried out by employees of the facility. Volunteers are not permitted to discipline residents and are encouraged to approach employees with any concerns. At no time will a resident at the facility discipline another resident.

6.3 The facility prohibits the following acts of punishments including spanking, punching, paddling, shaking, biting, rough handling of residents, deprivation of a scheduled meal or snack, assignments of physically strenuous work or exercise when used solely as a means of punishment, requiring or forcing a juvenile to maintain an uncomfortable position or continuously repeat physical movement when used solely as a means of punishment, verbal abuse or derogatory remarks, denial of planned and required recreational activity unless behavior during the activity warrants immediate removal, denial of social services or medical treatment, denial of educational services, inappropriate or intentionally painful physical restraint, organized social ostracism, and the use of chemical restraints.

Privacy

6.4 The residents at the facility have their own sleeping rooms. These rooms have doors that will be locked during the night. A small window is located on each door to allow privacy and permit staff to easily check on the resident for safety and security.

6.5 Residents will be permitted to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Any exigent circumstances requiring an invasion of privacy shall be fully documented. Female staff shall announce their presence when first entering the unit and all staff shall announce any time they enter an area where residents are likely to be showering, performing bodily functions, or changing clothing.

Opinions about Life Decisions

6.6 Residents are permitted to discuss their opinions with all staff when decisions are being made which affect the resident's life. The residents are encouraged to discuss issues with mental health professionals and/or counselors. They are also an integral part of the release plan and assist in its development.

Basic Life Necessities

6.7 Adequate and appropriate food, clothing and housing are provided to each resident. All necessary clothing is provided to the resident by the facility, the resident's family, and/or the resident's court. Food is served three times a day with a snack each night for all residents regardless of phase or behavior.

Education

6.8 Residents are required to attend school while at the facility. Education provided will be based upon the need for each individual resident. G.E.D. testing and work may be recommended and accomplished prior to release as determined on a case-by-case basis.

Conflicting Rights

6.9 When a restriction of a resident's rights affects another individual, that individual will be informed of the conditions and reasons for the actions taken in accordance with confidentiality requirements.

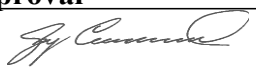
6.10 Resident rights are only infringed upon in the event of any emergency or as required to maintain safety and security.

Photographing, Audio and Visual Recording

6.11 Photographing and audio or audio-visual recordings of residents in facility custody shall require written consent of the juvenile and the juvenile's parent(s) or guardian when used for fundraising or program publicity purposes. All photographs and recordings shall be used in a manner which respects the dignity and confidentiality of the juvenile.

6.12 A photography waiver is signed by the resident and his parent(s) or guardian upon entrance to the facility. Parents and residents shall be informed that audio-visual recordings will be used for program purposes.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-16-19	

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Juvenile Rights**
Subject:	**Personal Property, Grooming & Dress**
Related Standards:	
O.A.C.	**5139-36-16 (F)(G)(1)(2)**
A.C.A.	**3-JCRF-3D-06**
P.R.E.A.	**None**

1.0 Purpose

To establish and maintain rules governing resident personal property possession and storage as well as setting reasonable limits on personal freedom in grooming and dress.

2.0 Persons Affected

All employees

3.0 Policy

Rules specify the personal property residents can retain in their possession and govern the control and safeguarding of such property. Personal property retained in the facility is itemized on a written list that is kept in a permanent file; the resident receives a copy listing the property retained for storage. The facility limits freedom in personal grooming and dress for valid interests.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Resident Care Workers are responsible for the following:

a. Approving resident clothing, conducting an initial and on-going clothing inventory, and washing items prior to use, storage or dispensing.

5.2 Shift Supervisors are responsible for the following:

a. Ensuring the completion of an initial and on-going resident clothing inventory.
b. Ensuring clothing that is inventoried into the facility are washed prior to storage or dispensing.
c. Approving all clothing requests in accordance with the resident handbook and procedures.
d. Providing residents with a copy of their inventory to maintain and retain in their room.
e. Ensuring rules of enforcement area being maintained for resident clothing inventories, appearance rules, and necessary grooming.

6.0 Procedures

6.1 All personal items are inventoried and logged during intake into the facility. The inventory sheet may be located in a log and/or kept with the resident's storage area. The final inventory is placed in the resident's binder and kept on permanent file. Residents are given a copy of their inventory sheet.

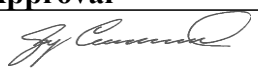
6.2 All necessary clothing is provided to the resident by the facility, the resident's family, and/or the resident's court. Residents may bring in undergarments, socks and approved t-shirts, shorts and pants. Residents are given more personal freedom in their dress after they receive Phase III.

6.3 The facility does not permit residents to wear clothing that does not fit securely around the waist. Belts and any personal jewelry are also prohibited. Concerns about a resident wearing gang colors will be addressed on an individual basis as needed.

6.4 Appearance is listed as part of the program. It helps to encourage the use of appropriate social skills and makes residents more acceptable to society. Because appearance is important, residents must have their shirts tucked in at all times except for recreation.

6.5 Residents are also required to shave all facial hair including sideburns and keep their hair cut no longer than one inch in length, above their ears and off their neck. Any haircuts that may cause residents to be less desirable in the job market are strongly discouraged. Exceptions or accommodations may be made for valid medical or religious reasons that are documented upon entry to the facility.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Juvenile Rights**
Subject:	**Juvenile Grievance Procedure**
Related Standards:	
O.A.C.	**5139-36-14 (EE)(1)(2)(3)**
A.C.A.	**3-JCRF-3D-07**
P.R.E.A.	**28 CFR §115.352 (f)(1)(2)**

1.0 Purpose

To ensure residents the opportunity to express themselves regarding problems they are having with the program without being subjected to any adverse action with the ability to appeal decisions.

2.0 Persons Affected

All employees

3.0 Policy

Perry Multi-County Juvenile Facility has a grievance and appeal process. The grievance shall be transmitted without alteration, interference, or delay to the party responsible for its receipt and investigation. A written report as to the final disposition of the grievance should be prepared and filed.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Shift Supervisors are responsible for ensuring each resident has completed a new resident orientation training which includes instructions for the grievance process.

5.2 The Compliance Coordinator is responsible for the following:

a. Checking the grievance box for written grievances and responding in a timely manner.
b. Processing each grievance conducting review into legitimacy of the claim.
c. Proving a written copy of grievance response within seven (7) days.
d. Retaining a copy of each grievance in a file, placing the grievances with the resident electronic file after discharge.
e. Filing a monthly grievance status report with the Director.

5.3 The Director is responsible for forwarding grievances to the Compliance Coordinator and providing written decisions on grievance appeals in the specified time frame.

5.4 All staff are responsible for immediately responding to an emergency grievance ensuring that any portion of the grievance that alleges the substantial risk of imminent harm is given to the Director or a level of review at which immediate corrective action may be taken.

6.0 Procedures

6.1 Residents are informed of the grievance process during their orientation. The forms for filing a grievance are located in the unit for easy access. A locked box is provided in each unit so that the grievances may be filed with minimal interference from staff. Keys providing access to the grievance box are given to the Director and Compliance Coordinator.

6.2 All grievances are processed by the Compliance Coordinator. The Compliance Coordinator shall process the grievance by conducting a review into legitimacy of the claim. The review may contain interviews with residents, staff, and video materials. The Compliance Coordinator shall respond to the resident in writing within seven (7) days.

6.3 If the resident is not satisfied, or if the grievance is with the Compliance Coordinator, the resident is permitted to give the grievance to the Director as soon as possible within seven business days. The Director will review the complaint and respond to the resident in writing within seven days. The Director's decision is final.

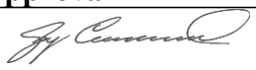
6.4 All grievances are processed in the administrative offices in a timely manner. The response to each grievance is documented. Each grievance is retained in a file.

Emergency Grievance

6.5 When a resident feels that he or another resident is subject to a substantial risk of imminent sexual abuse, he may file an emergency grievance with staff. After receiving the emergency grievance, staff shall immediately forward the grievance or any portion that alleges the substantial risk of imminent sexual abuse to the Director or a level of review at which immediate corrective action may be taken. An initial response shall be provided within forty-eight hours and a final facility decision shall be issued within five calendar days.

6.6 The initial response and final facility decision shall document the facility's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 06-02-14 Prior Effective Date: 07-02-15; 07-18-17 Date Revised: 07-17-18	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Operations**
Section:	**Food Services**
Subject:	**Budgeting and Purchasing**
Related Standards:	
O.A.C.	**5139-36-11 (H)(1)(2)(3)(4)**
A.C.A.	**3-JCRF-4A-01**
P.R.E.A.	**None**

1.0 Purpose

To ensure that meals are nutritionally balanced, well-planned, and prepared and served in a manner that meets established governmental health and safety codes.

2.0 Persons Affected

All employees

3.0 Policy

The food service budgeting, purchasing, and accounting practices include the following systems:

- Food expenditure cost accounting designed to determine cost per meal per resident
- Estimation of food service requirements
- Determination of and responsiveness to resident eating preferences
- Refrigeration of food with specific storage periods

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Food Service Manager is responsible for the following:

a. Food budgeting, purchasing, accounting and estimation of food service requirements.
b. Turning in all receipts and bills to Director.
c. Determining average cost per meal twice a year to be used for fiscal budget estimates.
d. Completing and maintaining records for all applications and documentation required for the facility to participate in the Ohio Department of Education's Child Nutrition Program.
e. Conducting resident food surveys to determine food preference making modifications as needed.
f. Ensuring all food placed in refrigerator is dated, discarded and documented in accordance with policies and procedures.

6.0 Procedures

Food Budgeting, Purchasing, Accounting and Estimation of Food Service Requirements

6.1 The Food Service Manager will prepare lists of necessary food items required for weekly meals.

6.2 The Food Service Manager is authorized to contact various food service providers to set up accounts with any provider and to make purchases as necessary to maintain adequate food supplies. The Director is given a list of providers to ensure the appropriate purchase orders have been obtained and the vendors registered with the Perry County Auditor. The Director will determine all necessary adjustments to the purchasing, accounting, and delivery systems.

6.3 All receipts or bills are turned in to the Director for processing through established fiscal accounting systems.

6.4 The Food Service Manager determines the average cost per meal on a semi-annual basis based upon food supplies purchased divided by the number of meals served. The most recent estimate is what the Director will use to determine the fiscal budget for the following year.

6.5 To determine the yearly food service budget, the Director will take the total cost of food supplies and determine the cost incurred for staff to prepare and serve the food. This will be added to the cost of supplies to determine the average cost per meal. The cost per meal is then multiplied by the number of meals served in a year based upon full occupancy rates. An estimate of federal reimbursement is then subtracted from the total.

6.6 The Director and Food Service Manager shall be responsible for completing all applications and other documentation required for the facility to participate in the Ohio Department of Education's Child Nutrition Program. The Food Service Manager shall maintain any records necessary for documentation of meals served to residents and will ensure all necessary information is available for completing all the necessary paperwork to maintain compliance with the program.

Determination of and Responsiveness to Resident Eating Preferences

6.7 Surveys are given on a semi-annual basis to residents to determine food preferences. The Food Service Manager uses the feedback provided to make modifications to the menu in response to resident preferences.

6.8 Residents may also be given the privilege of picking a meal for breakfast, lunch, dinner and/or snack in consultation with the Food Service Manager.

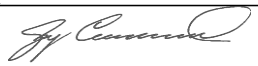
Refrigeration of Food with Specific Storage Periods

6.9 All food placed in the refrigerator will be dated.

6.10 A chart of the recommended storage time suggested by the American Food and Drug Administration and the Perry County Health Department will be kept in the food serving area.

6.11 When an item is placed in the refrigerator to be stored, it will be documented on a form. The recommended number of storage days will be determined and an expiration date will be documented next to the item description and date it was placed in the refrigerator. All items in the refrigerator will be discarded after their expiration date. Discarded items will be documented and initialed by the food service providers and Food Service Manager.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-21-20	

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Food Services**
Subject:	**Subject: Dietary Allowances, Special Diets, and Menu Approval**
Related Standards:	
O.A.C.	**5139-36-16 (A)(B)(C)(G)(I)(J)(K)**
A.C.A. Mandatory Required Standards:	**3-JCRF-4A-02 4A-05**
A.C.A.	**3-JCRF-4A-03 4A-04 4A-06 4A-07-1 4A-09 4A-10**
P.R.E.A.	**None**

1.0 Purpose

To ensure that meals are nutritionally balanced, planned, served and of the quantity and quality to meet the needs of the facility.

2.0 Persons Affected

All employees

3.0 Policy

A nutritionist, dietician, or physician approves the menu and annually approves the nutritional value of the food served. Food service staff develops advanced, planned menus and substantially follow the schedule in the planning and preparation of all meals, food flavor, texture, and temperature. Appearance and palatability shall be taken into consideration. There is a single menu for staff and residents. The facility provides for special diets as prescribed by appropriate medical or dental personnel and for residents whose religious beliefs require adherence to religious dietary laws. At least three meals, two of which are hot meals, are provided at regular meal times during each twenty-four-hour period, with no more than fourteen hours between the evening meal and breakfast. Provided basic nutritional goals are met, variations may be allowed based on weekend and holiday food service demands. Residents shall be encouraged to eat a variety of foods served, but no resident shall be subjected to coercion, including forced feeding for refusing to eat, unless for medical treatment-related reasons. Staff members supervise residents during meals.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Food Service Manager is responsible for the following:

a. Menus are annually prepared and approved by a licensed dietician.
b. Keeping the nutritional value of each meal in the food service area.
c. Conducting resident food surveys.
d. Completing monthly special and religious diet reviews.
e. Ensuring three meals a day and a snack are prepared including two hot meals with no more than 14 hours separating the evening meal and breakfast with exceptions for weekends and holidays.
f. Training all staff, contractors, and residents that work in the food service area of the use of food service equipment and in the safety procedures to be followed.

5.2 Food Service Staff are responsible for the following:
   a. Following the menu plan noting any modification made
   b. Logging daily cooking and serving temperatures
   c. Following and documenting any special and religious diets.

6.0 Procedures

Nutritionist Approval and Nutritional Value of Food

6.1 The Food Service Manager and the Food Service Assistants utilize menus from the Department of Youth Services. These menus are prepared by a licensed dietician and based upon the dietary allowance published by the "National Research Council of the National Academy of Sciences". The nutritional value for each meal is kept in the food service area. The menu cycle is reviewed annually with DYS personnel to ensure compliance with all applicable nutritional guidelines.

6.2 A private licensed dietician may be contacted and/or hired by the Food Service Manager with the permission of the Director to assist in the preparation and approval of menus and to ensure compliance with applicable nutritional guidelines. A copy of the name and dietician license will be retained whenever a dietician is consulted.

Menu and Food Schedule

6.3 The Food Service Manager and the Food Service Assistants may utilize menus prepared by a nutritionist, dietician or from the Department of Youth Services. These menus are planned a week in advance and are on a four-week cycle.

6.4 There is a minimum of one hour of preparation time available for each meal. Food is cooked and kept at the recommended temperatures. Cooking temperatures and serving temperatures are logged daily.

6.5 Appearance and palatability are taken into consideration by verbal feedback from residents and staff. Surveys are conducted where suggestions can be given and feedback may also be provided by the residents at their weekly house meeting and communicated to the Food Service Manager. Substitutions may be made in future planning in response to positive or negative feedback. All substitutions come from the same food category and are logged.

6.6 All food service plans provide for a single menu for residents, staff and visitors.

Special and Religious Diets

6.7 Any resident who requires a special diet for a documented medical condition, shall have appropriate meals prepared and served to meet his needs. These meals are prepared in accordance to standards set forth by the Perry County Health Department or the resident's attending physician. Documentation of the special menu shall be included in the resident's record.

6.8 Temporary accommodations to provide special diets for residents are communicated to the Food Service Manager or the Food Service Assistants as soon as possible. The length of necessary accommodations is noted. All special menus will be logged.

6.9 Special diets will be reviewed monthly as needed. They will conform as closely as possible to food served to other residents.

6.10 Any resident whose religious beliefs require a special diet, shall have appropriate meals prepared to comply with the religious dietary laws, at his/her written request, as long as these laws are reasonable and do not conflict with generally accepted civilized behavior or are contrary to facility safety, security or operation. Any special diet shall be documented in the resident's record.

Meals Served Daily

6.11 Three meals are served each day. Typically, breakfast is served cold with the lunch and dinner meals served hot.

6.12 Meals are scheduled at regular intervals. Breakfast is scheduled fourteen hours after the evening meal during the week. On weekends, residents are permitted to sleep in two hours later, which means that there is sixteen hours between the evening meal and breakfast.

6.13 During holidays, food service may vary to include more than one cold meal depending on food service worker availability.

6.14 All staff, contractors, and residents who work in the kitchen shall be trained in the use of food service equipment and in the safety procedures to be followed.

Coercion

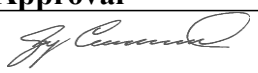
6.15 Residents will not be subjected to coercion, including forced feeding for refusing to eat, unless for medical treatment-related reasons.

6.16 If a resident requires medical forced feeding for refusing to eat, the probation officer and court of original jurisdiction will be notified. The facility will recommend immediate resident removal and placement into the Department of Youth Services.

Staff Supervision

6.17 There is a minimum of one staff member present supervising residents during all meals.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 07-19-11 Prior Effective Date: 07-02-15; 07-18-17 Date Revised: 07-17-18	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Food Services**
Subject:	**Health and Safety Regulations**
Related Standards:	
O.A.C.	**5139-36-11 (E)(F)(1)(2)(3)(H)(5)(M)**
A.C.A. Mandatory Required Standard 3-JCRF-4A-07	
A.C.A.	**3-JCRF-4A-08**
P.R.E.A.	**None**

1.0 Purpose

To ensure that staff are preparing and maintaining food in accordance with the health code.

2.0 Persons Affected

All employees

3.0 Policy

Food service staff shall comply with all sanitation and health codes enacted by state or local authorities. The kitchen shall have weekly inspections of all food service areas including dining and food preparation areas and equipment. Daily checks shall be conducted for sanitary, temperature-controlled storage facilities for all foods, and daily checks of the refrigerator and water temperatures.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Food Service Manager shall ensure that the food service department and staff are preparing and maintaining food in accordance with all sanitation and health codes.

6.0 Procedures

6.1 Food Service Personnel shall keep fingernails clean, filed and maintained so edges and surfaces are not rough. Nail polish or artificial nails cannot be worn when working with exposed food unless intact gloves in good repair are worn.

6.2 Any lesions on the hands or wrists or exposed portions of the arms or other parts of the body must be protected by an impermeable cover and covered by a single service glove (if located on the hands).

6.3 High risk conditions suspected of causing or being exposed to a confirmed food borne disease must be reported to the health department as follows: S.Typhi, Shigella spp., E. Coli, and hepatitis A virus.

6.4 When a food employee is diagnosed with salmonella, shigella, shiga toxin producing Escherichia coli, hepatitis A virus, Entamoeba histolytica, Campylobacter, Vibrio cholera, Cryptosporidium, Cyclospora, Giardia, or Yersinia, the person in charge must notify the health department.

6.5 Potentially hazardous foods are cooked to the required temperatures and times as specified and are received hot at 140 degrees or higher.

6.6 Milk and eggs are stored in temperatures forty degrees or below.

6.7 All refrigerator equipment is required to maintain forty-one degrees or less if purchased or placed into use after March 1, 2001. The facility will seek to replace any refrigerator equipment used for food storage that fails to keep temperatures consistently at forty degrees or less. All potentially hazardous food in refrigerator is clearly marked with date of opening with date in which food must be consumed at the time of preparation or opening. Ready to eat foods, such as lunchmeats may be stored no longer than seven days at forty-one degrees or four days at forty-five degrees. Food shall be discarded if contaminated or has exceeded the recommended days for consumption. The discarded food shall be logged.

6.8 Water temperature for hand washing must be 110 degrees or more. Hand washing signage is needed at all hand sinks used by food employees.

6.9 Special dietary needs must be documented with statements from a recognized medical authority. All specific food omissions and substitutions shall be logged.

Inspections

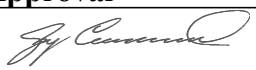
6.10 The facility shall comply with conducting daily food service inspections, using the food service daily checklist provided by the department of youth services.

6.11 Daily checks of the refrigerator and water temperatures will be performed.

6.12 Weekly inspections will include all food service areas including the dining and food preparations areas and equipment.

6.13 All food will be kept in sanitary and temperature-controlled storage facilities.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 07-02-15; 07-18-17; 07-17-18	
Date Revised: 07-21-20	

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Sanitation and Hygiene**
Subject:	**Sanitation and Safety Inspections, Pest Control, Garbage Removal & Water**
Related Standards:	
O.A.C.	**5139-36-08 (F)(2)(3) 5139-36-11 (F)(1)(2)(3)(4)(5)(L)**
A.C.A. Mandatory Required Standard: 3- JCRF-4B-02 4B-03 4B-04	
A.C.A.	**3-JCRF-4B-01**
P.R.E.A.	**None**

1.0 Purpose

The facility's sanitation and hygiene program complies with applicable regulations and standards of good practice to protect the health and safety of residents and staff.

2.0 Persons Affected

All employees

3.0 Policy

The facility complies with the sanitation and health codes of the local and/or state jurisdiction. Sanitation and safety inspections of all internal and external areas and equipment are conducted weekly. Vermin and pest control and garbage removal shall be provided. The facility's potable water source and supply is provided by the public water department and shall be approved by an independent, outside source to be in compliance with jurisdictional laws and regulations.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Food Service Manager will be responsible for the following:

a. Conducting weekly inspections of all food service areas including the dining and food preparations areas and equipment.
b. Participating in inspections made by the Perry County Health Department responding immediately to any negative findings.

5.2 The Food Service Assistants will be responsible for the following:

a. Conducting and documenting daily food service inspections.
b. Conducting and documenting daily refrigerator and water temperature checks.

5.3 Resident Care Workers are responsible for daily inspections of resident living areas and dining area to ensure residents have properly performed their chores.

5.4 Facility Maintenance Supervisor is responsible for conducting a weekly facility inspection including internal and external equipment.

5.5 The Director is responsible for contracting with professional licensed pest control and weekly garbage removal by a licensed trash removal company.

6.0 Procedures

Sanitation and Safety Inspections

6.1 The facility will be inspected annually by the Perry County Health Department. The kitchen will conduct weekly inspections of all food service areas including the dining and food preparations areas and equipment and daily food service inspections, using the food service daily checklist provided by the department of youth services. Daily checks of the refrigerator and water temperatures will also be performed. All food will be kept in sanitary and temperature-controlled storage facilities.

6.2 Resident living areas shall be cleaned and inspected by staff daily. A facility security check shall also be performed daily. A weekly facility inspection shall be performed by the facility manager including internal and external equipment.

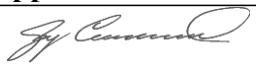
Pest Control and Garbage Removal

6.3 The facility has a contract with professional and licensed pest control. Pest control visits the facility once per month. The facility has weekly trash and garbage removed by a licensed trash removal company.

Water

6.4 The Southern Perry County Water District provides water. The water department tests the water regularly. Tests are available to the public.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-21-09 Prior Effective Date: 07-02-15; 07-18-17; 07-17-18 Date Revised: 07-21-20	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Sanitation and Hygiene**
Subject:	**Housekeeping, Clothing, Bedding, Linen and Towels, Personal Hygiene & Hair Care**
Related Standards:	
O.A.C.	**5139-36-08 (F)(5)(6)(M)(CC) 5139-36-18 (T)(U)**
A.C.A.	**3-JCRF-4B-05 4B-06 4B-07 4B-08** (Rev. Aug. 2007) **4B-09** (Rev. Jan. 1998)
P.R.E.A.	**None**

1.0 Purpose

To ensure the facility has standards for the practice of good hygiene to protect the health and safety of juveniles and staff.

