Report/ Allegation	Provider	Approximate Date Abuse Occurred	Did physical injury, sexual abuse or death result?
CCA220008 (4 allegations)	Morrison Center	01/2022	No
Nature of Abuse and Brief Narrative: Four allegations of Neglect were substantiated toward one staff member, when they failed to provide adequate supervision to four youth placed in the program. These failures included providing the youth with vape pens, engaging with the youth outside the program by taking them to the staff's personal home, and providing them with substances and phone access. The youth have significant risk factors and when the staff allowed them to access the community, they were placed at significant risk of harm.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** When the allegations came to light, the identified employee was placed on administrative leave, and her employment was subsequently terminated.	
Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA220029	Morrison Center	01/2022	No
Nature of Abuse and Brief Narrative: One allegation of neglect was substantiated against a staff member when they allowed the child to use their personal cell phone. This led to the child being in contact with someone who had previously abused them and placed their safety at risk.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** The identified staff member's employment had been terminated prior to this report of neglect due to other concerns about the staff member's lack of professional boundaries with the youth in the program.	
Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA220050 (2 allegations)	Trillium	04/2022	No
Nature of Abuse and Brief Narrative: Two staff members were substantiated for wrongful restraint of a child when it was determined the staff members used an unauthorized supine restraint to physically intervene.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Since the time of this incident, Trillium has worked to better educate Trillium personnel on the parameters surrounding the use of physical restraints as a behavior intervention, including the prohibition against the use of supine restraint, which applies to most, but not all facilities operated by Trillium. One of the two	

		identified employees is no longer employed at Trillium. The other employee continues to be employed at Trillium after undergoing a new background check and fitness determination conducted by the ODHS Background Check Unit, which considered the substantiated report of wrongful restraint.	
Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA220066	Trillium	05/2022	No
Nature of Abuse and Brief Narrative: One staff member was substantiated for Involuntary Seclusion when it was found the staff failed to provide the youth with adequate access to the bathroom while placed in seclusion. The child was in seclusion for over 90 minutes and requested to use the bathroom, which was not offered.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Since the time of this incident, Trillium has worked to better educate Trillium personnel on the parameters surrounding the use seclusion as a behavior intervention. The identified employee resigned from his position prior to the conclusion of the investigation.	
Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA220083	Maple Star Oregon	06/2022	No
Nature of Abuse and Brief Narrative: The foster parent was substantiated for neglect toward one child in care, after determining the foster parent continually misgendered the youth. This behavior continued after the foster parent received training from the program, and they continued to ignore the youth's needs. This led to the youth having thoughts of self-harm and disrupting from the placement.		**Corrective Actions Taken or Ordered by the Department, and Outcome:** Prior to the report that gave rise to the investigation, and prior to the identified youth being placed in the foster parent's home, Maple Star personnel had coached and trained the identified foster parent on her interactions with foster children. When concerns arose shortly after the youth's placement, Maple Staff moved the youth to a different Maple Star foster home. When the investigation concluded, Maple Star terminated the foster parent's certification.	

Oregon DHS Children's Care Licensing Program
Restraint and Involuntary Seclusion Report

Reporting time frame (indicate which quarter in months and year):	07-01-2022 / 09-30-2022
The total number of restraints used in programs that quarter.	1153
The total number of programs that reported the use of restraints of children in care that quarter.	31
The total number of individual children in care who were placed in restraints by programs that quarter.	150
The number of reportable injuries to children in care that resulted from those restraints.	137
The number of incidents in which an individual who was not appropriately trained in the use of restraint performed a restraint on a child in care in a program.	4
The number of incidents that were reported for potential inappropriate use of restraint.	69