



Oregon

Kate Brown, Governor

Department of Human Services

Office of the Director

500 Summer St. NE, E-15

Salem, OR 97301

Voice: 503-945-5600

Fax: 503-581-6198

**Legislative Report
Department of Human Services
Substantiated Investigation Quarterly Report
to Interim Legislative Committees on Child Welfare**

Reporting period: April 1, 2018 to June 30, 2018

Report date: September 21, 2018

Senate Bill 1515, effective April 4, 2016 following the 2016 Regular Legislative Session, directs the Department of Human Services (DHS) to submit a quarterly report to the interim legislative committees on Child Welfare. Section 58 of the bill prescribes an effective date of July 1, 2016 for certain parts of the bill, including Section 38 which contains the quarterly reporting provision.

Senate Bill 243, effective August 15, 2017 following the 2017 Regular Legislative Session (the section of the bill pertaining to reports was operative January 1, 2018), directs DHS to also submit a quarterly report to the interim legislative committees on Child Welfare regarding substantiated reports of abuse regarding DHS certified foster homes (Child Welfare and Office of Developmental Disabilities Services certified foster homes) and developmental disabilities residential facilities (Office of Developmental Disabilities Services licensed group homes).

The quarterly reports are for the purposes of legislative and public review and oversight of the quality and safety of providers that are licensed or certified by DHS to provide care or services for children in care.

The following report represents data from Child Caring Agencies (CCAs), Child Welfare (CW) certified foster homes, Office of Developmental Disability Services (ODDS) certified foster homes and ODDS licensed group homes in the second quarter of 2018, April 1 through June 30.

DHS is working on a comprehensive approach to analysis of the data within the SB 1515 and SB 243 reports that we are submitting in order to identify and respond to systemic issues or trends. A summary of that approach will be included in the next report.

The data is separated by provider type for clarity.

Related to Child Caring Agencies: information provided in this report contains:

- The name of any child-caring agency or proctor foster home where the department conducted an investigation pursuant to section where the department conducted an investigation pursuant to section 37, chapter 106, Oregon Laws 2016, that resulted in a finding that the report of abuse was substantiated during that quarter;
- The approximate date that the abuse occurred;
- The nature of the abuse and a brief narrative description of the abuse that occurred;
- Whether physical injury, sexual abuse or death resulted from the abuse; and
- Corrective actions taken or ordered by the department and the outcome of the corrective actions.

Time Period: Child Caring Agency (CCA)/Child Caring Provider (CCP) Abuse Reports Closed from April 1, 2018 through June 30, 2018

Summary: 8 Office of Training, Investigations and Safety (OTIS)(formerly known as Office of Adult Abuse Prevention and Investigations (OAPPI)) investigations with 13 substantiated allegations

Note:

- *Reports beginning with ‘CCP’* were investigated using the pre-SB 1515 abuse definitions and standard of proof for substantiation (preponderance of the evidence).
- *Reports beginning with ‘CCA’* were investigated using the post-SB 1515 abuse definitions and standard of proof for substantiation (reasonable basis to believe abuse occurred).
- The outcome of the following reports could change upon appeal.

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA180019 Allegation A	Morrison Center	01/13/2018	Yes- Physical Injury
Nature of Abuse and Brief Narrative: One allegation of neglect as defined in ORS 418.257(1)(b), ORS 418.257(11) and (12) and OAR 407-045-0887(3)(d)(A) was substantiated against Morrison Center- SAGE for failing to provide appropriate supervision after a youth was discharged from the hospital due to a suicide attempt and continued suicidal ideation. The lapse in supervision resulted in the youth self-harming which required them to be hospitalized again.		Corrective Actions Taken or Ordered by the Department, and Outcome: Following the incident Morrison reviewed and updated its protocols and tools for assessing suicide risk and its policies and practices related to prevention of suicide and self-harm. Staff at all levels were re-trained in these areas and in overall client safety and supervision protocols. The investigation into the incident revealed issues with communication that contributed to a lapse in supervision, and in response Morrison retrained staff on communication protocols with an emphasis on communication and decision-making in crisis situations. Additionally, Morrison conducted an assessment of their physical environment to identify objects that could potentially be used for self-harm, and identified items have been removed.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA180031 Allegation A Allegation B	Integral Youth Services	July-October 2017	Yes- Sexual Abuse
Nature of Abuse and Brief Narrative: Two allegations of sexual abuse as defined in ORS 418.257(1)(e) and (h), ORS 418.257(13), (14), and (15) and OAR 407-045-0887(3)(f)(A) were substantiated against a specific staff involving two youth. The staff exposed the youth to sexually explicit		Corrective Actions Taken or Ordered by the Department, and Outcome: It was determined that the identified employee had been trained in appropriate boundaries and conduct and chose to violate agency policy. Integral Youth Services placed the employee on leave upon learning of the allegations, and her	