2.0 Persons Affected

All employees

3.0 Policy

A housekeeping and maintenance plan is in effect to ensure that the facility is clean and in good repair. Specific duties and responsibilities shall be assigned to staff and residents. Residents shall be provided with clean clothing. The facility shall provide by allowing access to self-serve washer facilities, central clothing exchange, or a combination of the two. The facility shall also provide for the thorough cleaning and, when necessary, disinfecting of resident personal clothing before being stored or before allowing the resident to keep and wear personal clothing. The facility provides for the issue of suitable, clean bedding and linen, including two sheets, pillow and pillowcase, one mattress, and sufficient blankets to provide comfort under existing temperature controls. There is provision for linen exchange at least weekly. Blanket exchange must be available quarterly. Articles necessary for maintaining proper personal hygiene shall be provided to all residents.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Resident Care Workers are responsible for the following:

a. Performing and documenting daily housekeeping and cleaning duties.
b. Overseeing and inspecting resident chores.
c. Nightly washing and drying resident clothing, towels and wash cloths.
d. Providing residents with the appropriate facility bedding, linen, and towels.
e. Ensuring resident bed linens are washed on the weekends with blankets washed a minimum of once every two weeks.
f. Providing the opportunity for residents to take daily showers and with additional showers after strenuous activity as needed.

5.2 The Facility Maintenance Supervisor is responsible for the performing weekly maintenance checks.

5.3 The Director will contract with a licensed barber or cosmetologist for hair care services keeping a record of the contract on file.

6.0 Procedures

Housekeeping

6.1 Housekeeping and cleaning is performed and documented daily.

6.2 Maintenance is performed as needed and weekly maintenance checks are performed and documented. A checklist is compiled and completed with documentation for repairs.

6.3 Cleaning duties are assigned to the residents for the dayrooms including the resident showers and restroom. Staff is responsible for inspecting all chores.

Clothing

6.4 The facility has two washers and dryers for resident clothing. Clothing is washed and dried each night as a chore by the residents or by staff. Whites are washed and may be bleached by staff. All necessary clothing is provided to the resident by the facility, the resident's family, and/or the resident's court.

6.5 Staff must approve all clothing brought into the building. If clothing is not appropriate, it may be washed by the resident and placed into storage until it can be sent home. When a resident brings in clothing for approval, all necessary clothes are washed by the resident or staff before being given to the resident to wear.

6.6 If the resident wears unapproved street clothing into the building after an overnight visit, they must change into approved clothing at the facility and wash their personal clothing for placement in storage.

Bedding, Linen & Towels

6.7 The facility provides residents with a fitted sheet, a flat sheet, a pillow, pillowcase, one mattress, and sufficient blankets to provide comfort: Residents are given one blanket and may request more.

6.8 Residents wash their bed linens on the weekends, towels are washed nightly, and blankets are washed every other week.

Personal Hygiene and Hair Care Services

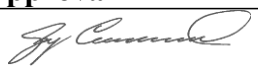
6.9 Residents are provided the opportunity for daily showers and showers after strenuous exercise.

6.10 As part of the admissions process, residents are provided with soap, shampoo, toothbrush, toothpaste or powder, comb, toilet paper, and/or special hygiene items when necessary. Shaving equipment is made available to residents after removal from orientation special watch.

6.11 All personal hygiene products are available in the facility and may be requested when needed. As a privilege, residents on higher phases may purchase personal hygiene products.

6.12 The facility contracts with a licensed barber or cosmetologist for hair care services. A copy of the barber's license or cosmetologist's license is on file.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-21-10	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-19-22; 07-18-23
Prior Effective Date: 07-02-15; 07-18-17; 03-16-18; 07-17-18	
Date Revised: 07-21-20	

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Health Care**
Subject:	**Responsible Health Authority, Personnel & Standing Orders**
Related Standards:	
O.A.C.	**5139-36-10 (D)(7) 5139-36-18 (H)(I)(M)**
A.C.A. Mandatory Required Standard: 3-JCRF-4C-01	
A.C.A.	**3-JCRF-4C-03** (Rev. Jan. 2005) **4C-04 4C-07 4C-16**
P.R.E.A.	**None**

1.0 Purpose

To establish comprehensive health care services by qualified personnel to protect the health and well-being of juveniles.

2.0 Persons Affected

All employees including the health authority

3.0 Policy

The facility has a designated health authority with responsibility for health care pursuant to a written agreement. The health authority shall be a physician, health administrator, or health agency. Appropriate state and federal licensure, certification or registration requirements, and restrictions apply to personnel who provide health care services to residents. The duties and responsibilities of such personnel are governed by written job descriptions approved by the health authority. Verification of current credentials is on file in the facility. Treatment by health care personnel other than a physician, dentist, psychologist, optometrist, podiatrist, or other independent provider shall be performed pursuant to written standing or direct orders by personnel authorized by law to give such orders. All staff on all shifts shall be certified and maintain annual certification in first aid and CPR. First aid kits shall be available and approved by qualified health care personnel.

4.0 Definitions/Documents

4.1 Health authority is a physician, health administrator, or health agency charged with oversight of facility health care and access to care pursuant to written agreement, contract or job description.

5.0 Responsibility

5.1 All employees are required to be certified and maintain annual certification in basic First Aid and CPR.

5.2 Resident Care Workers must be certified in the proper administration and distribution of medication to juveniles and be able to treat resident medical complaints based on first aid training and written standing orders.

5.3 Health authority shall be required to retain active and appropriate licensure to provide medical services within the State of Ohio. The provision of medical malpractice insurance shall be the responsibility of the health authority pursuant to written contract. Responsibilities of the health authority shall include the following:

- Annual review and approval of all medically related policies and procedures
- Annual review and approval of PMCJF standing medical orders
- Approval of PMCJF Nurse job description, duties and responsibilities
- Annual review and approval of PMCJF First Aid/CPR/ERT/AED curriculum
- Annual review and approval of PMCJF first aid kits and equipment
- Approve the method of monitoring alcohol & drug abuse among PMCJF residents
- Provide prescriptions for PMCJF stock medications such as Epi pens and TB tests

5.4 The Director shall be responsible for the written agreement of the health authority.

5.5 The Registered Nurse shall be required to pass a background check, pass the Ohio Child Abuse Registry, complete all PMCJF Prison Rape Elimination Act training requirements, and retain active and appropriate licensure to provide medical services within the State of Ohio. This position is responsible for the coordination and the delivery of health services including medication and scheduling appointments with appropriate health care providers as well as providing for other duties and responsibilities pursuant to the job description. The facility nurse shall be responsible for conducting and documenting monthly first-aid kit checks.

5.6 The Compliance Coordinator shall be responsible for maintaining records verifying state licensure for the health authority, registered nurse, clinical coordinator, and outside treatment providers.

6.0 Procedures

Health Authority

6.1 The facility shall designate a health authority with responsibility for health care pursuant to a written agreement. The health authority shall be a physician, health administrator, or health agency.

6.2 The health authority shall be required to pass a background check, pass the Ohio Child Abuse Registry, complete all PMCJF Prison Rape Elimination Act training requirements, retain active and appropriate licensure to provide medical services within the State of Ohio, and provide self-malpractice insurance with verification of current state licensure on file.

6.3 The health authority will be considered an independent contractor with no benefits accumulated during the length of the contract.

6.4 Responsibilities of the health authority shall include the following:

- Annual review and approval of all medically related policies and procedures
- Annual review and approval of PMCJF standing medical orders
- Approval of PMCJF Nurse job description, duties and responsibilities
- Annual review and approval of PMCJF First Aid/CPR/ERT/AED curriculum
- Annual review and approval of PMCJF first aid kits and equipment
- Approve the method of monitoring alcohol & drug abuse among PMCJF residents
- Provide prescriptions for PMCJF stock medications such as Epi pens and TB tests

Full-time Health-Trained Personnel

6.5 The facility shall employee a full-time registered nurse to provide health care services to the residents. This position shall coordinate the delivery of health services including medication and scheduling appointments with appropriate health care providers as well as providing for other duties and responsibilities pursuant to the job description.

6.6 The nurse shall be required to pass a background check, pass the Ohio Child Abuse Registry, complete all PMCJF Prison Rape Elimination Act training requirements, and retain active and appropriate licensure to provide medical services within the State of Ohio. Verification of current state licensure will be kept on file.

Health-Trained Staff Members

6.7 When facilities do not have full-time, qualified health-trained personnel, a health-trained staff member shall coordinate the health delivery services.

6.8 First-Aid kits shall be approved by the health authority and available at designated locations throughout the building. The kits shall be sealed. The facility nurse shall conduct monthly maintenance checks on all first-aid kits. An external defibrillator is available for use at the facility.

Credential of Licensed Health Care Personnel

6.9 When residents receive treatment by licensed health care personnel, copies of licenses will be kept on file.

Standing Orders

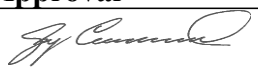
6.10 Treatment by health care personnel other than a physician, dentist, psychologist, optometrist, podiatrist, or other independent provider is performed pursuant to written standing or direct orders by personnel authorized by law to give such orders. Nurse practitioners and physician's assistants may practice within the limits of applicable laws and regulations.

6.11 In the event that health care personnel are not available, staff will treat residents with medical complaints based on first aid training and written standing orders. Standing orders shall be approved by the health authority as authorized by law to give such orders.

6.12 All staff shall be trained on implementation of standing orders. A copy of the standing orders shall be available on the computer and in a binder stored at Central Control. When a resident complains of an ailment, staff shall consult standing orders. Staff shall use standing orders as guidance in treating the resident including consulting prior to dispensing medication.

6.13 Staff shall follow standing orders unless told to deviate from the standing orders by medical personnel. Any order to deviate from standing orders shall be documented by staff.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-10-14 Prior Effective Date: 06-25-15; 03-08-18 Date Revised: 07-21-20	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Health Care**
Subject:	**Unimpeded Access to Care and Emergency Care**
Related Standards:	
O.A.C.	**5139-36-10 (D)(5)(6)(7) 5139-36-18 (A)(C)(E)(8)(I)(P)(Q)(R)(S)**
A.C.A.	**3-JCRF-4C-14 (Mandatory) 3-JCRF-4C-15 (Mandatory)**
A.C.A.	**3-JCRF-4C-02 4C-13 4C-17 4C-27 5G-08**
P.R.E.A.	**None**

1.0 Purpose

To ensure twenty-four-hour availability of consultation, advice and emergency service response for the medical supervision, care and treatment of the facility juvenile population.

2.0 Persons Affected

All employees

3.0 Policy

A. Emergency Plan

1. Perry Multi-County Juvenile Facility provides a written plan for 24-hour emergency medical, dental, and qualified mental health care availability that includes arrangements for on-site emergency first aid and crisis intervention, emergency evacuation of the resident from the facility, use of an emergency medical vehicle, use of one or more designated hospital emergency rooms or other appropriate health facilities, and security procedures providing for the immediate transfer of residents, when appropriate. If an emergency health facility is not located in a nearby community, a plan for emergency on-call physician, dental, and mental health professional services shall be available. Poison control numbers and other emergency numbers shall be readily accessible to staff and clearly posted throughout the facility. The facility shall be responsible for arranging emergency treatment for dental needs.

B. Training

1. Resident Care Workers and other personnel are trained to respond to health-related situations within a four-minute response time. Persons injured in an incident shall receive immediate medical examination and treatment. A training program is established by the responsible health authority in cooperation with the facility administrator that includes recognition of the signs and symptoms and knowledge of action required in potential emergency situations, the administration of first aid and cardiopulmonary resuscitation (CPR) and current certification, methods of obtaining assistance, signs and symptoms of mental illness, retardation, and chemical dependency, and procedures for patient transfers to appropriate medical facilities or health care providers.

C. Access to Care

1. Residents shall have access to health care and a system for processing complaints regarding health care. Person injured in an incident shall receive immediate medical examination and treatment. All decisions concerning access to health care are made by health care staff. The policies on access are communicated orally and in writing to residents on arrival to the facility in a language clearly understood by each resident.

D. Notification

1. The facility shall provide timely notification of resident parents/guardians in case of serious illness, surgery, injury or death and timely notification of a resident for the verifiable death or critical illness of an immediate family member. In case of the critical illness of an immediate family member, the resident is permitted, whenever statutes and circumstances allow, to go to the bedside under escort or alone.

E. Religious Conflicts

1. When a resident requires medical attention in a potentially health-threatening emergency and such treatment conflicts with the religious tenets or practices of the resident's custodial parent, the facility shall immediately transport the resident to a medical facility and refer the matter, as appropriate, to a juvenile judge in the committing county, the department, public children services agency, or county department of job and family services.

4.0 Definitions/Documents

4.1 Health Call is defined as the weekly check of all residents' medical well-being.

4.2 ERT is Emergency Response Training. All staff must be trained to respond to health-related situations within a four-minute response time.

4.3 AED stands for Automated External Defibrillator. This is a portable electronic device designed to analyze heart rhythm and deliver electrical shock when detecting a problem allowing the heart to reestablish an effective rhythm.

4.4 CPR stands for cardiopulmonary resuscitation. This is an emergency procedure that combines chest compressions often with ventilation to manually preserve blood circulation and breathing in a person who is in cardiac arrest.

5.0 Responsibility

5.1 The Facility Director shall be responsible for the following:

a. Ensure a facility plan provides for twenty-four (24) hour availability of consultation, advice, and emergency service response for medical supervision, care and treatment of the resident facility population.
b. Cooperating with the health authority in the approval of the emergency response training program
c. Providing timely notification of resident parents/guardians in case of serious illness, surgery, injury or death
d. Notifying local authorities of a death in the facility and placing the facility on lockdown
e. Providing oversight in the notification of a resident of the critical illness of an immediate family member
f. Making arrangements for a resident to go to the bedside of an immediate family member under escort or alone in case of critical illness when statute and circumstances allow.
g. Referring matters of religious conflicts with medical treatment after transport to a medical facility to a juvenile judge in the committing county, the department, public children services agency, or county department of job and family services.

5.2 Health Care Authority is responsible for the annual review and approval of PMCJF First Aid/CPR/ERT/AED curriculum, providing input for and approving all medical related policies and procedures, and approving the uniform method of collection and recording of health appraisal data.

5.3 Facility Nurse

a. Ensuring that the medical needs of the residents are being met in accordance with facility policies and procedures and pursuant to the facility nurse job description.
b. Making facility decisions concerning access to health care including providing or arranging for immediate examination and treatment to persons injured in an incident.
c. Providing input in health care policies and standard medical operating procedures for the facility.
d. Reporting medical and/or unsafe conditions that pose a danger to staff and youth.
e. Providing staff with access to information on infectious diseases, illness, bloodborne pathogens and exposure control training plan.
f. Providing orientation screening and ongoing service delivery to youth.
g. Providing weekly health call checks on the facility resident population.
h. Providing on-call services to include both phone consultations and on-site visits.
i. Checking the medical request box daily when present at the facility.
j. Filling all medical requests in a timely manner, coordinating and overseeing prescription medication delivery, and scheduling appointments for doctor, dental, and other medically related visits as appropriate.
k. Creating and ensuring that resident's medical records are complete and privacy is maintained.
l. Overseeing a medication record for each resident ensuring that signatures are in place and identifying medication was administered.
m. Acting as a liaison between resident's parents or legal guardians about medical issues that may arise during a resident's stay.
n. Assuring compliance and maintaining all required documentation for medical ACA standards.

5.4 Training Coordinator is responsible for the following:

a. Maintaining First Aid/CPR/AED and ERT trainer certification
b. Ensure the First Aid/CPR/AED and ERT training curriculum includes training in all required topics
c. Providing First Aid/CPR/AED and ERT training to employees during orientation and annually for all employees as part of an annual training plan
d. Notifying the director when an employee has failed to maintain annual requirements of certification in First Aid/CPR/AED and ERT

5.5 All staff are responsible for obtaining and maintaining annual certification in First Aid/CPR/AED and Emergency Response Training.

5.6 Resident Care Workers are responsible for the following:

a. Ensuring that the medical needs of the residents are being met in accordance with facility policies and procedures.

b. Receiving and maintaining annual certification in First Aid/CPR/AED and ERT.
c. Knowledge of and ability to follow standing orders.
d. Using knowledge and judgment in contacting 911 for emergency situations in accordance with facility training.
e. Using ERT training and knowledge of First Aid/CPR/AED to provide for the care and treatment of residents.
f. Providing notification to the nurse and director during emergency medical situations. g. Following policies and procedures during resident medical related transports.

6.0 Procedures

Emergency Plan

6.1 The facility plan ensures twenty-four (24) hour availability of consultation, advice and emergency service response for medical supervision, care and treatment of the resident facility population. The facility nurse is on-call and may be consulted in the event of an emergency or as a part of standing orders. Genesis Hospital is our primary emergency health care facility located in Zanesville, Ohio providing 24-hour medical, dental, and qualified mental health emergency services.

6.2 Standing orders contain instructions to call 911 under the following circumstances:

- Severe allergic reactions if there is difficulty in swallowing or having difficulty breathing
- Second Degree burns with blisters over a large area or burn in mucus membrane may require 911 called and squad transportation depending on severity
- Third Degree burns
- Probably Fracture that is open or compound
- Lacerations with uncontrolled bleeding
- Seizures

6.3 Residents not involved in the emergency situation should be kept in lock-down with observations being documented and performed every fifteen minutes until the situation is under control and any necessary cleanup is performed.

6.4 Employees are trained in first aid and crisis intervention and are expected to use their judgment when making the decision to contact 911 for emergency services. Calling 911 is not limited to the above circumstances. Respiratory crisis, unconsciousness, and serious injuries may all result in the need to contact 911. The Perry County 911 Center will dispatch ambulance services to the facility. All situations requiring immediate, emergency diagnosis or evaluation should be reported to the Director or designee as soon as possible.

6.5 If the emergency is serious but not life threatening, basic first aid should be provided to the resident following universal precautions and the nurse should be called for consultation and instructions. Sprains are a common injury. Treatment for suspected sprains should follow basic first aid principles including rest, ice, compression, and elevation of the affected limb. Ibuprofen may be given to help with swelling. Crutches may be obtained if needed for walking.

6.6 Standing orders include instructions to transport to urgent care under the following circumstances:

- Human or Animal bites
- Hemorrhaging in the eye
- Foreign body impaled in the eye
- Laceration that gapes or continues to bleed
- Nosebleed continuing after application of pressure and nurse contact

Ambulance Service

6.7 If the emergency requires evacuation of a resident from the facility, staff should comply by transporting each resident based on their security classification receiving permission from the director or supervisor to make adjustments to mechanical restraints regardless of security level. The resident should be immediately transferred to the emergency squad in accordance with the emergency medical technician instructions. A staff member will ride in the ambulance with the resident as permitted by the ambulance service.

Incident Report

6.8 The emergency situations should be described on an incident report, including the care and treatment provided, contacts made, and the time contacts were made. A copy of the incident report, the physician/emergency referral form, and all medical instructions obtained in the course of care and treatment should be provided to the nurse for follow-up evaluations. The nurse provides for the immediate examination and treatment to persons injured in an incident.

Poisoning

6.9 If a resident attempts suicide by drinking a substance in the facility, staff should check the Safety Data Sheets (SDS) for further instructions, the Director should be notified immediately, and Poison Control should be called at 1-800-222-1222. The resident should be placed on suicide watch and the Clinical Coordinator may also be notified. If this situation is life threatening, then staff should call 911 requesting emergency services while following all the above steps.

Training

6.10 Resident Care Worker staff and other personnel are trained to respond to health-related situations within a four-minute response time. The emergency response training program curriculum including instructions and testing for first aid and CPR are provided by the Ohio Department of Youth Services Training Academy and approved by the health authority in cooperation with the facility administrator that includes the following:

- Recognition of signs and symptoms and knowledge of action required in potential emergency situations
- Administration of first aid, cardiopulmonary resuscitation (CPR), use of the automated external defibrillator (AED) and current certification
- Methods of obtaining assistance
- Signs and symptoms of mental illness, developmental delays (formerly identified as retardation) and chemical dependency
- Procedures for patient transfers to appropriate medical facilities or health care providers

6.11 All staff on all shifts is required to be certified and maintain annual certification in basic First Aid/CPR/AED. Certification shall be obtained as soon as possible during the employee probationary period training. Copies of certification are kept on file. There must be one staff with basic first aid and CPR certification per shift daily. Annual training shall also include training in the implementation of the exposure control plan, instructions in universal precautions and emergency medical procedures.

6.12 Persons injured in an incident shall receive immediate medical examination and treatment pursuant to staff first aid training and in accordance with standing orders.

Access to Care

6.13 During orientation, residents receive instructions in how to make medical and other requests, the location of the request forms, and how to give the medical care requests to the facility nurse. The training is documented on the new resident training log along with instructions concerning the grievance process. If there is a complaint about any issue in the facility including health care, residents may follow the grievance procedure as reviewed orally and noted in their handbooks.

6.14 Residents have unimpeded access to the nurse box located outside the nurse office and may place requests or concerns into the box any time during transportation to or from meals. Medical concerns will be addressed by staff in accordance with standing medical orders in the absence of the nurse.

6.15 The facility nurse conducts health call on all residents once per week. She fills all medical requests, coordinates and oversees prescription medication delivery, makes appointments for doctor or dental visits and forwards requests for additional medical treatment to the Director.

6.16 The nurse schedules resident appointments for examination and non-emergency medical care with Genesis Health Care New Lex Family Practice and non-emergency dental care with Hopewell Medical Center. Dental care shall be provided to each resident under the direction and supervision of a dentist licensed in the state.

Notification

6.17 The Director shall be notified in all cases of serious illness, surgery, and injury to a resident at the facility. The Director will, either personally or with specific authorization, notify the resident's parent(s)/guardian(s) giving the medical information including current location of the resident.

6.18 In cases of death, the Director will promptly notify local authorities. Upon verification of death, the parent(s)/guardian(s) will be notified. Residents at the facility will be placed in lock-down with fifteen-minute checks performed. No residents or staff will be permitted to exit the facility until approved by the Director. All areas surrounding the scene of the death shall be secured.

6.19 All residents are informed in a timely manner of the verifiable death or critical illness of an immediate family member in conformity with family wishes. Special visits may be arranged for the purpose of informing the resident of the death. If possible, in the event that a special visit is not an option, counseling staff will directly speak to the resident or be made available to the resident to discuss the death or critical illness.

6.20 Special permission to go to the bedside of an immediate family member may be permitted in the case of critical illness with approval of the Director and/or sending court. The resident may be required to be escorted in shackles and handcuffs as required by procedure.

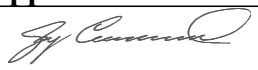
Religious Conflicts

6.21 When a resident requires medical attention in a potentially health-threatening emergency and such treatment conflicts with the religious tenets or practices of the resident's custodial parent, the facility shall immediately transport the resident to a medical facility and refer the matter, as appropriate, to a juvenile judge in the committing county, the Ohio Department of Youth Services, public children services agency, or county department of job and family services.

Narcotic Overdose

6.22 Opioid addiction is growing throughout the country. Ohio's epidemic is at a crisis level with this area of the state particularly vulnerable. Staff shall participate in community training on an on-going basis. The training includes recognizing overdose symptoms including slowed breathing, no breathing, very small or pinpoint pupils in the eyes, slow heartbeats, or extreme drowsiness and/or inability to wake the person from sleep. The facility shall keep Narcan stocked in the medication cart to be used for emergency overdose treatment as needed in accordance to emergency training.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Health Care**
Subject:	**Intake Health Screening and Orientation**
Related Standards:	
O.A.C.	**5139-36-17 (E)(1-7)(9-10)(F)(G) 5139-36-18 (B)(F)(K)(L)**
A.C.A.	**3-JCRF-4C-09 4C-10 4C-11 4C-13 4C-25 4C-28**
A.C.A.	**3-JCRF-4C-17**
P.R.E.A.	**None**

1.0 Purpose

To establish a systematic process for resident intake screening and orientation.

2.0 Persons Affected

Facility Nurse, Health Authority, Clinical Coordinator, Case Manager, Shift Supervisors, and Resident Care Workers

3.0 Policy

The program seeks medical consent authorization from each resident's parent, guardian, or committing authority as part of the admissions process; the basis for medical consent is noted in the program record of the resident. Medical, dental, and mental health screenings shall be performed by qualified health care personnel on all residents during the intake process. The screening shall include the following:

a. Current illness and health problems including venereal diseases and other infectious diseases
b. Dental problems
c. Mental Health Problems
d. Use of alcohol and other drugs, which includes types of drugs used, mode of use, problems that may have occurred after ceasing use (e.g., convulsions)
e. Past and present treatment or hospitalization for mental disturbance or suicide
f. Other health problems designated by the responsible members

Observation of:

g. Behavior, which includes state of consciousness, mental status, appearance, conduct, tremors and sweating
h. Body deformities, ease of movement, etc.
i. Condition of skin, including trauma markings, bruises, lesions, jaundice, rashes and infestations, and needle marks or other indications of drug abuse

Findings and health appraisal data shall be collected and recorded on an approved screening form and completed in a uniform manner as determined by the health authority. The health history and vital signs are collected by health-trained or qualified personnel. The collection of all other health appraisal data is performed only by qualified health personnel. Medical examinations shall be conducted within fourteen (14) days before or after admissions, and updated annually. Review of results of the medical examination, tests, and identification of problems is performed by a physician.