photographs and sexualized conversation while working at the program which made the youth feel uncomfortable.		employment was terminated shortly thereafter.		
Report/ Allegation				
Provider		Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?	
CCA180043 Allegation A		Redemption Ridge: Grace House	12/01/2017	No
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:		
One allegation of neglect defined in ORS 418.257(1)(b), ORS 418.257(11) and (12) and OAR 407-045-0887(3)(d) was substantiated against Redemption Ridge: Grace House for the provider's failure to provide timely medical care to a youth after they sustained a concussion.		Through an Imposition of License Conditions, the Department is requiring Redemption Ridge to: <ol style="list-style-type: none"> 1. Train or retrain all employees on mandatory child abuse reporting. 2. Develop and Demonstrate Quality Assurance Related to Medication Management. 3. Develop and Demonstrate Quality Assurance Related to Medical Care and Emergencies. 4. For 60 days send all Medication Administration Records to the Department and demonstrate full transparency and cooperation in reporting all medication errors with an explanation of how the error occurred, how it has been addressed, and how similar errors will be avoided in the future. While this investigation was still in process Redemption Ridge received consultation from a RN, reviewed policies and forms related to medication management, and hired staff experienced in medication management processes. Following the completion of this investigation Redemption Ridge hired a new Executive Director.		
Report/ Allegation				
Provider		Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?	
CCA180051 Allegation A		Morrison Center	3/13/2018	No
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:		

<p>One allegation of neglect defined in ORS 418.257(1)(b), ORS 418.257(11) and (12) and OAR 407-045-0887(3)(d) was substantiated against a specific staff for assisting a youth, who eloped from the program, cross state lines to placing the youth in potentially unsafe situations.</p>		<p>It was clear from interviews conducted during the investigation that employees at the facility, including the employee who was the subject of the investigation, received training on appropriate conduct and proper boundaries with program residents. The employee willfully disregarded the agency's training and policies. Morrison Center placed the employee on leave immediately after learning of the situation, and the employee resigned from her position shortly thereafter.</p>	
<p>Report/ Allegation</p>	<p>Provider</p>	<p>Approximate Date Abuse Occurred</p>	<p>Did physical injury, sexual abuse or death result?</p>
<p>CCA180067 Allegation A</p>	<p>Redemption Ridge: Grace House</p>	<p>3/22/2018-3/27/2018</p>	<p>No</p>
<p>Nature of Abuse and Brief Narrative:</p> <p>One allegation of neglect defined in ORS 418.257(1)(b), ORS 418.257(11) and (12) and OAR 407-045-0887(3)(d) was substantiated against Redemption Ridge: Grace House for the provider's failure to properly implement and train staff on a medication management system which resulted in a youth receiving an overdose of Adderall for six days.</p>		<p>Corrective Actions Taken or Ordered by the Department, and Outcome:</p> <p>Through an Imposition of License Conditions, the Department is requiring Redemption Ridge to:</p> <ol style="list-style-type: none"> 1. Train or retrain all employees on mandatory child abuse reporting. 2. Develop and Demonstrate Quality Assurance Related to Medication Management. 3. Develop and Demonstrate Quality Assurance Related to Medical Care and Emergencies. 4. For 60 days send all Medication Administration Records to the Department and demonstrate full transparency and cooperation in reporting all medication errors with an explanation of how the error occurred, how it has been addressed, and how similar errors will be avoided in the future. <p>While this investigation was still in process Redemption Ridge received consultation from a RN, reviewed policies and forms related to medication management, and hired staff experienced in medication management processes. Following the completion of this investigation Redemption Ridge hired a new Executive Director.</p>	