A suicide risk assessment shall be performed during the intake process prior to removing each resident from watch in accordance with the suicide prevention and intervention plan.

Appropriate staff shall be informed of mental health problems of each juvenile as well as resident special medical needs at the time of admission including any physical problems that might require medical attention.

Facility staff shall be assigned to provide orientation to each resident to the facility, rules, and consequences of violations of rules. Residents shall be informed of the procedures for gaining access to medical services as well as the system for processing complaints regarding health care. This orientation shall be documented by juvenile and staff signatures.

Medical examinations shall be conducted within fourteen (14) days before or after admissions, and updated annually. Review of results of the medical examination, tests, and identification of problems is performed by a physician.

A medical record shall be maintained on each resident including information concerning illness, communicable diseases, physical abnormalities, allergies and the administration of treatment.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Facility Nurse is responsible for the following:

a. Conducting resident intake screening using a screening instrument containing the information required by Ohio Administrative Codes and the American Correctional Association.
b. Documenting findings of intake screenings on the appropriate screening form.
c. Informing appropriate staff of special medical needs or physical problems that might require medical attention.
d. Conducting a dental screening and scheduling any appointments for required dental care.
e. Scheduling a medical exam within fourteen (14) days of admission.
f. Conducting tuberculosis testing or confirming documentation of recent testing at intake.

5.2 Facility Health Authority shall approve the uniform method and process of recording health appraisal data.

5.3 Clinical Coordinator shall be responsible for the following:

a. Conducting a suicide risk assessment during intake or as soon as possible following intake to determine suicide risk level and documenting on the appropriate forms.
b. Making a determination of whether each resident should be released from special watch, remain on special watch, or be placed on suicide watch.
c. Informing staff of any mental health issues or special accommodations needed for proper care and treatment of the resident.

5.4 Case Manager shall be responsible for the following:

a. Obtaining completed orientation documents including a medical consent form, emergency treatment authorization form, a medical release of information form, family medical history and an insurance form.
b. Completing an Ohio Youth Assessment System interview and rating risk level of each resident.

5.5 Shift Supervisors shall be responsible for providing and documenting orientation for each resident to the facility, rules, and consequences of violations of rules including informing residents of the procedures for gaining access to medical services as well as the system for processing complaints regarding health care.

6.0 Procedures

Medical Consent

6.1 During or prior to intake, the Case Manager obtains medical consent authorization from each resident's parent, guardian, or committing authority as part of the admissions process. Forms include Medical Consent Form, an Emergency Treatment Authorization Form, Medical Release Form, a Family Medical History including medical needs with notation of personal physician, and an Insurance Form.

Medical, Dental and Mental Health Screening

6.2 Medical, dental, and mental health screening shall be performed by the facility nurse on all residents during the intake process with findings recorded on an approved screening form. The screening shall include the following:

a. Current illness and health problems including venereal diseases and other infectious diseases
b. Dental problems
c. Mental Health Problems
d. Use of alcohol and other drugs, which includes types of drugs used, mode of use, problems that may have occurred after ceasing use (e.g., convulsions)
e. Past and present treatment or hospitalization for mental disturbance or suicide
f. Other health problems designated by the responsible members

Observation of:

g. Behavior, which includes state of consciousness, mental status, appearance, conduct, tremors and sweating
h. Body deformities, ease of movement, etc.
i. Condition of skin, including trauma markings, bruises, lesions, jaundice, rashes and infestations, and needle marks or other indications of drug abuse

6.3 Findings and health appraisal data shall be collected and recorded on an approved screening form and completed in a uniform manner as determined by the health authority. The screening shall contain the health history and vital signs are collected by the facility nurse. The collection of all other health appraisal data is performed only by qualified health personnel. Medical examinations shall be conducted within fourteen (14) days before or after admissions, and updated annually. Review of results of the medical examination, tests, and identification of problems is performed by a physician.

6.4 The medical care and treatment of each resident shall be coordinated by the facility nurse. Tuberculosis testing will occur at intake unless documentation of recent testing is confirmed. An appointment for a medical examination shall be made within fourteen (14) days after admissions, and updated annually. Review of results of the medical examination, tests, and identification of problems is performed by a physician. Dental and optical care shall be provided to each resident when needed. Any required care will be performed under the direction and supervision of a licensed medical personnel including dentists and optometrists.

6.5 The facility nurse shall provide information of juvenile special medical needs, physical, or mental health problems by communicating with the shift supervisors and writing the information on the shift report log. Any medications taken will be inventoried and placed in the medication cart.

Suicide Risk Assessment

6.6 A suicide risk assessment shall be performed by the clinical coordinator during the intake process to make a determination on whether each resident should be released from special watch, remain on special watch, or be placed on suicide watch in accordance with the suicide prevention and intervention plan. The clinical coordinator shall document the basis for decisions and inform staff of any mental health issues or special accommodations needed for proper care and treatment of the resident.

Ohio Youth Assessment System

6.7 A risk assessment will be conducted for each resident by the Case Manager as soon as possible after admission to the facility to determine appropriate risk classification based upon the Ohio Youth Assessment.

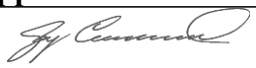
New Resident Orientation Access to Medical Care

6.8 The shift supervisor shall be responsible for conducting orientation for each resident to the facility, rules, and consequences of violations of rules. Residents shall be informed of the procedures for gaining access to medical services as well as the system for processing complaints regarding health care. This orientation shall be documented by juvenile and staff signatures. If a shift supervisor is not available for orientation, a staff member shall be assigned to provide orientation for the resident.

Health Record File

6.9 Each resident in the facility will have a health record file. The file will contain completed health screening forms, health appraisal data forms, all findings, diagnoses, treatments and dispositions, prescribed medications and their administration, signature and title of the documenter, consent and refusal forms, place, date, and time of health encounters, and dental, mental health, and consultation reports for all health services. The record shall also include information concerning illness, communicable diseases, physical abnormalities, allergies and the administration of treatment. The health authority shall approve the uniform method and process of recording health appraisal data, the form and format of the records, and the procedures for their maintenance and safekeeping.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Health Care**
Subject:	**Medication Verification, Pharmaceutical Storage and Distribution & Stock of Drugs**
Related Standards:	
O.A.C.	**5139-36-18 (D)(E)(1)(a)(b)(c)(2)(3)(4)(5)(6)(J)(N)**
A.C.A.	**3-JCRF-4C-08**
P.R.E.A.	**None**

1.0 Purpose

To ensure adherence to regulations regarding proper management of medications.

2.0 Persons Affected

All employees

3.0 Policy

The program's health care plan shall adhere to laws and regulations regarding storage and distribution of medications. The facility provides for the proper management of pharmaceuticals and shall address the following:

1) A formulary specifically developed for the facility prescription practices that requires
   a. Prescription practices including requirements that psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy
   b. Stop order time periods for all medications
   c. The prescribing provider reevaluates a prescription prior to its renewal

2) Procedures for medication receipt, storage, dispensing and administration or distribution

3) Maximum security storage and periodic inventory of all controlled substances, syringes, and needles

4) Dispensing of medicine in conformance with appropriate federal and state laws

5) Administration of medication by persons properly trained and under the supervision of the health authority and facility administrator or designee

6) Accountability for administering or distributing medications in a timely manner and according to physician's orders

Attempts to verify prescribed medication and proper dosages follows new resident admission at the time intervals prescribed by the appropriate medical authority.

The facility shall govern the development, and subsequent updating, of a facility formulary or drug list for pharmaceuticals stocked by the facility.

In consultation with the resident's physician, the facility shall periodically review each resident's current regiment of medication and, as authorized by the physician, may make adjustments to that regimen as appropriate. In no event shall a facility begin, alter or suspend a resident's medication without the approval of a physician.

4.0 Definitions/Documents

4.1 Pharmaceuticals are medicinal drugs.

4.2 Formulary is an official listing of generic and brand name pharmaceutical drugs

4.3 Psychotropic Medications are drugs that effect how the mind works

4.4 Controlled Medications refer to medications that contain a drug or chemical whose manufacture, possession or use is regulated by the government.

4.5 Controlled Substance Regulations list drugs as schedule I through V. Based upon their history, Schedule I drugs have a higher potential for abuse and are not prescribed compared to schedule V drugs with lower potential for abuse and typically available over-the-counter.

4.6 Over-the-counter (OTC) or non-prescription drugs are defined as drugs that are safe and effective for use by the general public without the need for supervision by a healthcare practitioner and therefore without a prescription

5.0 Responsibility

5.1 Facility Nurse is responsible for the following:

a. The identification of pharmaceuticals at intake, newly prescribed medications, and medication otherwise brought to the facility for resident use.
b. Completing inventory and initiating storage of all prescription medications in the storage cart.
c. Creating prescription medication sheets
d. Training staff in the procedures for self-assisted medication including how to dispense the medication and observe the resident to ensure that it is being properly taken.
e. Providing weekly accountability checks for administering or distributing medications in a timely manner and according to physician's orders

5.2 Health Authority is responsible for providing prescriptions for PMCJF stock medications such as Epi pens and TB tests as well as supervising the process of administration of medications with the facility nurse.

5.3 Resident Care Worker

a. Receiving medication training as approved and documented by the facility nurse.
b. Administering the correct medication and dosage, to the resident in which the medication was prescribed, at the correct time and in accordance with medication training.
c. Distributing OTC medications in accordance with standing medical orders.
d. Routinely checking residents each time medication is distributed in accordance with procedures.
e. Appropriate documenting medication distribution on the sick log, non-prescription medication log, prescription medication log, medication cart, and inventory control form as required.

f. In the absence of the nurse, may be required to identify medication brought to the facility, sign the medications into the medication cart, notify staff by adding the medication to the shift information log, create the medication log for dispensing, and dispense the medication to the appropriate resident in accordance with prescription.

6.0 Procedures

6.1 The facility adheres to all state and federal laws and regulations regarding the storage and distribution of medications.

Prescription Medication Cart

6.2 All prescription medication is kept in a medication cart in the locked, staff accessible area inside Central Control. The medication cart itself has a double-lock system for security of controlled medication.

Stock of Non-Prescription Medication

6.3 The facility will provide residents with non-prescription drugs for minor illnesses. A limited number of these drugs will be kept in a single locked cabinet and inside the medication cart located near the Central Control desk. All drugs removed from the cabinet are documented on the cabinet including the date, time, person removing the drug and the resident who is using the drug. The drug that is dispensed is further documented and signed by the resident in a non-prescription medication log.

6.4 Surplus drugs are kept behind a double-locked door in the nurse's office.

6.5 If the stock of non-prescription drugs is low, a supply request form may be made by any staff member and given to the Director for additional stocking or purchasing.

Drug Identification and Verification

6.6 The facility nurse verifies prescription drugs during a resident intake, when newly prescribed, and when medication is otherwise brought to the facility. In the absence of the nurse, a resident care worker that has received medication training may compare the medication received to the previous medication to ensure it is the same. The number of pills shall be counted and documented in the medical log. The medication shall then be placed into the appropriate storage area.

Medication Dispensing

6.7 Medication is dispensed under a system of self-assisted medication. Residents are responsible for taking their medication with staff dispensing the medication at the correct time. Staff obtains the medication from the medication cart and observes each resident as they take their medication. Residents may request medication at any time.

6.8 To prevent residents from illegally sharing their medication, staff shall routinely check each time medication is distributed. Residents shall place their medication on their tongues and show it to staff. Residents will then swallow the medication with water before using their own fingers to pull lips away from their teeth and gums and sweep in the jaw area to ensure the medication is being properly used. Staff shall check the cup and have residents repeat the sweeping procedure before returning to a secured area. Staff in the

secured area will conduct random frisk searches to further ensure medication is being taken appropriately.

6.9 During times when only two staff are present, the unit doors should not be opened for a resident for any reason other than an emergency (fire, tornado, suicide, or to provide emergency first aide). A resident requesting medication may leave the request on the table, notify staff and return to their rooms while staff gathers the medication. One staff member will enter the unit and place the medication in the dispensing cup on a cleared table and exit the unit. The resident will be released from his cell to take the medication with staff observation into the unit.

Pharmaceutical Practices, Distribution Training, Control Drugs and Accountability

6.10 All psychotropic medications prescribed to residents will be evaluated throughout the residents stay at the facility. Treatment teams will discuss resident issues including medications, their use and effectiveness during meetings. These discussions may be communicated to the resident's proscribing provider for reevaluation of medications.

6.11 Stop order time periods will be provided for all medications. Some medications will be designated as on-going as prescribed by a physician.

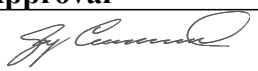
6.12 Following admission, the resident will receive a health screening and attempts will be made to verify any prescribed medication and proper dosages.

6.13 Staff is trained in the procedure for self-assisted medication. The training includes how to dispense the medication and observe the resident to ensure that it is being properly taken.

6.14 Control drugs must be accounted for by staff after dispensing. A list of control drugs currently in use will be located in the medication log. Each resident on a control drug will have an accountability sheet with their individual prescription medication log sheet that must be used to identify the number of pills remaining after every use by the staff member dispensing the pills.

6.15 The facility nurse will do a weekly accountability check on all prescription medication.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 06-25-15; 03-06-18
Date Revised: 07-21-20

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Health Care**
Subject:	**Communicable Disease Management, TB testing, Universal Precautions, HIV, Bloodborne Pathogens Training, Medical Isolation**
Related Standards:	
O.A.C.	**5139-36-18 (O)(V)**
A.C.A.	**3-JCRF-4C-12 4C-18 4C-19 4C-20 4C-21 4C-22 4C-26 4C-29**
P.R.E.A.	**None**

1.0 Purpose

To ensure appropriate care and treatment for residents with procedures addressing communicable diseases.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall address the management of serious and infectious diseases including updates as new information becomes available. Medical isolation shall occur under the directions of qualified health care personnel. Medical examinations of employees or residents suspected of having a communicable disease shall be provided. The facility shall also provide instructions and assistance in personal hygiene, grooming and health care to residents when needed. Policy and procedures specify approved actions to be taken by employees concerning residents who have been diagnosed with HIV. The policy shall be reviewed annually and shall include, at a minimum, the following:

a. When and where juveniles are to be tested
b. Appropriate safeguards for staff and juveniles
c. Who shall conduct the tests
d. When and under what conditions juveniles are to be separated from the general population
e. Staff and juvenile training procedures
f. Issues of confidentiality

The facility shall prohibit the use of residents for medical, pharmaceutical, or cosmetic experiments. This policy does not preclude individual treatment of residents based on his need for a specific medical procedure that is not generally available

4.0 Definitions/Documents

4.1 HIV stands for human immunodeficiency virus. The infection damages the immune system interfering with the ability to fight organisms that cause disease.

4.2 AIDS stands for acquired immune deficiency syndrome characterized by chronic failure of the immune system with potentially life-threatening infections caused by HIV.

4.3 Communicable diseases are infectious diseases that are transmitted through direct or indirect contact with an infected person. Included in these diseases are the common cold, pneumonia, influenza, strep throat, viral gastroenteritis, pink eye, whooping cough, ring worm, tuberculosis, hepatitis A, B, and C, mononucleosis, MRSA staph infection, and measles.

5.0 Responsibility

5.1 Compliance Coordinator is responsible for the annual review of policies and procedures.

5.2 Facility nurse is responsible for the following:

a. Providing intake medical screenings for new residents including tuberculosis testing or confirmation of previous test and arrangement of a physician examination within 14 days.
b. Ensuring employees at the facility have an initial tuberculosis testing during their probationary status and that all employees are tested annually.
c. Making determinations concerning resident need for medical isolation for appropriate care and treatment.
d. Providing examinations and advising staff suspected of having a communicable disease. Providing examinations of residents suspected of having a communicable disease, arranging doctor appointments as medically indicated and in accordance with standing orders.
f. Providing training in universal precautions and bloodborne pathogens to residents and staff.
g. Training staff annually in the implementation of the exposure control plan
h. Updating policies and procedures regarding the management of serious and infection diseases as new information becomes available.
i. Making recommendations for prevention of the spread of communicable diseases.
j. Provide a summary or copy of the medical history record forward to the receiving facility prior to arrival for juveniles transferred from this facility.

5.3 Resident Care Workers will be responsible for the following:

a. Placing a resident in medical isolation when a resident is sick and needs to be monitored.
b. Notifying and consulting with the nurse at the earliest possible moment when she is in the facility and in accordance with standing orders when she is not present.
c. Demonstrate proper hand washing for residents to prevent the spread of communicable diseases and teach residents how to clean properly and thoroughly to prevent the spread of communicable diseases.
d. Follow universal precautions in providing first aid care and treatment to others, when handling trash, and when handling resident laundry.
e. Ensuring residents are following universal precautions when cleaning the bathroom and shower areas, taking out trash, and when handling the dirty laundry of other residents.

6.0 Procedures

Communicable Diseases

6.1 The facility addresses the management of serious and infectious diseases through prevention and control. Contaminated hands are the most common means of transmission. Residents are encouraged to frequently wash their hands. There are wash basins in the living areas and bathroom of each unit with access to soap. Hand sanitizer is provided in the hallway outside the dining area, in the dining area, and inside the classrooms. Residents are required to perform daily chores which includes cleaning door handles.

6.2 During times when two or more residents or staff are or have been ill with a communicable disease, the facility shall increase cleaning efforts. This can be done by ensuring that the hospital grade disinfectant located in the mechanical room is used in all common areas. Chemical exception sheets may be completed for use of disinfecting in staff accessible areas.

6.3 The facility nurse shall provide medical examinations of employees and residents suspected of having a communicable disease. The facility nurse shall provide advice to staff suspected of having a communicable disease including making recommendations for staff treatment. Residents shall be treated for communicable diseases in accordance with standing orders with doctor appointments arranged as medically indicated.

Tuberculosis Testing

6.4 Medical screening examinations will be performed on each resident after entering into the Facility including inquiry into any current illness. All residents will be asked if they have had previous tuberculosis testing. If such a test was performed, documentation of the tests results will be kept in each resident's medical file. If a resident has not had a TB test, then a test may be performed.

6.5 All staff members are required to have and initial TB test during their probationary period and annually thereafter. The tests are administered by the facility nurse at no cost to employees unless other arrangements have been approved. Copies of the test and results are maintained in a separate file in the administrative office.

Universal Precautions and HIV

6.6 Universal precautions are simple infection control measures that reduce the risk of transmission of blood borne pathogens through exposure to blood or body fluids among residents and employees. Under the "universal precaution" principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or supposed status of the person.

6.7 Universal precautions are to be taken at all times including when treating a resident that is diagnosed as HIV positive.

6.8 Medical quality gloves shall be worn by staff or residents when cleaning any areas that may contain blood or body fluids. Vinyl gloves shall be available when allergies to latex are present. The gloves shall be disposed of in a plastic bag or lined trash container. Hands shall be washed for twenty seconds with soap and warm water after disposal of gloves. Injuries requiring the cleanup of blood or body fluids shall be handled by stopping the activity taking place, securing the area, using gloves, disposable cloths, and hospital grade cleaning solution (Suprox or equivalent) for the cleanup.

6.9 HIV and testing for other sexually transmitted diseases shall be performed at the request of the resident. Inquiry into sexual history is made at the initial medical examination with recommendations for testing when warranted. Any positive results will be communicated to the facility for additional counseling and treatment needs of the infected resident.

6.10 Residents with HIV will remain in the general population and be treated the same as any other resident in the facility. They will be separated from the general population only upon the orders of their treating physician.

Training

6.11 Occupational Safety and Health Administration rules require organizational exposure control plans. The exposure control plan for the facility is located on the computer and with the medical standing orders.

6.12 All staff will receive training universal precautions and following the exposure control plan by the facility nurse or other qualified professional. Resident Care Workers are expected to follow universal precautions while providing first aid care and treatment to others, when handling trash and resident laundry, and during cleaning of areas where there may be an exposure to blood or bodily fluids of others. Resident Care Workers shall supervise residents to ensure they are following universal precautions when cleaning the bathroom and shower areas, taking out trash, and when handling the dirty laundry of other residents.

6.13 Staff and residents are given blood borne pathogen training by the facility nurse or other qualified professional.

Chronic and Convalescent Care

6.14 Chronic care, convalescent care, and medical preventive care are provided to residents of the facility when medically indicated. The facility prohibits the use of residents for medical, pharmaceutical, or cosmetic experiments. Consideration for treatment of residents based on his need for a specific medical procedure that is not generally available shall be considered on an individual basis.

Prostheses

6.15 Residents in the facility are given a medical and dental screening. Medical and dental prostheses shall be provided when the health of the resident would otherwise be adversely affected as determined by the responsible physician.

Hygiene Education

6.16 The facility provides each resident a handbook that includes instructions and expectations of personal hygiene, grooming and health care. Additional instructions may be provided on an as needed basis when issues have been identified by staff.

Medical Isolation

6.17 The watch room shall be used as the medical isolation room. It is separate from the living units and equipped to provide for washing, drinking, toilet use, and safety needs of the confined resident with facilities for visual and audio monitoring. The resident may have a mattress and pillow with sheets and a pillowcase. The resident's shoes should be kept out of the watch room. Eyeglasses may be permitted during medical isolation.

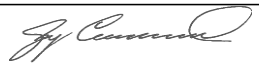
6.18 The facility nurse shall make determinations concerning resident need for medical isolation for appropriate care and treatment. When the nurse is not present, staff may place a resident in medical isolation when a resident is sick and needs to be monitored. Staff must notify and consult with the nurse at the earliest possible moment when she is in the facility and in accordance with standing orders when she is not present.

6.19 Staff shall follow the recommendations of the health care professional and document observations once every fifteen minutes or as prescribed.

Transfer of Records

6.20 The facility nurse shall forward a resident medical summary or copy of the medical history record to the receiving facility prior to arrival.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 07-19-11 Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
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Date Revised: 07-21-20

Perry Multi-County Juvenile Facility	
Chapter: 4.0	**Facility Services**
Section:	**Health Care**
Subject:	**Mental Health Services, Chemical Dependency Assessment, Coordinated Approach & Urine Screening**
Related Standards:	
O.A.C.	
A.C.A.	**3-JCRF-4C-05 4C-09-1 4C-23 4C-24**
P.R.E.A.	**None**

1.0 Purpose

To ensure residents receive coordinated mental health services by qualified mental health professionals.

2.0 Persons Affected

All employees

3.0 Policy

Mental health services will be provided to residents. These services include, but are not limited to, those provided by qualified mental health professionals who meet the educational and license/certification criteria specified by their respective professional discipline. The facility provides for the early identification and treatment of residents with alcohol and drug abuse problems through a standardized battery assessment. This assessment shall be documented to include the following:

a. Screening and sorting
b. Assessment and reassessment
c. Medical assessment for drugs and alcohol
d. Referrals
e. Monitoring and drug testing consistent with program needs and approved by the health care authority

The health care authority shall approve the methods for monitoring alcohol and drug abuse consistent with the program needs. A urine surveillance program shall be used with instructions for the collection and processing of samples and interpretation of results.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Clinical Coordinator shall be responsible for the following:

a. Maintaining Professional Clinical Counselor license/certification
b. Cooperating with the facility nurse in coordinating of provision of services from external providers as appropriate for treatment.
c. Administering the Millon Adolescent Clinical Inventory Assessment (MACI) to residents within fourteen (14) days of admission
d. Place resident in substance abuse group based upon results of MACI
e. Order additional urine surveillance for residents as needed

f. Provide treatment goals to educated each resident on the harmful effects of drug use, provide a link between resident drug use and their criminal behaviors, establish a support network and identify internal and external community support systems.
g. Write and post on-going treatment plans that includes individual goals and measurable objectives.
h. Conduct an annual review of all programming elements and update as needed.

5.2 Health Care Authority shall be responsible for approving the methods for monitoring alcohol and drug abuse consistent with the needs of the program.

5.3 Facility Nurse is responsible for the following:
a. Cooperating with the clinical coordinator in arranging provision of services from external providers.
b. Complete a medical intake screening that includes identification of alcohol and drug abuse assessment.

6.0 Procedures

6.1 The Clinical Coordinator shall provide all internal mental health services and cooperate with the facility nurse in coordination of provision of services from external mental health providers as appropriate for treatment. The Clinical Coordinator shall be a qualified mental health professional meeting the educational and license/certification criteria specified by their respective professional discipline. All mental health licensing and certifications will be verified and kept in the personnel files of the mental health professionals.

6.2 Residents at the facility will receive a Millon Adolescent Clinical Inventory assessment, (hereafter referred to as "MACI") within fourteen days of their admission to the facility. This assessment will include resident responses to the interviewer's questions, information provided by the courts and family, and the verbal reports of the courts and resident. The Clinical Coordinator, another designee or a qualified professional will conduct an interview of each resident in which the resident's substance abuse history is discussed, along with review of court reports and additional community reports. This information will be used to determine a resident's specific area of use and abuse, i.e. alcohol, marijuana. Based upon the results of the MACI assessment, the resident will be placed in substance abuse groups. Individual progress will be determined by participation in the program and progress on treatment goals.

6.3 All residents who test in the high-risk category will be required to attend substance abuse groups and complete assignments. All high-risk substance abuse residents may also be required to attend additional groups such as Alcoholics Anonymous and Narcotics Anonymous meetings at the facility as available. Each of these residents may be required to attend at least one AA or NA meeting in their community while on an off-grounds visitation unless otherwise specified by their probation officer, counselor or mental health professional.

6.4 Each resident may be required to submit to a urine drug screen and a Breathalyzer test upon their return to the facility following an off-ground visit. Additional testing may be ordered at the request of the Clinical Coordinator or treatment team members including the Director.

6.5 The facility's treatment goals will be to educated each resident on the harmful effects of drug use, provide a link between a resident drug use and their criminal behaviors, establish a support network and identify internal and external community support systems.

6.6 The facility will also work with each resident family to educate the family on relapse prevention and identify relapse triggers, improve relationships between resident and their families and develop and/or expand the relationships between a resident and their family.

6.7 Any additional services and/or referrals will be recommended in the discharge report submitted to the court upon release.

Coordinated Staff Treatment

6.8 The facility will utilize a coordinated staff approach to deliver treatment services. This will include each staff member being made aware of each resident's substance abuse history and incorporating that resident's history of use into the resident's treatment at the facility. The treatment plan will be available with the MACI in each resident's electronic record.

6.9 While the Clinical Coordinator will be the resident's main contact in substance abuse treatment, coordination of those services will be discussed at treatment team meetings. Documentation of treatment discussions and the on-going treatment plan will be available for staff access in the electronic files.

Incentives

6.10 Each resident who is participating in the substance abuse program will be provided with incentives as they complete each of the four phases in the program. All residents will have the incentive that as they complete each phase they will be able to advance toward the next phase moving one step closer to being released from the facility.

6.11 Completion of Phase 1: Each resident will advance to Phase 2. Availability of privileges will increase.

6.12 Completion of Phase 2: Each resident will advance to Phase 3. Availability of privileges will increase including opportunities for off-ground visits. Each resident may be allowed to have a six hour and twelve hour off-ground visit. Visit lengths may take travel time to the facility into consideration.

6.13 Completion of Phase 3: Each resident will advance to Phase 4. One twenty-four and three forty-eight hour off-ground visits may be permitted. The resident will have displayed more personal responsibility that should result in reduced staff supervision.

6.14 Resident visits may be changed with court and/or treatment team approval as needed. Any incidents on a phase may result in a longer stay for the resident before moving to the next phase.

6.15 Residents may graduate from substance abuse groups in accordance with treatment plans. Higher risk residents will be expected to work on substance abuse issues in groups throughout their programs addressing high risk situations and seemingly unimportant decisions.

Testing

6.16 Each resident approved for an off-grounds visitation without supervision of the staff at the facility will be required to submit to a urine drug screen and breathalyzer test if they have a substance abuse history within sixty (60) minutes of return to the facility.

6.17 If the facility has a reason to believe that a resident may have used alcohol or drugs during an off-ground visit while supervised by staff, the resident will be required to complete a urine drug test and breathalyzer alcohol test.

6.18 Additional urine tests may be requested by the Clinical Coordinator or treatment team including the Director to ensure appropriate treatment and compliance with the treatment goals.

6.19 All urine tests should be performed with the general steps as follows:

- Resident is instructed to remove all outer clothing and empty pockets
- A frisk search is performed
- Resident is instructed to go to the sink and be observed while washing their hands.
- Staff shall write resident's identification number, date of collection and collector's initials on the test strip
- Staff hand resident the urine cup and instruct resident to go into the bathroom to give a sample.
- Staff of the same sex as the resident shall observe the resident in the bathroom while urinating into the cup. Another staff member should be observing the staff member at the bathroom. If a staff member of the same sex is unavailable, the observed test may wait for eight hours if the schedule indicates a member of the same sex is going to be available: The resident may be awakened for the test. If a staff member of the same sex will not be available within the eight hour time frame, an unobserved test will be performed followed by an observed test conducted as soon as possible.
- Disposable gloves should be worn by staff when handling the urine specimen.
- When using temperature strips, any urine that shows a temperature out of range should be treated as a positive result.
- All results should be documented.
- The specimen cup containing any urine that shows a positive result is to be placed in a bag that is dated, signed and sealed by the staff collecting the urine as indicated on specific urine screening instructions. The contents are then placed in the refrigerator in Central Control.

- Resident that are taking medication that are known to affect the urine testing will be informed they are likely to test positive prior to the testing.
- All residents should be informed of the outcome of the testing.

Philosophy

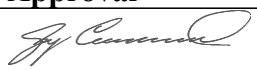
6.20 The facility will adhere to the drug and alcohol philosophy that all residents will not participate in any use or abuse of any illegal or illicit drugs, alcohol and tobacco products. The facility's treatment goals will be to educate each resident on the harmful effects of drug use, provide a link between a resident's drug use and their criminal behaviors, establish a support network and identify internal and community support systems. The facility will also work with each resident and family to educate them on relapse prevention and identification of relapse triggers.

6.21 Facility goals include improving relationships between each resident and their families. Improving the relationship may include developing and/or expanding the relationships between a resident and their family.

6.22 Each resident has a treatment plan that includes individual goals and measurable objectives.

6.23 All programming elements are reviewed annually and updated as needed.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Effective Date:	06-25-15; 03-15-18	
Date Revised:	07-21-20	

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Juvenile Services**
Subject:	**Admission**
Related Standards:	
O.A.C.	**5139-36-12 (A)**
A.C.A.	**3-JCRF-5A-01**
P.R.E.A.	**None**

1.0 Purpose

To establish a thorough screening and assessment at admission and receive a thorough orientation to the facility's procedures, rules, programs, and services.

2.0 Persons Affected

All employees

3.0 Policy

Facility admission shall be decided on a tier system. Referrals shall come from the eight core counties or other sources. All residents shall be accepted into the facility if the services provided shall be appropriate for the care of the resident. If services are deemed inappropriate by the facility, an appeals process is in place for the governing board to override the placement decision.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Case Manager is responsible for the following:

a. Receiving, interviewing and processing resident referrals obtaining the necessary information to determine whether the services provided will meet the needs of the referred youth.
b. Conferring with the Director in making admission decisions.
c. Providing a written explanation to the referring court stating the specific reasons for admission refusal and to the referred youth upon request.

5.2 The Director is responsible for the following:

a. Reviewing admissions policies and procedures with the governing board.
b. Determining whether a youth is accepted into the facility.
c. Responding to an appeal from a core county by notifying the governing board.

5.3 The Governing Board is responsible for answering an appeal for admission placement from the referring count within 10 days.

6.0 Procedures

6.1 The facility will accept all residents referred when the following criteria are met:

a. The referral is from Coshocton, Fairfield, Licking, Muskingum, Delaware, Knox, Perry, or Morgan County.
b. The resident has a felony charge.
c. Services provided by the facility are adequate to meet the needs of the resident.
d. Services provided by the facility are adequate to address the risks of the resident.

6.2 The facility shall not accept into care any resident for whom the treatment and services available by the facility are insufficient to address the resident risks and needs.

6.3 Residents with histories of mental health problems, excessive violent behaviors, sexually related charges, arson charges, or public safety beds shall be considered on an individual basis upon referral.

6.4 Youth with a prior sexual offense history shall only be accepted when the following criteria are met:

a. The referral is from Coshocton, Fairfield, Licking, Muskingum, Delaware, Knox, Perry, or Morgan County.
b. The referring court provides all the necessary documentation and includes it in the referral packet.
c. The referring court provides a current release of information from the treatment organization that provided the sex offender treatment to enable the facility to obtain treatment records.
d. Youth successfully completed sex offender treatment and has a current documented low-risk score of re-offending provided by a licensed community treatment provider.
e. Youth cannot be admitted to the facility solely on a sex offense felony.

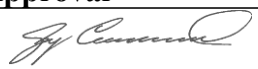
6.5 There shall be a "No acceptance policy" for any youth with a prior sex offense on their record for counties outside the core area.

6.6 All referrals will receive an intake staffing interview from the Case Manager, Clinical Coordinator, Director or designee. A recommendation will be made based upon the information received considering the safety and security needs of all residents at the facility. The additional information may be requested in order to make a decision. The Director will be consulted and will make the final decisions concerning admission.

6.7 If the Director agrees that the placement is inappropriate, this decision can be overridden with a majority vote from the governing board. The referring court may appeal the decision of the Director to the governing board. The governing board will have 10 days to answer the appeal.

6.8 If a juvenile referred to the facility is not accepted, a written explanation will be provided to the referring court stating the specific reasons for refusal. A written notice indicating the specific reasons why he/she was not accepted will also be provided to the juvenile upon request.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Juvenile Services**
Section:	**Juvenile Services**
Subject:	**Discrimination in Referral, Access to Programs and Services & Provision of Services to Disabled**
Related Standards:	
O.A.C.	**5139-36-16 (A)(M)**
A.C.A.	**3-JCRF-5A-01-1** Added Aug. 1995 **3D-03** Rev. Aug. 1995 **5A-09** **3-JCRF-5B-01-1** Added Aug. 1995 Rev. Aug. 2002 **5B-01-2** Added Aug. 2002
P.R.E.A.	**None**

1.0 Purpose

To ensure nondiscriminatory treatment for all resident referrals and in the provision of services and treatment at the facility.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall not discriminate in accepting referrals or in providing access to programs on the basis of race, color, creed, religion, national origin, gender, sexual orientation, disability or political views. Discrimination on the basis of disability in the provision of services, programs, and activities administered for program beneficiaries and participants shall also be prohibited. All legal requirements and protections shall be afforded to juveniles with disabilities including providing staff and residents with access to an appropriately trained and qualified individual educated in the problems and challenges faced by juveniles with physical and/or mental impairments and programs designed to educate and assist disabled juveniles.

4.0 Definitions/Documents

4.1 Creed is defined as a set of beliefs, principles, or opinions that strongly influence the way people live or work.

5.0 Responsibility

5.1 Director is responsible for the following:

a. Ensuring there is no discriminatory treatment for residents in admission decisions, provision of services, programs, and activities.
b. Providing staff and residents access to an appropriately trained and qualified individual educated in the problems and challenges faced by residents with physical and/or mental impairments, programs designed to educate and assist disabled juveniles, and all legal requirements for the protection of juveniles with disabilities.
c. Collaborating with the educational services center to provide qualified individuals to meet the educational needs of each resident.

5.2 Case Manager is responsible for providing the referring court with a written explanation stating the specific reasons for refusing a juvenile admission to the facility.

6.0 Procedures

6.1 No referral will be refused acceptance to the facility on the basis of race, religion, national origin, gender or disability. If a juvenile referred to the facility is not accepted, a written explanation will be provided to the referring court stating the specific reasons for refusal.

6.2 The facility prohibits discrimination based on a resident's race, religion, national origin, gender, disability, or political view in making administrative decisions and in providing access to programs.

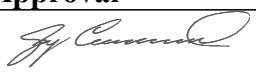
6.3 The facility will not discriminate on the basis of disability in the provision of services, programs, and activities for program beneficiaries and resident participants.

6.4 Services, programs, and activities including opportunities for recreation, exercise, mail, telephone, visiting, library, religious programs, reception and orientation, transportation services, classification, food service, sanitation and hygiene, health care, social services, release, discipline, grievance procedures, and due process proceedings, safety and emergency procedures, access to media, courts, counsel, and law library, commissary/canteen, volunteer programs, and psychological and psychiatric services will be provided to all residents.

6.5 Staff and residents are provided with access to an appropriately trained and qualified individual who is educated in the problems and challenges faced by juveniles with physical and/or mental impairments, programs designed to educate and assist disabled juveniles, and all legal requirements for the protection of juveniles with disabilities.

6.6 An appropriately trained and qualified individual is one who has been designated to coordinate efforts to comply with and carry out responsibilities defined by the ADA. That individual should develop relationships with, and use the expertise of institutional staff, advocacy groups, nonprofit organizations, agencies of government, and others that have relevant knowledge and experience.

7.0 Document Approval

Signature: 

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Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Juvenile Services**
Subject:	**Admission Policies Distributed, Referral Information & Follow-up to Referrals**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-5A-04 5A-05 5A-06 5A-08**
P.R.E.A.	**None**

1.0 Purpose

To ensure open and informed communication during the referral process.

2.0 Persons Affected

All employees

3.0 Policy

The facility distributes a copy of admission policies to referring agencies and interested parties. The Director or designee shall receive appropriate information on each resident being considered for admission to the program. The facility advises the referring party when a prospective juvenile is not accepted into the program, stating specific reasons. The facility indicates, upon written request from the prospective juvenile, the reason(s) why he/she was not accepted into the program.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 Director is responsible for the following:

a. Keeping the referring courts informed of the referral process and making changes as necessary.
b. Ensuring that the facility is capable of providing care and services to sufficiently address resident risks and needs.

5.2 Case Manager is responsible for the following:

a. Processing referrals, scheduling interviews, and gathering information on all juveniles referred to the facility.
b. Making referral recommendations to the Director.
c. Providing probation officers and courts copies of admission policies and procedures when requested.
d. Providing the referring court with a written explanation stating the specific reasons for refusing a juvenile admission to the facility

6.0 Procedures

6.1 Copies of admission policies are provided to Coshocton, Delaware, Fairfield, Knox, Licking, Morgan, Muskingum and Perry County Juvenile Court. Additional copies may be given to individual probation officers and other interested parties when requested.

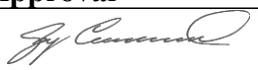
6.2 Information is gathered about the juvenile from the court during a referral process. This information may include the juvenile's name, age, the referring offense, the number of prior adjudications, and any prior dispositions.

6.3 An interview takes place after each referral with the juvenile and his/her parents or guardians. The Director, Clinical Coordinator, Case Manager, Mental Health Professional or Counselor may request any additional information to aide in the determination of proper placement. This may include school records and mental health evaluations.

6.4 The facility shall not accept into care any resident for whom the treatment and services available by the facility are insufficient to address the resident risks and needs.

6.5 If a juvenile referred to the facility is not accepted, a written explanation will be given to the referring court stating the specific reasons for refusal. A written notice will be given at the request of the juvenile indicating the specific reasons why he/she was not accepted.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Juvenile Services**
Subject:	**Legal Commitment, Resident Records & Orientation**
Related Standards:	
O.A.C.	**5139-36-12 (B)(D)(2)(4)(6)(7)(8)(9)(12)(17)(18) (E)(9)(10) (H) (I) (G)**
A.C.A.	**3-JCRF-5A-02 5A-03 5A-07 5A-13 5B-08**
P.R.E.A.	**None**

1.0 Purpose

To ensure the facility has resident information including legal commitment and basic data necessary to make informed admission decisions while also providing each resident with orientation to the facility programs, goals and services.

2.0 Persons Affected

All employees

3.0 Policy

Legal commitment authority shall be documented by court order, statute, or compact for all residents in facility custody. The facility records shall include an extensive interview and history for each resident. At the time of admission, facility staff shall discuss program goals, services available, and rules governing conduct, program rules, and possible disciplinary actions with the resident. Residents new to the facility receive written orientation materials and/or translations in their own language, if they do not understand English. When a literacy problem exists, a staff member assists the resident in understanding the material. The orientation shall be documented by employee and resident signatures.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Governing Board is responsible for approving the placement of a juvenile who is a resident of another state or country in accordance with interstate compact.

5.2 The Director is responsible for ensuring that a translator is obtained when needed.

5.3 The Clinical Coordinator is responsible for communicating any literacy problems to the Shift Supervisors or other staff as needed during orientation.

5.4 The Case Manager is in charge of ensuring each resident has the necessary admission materials including legal commitment to the program and special accommodations needed.

5.5 The Shift Supervisors are responsible for the following:

a. Providing a current Resident Handbook to each new resident.
b. Reviewing or assigning staff to review program goals, rules, and services and documenting the review by completed the new resident training log.

5.6 The Central Control Operator is responsible for conducting monthly reviews of resident records ensuring required documentation is in place or has been otherwise addressed.

6.0 Procedures

Legal Commitment

6.1 The facility shall not admit any juvenile who is a resident of another state or country unless the party making the placement has the legal authority to make the placement. All such placements shall be made in conformity with the terms of the interstate compact on juveniles or the interstate compact on the placement of children. All such placements will be made with the approval of the Governing Board.

6.2 A court order must be on file placing the juvenile in facility custody in order to process the resident during intake.

Facility Records

6.3 Facility records will include date and time of admission, names, social security number, address or last known address, date of birth, gender, race or ethnic origin, reason for referral, offenses, whom to notify in case of emergency, name of person(s) the resident resided with prior to admission and relationship to that person, date information gathered, name of referring agency or committing authority, educational/school history, social history where available, previous employment, driver's license number if available, religion, physical description and recent photograph, special medical problems or needs including medications taken, personal physician if applicable, legal status, including jurisdiction, length and conditions of placement and signature of both interviewee and employee gathering information.

Orientation

6.4 The Shift Supervisor and/or assigned facility staff reviews program goals, rules, and services with the resident during his interview and admission process. This is documented by employee and resident signatures.

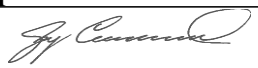
6.5 During intake, each resident is given a copy of the resident handbook. The handbook summarizes the program, contains regulations for residents and consequences for violations, visiting hours and policies, the role and responsibility of the family in the care and treatment of the resident, and a complaint procedure for the resident and family. A copy of the resident handbook is made available to parent(s)/guardian(s) during their orientation meeting or can be viewed on the facility website.

6.6 If a resident has problems with literacy, staff must read the book to the resident or assign and supervise someone else, including another resident, as they read the handbook to the new intake. An interpreter shall be used if language is a barrier.

6.7 The front of the binder for each resident contains a checklist with basic information concerning areas of the program the resident should have knowledge of and the staff and resident sign and date this material.

6.8 After fourteen days, if the resident has their privileges and completes all the assignments for the orientation part of their phase, they may be placed onto Phase I. Exceptions may be made to accommodate residents with Individual Education Plans. All residents are tested in writing or verbally and are required to know the facility rules.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 07-19-11	Date Reviewed: 07-17-17; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 06-18-15; 07-17-18; 07-21-20; 07-20-21	
Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Classification**
Subject:	**Assessment & Treatment Plan, Progress Review, Resident Input & Progress Reports**
Related Standards:	
O.A.C.	**5139-36-19 (A)(B)(H)(L)(M)(1)(2)(3)(4)(5)(6)(N)**
A.C.A.	**3-JCRF-5B-01, 5B-02, 5B-03, 5B-04, 5B-5, 5B-06, 5B-07, 5A-10, 5A-11, 5C-02**
P.R.E.A.	**None**

1.0 Purpose

To ensure each resident has a treatment program in place with a regular system of review of issues and needs.

2.0 Persons Affected

All employees

3.0 Policy

Residents are classified to the most appropriate level of supervision and programming, both upon admission and upon review of their status.

Residents shall be interviewed and placed in the program based upon the type of program needed and level of control required for the resident. Each resident will be assigned a facility staffing team to help guide the resident through the program. Staff shall design and complete each resident's personal program within the first twenty-one days of admission. The plan shall be documented with staff and resident signatures and shared with the resident's parents or guardians as soon as possible. The plan shall be used and progress reviewed either through staff meetings or by individual staff a minimum of once every two weeks with the outcome of each review documented. Residents are expected to give input into planning, problem solving, and decision making related to their participation in the program. A resident may initiate a review of progress and program status. Any changes in a personalized program shall be reviewed, discussed with the resident, dated and documented by staff and resident signatures. A monthly progress report shall be made available to the parents or legal guardians of each resident and the resident as well the committing or releasing authority stating the resident's current phase and progress in the program. The community residential program shall systematically and periodically identify the needs of its residents.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Clinical Coordinator is responsible for the following:

a. Performing an initial vulnerability assessment for each resident at intake and a Millon Adolescent Clinical Inventory (MACI) as soon as possible after admission.
b. Classifying and assigning residents to their unit based upon their individual needs.
c. Developing a treatment plan within the first twenty-one days (21) days of admission documenting review with staff and resident signatures.
d. Sharing the treatment plan with each resident's parent/legal guardian as soon as possible documenting the review.

e. Reviewing and discussing with the resident any changes in their treatment plan, documenting the changes with staff signature, resident signature and the date.
f. Ensuring that individual treatment is provided and documented a minimum of one time per week.

5.2 The Case Manager is responsible for the following:
a. Performing an Ohio Youth Assessment System as soon as possible after admission.
b. Conducting regular resident treatment plan reviews during treatment team and staffing meetings.
c. Documenting current phase and progress in the program in a monthly progress report made available to parent/legal guardian of each resident, each resident, and to the committing courts.
d. Reviewing and documenting the treatment plan review a minimum of once every thirty (30) days.

5.3 The Resident Staffing Team is responsible for the following:
a. Working with orientation resident on their assignments and in learning the rules of the facility.
b. Meeting with a resident every fourteen (14) days to discuss issues and progress.
c. Assisting with written phase assignments, problem solving and decision-making and assigning additional phase work for the resident to help support his program.
d. Advising resident on issues that will affect phase changes including completion of assignments.
e. Making recommendations and communicating with the treatment team when residents are meeting phase expectations.

6.0 Procedures

Assessment and Treatment Plan

6.1 The Ohio Youth Assessment System assesses resident risk and need. Based upon that and other assessments including the PREA vulnerability assessment, the treatment plan is developed within twenty-one days of admission including program needs and control required for the resident. This plan will be documented with signatures of treatment staff and the resident and it will be shared with parents or guardians as soon as possible following completion of the plan. The treatment plan is regularly reviewed during treatment team and staffing meetings that are held a minimum of once a month. It shall contain presenting problems, needs, behavioral goals and measurable objectives, a statement of the time frame projected for attaining the goals and objectives, and specific activities that will be provided and any specialized services.

6.2 The treatment plan will also be based upon a completed Millon Adolescent Clinical Inventory (MACI), court documentation and input from court personnel, educational assessment results and staff observation.

6.3 Any changes in a personalized program is reviewed and discussed with the resident. This review will be documented on the treatment plan and the review will be signed and dated by the mental health professional and resident.

Staffing Team & Progress Review

6.4 During orientation, various staff members will work with the new resident on their assignments and in learning the rules of the facility. If a staff member feels that a bond has been established they may request to be on the resident's staffing team. If no significant bond has been established during orientation, the resident will be assigned to a staffing team.

6.5 The staffing team goal is to meet with the resident who has been assigned to them every fourteen days. If the resident has had a treatment team meeting or has had progress in the program reviewed when applying for phase change, the length of time between meetings with the staffing team may be longer than fourteen days. The staffing team has the ultimate responsibility of telling the resident when he has completed his assignment and indicating their approval by communicating with the resident treatment team.

6.6 The staffing team may assist with written phase assignments, problem solving and decision-making. They may also assign additional phase work for the resident to help support his program.