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA180078 Allegation A Allegation B Allegation C	Looking Glass: Stepping Stone	04/15/2018	No
Nature of Abuse and Brief Narrative: Three allegations of neglect defined in ORS 418.257(1)(b), ORS 418.257(11) and (12) and OAR 407-045-0887(3)(d) were substantiated against a specific staff for sleeping while they were required to supervise three youth while on a community outing placing the youth at risk due to their history of misconduct, risky behaviors and mental health needs.		Corrective Actions Taken or Ordered by the Department, and Outcome: Looking Class Community Services immediately terminated the identified employee upon learning of the situation and the employee's failure to follow established supervision protocols.	
<hr/>			
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA180092 Allegation A Allegation B	Greater Oregon Behavioral Healthcare Inc	March/April 2018	Yes- Sexual Abuse
Nature of Abuse and Brief Narrative: Two allegations of sexual abuse as defined in ORS 418.257(1)(e) and (h), ORS 418.257(13), (14), and (15) and OAR 407-045-0887(3)(f)(A) were substantiated against two adult children of GOBHI foster parents to a youth placed in the home. The respondents were approved by GOBHI to babysit and supervise the youth placed in the foster home. Both respondents were criminally charged with Sexual Abuse in the 3 rd degree.		Corrective Actions Taken or Ordered by the Department, and Outcome: All contact between the identified young adult daughters of the foster parents and youth in the care of the foster parents ceased immediately after the situation came to light. A formal safety plan was worked out between DHS, GOBHI and the foster parents shortly thereafter under which it was agreed that the two adult daughters of the GOBHI foster parents would not be in the foster home and would not have any contact with foster youth going forward, and GOBHI would conduct announced and unannounced visits to the foster home on an on-going basis. The safety plan remains in effect at this time.	
<hr/>			
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA180112 Allegation A Allegation B	Redemption Ridge	05/27/2018	No

Allegation C			
<p>Nature of Abuse and Brief Narrative:</p> <p>Three allegations of neglect defined in ORS 418.257(1)(b), ORS 418.257(11) and (12) and OAR 407-045-0887(3)(d) were substantiated against a specific staff for failing to provide required supervision to three youth while on a community outing by leaving them alone in a running car with access to the respondent's phone, purse, and marijuana that was kept in the car's center console.</p>		<p>Corrective Actions Taken or Ordered by the Department, and Outcome:</p> <p>Redemption Ridge placed the identified employee on leave immediately upon learning of the incident, and the employee resigned from her position shortly thereafter.</p>	

Related to Child Welfare certified foster care and relative caregiver providers: Information provided in this report contains:

- The number of allegations (children) for each report and type of allegation (Neglect, Physical Abuse, Sexual Abuse, and Threat of Harm)
- Name of the county (provided that there are five or more certified foster homes in the county) where DHS conducted an investigation pursuant to section 37, chapter 106, Oregon Laws 2016,
- The approximate date the abuse occurred;
- The nature of the abuse and a brief narrative description of the abuse that occurred;
- Whether physical injury, sexual abuse or death resulted from the abuse; and
- Corrective actions taken or ordered by the DHS and the outcome of the corrective actions

Time Period: Child Welfare certified foster home abuse reports substantiated from April 1, 2018 through June 30, 2018. Reports may have been received prior to the reporting period.

Summary: 7 reports were substantiated in Child Welfare certified foster homes (this includes certified relative caregivers).

Note: There were 4,663 Child Welfare certified foster care providers who held a Certificate of Approval in the time period 4/1/2018-6/30/2018.

Explanation of terms: Although every applicant who applies to become a certified family for Child Welfare must be assessed and approved under the same set of rules and procedures, there are different types of certificates.

- *General Certificate of Approval:* Issued to individuals who do not have a previous relationship with a child in care and are applying to become foster parents for the general foster child/young adult population.
- *Child Specific Certificate of Approval:* Issued to individuals to provide care for a specific child/young adult, including relatives of the child/young adult or others who know the child or family of the child needing placement.
- *ICPC (Inter State Compact for the Placement of Children):* A case where a state requests Child Welfare assess and certify a home for placement of a specific child from their state.