Resident Input and Phase Change

6.7 All residents have input into planning, problem solving, and decision making related to their participation in the program.

6.8 Each resident assists with their own planning by participating in the assessment process at intake. Input into problem solving presents itself in the form of counseling sessions, groups, and interaction with staff members.

6.9 Decision making includes discharge planning as well as input into any decision made that will affect the life of the resident including mental health, medical, educational and vocational.

6.10 When a resident has completed all phase work, the resident can initiate a review of progress and program status by applying for phase level advancement. Residents will receive comprehensive feedback from staff members as well as other residents during the phase change process. Residents may also request a review of progress and program status during weekly group sessions.

6.11 Residents of the facility are given an opportunity to provide feedback and identify needs at house meetings, periodic programming evaluations, staff evaluations, staffing meetings, treatment team meetings and through exit interviews. Residents will be given opportunities to offer suggestions for improvement throughout each of these processes.

Progress Reports

6.12 Parents or guardians are updated on the progress of residents during counseling sessions and treatment team meetings. Contents of treatment team meetings will be reviewed with residents to process resident progress. Residents will also receive progress reports from their individual staffing person.

6.13 Parents or guardians are sent monthly written progress reports via mail or email.

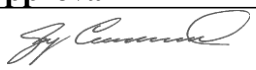
6.14 Residents sentenced to the facility are ordered to complete the facility program. The program is designed to take approximately six months to complete. Probation officers are emailed the monthly progress reports of the resident they are supervising. The Director and the committing or releasing authority are given verbal and/or written reports stating the resident's current phase and progress in the program.

Individual Treatment

6.16 Individual treatment to each juvenile will be provided at a minimum of one time per week and this must be documented.

6.17 Residents will be assigned a staffing team and/or Case Manager to assist the resident with any needs that the resident will have during their incarceration. The Case Manager will take an active part in assisting the residents in their decision-making and problem solving. Each resident may also meet with facility staff on an individual basis as needed upon request. Documentation of the meetings will be available.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-11-14 Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22;07-18-23 Prior Effective Date: 06-25-15: 07-17-18; 07-08-19; 07-21-20; 07-20-21 Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Social Service**
Subject:	**Scope of Services**
Related Standards:	
O.A.C.	**5139-36-14 (D)(E)(F)(I)**
A.C.A.	**3-JCRF-5C-01 5C-04 5C-05 5E-02 5E-03 5A-12**
P.R.E.A.	**None**

1.0 Purpose

The facility makes available the professional services necessary to meet the identified needs of juveniles. Such services may include individual and family counseling, family planning and parent education, and other progress release planning for residents with drug and alcohol addictions.

2.0 Persons Affected

All employees

3.0 Policy

A social services program is provided that makes available a range of resources appropriate to the needs of residents, including individual, group, and family counseling; drug and alcohol treatment; family planning; HIV and AIDS education; and special offender treatment. The facility shall also provide or make arrangements for the provision of educational, vocational, and psychological assessments, educational/vocational programs, individual and group counseling activities, appropriate recreation and leisure activities, consistent family contact, food service, assistance with transportation, transitional services, emergency financial assistance, medical health services, mental health services and employment counseling and placement. The facility provides rules and guidance in the use of community service programming. Staff may seek the cooperation of various community groups offering activities that benefit residents.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Providing oversight of the Clinical Coordinator.
b. Coordinating with the Muskingum Valley Educational Services Center in the provision of educational services to the residents.
c. Approving community service activities.
d. Collaborating with various community groups offering activities that benefit residents.

5.2 The Clinical Coordinator is responsible for the following:

a. Developing and implementing facility programming and treatment.
b. Providing assessments and recommending services necessary for resident treatment.
c. Supervising, training, and monitoring staff in the implementation of cognitive behavioral programming.

6.0 Procedures

6.1 Residents are provided with a wide variety of services during their stay at the facility based upon their individual needs including the following:

Commitment to Change/Thinking Pattern Identification

6.2 Residents are asked to learn the different types of thinking that may have led them to become involved in criminal activity and to take responsibility for their behavior. Residents and peers are asked to identify behavior and problems that show current thinking patterns and identify how to correct those patterns.

Social Skills

6.3 Residents with identified social skill deficits will review social skills steps and perform role playing activities to help build and/or strengthen skills to address their deficits.

Life Skills/Career Development/Anger Management/Relationship Building

6.4 Various areas involve a range of skills residents need to be successful in the real world including money management, filling out a check, creating a resume, completing a job application, interviewing, taking care of a family, problem solving, cooking, building relationships and controlling anger. These areas may be addressed in a group setting or on an individual treatment basis.

Substance Abuse Treatment Programs and Counseling

6.5 Residents are evaluated and then placed into a drug and alcohol treatment group based upon their level of risk. Counseling sessions are offered to residents including individual, group, and family counseling.

HIV and AIDS Education

6.6 Residents may be provided with HIV and AIDS education upon request or as staff is available. Residents are offered testing for sexually transmitted diseases during their initial intake physical.

Other Needed Services

6.7 While the program will make an effort to provide all residents with the needed services, some services may not be available within the facility. A referral to a community service will be made if a resident is observed, noted or determined to need services that are not offered in the facility. When possible, the service should take place in the resident's home county. This will assist the resident in being able to follow-up or continue the services upon their discharge from the facility.

6.8 Services include but are not limited to specialized group counseling programs, such as AA or NA meetings and various support groups, psychological assessments, medication somatic services, mental health support groups and other mental health services. If these services are not available without charge, the program should assist in the provision of funds. Involvement of other support services for the residents is an essential element of community residential programs, and referral to and assistance with community agencies will be encouraged whenever possible.

Community Resources

6.9 The agency will maintain and periodically update an inventory and evaluation of functioning of the specific community agencies that can provide services to residents in their community.

6.10 The facility will work in establishing treatment plans that address each resident and their individual needs. If the facility is unable to meet a specific need, efforts will be made to involve community resources to provide the resident with the needed services to meet their developmental needs.

6.11 Residents are not permitted to go off-ground until Phase III and IV unless they have special permission from their probation officer. After residents have the privilege of going off-ground, staff may seek opportunities for the residents to participate in activities of various community groups. These activities may include but are not limited to community service opportunities, participation in AA/NA meetings, sporting activities, visits to public parks, museums, and library trips.

Community Services

6.12 Residents may engage in off-ground community service opportunities after they have reached Phase III or with special permission from their probation officer. The resident's probation officer and court may designate the resident as low flight potential and recommend community service work that does not require staff direct supervision to aid the resident in their attempt to work community service and/or learn new job skills prior to release.

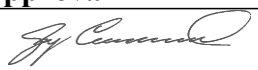
6.13 During community service, residents will not be permitted to operate gas powered or electrical machinery. They shall be supplied adequate protection based upon the work they are doing. A staff person will be supervising the residents during community service unless otherwise approved by the court.

6.14 Residents will be expected to follow the rules of the facility during their community service. They should be instructed on the community service and the benefits the service would have on others to increase their knowledge and awareness of their role in their own community and the opportunities that exist to help others.

6.15 Community service hours may be tracked to permit residents to work off some of the hours required by their court.

6.16 At no time will community service solely benefit one party or person.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-11-14 Prior Effective Date: 04-11-14; 06-25-22 Date Revised: 07-19-22	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Social Services**
Subject:	**Counseling**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-5C-03**
P.R.E.A.	**None**

1.0 Purpose

To ensure each resident has staff available to assist with personal issues when requested and during emergency situations.

2.0 Persons Affected

All employees

3.0 Policy

Staff members are available to counsel residents at their request. Provisions are made for counseling residents on an emergency basis. Such services may include individual and family counseling, family planning and parent education, and other progress release planning for residents with drug and alcohol addictions.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Clinical Coordinator is responsible for providing regular counseling to residents and providing emergency counseling when needed.

5.2 Staffing Team Members are responsible for being available to help guide residents through the program as requested.

5.3 Treatment Team Members are responsible for being accessible to staff and residents when requested and when needed during resident emergencies.

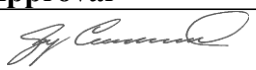
6.0 Procedures

6.1 Residents will be assigned a staffing team to help guide them through the program. During regular hours, residents shall be able to access a staffing team member, case manager and/or mental health professional by filling out a request to speak with the desired party.

6.2 In the case of a mental health emergency, a resident will be able to access the Clinical Coordinator available twenty-four hours a day.

6.3 During other emergencies or when the Clinical Coordinator is unavailable, a resident may access a treatment team member. Staff phone numbers are located at Central Control.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-11-14 Prior Effective Date: 06-25-15 Date Revised: 07-17-18	Date Reviewed: 07-17-18; 07-16-19; 07-21-20: 07-20-21: 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Education/Vocation**
Subject:	**Educational Coordination, Teachers, Special Education Programs & Literacy**
Related Standards:	
O.A.C.	**5139-36-19 (Q)(R))(T)(U)(V)(W)(X)(Y)**
A.C.A.	**3-JCRF-5D-01 5D-02 5D-03 5D-04**
P.R.E.A.	**None**

1.0 Purpose

To ensure residents are provided with an individualized program that will contain elements of education, vocational education, work, recreation, and social services.

2.0 Persons Affected

All employees

3.0 Policy

A written body of policy and procedure governs the facility's programs. All residents will have an individualized program that will contain elements of education, vocational education, work, recreation, and social services. There shall be coordination and continuity between educational, vocational, and work programs. The facility shall comply with laws pertaining to individual special education plans prior to placement of juveniles into or out of special education programs. Educational, vocational, work and treatment programs, credits, certificates, or diplomas shall be accepted by community agencies. Residents who complete the GED receive educational and/or vocational programs that will provide instruction to develop basic literacy and job skills. Residents who have attained basic literacy skills should be required to attend remedial education classes on a daily basis during the regular school day hours.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Providing oversight of the Clinical Coordinator.
b. Coordinating with the Muskingum Valley Educational Services Center in the provision of educational services to the residents.
c. Approving community service activities, offsite educational opportunities, outside facility employment, and vocational/job training.
d. Collaborating with various community groups offering activities that benefit residents.
e. Coordinating educational, vocational, and work programs through the treatment team.

5.2 The Case Manager is responsible for assisting residents in meeting employment requirements during the final stages of their program.

5.3 The Muskingum County Educational Services Center is responsible for providing qualified teachers and an intervention specialist to meet the educational needs of the facility.

6.0 Procedures

Coordination

6.1 The facility will provide for coordination and continuity between educational, vocational and work programs through communication during the treatment team meetings. The Clinical Coordinator, Case Manager, Compliance Coordinator, Resident Staff Person, and the appropriate educational personnel may attend the treatment team meeting.

6.2 While at the facility, each resident will be able to participate in work programs or community services when available. A resident must be on a minimum of Phase 3 or have the approval of their probation officer to participate in community services outside the facility.

6.3 The resident's probation officer and court may designate the resident as low flight potential and recommend community service work that does not require staff direct supervision to aid the resident in their attempt to work community service and/or learn new job skills prior to release.

6.4 During the discharge meeting, each resident will be referred to the appropriate educational or vocational setting.

Teachers, Assessment and Special Education Plans

6.5 The facility will use the services of the Muskingum Valley Educational Service Center to provide teaching staff for all the residents. All academic teachers must be certified by the Ohio Department of Education with a copy of the certification kept on file. All educational, vocational, work and treatment programs, credits, certificates or diplomas will be fully accredited and accepted by community agencies.

6.6 The credentials of the teaching staff must include ability to work with special education students. Special education programs are available to meet the needs of special education students as defined in public law.

6.7 All residents are required to attend education classes on a daily basis unless special circumstances exist. Residents will begin school attendance during their orientation while many of their education plans are unavailable. Residents will be required to take an academic test to measure their classroom ability. The teachers will use this assessment to help place the resident until their academic plans are available.

6.8 After receiving the education plans, the teaching staff or treatment team may call for an updated evaluation of the resident. All special education recommendations will be followed.

Literacy

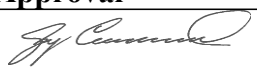
6.9 The facility provides instructions for all residents with literacy problems. A computer program was purchased to help residents to develop basic literacy skills.

6.10 Job skills may be taught during social skills groups and/or individual programs as needed. Residents may be required to complete job applications and apply for employment during their final phases. Staff at the facility may assist in providing instructions to the residents. The Case Manager will help to oversee employment requirements during the final stages.

6.11 The facility has a large library of books including fiction, non-fiction, educational, and self-help. Residents are able to choose reading material from the shelves in the classrooms and elsewhere in the facility. The facility also maintains a library card with the Perry County District Library. The library may send personnel to offer books and/or programs for the residents at the facility. Staff may honor requests from residents and use the library as an additional resource.

6.12 Residents are expected to keep all materials in good condition. The resident and his Parents/legal guardian will be responsible for any damage to library or facility materials.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 03-24-14 Prior Effective Date: 06-18-15; 07-17-18; 07-21-20 Date Revised: 07-19-22	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Education/Vocation**
Subject:	**Work, Agency Resources & Interference in Education and Treatment**
Related Standards:	
O.A.C.	**5139-36-14 (S)(AA)(BB)(CC)**
A.C.A.	**3-JCRF-5D-05 5D-06 5D-07**
P.R.E.A.	**None**

1.0 Purpose

To ensure residents receive individualized treatment including assistance in employment preparation as identified as part of their reentry to society.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall work in the best interest of the resident and community in preparing the resident to reenter society. Education and work shall be emphasized when appropriate. Agency resources and staff time shall be devoted to assisting employable residents in locating jobs. The use of work shall not interfere with educational and treatment programs. Juveniles employed outside the program, either full-time or part-time, shall comply with all legal and regulatory requirements.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for approving off-site employment and job training as well as coordinating with the educational department to ensure resident needs are being met.

5.2 The Case Manager is responsible for helping residents needing employment preparation assistance as part of the reentry program.

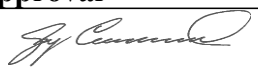
6.0 Procedures

6.1 Residents who will be employable following release from the facility and whose case plans have designated employment as part of a release plan will be assisted by staff in locating jobs. Staff will assist resident as each situation dictates. The assistance may include specific help with resume writing, obtaining and completing applications for employment or searching for employment.

6.2 The treatment program at the facility is coordinated to include work when recommended. The treatment team includes educational staff to address any concerns and ensure that work will not interfere with the educational and treatment programs goals.

6.3 Job applications and employment may be sought in the final phases of the program. However, residents will not be employed while at the facility unless required by their committing court and discharge plan. All employment will comply with legal and regulatory requirements.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-21-09	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 06-25-15; 07-17-18; 07-21-20	
Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Recreation**
Subject:	**Staff and Space Requirements**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-5E-01** Revised January 2005
P.R.E.A.	**None**

1.0 Purpose

To ensure a written body of policy and procedure governs the facility's recreation and activity programs for residents, including coordination and supervision, facilities and equipment, community interaction, and activities initiated by residents.

2.0 Persons Affected

All employees

3.0 Policy

Indoor and outdoor recreational and leisure time needs will be provided for residents. Residents are encouraged to be physically active, dependent upon their capabilities, and receive at least two hours of planned recreation per day.

4.0 Definitions/Documents

None

5.0 Responsibility

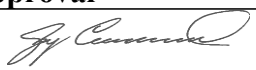
5.1 The Clinical Coordinator is responsible for ensuring the facility programming provides for a minimum of two hours of planned recreation each day as listed below.

6.0 Procedures

6.1 Residents have a minimum of two hours of planned recreation each day. Recreational activities include the following:

1) Residents have leisure time in their rooms during all shift changes.
2) Between 8:30 and 10 p.m. from Sunday through Thursday, residents have leisure time: Activities permitted during these times are based upon phase privileges.
3) Wednesday movie may be viewed by residents based upon the privilege status.
4) Friday movie may be viewed by residents who have earned privileges five (5) of seven (7) days who do not have an incident report.
5) Physical recreation is scheduled daily. All residents are required to participate in one hour of physical activity dependent upon their capabilities.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 06-23-14	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 06-25-15	
Date Revised: 07-17-18	

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Juvenile Services**
Section:	**Religion**
Subject:	**Religious Participation**
Related Standards:	
O.A.C.	**5139-36-14 (P) 5139-36-08 (R)(3)**
A.C.A.	**3-JCRF-5F-01**
P.R.E.A.	**None**

1.0 Purpose

To ensure a written body of policy and procedure governs the facility's religious programs for residents, including coordination and supervision, opportunities to practice the requirements of one's faith, and use of community resources.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall determine religious faith upon intake. Religious services shall be offered at the facility as able. Residents shall have the opportunity to participate in practices of their religious faith in accordance with legislation of the authority having jurisdiction.

4.0 Definitions/Documents

None

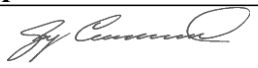
5.0 Responsibility

5.1 The Director shall be responsible for the coordination of the facility's religious programs.

6.0 Procedures

6.1 Reasonable access to religious programming is provided by the facility. No negative consequences shall accrue from a resident's refusal to participate in a religious service or function. All religions shall be accorded equal status and protection, subject to the limitations necessary to maintain order and security.

7.0 Document Approval

Signature: 

8.0 Review History

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Prior Effective Date: 06-25-15	
Date Revised: 07-17-18	

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Mail, Telephone, Visiting**
Subject:	**Mail, Postage, Publications, Inspection for Contraband & Forwarding After Release**
Related Standards:	
O.A.C.	**5139-36-15 (E)(1)(2)(3) (F)(1)(2) (H)**
A.C.A.	**3-JCRF-5G-01 5G-02 5G-03 5G-04**
P.R.E.A.	**None**

1.0 Purpose

To ensure there are rules that govern the facility's mail, telephone, and visiting services, including mail inspection, public phone use, and routine and special visits.

2.0 Persons Affected

All employees

3.0 Policy

Residents shall be encouraged to improve communications with their families. Residents shall receive a specified postage allowance to maintain community ties. Resident shall be granted access to appropriate publications. Resident's mail, both incoming and outgoing, may be opened and inspected for contraband. When based on legitimate facility interests of order and security, mail shall be read or rejected. The resident shall be notified when incoming mail is returned or outgoing mail is withheld. First-class letters and packages will be forwarded after transfer or release.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Case Manager is responsible for the following:

a. Knowing the rules governing facility mail.
b. Opening resident mail in front of the resident, removing the stamp or discarding the envelope, inspecting the mail for contraband, logging the correspondence, and handing the mail to the resident.
c. Inspecting outgoing mail, logging the correspondence, and observing while the resident seals each envelope ensuring the mail is placed in the outgoing mailbox.
d. Not permitting residents to share mail or addresses.
e. Documenting required information on all incoming and outgoing mail in the mail log.
f. Documenting mail limitations in the resident mail log.
g. Providing residents with written notice when mail is read, rejected, or contact is limited.
h. Notifying the Director when incoming mail is rejected or outgoing mail held.

5.2 The Shift Supervisor is responsible for providing residents with two stamped envelopes a week as requested, documenting, and maintaining documentation of stamps provided.

5.3 The Director is responsible for approving incoming mail limitation and rejections, ordering publications for the use of residents in the facility, approving holding of outgoing mail and forwarding resident mail after transfer or release.

6.0 Procedures

6.1 Residents shall be encouraged to send and receive mail. Correspondence shall be uncensored as long as it poses no threat to the safety and security of the facility, public officials, or the general public and is not being used in the furtherance of illegal activities.

6.2 All incoming mail must have a return address on the envelope. If the envelope does not have a return address, the mail will be temporarily withheld, opened in front of the resident, and inspected closely by staff.

6.3 All incoming mail shall be opened, inspected, and logged in front of the resident by the Case Manager or designee. Once inspected for contraband, the stamp shall be removed or the envelope discarded and the mail shall be forwarded to the resident. Incoming and outgoing mail shall be forwarded within twenty-four hours, excluding weekends and holidays. No addresses or mail can be shared among residents.

6.4 Residents cannot send or receive mail from any inmate housed in a correctional facility or from juveniles in other facilities or on probation unless the other person is an immediate family member and the correspondence is authorized by the Director.

6.5 Mail may be rejected if it contains contraband, instructions for making a weapon, drug or alcoholic beverage, advocates violence, contains threats or intimidation based on a person's race, ethnicity, gender, religion, or sexual orientation, includes sexually explicit pictures or writing, gang symbols or activity, or contains information that is not conducive to resident rehabilitation.

6.6 If the Case Manager has reasonable belief that the incoming mail may incite danger for the facility security and order, he/she may read the mail before distributing it to the resident or rejecting the mail. The resident shall be notified in writing any time mail is read or rejected. All reading or rejection of mail shall be thoroughly documented. If the mail is rejected prior to opening, the letter may be marked return to sender.

6.7 Probation officers and/or family may request that mail be withheld from unapproved parties. Such requests shall be documented and enforced.

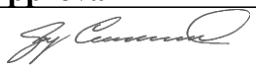
6.8 Residents shall be given two first class stamped envelopes per week as needed and/or requested. Any additional postage shall be the responsibility of the resident and shall be unlimited. Stamped envelopes shall also be available through the facility point store. The facility will provide residents access to appropriate publications.

6.9 All outgoing mail must be placed in a stamped envelope with the resident name, facility name and address. Outgoing mail shall have no writing or pictures on the envelopes. The unsealed stamped envelopes shall be placed in the Case Manager's mailbox or be given to the Case Manager to be inspected, sealed and logged prior to mailing.

6.10 Outgoing mail shall be held and the Director notified when based on the belief that mailing the correspondence constitutes a legitimate threat to facility security and order. The resident shall be notified in writing when and why the mail is being withheld. The mail may be destroyed in front of the residents, destroyed by the resident, or forwarded to the resident probation officer or court.

6.11 Any first-class letter or package that is sent to the facility after the resident is transferred or released shall be forwarded to the resident's new address if available.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-21-09 Prior Effective Date: 06-25-15; 07-17-18; 07-21-20 Date Revised: 07-19-22	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Mail, Telephone and Visiting**
Subject:	**Telephone Services & Reasonable Priced Telephone Services**
Related Standards:	
O.A.C.	**5139-36-15 (C)**
A.C.A.	**3-JCRF-5G-05** Rev. 1998 Rev. Aug. 2002 **5G-05-1** Added Aug. 2002
P.R.E.A.	**None**

1.0 Purpose

To ensure reasonably priced telephone access to all residents.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall ensure that residents shall have access to reasonably priced public telephones. Any contracts with public telephone systems shall comply with regulations and be comparable to services offered to the public. Residents with hearing and/or speech disabilities, and residents who wish to communicate with parties who have such disabilities, shall be afforded access to a Telecommunications Device for the Deaf (TDD), or comparable equipment. Public telephones with volume control shall be made available to residents with hearing impairments.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for ensuring the provision of access to reasonably priced public telephones including a Telecommunication Device for the Deaf for residents with hearing and/or speech disabilities or who wish to communication with parties who have such disabilities.

5.2 Resident Care Worker is responsible for the following:

a. Dialing numbers that have been placed on the resident approved contact list.
b. Confirming the contacted person is the approved contact before handing the phone to the resident.
c. Providing the residents with reasonable conditions of privacy for their call.
d. Interrupting the call if there is reason to suspect the resident is not talking to an approved party and disconnecting the line.
e. Documenting all calls, refusals, and terminations.

6.0 Procedures

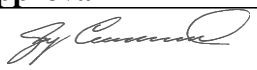
6.1 The facility permits all residents to make or accept a minimum of three (3) phone calls per week to approved parties in accordance with the service plan. Two (2) of the calls may be Skype calls. The calls shall be limited to fifteen (15) minutes. An additional phone call is available to be purchased by the resident from the resident point store. There shall be no party line calls or use of a speaker phone to talk to unapproved parties. Violations may result in restricted phone privileges.

6.2 Staff will dial all the numbers to ensure the person on the resident approved contact list is whom the resident is speaking to before handing the phone to the resident.

6.3 There is a volume control on the phone for the resident to adjust. We have also used a Telecommunications Device for the Deaf to enable contact between a resident and his/her parents.

6.4 Residents shall be provided reasonable conditions of privacy for their telephone call. However, if the resident becomes agitated during the call, staff shall interrupt the phone call and notify the other party that the call is being terminated. If staff has reason to suspect the resident is not talking to an approved party, they may interrupt the call to talk to the person on the other end of the call. They shall document their reasonable suspicion and note the results of their interruption. The line shall then be disconnected. All calls, refusals and terminations shall be documented.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-20-09 Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Dates: 06-25-15; 07-25-15: 07-18-17
Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Mail, Telephone, Visiting**
Subject:	**Visiting**
Related Standards:	
O.A.C.	**5139-36-15(A)(1)(2)(3) (B)**
A.C.A.	**3-JCRF-5G-06 5G-07**
P.R.E.A.	**None**

1.0 Purpose

To provide residents with the opportunity to improve communication within their family.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall encourage improved relationships and communications between residents and their families. Residents shall receive approved visitors during normal visiting hours, except where there is substantial evidence that a visitor poses a threat to the safety of the resident or the security of the program. The facility shall make provisions for special visits when appropriate.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Ensuring that visitation is arranged in accordance with the court wishes.
b. Permitting a visit to occur in the residential living area.
c. Approving special visits.

5.2 The Clinical Coordinator is responsible for the following:

a. Providing parent(s)/legal guardians with visit information at intake or as soon as communication with the family is possible.
b. Approving visitors for the visitation list.
c. Ensuring all visitors attending family counseling sessions are subject to search prior to entering the facility and subject to the rules that are applicable during regular visitation.

5.3 The Shift Supervisors are in charge of the following:

a. Ensuring regularly scheduled visitors follow the visitation rules and are searched prior to entering the facility.
b. Denying entry into the facility if visitors are suspected of being intoxicated or under the influence of substances.
c. Denying or ending visits if the visitor poses a threat to the safety or the resident or the security of the program.
d. Writing an incident report documenting any denial of entry or suspension of visitation including details of what occurred and reasoning surrounding the denial or suspension of the visit.

e. Ensuring any items brought into the facility were requested by a resident and had prior approval, maintaining an accurate resident inventory, and sending any unnecessary items home.

5.4 The Case Manager is responsible for documenting chronic parental/legal guardian absence from visitation and/or family counseling on the progress reports.

5.5 The Resident Care Workers are responsible for supervising regularly scheduled visits as well as conducting and documenting resident frisk searches following visitation.

6.0 Procedures

6.1 All families are encouraged to visit with residents at the facility. Visits are arranged with the time and date of the visit given to parents upon intake. If the parents/guardians do not accompany a resident at intake, they are provided with visit information as soon as communication with the family is possible. Due to limited time and visitation area, visitations shall be a minimum of a single one (1) hour visit per resident, per week. Residents and their visitors shall be provided reasonable conditions of privacy. However, if the facility and/or court have determined that the visit shall be supervised, facility staff shall supervise the visit. All visits shall be monitored by staff. Each visit is documented in the visitation log and signed by the visitor.

6.2 Visitors are expected to follow the rules of visitation. No visitors shall be permitted in the living areas of the facility without permission of the Director. Visits may be ended or denied if the visitor poses a threat to the safety of the resident or the security of the program. Visitors may also be denied entry into the facility if they are suspected to be intoxicated or under the influence of substances. When a visit is ended early or denied by a staff member, reasons will be documented on an incident report.

6.3 Visitors shall be subject to scans, frisks and/or wand searches prior to visitation. Refusal to consent to a search shall be grounds for removal from the premises. Visitors shall not be permitted to bring any gifts, packages, food or other items into the facility without prior written consent from facility administration. Any approved item shall be inspected before it shall be taken into the secure area of the facility. Visitors are not permitted to exit and reenter the facility during visitation except for emergency reasons as approved by staff.

6.4 Initially, only parents/guardians will be permitted to visit. As family counseling progresses, the Clinical Coordinator may allow siblings to join the sessions and visit with the resident. This is determined on an individual basis and takes into consideration the age of the siblings and involvement with the resident.

6.5 Residents shall not be denied visits with parent(s)/guardian(s) because of behaviors unless a resident is in isolation or presents a risk to himself or others. All visits or denial of visits shall be documented.

6.6 Visitation and other contacts with a resident are important for establishing or maintaining support while the resident is living at the facility. Habitual or chronic no-shows for visits

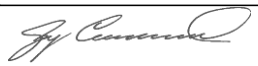
by parents/guardians shall be documented and the information shall be shared with the court. This information will also be included in progress reports.

6.7 All residents shall be frisk searched following a visit with their family.

Special Visits

6.8 Special visits are permitted with prior approval from the Clinical Coordinator or Director. Special visits may be permitted when the resident has a family member(s) involved in active military operations, grandparent(s) are visiting from out of state, an immediate family member is diagnosed with a serious illness and when informing the resident of the death of a family member.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-21-09 Prior Effective Date: 06-25-15; 07-17-18 Date Revised: 07-21-20	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Release**
Subject:	**Release Preparation, Progress Report, Discharge Plan & Criteria for Release**
Related Standards:	
O.A.C.	**5139-36-12 (L)(M) 5139-36-17 (B)**
A.C.A.	**3-JCRF-5H-01, 5H-02, 5H-03, 5H-06 & 5B-09**
P.R.E.A.	**None**

1.0 Purpose

To establish a structured program to help residents make a satisfactory transition upon release from their commitment.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall prepare all residents for integration into their communities by working on their treatment plan and a program of release preparation throughout their stay and prior to their discharge. A discharge plan shall be written for the resident, the family and committing courts including a current and complete history of the resident's activities in the facility and proposed release plan including any recommendations and referrals for additional services. Prior to a release hearing, a progress report shall be made available to the release authority.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Clinical Coordinator is responsible for the following:

a. Writing, implementing, reviewing, and revising each resident treatment plan from intake through discharge in accordance with policies and procedures.
b. Meeting with residents weekly and parents monthly to discuss progress, specifically addressing discharge planning options, and establishing treatment goals.

5.2 The Case Manager is responsible for the following:

a. Meeting with residents to process off-grounds visits to be able to specifically address discharge planning and options.
b. Writing the discharge summary plan including services received at the facility and recommendations of any services that may be needed to be successful upon discharge.

5.3 The Treatment Team is responsible for meeting weekly to review resident progress, determine phase status, make recommendations in programming and communicate resident issues.

6.0 Procedures

6.1 Residents will participate in their discharge plan. The discharge plan will act as a preparation for the release of the resident into the community. Every resident should be preparing for release into the community upon their admission to the facility. This will be evident by the gradual decreasing of the need of supervision and increasing of personal responsibility for each resident. Throughout a residents' stay at the facility, release options and discharge planning will be taking place.

6.2 Phase level advancement is determined when a resident applies for the phase and receives the approval from staff as well as the treatment team which includes the Director, Clinical Coordinator, Case Manager, Resident Care Supervisors, and Compliance Coordinator. Advancement is based upon the resident ability to display personal responsibility and achievement of established goals in their treatment plans. Phase privileges accompany each new phase with increased responsibility and accountability for each phase.

6.3 Each resident will be required to meet with a Mental Health Professional and/or Case Manager to specifically address discharge planning and discharge options. This process will be formulized during Phase II. Once a resident has begun Phase III, a specific discharge plan should be in place with specific requirements for the resident. This discharge plan should be in place before a resident is able to participate in any overnight off-ground visitation without supervision of a facility staff member.

6.4 Each resident will be able to identify areas of need, services that they feel they will need to be successful upon release, identify needed mental health and community services along with various community substance abuse services.

6.5 On Phase III and IV, the resident will begin to be permitted outside the facility with staff supervision or for off-ground visits with parent(s) or guardian(s). As part of these privileges, residents may be required to perform community service, attend treatment support groups, obtain job applications, submit job applications, and work in establishing a stronger support system within their community.

6.6 While a resident is on Phase III and IV, his status, behaviors and personal responsibility will be reviewed every two weeks to determine if the resident has displayed appropriate qualities and behaviors to either remain on the phase, advance to the next phase or be appropriate for discharge in accordance with his individual plan. Residents may also request additional time prior to review if they feel that further advancement is not warranted.

6.7 The decision of advancement to the next phase, continuation on the existing phase, or discharge will be documented and made available to the resident through the phase change meeting. The decision will include clear and explicit examples of why the specific decisions were made and the basis of the decision. The results of the facility's decisions may be made available to the resident, probation officer, and court personnel.

6.8 To receive discharge from the facility, a resident should be incident report free, have a positive attitude, be actively participating in the program, identify relapse triggers, have a relapse prevention plan and be actively using that plan, and attend a minimum of six off-ground visits unless otherwise approved by the appropriate court personnel.

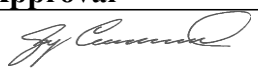
6.9 All parties including the resident that attends the discharge meeting will sign the formulized discharge plan. The plan will then be placed in the resident records and made available to the parties that attended the discharge meeting. These parties may include the resident's parent(s) or guardian(s), staffing person, Director, Case Manager, Clinical Coordinator, resident, Probation Officer or court personnel, teacher of the facility, and any community resource to include but not limited to the resident's mental health counselor, and community educational personal.

6.10 The formulized release plan may be discussed at a discharge meeting in which the resident meets with the probation officer, family or caregivers, and facility supervisory staff including the resident's staffing person. The discharge plan will focus on a resident educational needs, personal and mental health needs, community supervision, and recreation and substance abuse issues, along with any other issues that may contribute to a resident's success upon discharge.

6.11 Prior to a resident's release, a progress report will be made with recommendations concerning the release plan. The release authority is given a progress report a minimum of once a month through the resident's probation officer.

6.12 When a resident is discharged, the facility shall prepare, within seven business days following the date of discharge, a written discharge summary. A copy of the discharge summary shall be maintained within the record and a copy shall be provided to the court. The report will include a current and complete history of the resident's activities in the facility and proposed release date.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 03-24-14 Prior Effective Date: 06-25-15; 07-17-18; 07-21-20 Date Revised: 07-19-22	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Release**
Subject:	**Family Involvement & Off-Ground Visits**
Related Standards:	
O.A.C.	**5139-36-12(M)**
A.C.A.	**3-JCRF-5H-04 5H-05**
P.R.E.A.	**None**

1.0 Purpose

To ensure that family involvement and an opportunity for community reintegration takes place to make a satisfactory transition upon release.

2.0 Persons Affected

All employees

3.0 Policy

Family involvement shall be encouraged throughout the program. Whenever possible, staff members shall counsel the parents or guardians in preparation for the resident's return to their home or other placement. Provisions shall be made for trial visits before such decisions are made. Opportunities for involvement with family and participation in community activities are provided before final release.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Clinical Coordinator is responsible for providing family counseling sessions monthly or as specified in the resident treatment plan.

5.2 The Case Manager is responsible for the following:

a. Ensuring court approval of resident off-ground activities including visits and community service.
b. Scheduling resident visits and approving visit plans.
c. Organizing and communicating staff off-ground resident contacts during visitation.
d. Assigning activities for visitation to establish a stronger support system as needed.

6.0 Procedures

6.1 Each resident's family or caregiver will be strongly encouraged to attend a minimum number of family counseling sessions equal to the number of months that a resident is at the facility. If the resident is at the facility for four months, then a family should attend at least four family counseling sessions. This requirement may be waived based on the approval of facility supervisory staff along with resident's probation officer or court personnel. The family counseling will focus on preparing the family/parents or caregivers for the resident's return to the community.

6.2 On Phase III and IV, the resident will begin to be permitted outside the facility with staff supervision or for off-ground visits with parent(s) or guardian(s). These trial visits allow the family and resident time to re-adjust to each other with the support of the facility staff. As part of these privileges, residents may be required to perform community services, attend treatment support groups, obtain job applications, submit job applications, participate in a pro-social activity, and work in establishing a stronger support system within their community. The Case Manager may supervise and/or oversee the visits.

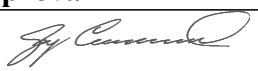
6.3 Each resident who has been identified as High Risk for substance abuse or substance dependence may be required to attend either AA or NA meetings while on their off-ground visits.

6.4 The visits will consist of following unless modified by the treatment team or admitting authority:

Visit 1: 6 hours off-ground
Visits 2: 12 hours off-ground
Visits 3-6: 24 to 120 hours off-ground

6.5 Residents may be permitted therapeutic visits consisting of community support group meetings even when other visits are suspended to help strengthen the ties to the community.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-22-09 Prior Effective Date: 06-25-15; 07-17-18; 07-21-20 Date Revised: 07-19-22	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 5.0	**Juvenile Services**
Section:	**Release**
Subject:	**Exit Interview & Revocation**
Related Standards:	
O.A.C.	**5139-36-14 (DD)**
A.C.A.	**3-JCRF-5H-07**
P.R.E.A.	**None**

1.0 Purpose

To inform the court of all willful noncompliance of discharge summary plan.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall have provisions to conduct exit interviews, when practical. The exit interview shall be used to provide feedback to staff. The agency responsible for the community supervision of the resident is authorized to petition the placing/releasing authority, if it appears that the resident has willfully failed to comply with any part of the disposition or release order. A copy of this petition is provided to the resident, his/her attorney, parent(s), and/or guardian.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director or designee is responsible for providing each resident with an exit interview form.

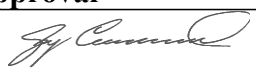
5.2 The Case Manager shall forward the discharge summary to the court of the resident upon resident release.

6.0 Procedures

6.1 An exit interview form shall be given to each resident to complete as part of discharge. The resident may complete the form and return to staff or place it in the director's mailbox.

6.2 The facility will forward a discharge plan to the court of the resident to assist in the monitoring of the resident upon release.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 12-21-10
Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 06-18-15; 07-17-18; 07-21-20
Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 6.0	**Prison Rape Elimination Act**
Section:	**General Definitions**
Subject:	**Definitions Adopted from the Prison Rape Elimination Act**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	**28 CFR §115.5 and §115.6**

1.0 Purpose

The goal of PREA is to implement national standards for enhancing the detection, prevention, reduction, and punishment of prison rape. The general definitions in 28 CFR §115.5 and the definitions related to sexual abuse and harassment in 28 CFR §115.6 shall be adopted as well as the Ohio Revised Code Annotated §2907.03 definition of Sexual Battery. The facility shall have zero tolerance toward all forms of sexual abuse and sexual harassment.

2.0 Persons Affected

All employees

3.0 Policy

For purposes of implementation of the Prison Rape Elimination Act, the general definitions in 28 CFR §115.5 and the definitions related to sexual abuse and harassment in 28 CFR §115.6 shall be adopted

4.0 Definitions/Documents

§115.5 General definitions: For purposes of this part, the term –

4.1 *Agency* means the unit of a State, local, corporate, or nonprofit authority or of the Department of Justice, with direct responsibility for the operations of any facility that confines inmates, detainees, or residents, including the implementation of policy as set by the governing, corporate, or nonprofit authority.

4.2 *Agency head* means the principal official of an agency.

4.3 *Community Confinement Facility* means a community treatment center, halfway house, restitution center, mental health facility, alcohol or drug rehabilitation center, or other community correctional facility (including residential re-entry centers), other than a juvenile facility in which individuals reside as part of a term of imprisonment or as a condition of pre-trial release or post-release supervision, while participating in gainful employment, employment search efforts, community service, vocational training, treatment, educational programs, or similar facility-approved programs during nonresidential hours.

4.4 *Contractor* means a person who provides services on a recurring basis pursuant to a contractual agreement with the agency.

4.5 *Detainee* means any person detained in a lockup, regardless of adjudication status.

4.6 *Direct staff supervision* means that security staffs are in the same room with, and within reasonable hearing distance of, the resident or inmate.

4.7 *Employee* means a person who works directly for the agency or facility.

4.8 *Exigent Circumstances* means any set of temporary and unforeseen circumstances that require immediate actions in order to combat a threat to the security or institutional order of a facility.

4.9 *Facility* means a place, institution, building (or part thereof), set of buildings, structure, or area (whether or not enclosing a building or set of buildings) that is used by an agency for the confinement of individuals.

4.10 *Facility head* means the principal official of a facility.

4.11 *Full compliance* means compliance with all material requirements of each standard except for de minims violations, or discrete and temporary violations during otherwise sustained periods of compliance.

4.12 *Gender nonconforming* means a person whose appearance or manner does not conform to traditional societal gender expectations.

4.13 *Inmate* means any person incarcerated or detained in a prison or jail.

4.14 *Intersex* means a person who's sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female. Intersex medical conditions are sometimes referred to as disorders of sex development.

4.15 *Jail* means a confinement facility of a Federal, State, or local law enforcement agency whose primary use is to hold persons pending adjudication of criminal charges, persons committed to confinement after adjudication of criminal charges for sentences of one year or less, or persons adjudicated guilty who are awaiting transfer to a correctional facility.

4.16 *Juvenile* means any person under the age of 18, unless under adult court supervision and confined or detained in a prison or jail.

4.17 *Juvenile facility* means a facility primarily used for the confinement of juveniles pursuant to the juvenile justice system or criminal justice system.

4.18 *Law enforcement staff* means employees responsible for the supervision and control of detainees in lockups.

4.19 *Lockup* means a facility that contains holding cells, cell blocks, or other secure enclosures that are: (1) Under the control of law enforcement, court, or custodial officer; and (2) Primarily used for the temporary confinement of individuals who have recently been arrested, detained, or are being transferred to or from a court, jail, prison, or other agency.

4.20 *Medical practitioner* means a health professional who, by virtue of education, credentials, and experience, is permitted by law to evaluate and care for patients within the scope of his or her professional practice. A "qualified medical practitioner" refers to such a professional who has also successfully completed specialized training for treatment sexual abuse victims.

4.21 *Mental health practitioner* means a mental health professional who, by virtue of education, credentials, and experience, is permitted by law to evaluate and care for patients within the scope of his or her professional practice. A "qualified mental health practitioner" refers to such a professional who has also successfully completed specialized training for treating sexual abuse victims.

4.22 *Pat-down search* means a running of the hands over the clothed body of an inmate, detainee, or resident by an employee to determine whether the individual possesses contraband. P*rison* means an institution under Federal or State jurisdiction whose primary use is for the confinement of individuals convicted of a serious crime, usually in excess of one year in length, or a felony.

4.23 *Resident* means any person confined or detained in a juvenile facility or in a community confinement facility.

4.24 *Secure juvenile facility* means a juvenile facility in which the movements and activities of individual residents may be restricted or subject to control through the use of physical barriers or intensive staff supervision. A facility that allows residents' access to the community to achieve treatment or correctional objectives, such as through educational or employment programs, typically will not be considered to be a secure juvenile facility.

4.25 *Security staff* means employees primarily responsible for the supervision and control of inmates, detainees, or residents in housing units, recreational areas, dining areas and other program areas of the facility.

4.26 *Staff* means employees.

4.27 *Strip search* means a search that requires a person to remove or arrange some or all clothing so as to permit a visual inspection of the person's breasts, buttocks or genitalia.

4.28 *Substantiated allegation* means an allegation that was investigated and determined to have occurred.

4.29 *Transgender* means a person whose gender identity (i.e., internal sense of feeling male or female) is different from the person's assigned sex at birth.

4.30 *Unfounded allegation* means an allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred.

4.31 *Unsubstantiated allegation* means an allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the even occurred.

4.32 *Volunteer* means an individual who donates times and effort on a recurring basis to enhance the activities and programs of the agency.

4.33 *Youthful inmate* means any person under the age of 18 who is under adult court supervision and incarcerated or detained in a prison or jail.

4.34 *Youthful detainee* means any person under the age of 18 who is under adult court supervision and detained in a lockup.

§115.6 Definitions related to sexual abuse:

4.35 For purposes of this part, the term sexual abuse includes (1) Sexual abuse of an inmate, detainee, or resident by another inmate, detainee, or residents and (2) Sexual abuse of an inmate, detainee, or residents by a staff member, contractor, or volunteer.

4.36 Sexual abuse of an inmate, detainee, or residents by another inmate, detainee, or residents includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse: (1) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight; (2) Contact between the mouth and the penis, vulva, or anus; (3) Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instruments; and (4) Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation.

4.37 Sexual abuse of an inmate, detainee, or resident by a staff member, contractor, or volunteer includes any of the following acts, with or without consent of the inmate, detainee, or resident:

(1) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;

(2) Contact between the mouth and the penis, vulva, or anus;

(3) Contact between the mouth and any body part where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

(4) Penetration of the anal or genital opening, however slight, by a hand, finger, object, or other instrument, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

(5) Any other intentional contact, either directly or through the clothing, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

(6) Any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in paragraphs (1) through (5) of this definition:

(7) Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of an inmate, detainee, or resident, and

(8) Voyeurism by a staff member, contractor, or volunteer.

Sexual harassment includes the following:

4.38 (1) Repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one inmate, detainee, or residents directed toward another; and

4.39 (2) Repeated verbal comments or gestures of a sexual nature to an inmate, detainee, or resident by a staff member, contractor, or volunteer, including demeaning reference to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

4.40 Voyeurism by a staff member, contractor, or volunteer means an invasion of privacy of an inmate, detainee, or resident by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals, or breasts; or taking images of all or part of an inmate's naked body or of an inmate performing bodily functions.

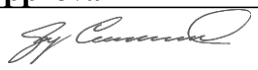
5.0 Responsibility

None

6.0 Procedures

None

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 6.0	**Prison Rape Elimination Act**
Section:	**Prohibitions and Employee Education**
Subject:	**Prohibited Sexual Activity & Employee Training**
Related Standards:	
O.A.C.	**None**
O.R.C.	**§2907.03**
A.C.A.	**3-JCRF-3D-04-7**
P.R.E.A.	**28 CFR §115.334 (a) (b) (c) (d)**

1.0 Purpose

To ensure the application of administrative and criminal disciplinary sanctions for sexual conduct between staff and residents as well as volunteers or contract personnel and residents regardless of consensual status.

2.0 Persons Affected

All employees, volunteers and independent contractors

3.0 Policy

Ohio custodial sexual misconduct laws from Ohio Revised Code Annotated §2907.03 applies to all Perry Multi-County Juvenile Facility employees, interns, contractors, and volunteers. Any sexual conduct between staff and juveniles, volunteers or contract personnel and juveniles, regardless of consensual status, is prohibited and subject to administrative and criminal disciplinary sanctions. All employees, volunteers and independent contractors are expected to have a clear understanding of the prohibitions on any type of sexual relationship with a youth in placement.

4.0 Definitions/Documents

4.1 The general definitions in 28 CFR §115.5 and the definitions related to sexual abuse and harassment in 28 CFR §115.6.

5.0 Responsibility

5.1 All employees shall participate in an annual PREA Training, either in person or via the National Institute of Corrections. Employees shall not permit contractors or volunteers in the building until they have completed the Citizen Involvement Agreement located with the facility pamphlet in the lobby.

5.2 The Director is responsible for the following:

a. Ensuring all contractors and volunteers complete a Citizen Involvement Agreement explaining the facility zero tolerance policy regarding sexual abuse and sexual harassment.
b. Making referrals to law enforcement as needed.

5.3 The Compliance Coordinator is responsible for the following:
   a. Taking specialty investigator training.
   b. Conducting internal administrative reviews of PREA allegations.
   c. Completing the Administrative Review form making recommendations for criminal referral and other documentation as required by policies and procedures.
   d. Assisting the Training Coordinator in conducting annual PREA training.

6.0 Procedures

6.1 Any sexual conduct, contact or activity between staff and youth and volunteers or contract personnel and youth, is strictly prohibited. The Ohio Revised Code Annotated §2907.03 defines such conduct as Sexual Battery and prohibits it as follows: No person shall engage in sexual conduct with another, not the spouse of the offender, when any of the following apply: the other person is in custody of law or a patient in a hospital or other institution, and the offender has supervisory or disciplinary authority over the other person. Whoever violates this section is guilty of sexual battery, a felony of the third degree.

6.2 Employee, Volunteer and Independent Contractor Training
All employees, volunteers and independent contractors are expected to have a clear understanding of the prohibitions on any type of sexual relationship with a youth in placement. Each employee, volunteer, and independent contractor shall receive the training specified as appropriate for their positions as indicated in the training and staff development section of policies and procedures.

6.3 All staff shall be trained regarding sexual abuse and assault policy, PREA, and suspected child abuse and neglect. The information provided for the training will include definitions of sexual abuse, assault, activity, contact and conduct. When an employee is unable to attend a PREA training, they shall be required to take the National Institute of Corrections online training, "PREA: Your Role Responding to Sexual Abuse." All employee trainings will be documented in the employee training files.