- *Inactive referral status:* A designation given to a foster home or relative caregiver home where no additional children may be placed in the home.

Report ID	Allegations (Number of Children)	County	Approximate Date Abuse Occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
3028311	Neglect(1)	DESCHUTES	4/4/2018	Substantiated for Neglect of the foster child by the foster father. Foster father failed to provide adequate supervision due to the foster child's mental health needs.	No	General Applicant foster home. Child moved from home, no additional children placed in the home. After meetings with the family and their attorney, the family did not apply for a renewal, home will close as of 7/31/2018.
3004662	Threat Of Harm(5)	POLK	4/15/2018	Substantiated for Threat of Harm against foster father for physically assaulting his significant other while she was holding their 2-year-old child. The foster children were present in the	No	General Applicant foster home. Child moved from home, no additional children placed in the home. Home was closed 6/15/2018.

				home when the incident occurred and disclosed five additional physical altercations between the foster parents.		
3022012	Physical Abuse(3), Threat Of Harm(1)	Yamhill	5/16/2018	Substantiated for Physical Abuse of three foster children by foster parents. All of the foster children made disclosures of both experiencing physical abuse and witnessing the physical abuse of the other children.	Yes	General Foster Home. Children moved from home. Home is placed on "inactive referral status" meaning no additional children may be placed in the home. Further certification action pending completion of Founded appeal process.
3017416	Neglect(2)	Tillamook	5/4/2018	Substantiated for Neglect of the foster children by their relative foster mother/ paternal grandmother. Foster mother and the children's aunt engaged in a physical altercation in the presence of the children after	Yes	Child Specific Foster home. Child was moved from the home, certification closed 5/18/2018.

				the aunt expressed concern regarding their care. The children were frightened and one was scratched on the neck during the incident. The aunt left the home with the children and the grandmother pursued in her motor vehicle while under the influence, resulting in her losing control and crashing the car.		
3033575	Neglect(1)	Jefferson	6/8/2018	Substantiated for Neglect of foster child by foster mother due to verbal abuse. Comments made by the foster mother in the presence of the foster child were perceived to be derogatory, negative and	No	General applicant foster home. Child was moved and no children are placed in the home. Pending further certification action, the foster home is on inactive referral status, meaning no additional children may be placed in the home.

				detrimental to the child's mental health.		
3022637	Physical Abuse(1)	Douglas	5/18/2018	Substantiated for Physical Abuse of foster child by foster father. Foster father struck the child in the back of the head during an argument. The child suffered injuries on the back of the head/neck in the form of redness, swelling and tenderness.	Yes	Child Specific Foster Home. Children moved from placement, certification closed 6/27/2018.
2999538	Neglect(2)	Polk	4/9/2018	Substantiated Neglect of foster children by foster parents due to their allowing the children's mother to come into the foster home and allowed the children to spend the night with their mother, despite strict	No	Child Specific certification. Children moved from home and certification closed 5/1/2018.

				guidelines around visitation. The children also found inappropriate videos on the foster father's cell phone, making them uncomfortable in the placement.		
--	--	--	--	---	--	--

Related to developmental disabilities certified foster care:

During this reporting period, there was one substantiated report in ODDS certified foster care.

Report ID	Allegations (Number of Children)	County	Approximate Date Abuse Occurred	Nature of abuse and brief narrative	Did physical injury, sexual abuse or death result?	Corrective actions taken or ordered by the department, and outcome
2994602	Physical Abuse(1)	Multnomah	4/2/2018	Substantiated for Physical Abuse of the foster child by foster father. Foster child has been identified as having developmental delays and mental	No	ODDS issued a condition of Inactive Referral status on 06.13.2018; no children living in the CFH; Provider is appealing the founded CW allegation of abuse.

				health concerns and while tantruming, the foster father yelled at the child to stop. When the child did not comply, the foster father intentionally hit the foster child on his ear, causing pain.		
--	--	--	--	--	--	--

Related to developmental disabilities residential facilities (Office of Developmental Disabilities Services (ODDS) licensed group homes). Information provided in this report contains:

- The name of any ODDS licensed group home where DHS conducted an investigation pursuant to section 37, chapter 106, Oregon Laws 2016,
- The approximate date the abuse occurred;
- The nature of the abuse and a brief narrative description of the abuse that occurred;
- Whether physical injury, sexual abuse or death resulted from the abuse; and
- Corrective actions taken or ordered by the DHS and the outcome of the corrective actions

Time Period: ODDS licensed group home abuse reports substantiated from April 1, 2018 through June 30, 2018. Reports may have been received prior to the reporting period.

Summary: 54 Office of Training, Investigations and Safety (OTIS) (formerly known as the Office of Adult Abuse Prevention and Investigations (OAPPI)) investigations with 23 substantiated allegations.

Explanation of terms:

- OTIS is responsible for investigating allegations of abuse or neglect in a child-caring agency, proctor foster home, or developmental disabilities residential facility. Child Welfare is responsible for investigating allegations of abuse or neglect in certified foster homes.
- The outcome of the following reports could change upon appeal

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD180016 Allegation B	Work Unlimited, Inc.	02/01/2018	No
Nature of Abuse and Brief Narrative: One allegation of wrongful restraint as defined in ORS 418.257 and OAR 407-045-0887 was substantiated against a specific staff as that staff wrongfully placed the youth in an unapproved restraint. Other staff present stated the youth was not being unsafe and did not warrant such an aggressive approach. Staff were concerned this could have caused physical injury to the youth and attempted to intervene. The respondent was terminated.		Corrective Actions Taken or Ordered by the Department, and Outcome: The Agency terminated the respondent and retrained employees. No licensing action taken by the Department.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18038 Allegation A/B	Center for Continuous Improvement, Inc.	03/25/2018	No
Nature of Abuse and Brief Narrative: Two allegations of neglect as defined in ORS 418.257 and OAR 407-045-0887 were substantiated against a specific staff for failing to properly supervise two youth which allowed opportunity for one of the youth to act out sexually toward the other.		Corrective Actions Taken or Ordered by the Department, and Outcome: The two respondents were moved to work in an adult group home pending the completion of the investigation. After the substantiated finding, one respondent was terminated. The other was suspended until she was cleared to work by the Background Checks Unit. She was cleared to work. The Agency retrained her and she is currently working at an adult group home.	

			Department issued a \$2,000 civil penalty to the agency.
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18045 Allegation B/C	Cornerstone Valley	04/10/2018	No
Nature of Abuse and Brief Narrative: One allegation of wrongful restraint as defined in ORS 418.257 (1)(j) and OAR 407-045-0887 and one allegation of verbal abuse as defined in ORS 418.257 (1)(16)(a)(b) and OAR 407-045-0887 were substantiated after a specific staff became aggressive with a youth, cornered him in the bathroom, placed him in an inappropriate hold, and was yelling obscenities at the youth causing the youth to be fearful.		Corrective Actions Taken or Ordered by the Department, and Outcome: The respondent was immediately suspended and then shortly after being suspended was terminated from the program. The Department issued a \$1,000 civil penalty to the agency.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18049 Allegation A	Albertina Kerr Centers	04/13/2018	No
Nature of Abuse and Brief Narrative: One allegation of wrongful restraint as defined in ORS 418.257 (1)(j) and OAR 407-045-0887 was substantiated against a specific staff after staff engaged in a power struggle with a youth which led to the staff dragging the youth on the ground by his ankle to his room.		Corrective Actions Taken or Ordered by the Department, and Outcome: The respondent was suspended at the time of the incident and then terminated following the completion of the investigation. The Department issued a \$500 civil penalty to the agency.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18051 Allegation A	Center for Continuous Improvement	04/15/2018	No
Nature of Abuse and Brief Narrative: One allegation of neglect as defined in ORS 418.257 and OAR 407-045-0887 after a specific staff failed to lock the kitchen door and failed to supervise a youth during medication distribution resulting in the youth entering the kitchen and ingesting another youth's medications that were left on the kitchen counter. After being taken to the emergency department for treatment it was		Corrective Actions Taken or Ordered by the Department, and Outcome: The respondent was immediately terminated. The Department Issued a \$500 civil penalty to the agency.	