6.4 All volunteers and independent contractors shall be offered a facility pamphlet and given a Citizen's Involvement Form to complete instructing them on the facility's zero tolerance policy and how to report and respond to concerns regarding sexual abuse or harassment.

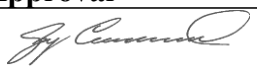
6.5 Specialized Trainings for Investigations
The facility will conduct internal administrative reviews. All allegations of sexual misconduct that involve potentially criminal behavior and have any foundation shall be referred to the Perry County Sheriff's Department for investigation.

6.6 In addition to general training provided to all employees who may have contact with residents, the facility shall ensure that, to the extent the facility itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper us of *Miranda* and *Garrity* warnings, sexual abuse

evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action of prosecution referral. The National Institute of Corrections online training, "Investigating Sexual Abuse in a Confinement Setting" will be required for all investigators.

6.7 The facility shall maintain documentation the facility investigators have completed the required specialized training in conducting sexual abuse investigations. Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement setting shall provide such training to its agents and investigators who conduct such investigations.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 6.0	**Prison Rape Elimination Act**
Section:	**Resident Screening and Housing**
Subject:	**Orientation, Screening and Follow-up Treatment, Vulnerability Assessment and Placement**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-3D-04-2 3D-04-3 3D-04-4 3D-04-5 3D-04-6 3D-04-9**
P.R.E.A.	28 CFR §115.316 (a)(b)(c) §115.333 (a)(b)(c)(d)(e)(f) §115.341 (a)(b)(c)(1-11)(d)(e) 28 CFR §115.342 (a)(c)(d)(e)(f)(g) §115.381(a)(b)(c)(d)

1.0 Purpose

To ensure that residents receive screening, orientation, placement and future treatment to assist in preventing, protecting, intervening and reporting of sexual abuse, sexual assault, and sexual harassment.

2.0 Persons Affected

All employees

3.0 Policy

Prevention of sexual activity, assault, rape, conduct and contact is a top priority designed to ensure the safety and security of residents. Upon arrival at the facility, information is communicated orally and in writing in a language clearly understood by the juvenile about sexual abuse/assault/harassment, prevention/intervention, self-protection, reporting sexual abuse/assault, and treatment and counseling. All juveniles identified as high risk with a history of assaultive behavior or as at risk for sexual victimization are assessed by a mental health or other qualified professional. Such juveniles are identified, monitored, counseled, and provided appropriate treatment. An investigation is conducted and documented whenever a sexual assault is alleged, threatened or occurs. Immediate treatment shall be provided to any victim of sexual assault.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Clinical Coordinator is responsible for the following:

a. Conducting an intake Vulnerability Assessment and assigning resident unit placement with the goal of keeping all residents safe and free from sexual abuse.
b. Providing the Compliance Coordinator a copy of the Resident Vulnerability Assessment.
c Providing residents with PREA training ensuring residents clearly understand the facility zero tolerance policies and procedures concerning sexual abuse/assault/ harassment, prevention/intervention, self-protection, reporting of incidents or suspicions, and treatment and counseling which documenting the training.
d. Communicating any need for special accommodations for resident barriers to treatment to the shift supervisors including inability to read or comprehend materials.
e. Providing screening and follow-up treatment within fourteen (14) days of intake when a resident indicates they have previous sexual victimization or have or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community.

f. Ensuring all residents identified as high risk with a history of assaultive behavior or as at risk for sexual victimization are assessed by a mental health or other qualified professional and are monitored, counseled, and provided appropriate treatment.

5.2 The Compliance Coordinator is responsible for the following:

a. Maintaining an electronic record of the resident Vulnerability Assessment with limited access and the PREA Training Log.
b. Providing and documenting quarterly resident PREA training.
c. Ensuring posters are readily available and visible to residents throughout their living quarters.
d. Providing compliance tracking reports to the Director.

6.0 Procedures

6.1 Prevention Orientation

Upon arrival at the facility, residents are informed orally and in writing in a language clearly understood the facility zero tolerance policies and procedures concerning sexual abuse/assault/harassment, prevention/intervention, self-protection, reporting of incidents or suspicions, and treatment and counseling. Disabilities and special needs shall be addressed as needed to ensure effective, age-appropriate communication with residents including providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively using any specialized vocabulary. Any resident needing language interpreters should be identified during the referral process. The facility will use interpreters provided by the court of the jurisdiction of referral, as recommended by the court, or as otherwise available.

6.2 PREA orientation materials will be provided at intake with a review by the Clinical Coordinator or designated mental health professional conducted within twenty-four hours to ensure the materials are understood. Mental health professionals are trained to identify any potential issues that could be a barrier in treatment at the facility and to communicate in a manner to overcome any responsivity issues including intellectual disabilities, limited reading skills, mental illnesses, and visual problems. Materials shall be in formats accessible to all residents including those who are limited English proficient, deaf, visually impaired, or otherwise disable, as well as to residents who have limited reading skills. The materials shall include residents' rights to be free from sexual abuse and sexual harassment and from retaliation from reporting such incidents, and regarding facility policies and procedures for responding to such incidents.

6.3 The facility shall not rely on resident interpreters, resident readers, or other types of resident assistants for PREA orientation. Residents will assist only in limited circumstances where an extended delay in obtaining an effective interpreter could compromise resident's safety, the performance of first-responder duties, or the investigation of the resident's allegations. Such assistance shall be documented in an incident report detailing the need for resident assistance.

6.4 Self-Protection and Education
Residents are given written and verbal information concerning sexual abuse and assault. They are provided with opportunities to meet with and freely disclose information about current or past abuse in private sessions with a mental health counselor and/or medical professional.

6.5 Resident participation in PREA education shall be documented. Key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

6.6 Screening and Follow-up Treatment During Orientation Period
The facility shall conduct screening including a vulnerability assessment within the first 24 hours after arrival. If the screening indicates that a resident has experienced prior sexual victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical and/or a mental health practitioner within 14 days of the screening process.

6.7 Information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments or as otherwise required by Federal, State, or local law. Medical and Mental Health Practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of eighteen.

6.8 Vulnerability Assessment
Within twenty-four hours of arrival at the facility, the Clinical Coordinator or designee will obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. A vulnerability assessment shall be completed for each resident. Resident vulnerability and aggression will be reviewed as needed during weekly administrative treatment meetings and throughout the period of confinement. Information will be used to guide decisions indicating heightened need for supervision, additional safety precautions needed, separation and movement into another unit.

6.9 The vulnerability assessment shall be an objective screening instrument, and contain information ascertained through conversations with the resident during the intake process and medical and mental health screening, during classification assessments and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's file. The assessment shall contain information about the following: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) Current charges and offense history; (4) Age; (5) Level of emotional and

cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The residents' own perceptions of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation for certain other residents.

6.10 Results of the screening shall be shared with all facility personnel responsible for resident oversight and treatment. Staff shall be made aware if an intake is potentially vulnerable or has tendencies of acting out with sexually aggressive behavior. Any identified issues shall be incorporated into the resident's treatment plan. The assessment instrument shall not be disseminated within the facility. The instrument shall be scored by the Clinical Coordinator before being forward to the Compliance Coordinator who will scan it and keep it in electronic form in a private drive to ensure sensitive information is not exploited to the resident's detriment by staff or other residents.

6.11 Placing of Residents in Housing, Bed, Program, Education, and Work Assignments
Housing, bed, program, education, and work assignments will be made according to the vulnerability assessments with the goal of keeping all residents safe and free from sexual abuse.

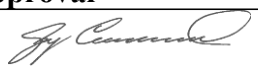
6.12 Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed or other assignments solely on the basis of such identification or status, nor shall the facility consider lesbian, gay, bisexual, transgender or intersex identification or status as an indicator of likelihood of being sexually abusive. In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the facility shall consider on a case-by-case basis whether a placement would ensure the residents' health and safety, and whether the placement would present management or security problems. A transgender or intersex resident's own view with respect to his or her own safety shall be given serious consideration. Placement and programming assignments shall be reassessed at least twice a year to review any threats to safety, and whether a placement would ensure the residents' health and safety, and whether placement would present management or security problems.

6.13 All residents shall be assigned to single occupancy rooms. Residents are not permitted to use the bathroom or to be together in any other closed areas without staff observation. All residents shall shower separately. Resident rooms are off limits to other residents. Staff is not permitted in residents' sleeping rooms with the resident unless exigent circumstances exist such as an illness or life-threatening emergency. Such exceptions shall be documented. To speak to a resident in their room, staff shall use the intercom system or stand in the residents' doorway with the door open.

6.14 All juveniles identified as high risk with a history of assaultive behavior or as at risk for sexual victimization are assessed by a mental health or other qualified professional. Such juveniles are identified, monitored, counseled, and provided appropriate treatment.

6.15 The building is designed to allow maximum observation to ensure the safety and security of all occupants. Concerns for safety and security should be documented and reported to the appropriate administrators for action.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 6.0	**Prison Rape Elimination Act**
Section:	**Reporting**
Subject:	**Resident, Third-Party, Staff, Medical and Mental Health Practitioners and Director Reporting**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-3D-04-9**
P.R.E.A.	28 CFR §115.351 (a)(b)(c)(d)(e) §115.354 §115.361 (a)(b)(c)(d)(1)(2)(e)(1)(2)(3)(f) 28 CFR §115.363 (a)(b)(c)(d) §115.381 (d)

1.0 Purpose

To establish an environment supportive of rehabilitation with zero tolerance for sexual abuse and sexual harassment encouraging all residents, employees, interns, contractors, volunteers, and other concerned third-parties to freely report knowledge or suspicion of sexual misconduct that triggers an immediate investigation and response.

2.0 Persons Affected

All employees

3.0 Policy

Youth to youth sexual activity, assault, rape, conduct, and contact are prohibited. The facility will have multiple ways for residents, third parties, and employees to report sexual abuse and misconduct. Juveniles who are victims of sexual abuse have the option to report the incident to a designated staff member other than an immediate point-of-contact line staff member.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 All staff are responsible for the following:

a. Immediately reporting any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any facility, retaliation against residents or staff who report such incidents, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.
b. Knowing what to do when receiving a report of sexual abuse including immediately notifying the Director.

5.2 The Director is responsible for being a point of contact for third party reporting, communicating reports to the necessary parties, and notifying other facilities and investigating agencies when allegations of abuse occur within seventy-two (72) hours.

5.3 The Compliance Coordinator is responsible for the following:

a. Making staff and residents are aware of the multiple ways to report sexual abuse or sexual harassment through quarterly resident training and annual staff training.
b. Posting PREA posters in the living units and hallway where contact information is readily available to residents and visiting parent(s)/legal guardians.
c. Ensuring third-party reporting forms are available in the facility lobby.

5.4 The Training Coordinator is responsible for the following:
a. Obtaining certification and assisting in facility PREA training.
b. Providing staff training on their responsibilities as a mandatory reporter of child abuse.

6.0 Procedures

6.1 Resident Reporting

The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

6.2 Residents may privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents to any staff member who shall follow first responder duties. Such reports may be verbal or written. Access to writing tools and paper are available in the resident living units and in school.

6.3 The facility shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request.

6.4 Posters with phone numbers and the address of Family Health Services of East Central Ohio shall be available for residents. A phone shall be provided in each unit with a direct line to Family Health Services of East Central Ohio. Staff shall not interfere in usage of the rape crisis phone. Phone calls with outside numbers and letters with addresses to other outside agencies shall be permitted with limited assistance from staff and without staff interference. Letters to these addresses may be sealed in front of staff without staff inspection. Phone calls may be made in the privacy of a counselor or assistant director office. Residents may also place complaints in the locked grievance boxes without placing their name on the complaints.

6.5 Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

6.6 Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

6.7 Third-Party Reporting

Information shall be publicly posted on the facility website and made available in written form on how to report sexual abuse and sexual harassment on behalf of a resident. A third- party reporting form is available in the lobby. The Director shall be the point of contact for third party reports.

6.8 Staff Reporting

The facility shall provide a method for staff to privately report sexual abuse and sexual harassment of residents. Any staff member can privately report concerns, suspicions, or acts to any member of administration including Supervisors, Mental Health Professionals, Case Manager, Clinical Coordinator, Compliance Coordinator, and the Director. Staff may anonymously report in writing to any member. All reports shall trigger investigations.

6.9 All staff shall report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any facility, whether or not it is part of the Perry Multi-County Juvenile Facility, retaliation against residents or staff who report such incidents, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

6.10 The facility requires all staff to comply with mandatory child abuse reporting laws. Any allegations of sexual abuse and sexual harassment including third-party and anonymous reports must be immediately reported to the Director.

6.11 Apart from reporting to designated supervisors or officials and designated state or local agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation and other security and management decisions.

6.12 Medical and Mental Health Practitioners

Residents must be informed by Medical and Mental Health Practitioners at the initiation of services of their duty to report and the limitations of confidentiality. Informed consent to report prior sexual victimization that did not occur in an institutional setting must be granted by residents eighteen and older. Information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments or as otherwise required by Federal, State, or local law.

6.13 Medical and Mental Health Practitioners shall be required to report sexual abuse to designated supervisors and officials including any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any facility, whether or not it is part of the Perry Multi-County Juvenile Facility, retaliation against residents or staff who report such incidents, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Reports must also be made to the designated state and local services agency as required by mandatory reporting laws.

6.14 Director Reporting Duties

Staff shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the Director or designee for administrative review. The Director shall refer all allegations that have foundation and may involve a criminal offense to the Perry County Sheriff's Department for investigation, Perry County Children Services, and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified.

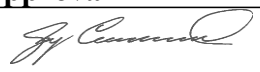
6.15 If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians.

6.16 If a juvenile court retains jurisdiction over the alleged victim, the Director or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within fourteen days of receiving the allegation.

6.17 The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the Director or designee for administrative review. All allegations that have foundation and may involve a criminal offense will be referred to the Perry County Sheriff's Department for investigation.

6.18 Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Director of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency as soon as possible, but no later than seventy-two hours after receiving the allegation. Such notification shall be documented. The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with PREA standards.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 06-03-14 Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23 Prior Effective Date: 06-18-15; 07-18-17; 07-17-18; 07-21-20 Date Revised: 07-19-22

Chapter: 6.0	**PREA**
Section:	**Reporting**
Subject:	**Reporting Sexual Abuse or Harassment Grievances**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-3D-04-4**
P.R.E.A.	28 CFR §115.352 (a)(b)(1)(2)(3)(4)(c)(1)(2)(d)(1)(2)(3)(4)(e)(1)(2)(3)(4)(g)

1.0 Purpose

To provide a framework for investigations of grievances alleging sexual abuse or sexual harassment.

2.0 Persons Affected

All employees

3.0 Policy

Sexual abuse and harassment allegations shall be investigated any time they are reported. No time limits on grievances shall preclude an investigation into such allegations. Residents shall not be required to informally pursue allegations of sexual misconduct.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for reviewing grievance appeals and responding to the resident in writing in seven (7) days.

5.2 The Compliance Coordinator is responsible for the following:

a. Checking the grievances boxes located in each unit.
b. Conducting an administrative review into claims of sexual abuse or sexual misconduct no longer than forty-eight (48) hours after receipt of the grievance.
c. Providing a written response within seven (7) days of receipt.
d. Determining whether the grievance was filed in bad faith.

6.0 Procedures

6.1 Residents have access to grievance forms and writing instruments in the units. Once completed, the grievance forms may be placed in the grievance boxes located in each unit or in the box outside of the watch room marked "Confidential to the Director". The Compliance Coordinator shall process each grievance and conduct an administrative review into the legitimacy of the claim as soon as possible and no longer than forty-eight (48) hours after receipt of the grievance. A written response will be provided within seven (7) days of receipt.

6.2 If the resident is not satisfied, or if the grievance is with the Compliance Coordinator, the resident is permitted to give the grievance to the Director. The Director will review the complaint and respond to the resident in writing in seven (7) days.

6.3 The facility shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. The facility may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse. The

agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse. Nothing in PREA standards shall restrict the facility's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

6.4 The facility shall ensure that a resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and such grievance is not referred to a staff member who is the subject to the complaint.

6.5 The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within ninety days of the initial filing of the grievance. Computation of the ninety (90) day time period shall not include time consumed by residents in preparing any administrative appeal.

6.6 The agency may claim an extension of the time to respond, of up to seventy (70) days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.

6.7 At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.

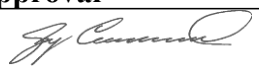
6.8 Third parties, including fellow residents, staff members, family members, attorneys and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.

6.9 If a third party, other than a parent or legal guardian, files such a request of behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process. If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.

6.10 A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf.

6.11 The facility may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrated that the resident filed the grievance in bad faith.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 06-03-14	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
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Date Revised: 07-17-18	

Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Protection from Imminent Harm and Retaliation**
Subject:	**Isolation, Emergency Isolation, and Protection Against Retaliation**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	28 CFR §115.342 (b) (h)(1)(2) (i) §115.352 (f)(1) §115.362 §115.367 (a)(b)(c)(d)(e)(f) 28 CFR §115.368

1.0 Purpose

To ensure procedures are in place to ensure residents are protected from imminent sexual abuse or sexual harassment with measures taken to protect reporters from retaliation by other residents or staff.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall take immediate steps to protect residents from any reports indicating the resident is subject to a substantial risk of imminent sexual abuse. All residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations will be protected by the facility from retaliation by other residents or staff.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Clinical Coordinator is responsible for the following:

a. Placing residents in housing, bed, program, education and work assignments based upon vulnerability assessments
b. Periodically updating vulnerability assessments with the treatment team as needed.
c. Providing daily checks of residents who are in isolation
d. Monitoring retaliation concerning residents or staff reporters of allegations of sexual abuse or sexual harassment.

5.2 The Compliance Coordinator is responsible for the following:

a. Responding within forty-eight (48) hours to emergency grievances.
b. Monitoring isolation status and reviewing the continuing need for separation from the general population.
c. Conducting status reviews every thirty (30) days for a minimum of ninety (90) days when allegations occur.
d. Monitoring retaliation concerning residents or staff reporters of allegations of sexual abuse or sexual harassment.
e. Acting upon fears of retaliation by taking appropriate measures to protect an individual against retaliation.

5.3 All staff are responsible for the following:
   a. Immediately responding to allegations of imminent harm of sexual abuse or sexual harassment.
   b. Knowing the requirements of isolation and ensuring resident rights are being met.
   c. Reporting any retaliation concerning residents or staff reporters of allegations of sexual abuse or sexual harassment.

6.0 Procedures

6.1 Residents shall be placed in housing, bed, program, education and work assignments based upon vulnerability assessments that are updated periodically as needed.

6.2 Isolation

Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

6.3 When isolated, the facility shall clearly document the basis for the concern for the resident's safety and the reason why no alternative means of separation can be arranged. All guidelines for room isolation shall be implemented. A review of the continuing need for separation from the general population shall be made every thirty (30) days.

6.4 Emergency Isolation

When the facility learns that a resident is subject to a substantial risk of imminent sexual abuse it shall take immediate action to protect the resident. A response to the emergency grievance shall be required within forty-eight (48) hours. Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse will comply with isolation standards including daily visits from a medical or mental health care clinician.

6.5 Protection Against Retaliation

The facility shall protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The facility Director, Case Manager, Clinical Coordinator, and Compliance Coordinator shall be charged with monitoring retaliation.

6.6 Multiple protection measures shall be employed including housing changes, transfers of 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.

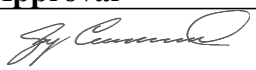
6.7 For at least ninety (90) days following a report of sexual abuse, the facility shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any

such retaliation. Items the facility shall monitor include any resident disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. The facility shall continue such monitoring beyond ninety (90) days if the initial monitoring indicates a continuing need. In the case of residents, such monitoring shall also include periodic status checks.

6.8 If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation.

6.9 A facility's obligation to monitor shall terminate if the facility determines that the allegation is unfounded.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-19-22	

Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Response**
Subject:	**Staff Coordinated Response, Director Response, Treatment, Criminal and Administrative Investigation**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-3D-04-8**
P.R.E.A.	28 CFR §115.321 (a)(b)(c)(d)(e)(f)(g)(1)(2)(h) §115.322 (a)(b)(c)(d)(e) 28 CFR §115.364 (a)(1)(2)(3)(4)(b) §115.365 §115.383 (a)(b)(c)(f)(g) 28 CFR §115.371 (a)(b)(c)(d)(e)(f)(g)(1)(2)(h)(i)(k)(l)(m) §115.382 (a)(b)(c)(d)

1.0 Purpose

To ensure a coordinated response for victims of sexual assault with provisions in place for referral for treatment and the gathering of evidence.

2.0 Persons Affected

All employees

3.0 Policy

Staff shall take immediate actions to implement a coordinated response to reports of sexual misconduct. Whenever a sexual assault is alleged, an investigation or review into the incident must be conducted and documented. Any state entity or Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy for governing the conduct of such investigations and shall conform to the requirements of the criminal and facility investigations. The facility shall ensure that an administrative review or criminal investigation is promptly, thoroughly, and objectively completed for all allegations of sexual abuse or harassment including third-party and anonymous reports. All residents who experienced sexual abuse shall have access to free off-site forensic medical examinations where evidentiary or medically appropriate.

4.0 Definitions/Documents

Appendix D: Coordinated Response Plan

5.0 Responsibility

5.1 All employees are responsible for immediately responding to allegations of sexual misconduct in accordance with policies and procedures and the coordinated response plan.

6.0 Procedures

6.1 Staff Coordinated Response for Recent Event

An employee who receives any allegation or report of sexual misconduct or possible sexual assault, whether verbally or in writing shall respond immediately. The alleged victim and aggressor shall be separated and remain separated until an investigation or review is completed.

6.2 If the first responder is not a security staff member, the responder shall request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

6.3 The Director and Nurse shall be notified. If the allegation concerns a recent event, the facility shall be placed on lock down while the Perry County Sheriff's Department is notified by the Director or a designee and an ambulance is requested.

6.4 The Director or designee will offer the resident a victim advocate from Family Health Services of East Central Ohio. The victim may also request a specific staff member to remain with them during emergency transportation. If staff is able, they may accompany the victim and provide support as requested.

6.5 The alleged abuser shall be placed in the watch room on special watch with water turned off. If the abuse occurred within a time period that still allows for the collection of physical evidence, staff shall ensure that the alleged abuser does not take any actions that could destroy physical evidence, including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.

6.6 The alleged victim shall be placed on special watch and remain with the staff member of their choosing. If the nurse is available and the alleged victim is able to be moved, he shall go to the nurse office with an accompanying staff member until an ambulance arrives. If the nurse is unavailable, he shall go to the administrative office area with a staff member remaining in full view of cameras until an ambulance arrives. If the abuse occurred within a time period that still allows for the collections of physical evidence, staff should request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.

6.7 If the alleged abuser is an employee, the employee shall be instructed to turn over the facility keys and shall wait for the arrival of the Perry County Sheriff's Department in the administrative office area in full view of the cameras where video recording will ensure staff has not taken any steps to destroy evidence. The employee will be placed on administrative leave pending the outcome of the investigation. The alleged victim shall remain with a staff member of their choosing in the Central Control area.

6.8 Staff shall preserve and protect the crime scene until the Perry County Sheriff's Department commences an investigation and takes appropriate steps to collect any evidence. The employee who first received the allegation of sexual abuse or sexual assault is responsible for completing a significant incident report detailing the report and actions taken. All staff involved at the facility at the time of the allegation shall complete an incident report.

6.9 The Director or a designee shall be responsible for ensuring appropriate notifications have been made. Notifications may include the Perry County Sheriff's Department, Family Health Services of East Central Ohio, Perry County Children Services, the governing board, and the Ohio Department of Youth Services. Resident's parents and juvenile court must also be notified of the situation in a timely manner.

6.10 Discipline and/or additional criminal charges for the alleged aggressor may occur pending investigation results. The Director shall ask for any alleged sexual abuser to be removed to a detention facility pending the results of an investigation. The resident may be returned to the facility pending the outcome of the investigation.

6.11 Staff Coordinated Response for Past Allegation of Sexual Abuse or Harassment Any state entity or Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy for governing the conduct of such investigations and shall conform to the requirements of the criminal and facility investigations.