reported by the physician assistant these medications could have caused the youth to go in to a coma or it could have been fatal.			
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18052 Allegation A/B/E/F	Center for Continuous Improvement, Inc.	04/13/2018	Yes, one youth sexually offended a second youth
Nature of Abuse and Brief Narrative: Four allegations of neglect as defined in ORS 418.257 and OAR 407-045-0887 after two specific staff failed to provide the designated supervision to two youth, during which time one of the youth sexually offended the second youth.		Corrective Actions Taken or Ordered by the Department, and Outcome: ODDS contacted the Director of the Agency to ensure that the child who had offended received line of sight supervision at all times. All employees were retrained on the importance of constant supervision. The team is currently in the process of identifying another placement option for the child who offended. The Department issued a \$2,000 civil penalty to the agency.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18053 Allegation A/B	Albertina Kerr Centers	02/24/2018 (Reported 04/13/2018)	No
Nature of Abuse and Brief Narrative: Two allegations of wrongful restraint as defined in ORS 418.257 (1)(j) and OAR 407-045-0887 were substantiated against two specific staff after placing a youth in an unauthorized restraint which could have resulted in injury to the youth.		Corrective Actions Taken or Ordered by the Department, and Outcome: The respondents were separated and worked different shifts at the group home. Neither respondent worked with the victim. Following the completion of the investigation both respondents were terminated. The Department issued a \$1,000 civil penalty to the agency. Agency appealed the penalty; scheduling informal conference with the agency.	
Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18064 Allegation A/B/C	Albertina Kerr Centers	05/05/2018	No
Nature of Abuse and Brief Narrative:		Corrective Actions Taken or Ordered by the Department, and Outcome:	

<p>One allegation of neglect as defined in ORS 418.257 and OAR 407-045-0887 against a specific staff, one allegation of physical abuse as defined in ORS 418.257(1)(a) and (d), and OAR 407-045-0887(3)(e) and one allegation of verbal abuse as defined in ORS 418.257(1)(f) and OAR 407-045-0887(3)(g) both against an unknown staff after a youth reported two staff picked him up after he ran from the program. The youth stated the identified female staff allowed the unidentified male staff to physically and verbally assault him while in the vehicle at which point the youth jumped out of the vehicle and again ran from staff. The identified staff refused to provide information as to the unidentified male seen on video in the vehicle.</p>	<p>The respondent was immediately suspended and soon after they resigned.</p> <p>Department issued a \$1500 civil penalty; sent out 8/1/18.</p>
--	---

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18072 Allegation A/B/C/C	Albertina Kerr Centers	05/10/2018	No

<p>Nature of Abuse and Brief Narrative:</p> <p>Four allegations of neglect as defined in ORS 418.257 and OAR 407-045-0887 after the only staff present at the house during graveyard shift left the home for several hours resulting in the four youth being unsupervised for a significant period of time. One of the youth contacted the program manager, who responded and terminated the employee when the staff returned to the home.</p>	<p>Corrective Actions Taken or Ordered by the Department, and Outcome:</p> <p>The respondent was immediately terminated.</p> <p>The Department issued a \$2,000 civil penalty to the agency. Agency appealed; informal conference being scheduled with the agency</p>
---	--

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CDD18076 Allegation A	Work Unlimited, Inc.	05/14/2018	No

<p>Nature of Abuse and Brief Narrative:</p> <p>One allegation of wrongful restraint as defined in ORS 418.257 (1)(j) and OAR 407-045-0887 was substantiated against the program manager after placing a youth in an unauthorized and unapproved hold which may have resulted in physical injury to the youth.</p>	<p>Corrective Actions Taken or Ordered by the Department, and Outcome:</p> <p>The respondent was terminated.</p> <p>Issued a \$500 Civil Penalty.</p>
--	--

Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
---------------------------	-----------------	--	---

SC18004 Allegation A	Stabilization and Crisis Unit	03/14/2018	No
<p>Nature of Abuse and Brief Narrative:</p> <p>One allegation of neglect as defined in ORS 418.257 and OAR 407-045-0887 was substantiated against a specific after management found this staff failing to provide the designated supervision to a youth with a seizure protocol placing the youth at risk.</p>		<p>Corrective Actions Taken or Ordered by the Department, and Outcome:</p> <p>The Agency terminated the respondent and retrained staff.</p> <p>No action taken by the Department.</p>	