6.12 If the allegation concerns an event that occurred in the past where no material evidence exists, the alleged victim and alleged abuser shall be immediately separated and placed upon special watch. The Director shall be notified and will order the Compliance Coordinator to conduct a prompt, thorough and objective review of all the allegations of sexual abuse or harassment including third party and anonymous reports within a maximum of three business days.

6.13 A review will also be conducted for allegations of past sexual assault where no corroborating physical evidence is likely to be found. The review will be documented and will determine if the allegation has any foundation. All allegations of sexual abuse or harassment that are determined to have some foundation and involve potentially criminal behavior during a review shall be referred the Perry County Sheriff's Department and/or Perry County Children Services to conduct criminal investigations. This policy shall be publicly available on the PMCJF website with details concerning responsibilities of both the facility and other entities. All referrals shall be documented.

6.14 Administrative reviews shall include an effort to determine whether staff failures to act contributed to the abuse and shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The alleged victim and alleged victimizer shall remain separated until the conclusion of the review and/or the Perry County Sheriff's Department investigation.

6.15 The facility shall not terminate an investigation or review solely because the source of the allegation recants the allegation or the alleged abuser or victim departs from the employment or control of the facility. Where quality of evidence appears to support criminal prosecution, the facility shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No facility shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

6.16 The Perry County Sheriff's Department shall be responsible for conducting all investigations of sexual abuse or sexual assault. Their investigative protocols shall be developmentally appropriate and adapted from or otherwise based upon the most recent edition of the Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents" or similarly comprehensive and authoritative protocols developed after 2011. The Perry County Sheriff's Department investigator shall receive special training in sexual abuse investigations involving juvenile victims. The investigator shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

6.17 Criminal investigations shall be documented in written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

6.18 When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

6.19 Treatment

To the extent the facility is not responsible, requirements specified below shall be requested to be followed by all state entities outside of the facility responsible for investigating allegations of sexual abuse in juvenile facilities including any Department of Justice component or investigating agency.

6.20 Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners. The Clinical Coordinator and facility nurse shall each document in case notes in private files noting the timeliness of emergency medical treatment and crisis intervention service that were provided, evaluation of the appropriate response by non-health staff in the event that health staff are not present at the time the incident is reported, and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis.

6.21 The facility shall attempt to make available to the victim a victim advocate from the local rape crisis center, Family Health Services of East Central Ohio. A 24-hour hotline is available at 1-800-688-3266. If the local rape crisis center is not available to provide victim advocate services, the facility shall make available to provide these services a qualified staff member from a community-based organization or a qualified facility staff member. Qualifications for victim advocates from the community or facility include prior

screening for appropriateness to serve in this role and receipt of education concerning sexual assault and forensic examination issues in general.

6.22 Facilities shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

6.23 The victim may request that a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

6.24 The facility shall offer the resident who experienced sexual abuse access to forensic medical examination at Genesis Hospital, without financial cost, where evidentiary or medically appropriate. Genesis Hospital has a memorandum of understanding providing that such examination shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. Facility efforts to provide SAFEs or SANEs and requests for this to occur shall be documented. Any alleged victim under the age of fourteen, shall be transported to Children's Hospital in Columbus for SAFE or SANE forensic medical examination.

6.25 Resident victims of sexual abuse while incarcerated shall be offered timely information about and access to emergency sexually transmitted infections prophylaxis in accordance with professionally accepted standards or care where medically appropriate. Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

6.26 Any evidence shall be given directly to the Perry County Sheriff's Department or State Highway Patrol. Such evidence includes forensic evidence secured by the emergency room hospital. Supervising staff must obtain copies of examination results.

6.27 Upon returning to the facility, the nurse shall be responsible for ensuring that the resident receives testing to include, but not be limited to: Gonorrhea, Chlamydia, Syphilis, Hepatitis B, and HIV testing if testing did not occur at the emergency room. The nurse shall also ensure testing of the alleged aggressor if the aggressor was a youth. Medical follow-up shall reflect re-testing five to six months after the initial test.

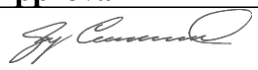
6.28 The resident shall be seen by the facility mental health professional as soon as possible. Other appropriate referrals shall be made.

6.29 If the victimization was not recent, the facility nurse may be contacted and appropriate referrals for treatment and gathering of evidence shall be made within a reasonable timeframe. Residents will be permitted to call the victim support hotline and/or talk to the Mental Health Professional as needed.

6.30 Electronic Monitoring Evidence

Available electronic monitoring data shall be accessed by the Director, Assistant Director, Compliance Coordinator, and Shift Supervisors only. When observations reveal evidence of sexual abuse, data will be preserved as evidence and turned over to the Perry County Sheriff's Department for investigation.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Revised: 07-21-20	

Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Access to Care**
Subject:	**On-Going Medical and Mental Health Care for Sexual Abuse Victims and Abusers**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	28 CFR §115.383 (a)(b)(c)(d)(e)(f)(h)

1.0 Purpose

To ensure provisions of medical and mental health care for sexual abuse victims as well as abusers.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup or juvenile facility.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for ensuring all residents who have been victimized by sexual abuse are offered mental and medical health evaluations and appropriate treatment.

6.0 Procedures

6.1 Ongoing Treatment for Sexual Abuse Victims and Abusers

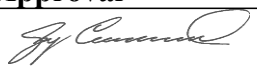
The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. The evaluation and treatment of such victims shall include the following when necessary: follow-up services, treatment plans, and, when necessary, referrals for continued care following transfer to or placement another facility or their release from custody.

6.2 The facility shall provide victims with medical and mental health services consistent with the community level of care. Victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

6.3 The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within sixty (60) days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

6.4 Discipline shall be based on the criminal and/or administrative investigation results.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Access to Care**
Subject:	**Resident Access to Outside Support Services**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	28 CFR §115.353 (a)(b)(c)(d)

1.0 Purpose

To ensure residents are provided with access to communications with victim advocates, parents or legal guardians, and attorneys outside the facility respecting confidentiality rights.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall provide residents with access to outside victim advocates. Communication between residents and toll-free hotline numbers of local, State, or national victim advocacy or rape crisis organizations shall be granted in a manner as confidential as possible. The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for entering into memoranda of understanding or agreements with community service providers that are able to provide residents with confidential emotional support.

5.2 The Compliance Coordinator is responsible for the following:

a. Ensuring resident access to mailing addresses, telephone numbers, and a victim advocate through posted materials.
b. Testing phone lines to ensure Family Health Services of East Central Ohio is readily available to respond to resident needs.

6.0 Procedures

6.1 The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers including toll free hotline numbers of local, State, and national victim advocacy or rape crisis organizations. Such numbers will be posted in the facility and located in the resident handbook.

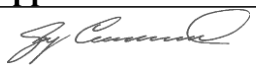
6.2 Residents shall be informed in the handbook as well as by staff of the extent their communications will be monitored and reports of abuse forwarded to authorities in accordance with mandatory reporting laws. All residents are informed that staff has a duty to inform the director of any reports of sexual abuse or harassment.

6.3 Residents wishing to contact these organizations via mail shall seal letters in front of staff without staff inspection of the written material. Residents wishing to telephone such organizations may do so in the unit or within the privacy of the mental health care practitioner or case manager offices. The contact information for Family Health Services of East Central Ohio is readily available throughout the building and the phone on the wall in each unit is directly connected to the outside agency.

6.4 The facility shall attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The facility shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

6.5 The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. Parents and guardians may receive a minimum of one phone call each week and are able to visit every Sunday or as arranged.

7.0 Document Approval

Signature: 

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Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Response**
Subject:	**Substantiating Investigations and Reporting to Residents**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	28 CFR §115.372 28 CFR §115.373 (a)(b)(c)(1)(2)(3)(4)(d)(1)(2)(e)(f)

1.0 Purpose

To ensure victims are given information regarding the status of the investigation, findings, and status of the perpetrator as permitted by law.

2.0 Persons Affected

All employees

3.0 Policy

Following an investigation, the investigator shall make a determination whether allegations of sexual abuse or sexual harassment are substantiated, unsubstantiated, or unfounded. As long as the resident remains committed at the facility or within the Ohio Department of Youth Services, he shall be told of the findings and given information regarding the status of the investigation and perpetrator as permitted by law.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Conducting disciplinary actions removing staff from contact with resident and informing the residents on the status of employment or criminal charges.
b. Maintaining communication with the Perry County Sheriff Department after referral to request relevant information on the status of the investigation.
c. Informing the resident victim whenever the facility learns the alleged abuser has been indicted and/or convicted on a charge related to sexual abuse within the facility.

5.2 The Compliance Coordinator is responsible for the following:

a. Conducting an administrative review of allegations of sexual abuse or sexual harassment.
b. Determining whether claims of sexual abuse or sexual harassment are substantiated, unsubstantiated, or unfounded.
c. Informing the resident of the status of the investigation.
d. Forward all reviews that have foundation or merit and involve potentially criminal behavior to the Perry County Sheriff's Department for investigation.

6.0 Procedures

6.1 Each administrative review into an allegation of sexual abuse or sexual harassment shall be concluded by a finding of substantiated, unsubstantiated, or unfounded. The Compliance Coordinator shall impose a standard of no higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The Compliance Coordinator shall inform the resident as to determination of the allegation and forward all reviews that have foundation or merit and involve potentially criminal behavior to the Perry County Sheriff's Department for investigation.

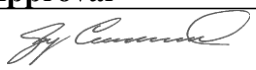
6.2 Until the Perry County Sheriff's Department concludes the investigation, the facility will request the relevant information every thirty (30) days in order to keep the resident informed of the status of the investigation.

6.3 If the allegation concerned sexual abuse perpetuated by a staff member, the facility shall inform the resident whenever the staff member is no longer posted within the resident's unit, no longer employed at the facility, has been indicted on charges related to sexual abuse within the facility, and/or has been convicted on a charge related to sexual abuse within the facility. If the allegation concerned sexual abuse by another resident, the facility shall subsequently inform the alleged victim whenever the facility learns the alleged abuser has been indicted and/or convicted on a charge related to sexual abuse within the facility.

6.4 All such notifications or attempts at notification shall be documented.

6.5 A facility's obligation to report under this standard is terminated if the resident is released from the facility's custody and no longer a part of the Ohio Department of Youth Services.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 06-03-14 Prior Effective Date: 06-25-15; 07-18-17 Date Revised: 07-17-18	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Discipline**
Subject:	**Discipline for Staff, Resident, Contractors and Volunteers**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-3D-04-2 3D-04-3 3D-04-4 3D-04-05 3D-04-6 3D-04-9 3D-04-10**
P.R.E.A.	28 CFR §115.366 (a)(b)(1)(2) §115.376 (a)(b)(c)(d) §115.377(a)(b) 28 CFR §115.378 (a)(b)(c)(d)(e)(f)(g)

1.0 Purpose

To ensure the discipline for violations of the facility sexual abuse or sexual harassment policies while protecting residents from contact with abusers.

2.0 Persons Affected

All employees

3.0 Policy

All staff, residents, contractors and volunteers are subject to discipline for violations of the facility sexual abuse or sexual harassment policies. The facility shall make every effort to protect residents from contact with abusers.

4.0 Definitions/Documents

None

5.0 Responsibility

5.1 The Director is responsible for the following:

a. Immediately placing all employees accused of sexual abuse or sexual harassment on administrative leave until an investigation can take place.
b. Disciplining staff for violations of facility policies related to sexual abuse and sexual harassment.
c. Reporting terminations for violations of the facility sexual abuse or sexual harassment policies or resignations by staff who would have been terminated if not for their resignation to law enforcement agencies unless the activity was clearly not criminal, and any relevant licensing bodies.
d. Terminating and/or suspending contracts and volunteer placements upon allegations of sexual abuse or sexual harassment and approving any reassuming of duties for an unsubstantiated report.
e. Asking courts to remove the alleged perpetrator of sexual abuse and insuring the immediate separation of the alleged perpetrator and victim.

5.2 The Compliance Coordinator is responsible for the following:

a. Investigating allegations of sexual abuse or sexual harassment and making disciplinary recommendations according to the findings.
b. Making recommendations of resident disciplinary action pursuit to an administrative conference hearing if the allegation was made in bad faith.

6.0 Procedures

6.1 Staff

If an employee is accused of sexual abuse or sexual harassment the employee shall be immediately placed on administrative leave from the facility until an investigation can take place. There shall be no contact between the alleged victim and the person until an investigation is complete.

6.2 Staff shall be subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies. Termination shall be the presumptive disciplinary sanction for staff who engaged in sexual abuse.

6.3 Disciplinary sanctions for violations of facility policies relating to sexual abuse or sexual harassment shall be commensurate with the nature and circumstance of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

6.4 All terminations for violations of facility sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

6.5 Neither the facility nor any other governmental entity responsible for collective bargaining on the facility's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the facility's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of determination of whether and to what extent discipline is warranted. This does not restrict the entering into or renewal of agreement that govern the conduct of the disciplinary process as long as these agreements are not inconsistent with the evidentiary standards or disciplinary sanctions for staff.

6.6 All allegations shall remain in a staff member's personnel file records including a no-contact assignment that is imposed pending investigation as long as the alleged abuser is incarcerated or employed by the facility, plus five years.

6.7 Residents

Resident disciplinary sanctions shall only occur pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. A resident may be disciplined for sexual contact with a staff only upon finding that the staff member did not consent to such contact. Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. Such sanctions shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

6.8 If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The facility may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

6.9 Upon administrative determination that the alleged sexual abuse more likely than not occurred, the facility will ask for the alleged perpetrator to be removed to a detention facility. If such removal is not immediate, the alleged perpetrator shall be isolated from the general population following isolation guidelines including permitting daily large-muscle exercise and legally required educational programming or special education services. Access to other programs and work opportunities may be granted to the extent possible. Daily visits from a mental health care clinician shall occur.

6.10 For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. A resident may be disciplined for filing a grievance related to alleged sexual abuse only where the agency demonstrates the resident filed the grievance in bad faith.

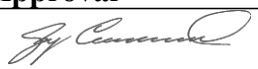
6.11 The facility prohibits all sexual activity between residents and shall discipline residents for such activity. Such sexual activity shall not be deemed to constitute sexual abuse if it is determined that the activity is not coerced.

6.12 Contractors and Volunteers

Any contractor or volunteer who allegedly engages in sexual abuse shall be prohibited from contact with residents, temporarily not permitted on facility property, and reported to law enforcement agencies and relevant licensing bodies unless the activity was clearly not criminal. Substantiated reports of sexual abuse shall result in termination of any individual contracts with the facility and permanent revocation of privileges to be on facility property. Unsubstantiated reports shall require Director approval prior to reassuming any role within the facility.

6.13 In the case of any other violation of facility sexual abuse or sexual harassment policies by a contractor or volunteer, the Director shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents and the facility.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Incident Review**
Subject:	**Incident Review Team**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	28 CFR §115.386 (a)(b)(c)(d)(1)(2)(3)(4)(5)(6)(e)

1.0 Purpose

The goal of the facility is to meet and exceed all local, state, and national standards. A regular system of internal and external reviews shall enhance awareness of issues.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

4.0 Definitions/Documents

The Review Team for sexual abuse investigations is comprised of the members of the facility treatment team and other staff as designated by the director with an invitation to participate in the meeting offered to the Perry County Sheriff Department Investigating officer.

5.0 Responsibility

5.1 The Director is responsible for overseeing the sexual abuse incident review within thirty (30) days of the conclusion of a sexual abuse investigation unless the allegation was determined to be unfounded.

5.2 The Compliance Coordinator is responsible for the documentation of the sexual abuse incident review.

6.0 Procedures

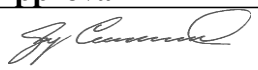
6.1 The facility shall conduct a sexual abuse incident review within thirty (30) days of the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation was determined to be unfounded.

6.2 The review team shall include the Director, Compliance Coordinator, Clinical Coordinator, Case Manager, mental health professional, line supervisors and other staff as designated by the director. The Perry County Sheriff's Department Investigating officer shall also be invited to participate in the review.

6.3 The review team shall consider 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) Whether the incident or allegation was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender, or intersex identification status or perceived status, gang affiliation, or 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 the above with any recommendations for improvement and submit such report to the Director and the PREA Coordinator.

6.4 The facility shall implement the recommendations for improvement or shall document its reasons for not implementing recommendations.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 03-21-13 Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23
Prior Effective Date: 06-25-15; 07-18-17; 07-17-18; 07-21-20
Date Revised: 07-19-22

Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Data**
Subject:	**Collection, Review, Public Report, and Retention**
Related Standards:	
O.A.C.	**None**
A.C.A.	**3-JCRF-4D-04-10**
P.R.E.A.	28 CFR §115.371 (j) §115.387 (a)(b)(c)(d)(f) §115.388 (a)(1)(2)(3)(b)(c)(d) §115.389 (a)(b)(c)(d)

1.0 Purpose

To ensure a process is in place for data collection using standardized instrument, set definitions, and reviews.

2.0 Persons Affected

All employees

3.0 Policy

The facility shall collect accurate and uniform data for every allegation of sexual abuse using a standardized instrument and set definitions. Data collected shall be reviewed annually and as needed to improve effectiveness of sexual abuse prevention, detection, and response policies, practices, and training. All data collected shall be securely retained pursuant to law.

4.0 Definitions/Documents

None.

5.0 Responsibility

5.1 The Compliance Coordinator is responsible for the following:

a. Maintaining, reviewing and collecting date from all documents including reports, investigations and incident reviews.
b. Completing the Survey of Sexual Violence based upon the data from the previous year and making the report available at the request of the Department of Justice.
c. Reviewing aggregate date to assess and improve effectiveness of the sexual abuse prevention, detection, and response policies, practices and training.
d. Retaining data for at least ten (10) years after the date of collection.

6.0 Procedures

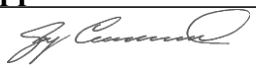
6.1 The agency shall collect accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set definitions. The facility shall aggregate the incident-based sexual abuse data at least annually. The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The facility shall maintain, review and collect data from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Upon request, the facility shall provide all data obtained from the previous year to the Department of Justice no later than June 30.

6.2 The facility shall review the aggregate data collected in order to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training including identifying problem areas, taking corrective action on an ongoing basis, and preparing an annual report of its findings and corrective actions for the facility. The report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the facility's progress in addressing sexual abuse. The facility report shall remove all personal identifiers, be approved by the agency head and made available to the public through its Website. The facility shall redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

6.3 Data collected concerning allegations of sexual abuse shall be securely retained for at least ten years after the date of its initial collection unless Federal, State, or local law requires otherwise.

6.4 All written reports of the investigation shall be retained as long as the alleged abuser is incarcerated or employed by the facility, plus five years unless the abuse was committed by a juvenile residents and applicable law requires a shorter period of retention.

7.0 Document Approval

Signature: 

8.0 Review History

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Perry Multi-County Juvenile Facility	
Chapter: 6.0	**PREA**
Section:	**Audits**
Subject:	**Auditing and Corrective Actions**
Related Standards:	
O.A.C.	**None**
A.C.A.	**None**
P.R.E.A.	28 CFR §115.393

1.0 Purpose

To ensure oversight of the facility through cooperation with auditing agencies or individuals.

2.0 Persons Affected

All employees

3.0 Policy

The Perry Multi-County Juvenile Facility will comply with PREA standards and cooperate with PREA audits conducted by the Ohio Department of Youth Services, Department of Justice, and/or American Correctional Accreditation Audits.

4.0 Definitions/Documents

None

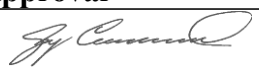
5.0 Responsibility

5.1 The Director and all facility employees are responsible for cooperating with facility audits.

6.0 Procedures

6.1 The facility shall work with all auditing personnel to ensure compliance with PREA standards.

7.0 Document Approval

Signature: 

8.0 Review History

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Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile Facility	
Chapter: 3.0	**Facility Operations**
Section:	**Supervision**
Subject:	**Response to Resistance Chart**
Related Standards:	
O.A.C.	**5139-36-10(A)(B)(1)(2)(3)(C)(1)(2)**
A.C.A.	**3-JCRF-3A-02 Revised August 2000 (Mandatory)**
P.R.E.A.	**None**

Definitions/Documents
Attachment Appendix A: General Guide for Response to Resistance

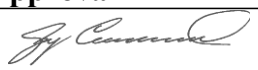
Appendix B Response to Resistance Chart
The following chart is meant as a general guide for staff control or physical response:

Behavior Level 1 Frustration	Resident Actions	Staff Response
-Body languag indicates residen is upset -Resident may b experiencing fre floating anxiety -Resident bod language ma reveal a need fo power	1. Physically clenching fists, grinding teeth, jaw ticks, and/or cracking knuckles. 2. Verbally Questioning a. Information Seeking b. Challenging 3. Release: Resident looks upset 4. Refusals	1. Use empathetic response. 2-way non-emotional communication. 2. Verbally Questioning a. Answer questions b. Ignore and redirect challenges 3. Release a. Isolate from peer group b. Allow to vent 4. Refusals a. Set clear, simple, reasonable limits b. If (+) then this will Happen, if (-) then this will happen. c. Follow through and enforce consequences.
Behavior Level 2 Rage **Passive Physical Resistance** -Resident is angry and out-of-focus	1. Resident is physically not complying. He does not attempt to defeat actions, but staff must employ physical maneuvers to establish control. 2. Verbal directions and soft touch has failed. 3. Resident pulls away but does not strike or	At this point, verbal means of managing the situation have been exhausted. Choices an consequences have failed to gain a cooperativ response. The resident is not responding t reason. Resident should be isolated from audience….other residents in lock-down. Assistance should be gained with a team leade assigned: Person with the most rapport wit the resident. Team leader should assess the situation, plan

	move aggressively 4. Face may have turned red and then white, tense jaw, tight lower lip, furrowed eyebrow and fixed stare. 5. May be very vocal including threats to staff or others	the intervention, direct the intervention and talk afterward (give time to cool off) Transport – Staff may use techniques to contro and move resident to isolation cell. Take Downs – Staff may use techniques o redirect resident, in controlled manner, in orde to limit physical resistance and apply restrain devices. Mechanical Restraints – Staff may use tools t restrict movement.
Behavior Level 3 Aggression **Active Physical Resistance** -Resident makes overt hostile, attacking movement which may cause injury but not likely to cause death or great bodily harm. **Aggravated Physical Resistance** -Resident makes overt hostile attacking movement with or without a weapon with the intent to cause death or great bodily harm to staff or others -This includes spitting, throwing feces or urine, and minor property destruction.	**Active Physical Resistance** Watch the hands. 1. Resident is showing a total loss of control or physical acting out 2. Resident is striking out at staff and/or moving aggressively **Aggravated Physical Resistance** 1. Resident is attempting to attack staff with the intent to cause death o great bodily harm.	At this point, staff must employ safe, non-injurious defensive tactics. **Active Physical Resistance** May use all previous responses following Managing Youth Resistance Training **Aggravated Physical Resistance** May use all previous responses following Managing Youth Resistance training. Staff should attempt to isolate the resident and call 911 for assistance. The director shall be immediately notified of the situation when safely possible.

There is a period of tension reduction after a physical incident where the resident is regaining rationality after physically acting out. Residents may show signs of fear, remorse, and loss of memory. This is a time to establish a therapeutic rapport by restarting the communication process. Staff that have a good relationship with the resident or were not involved in the incident should find out what happened, listen, and suggest a more mature mode of behavior. This is a time to give control back to the resident. If able, the resident should fill out conflict forms and/or write in their journal as able.

7.0 Document Approval

Signature: 

8.0 Review History

Date Issued: 04-16-13 Prior Date Effective: 06-19-15: 07-18-17 Date Revised: 07-17-18	Date Reviewed: 07-17-18; 07-16-19; 07-21-20; 07-20-21; 07-19-22; 07-18-23

Perry Multi-County Juvenile
Facility Tour
Sign-In Sheet

Date: _____ **Time:** _____ **Group Information:** _____

Prior Appointment made for tour? □ Yes □ No **If yes, when?** _____

Group Time In: _____ **Group Time Out:** _____

General Confidentiality Statement:

While taking this tour, I understand that I may recognize the name or face of a juvenile residing in the facility. I shall respect the privacy of each juvenile served and hold in confidence any information obtained. I further understand that I could be subject to legal action for violations of confidentiality and indicate my agreement by signing this sheet.

Signature and Date