Oregon Department of Human Services

Oregon DHS Children's Care Licensing Program
Child Caring Agency Leg Report

Report/ Allegation	**Provider**	**Approx. Incident Date**	**Abuse type**	**Did phys. injury, sexual abuse or death result?**
CCA230092	Morrison Center	Multiple	Sexual Abuse	Yes-Sexual abuse
Nature of Abuse and Brief Narrative:		**Corrective Actions Taken or Ordered by the Department, and Outcome:**		
One allegation of Sexual Abuse was substantiated on a staff after that staff engaged in a pattern of grooming behavior with a child in care which led to the staff kissing and fondling the youth.		Morrison center personnel were not aware of the reported abuse until after the identified youth has discharged from the program. The situation came to light after other youth still in care at Morrison reported it to staff. Once the program was made aware, the identified employee was not scheduled to work again, and her employment was subsequently terminated while the ODHS investigation was still in process.		

Report/ Allegation	**Provider**	**Approx. Incident Date**	**Abuse type**	**Did phys. injury, sexual abuse or death result?**
CCA240061	Janus Youth Programs - Cordero House	Multiple	Sexual Abuse	Yes - Sexual abuse
Nature of Abuse and Brief Narrative:		**Corrective Actions Taken or Ordered by the Department, and Outcome:**		
One allegation of Sexual Abuse was substantiated on a staff after that staff had sexual contact with a youth placed in the program, assisted that youth in eloping and is believed to have taken the youth to California where they remain.		Janus Youth Program's management and staff were not aware of the reported abuse until after the identified youth had left the program. The identified staff person's employment has been terminated, and a warrant has been issued for her arrest. Janus has updated its policies to place limits on staff being alone with program residents.		

Report/ Allegation	**Provider**	**Approx. Incident Date**	**Abuse type**	**Did phys. injury, sexual abuse or death result?**
CCA240075	St. Marys Home	Multiple	Neglect	No
Nature of Abuse and Brief Narrative:		**Corrective Actions Taken or Ordered by the Department, and Outcome:**		
Three allegations of Neglect were substantiated against the program after multiple incidents of sexual contact among three youth were discovered. These incidents occurred on multiple days, times and shifts when several different staff were responsible for providing supervision to the youth. It was determined a lack of training and written policy were the root cause of these incidents occurring rather than specific staff negligence.		ODHS followed up with St. Mary's management, and management has indicated that the program has provided re-training and coaching on established and long-standing supervision protocols designed to prevent incidents like the one that resulted in a substantiation of the reported neglect in this case. Management determined that staff deviated from the protocols they were trained on. In addition to the retraining and coaching that occurred afterwards, St Mary's has made adjustments to its training curriculum for new employees to better emphasize the elements of the established supervision protocol that staff failed to adhere to.		

Report/ Allegation	**Provider**	**Approx. Incident Date**	**Abuse type**	**Did phys. injury, sexual abuse or death result?**
CCA240087	Albertina Kerr Centers	7/1/2024	Neglect	No
Nature of Abuse and Brief Narrative:		**Corrective Actions Taken or Ordered by the Department, and Outcome:**		
One allegation of Neglect was substantiated against the program after a youth was discovered to have collected and hid medications for a period of two weeks with a plan to complete suicide. Multiple staff members failed to perform through checks of the youth's room allowing the youth to continue hoarding the medication.		In following up with Albertina Kerr after the incident that gave rise to the substantiated report of neglect, it was determined that the program was not strictly adhering to its own established policies and protocols regarding room-searches, both in terms of the required frequency of searches and in terms of the thoroughness of searches. Staff were re-trained on the requirements. ODHS conducted a subsequent unannounced visit to the site, and program documentation reflected improved performance in this area. ODHS also made suggestions about potential changes to the program's room-search protocols that may lead to more consistent adherence long term. ODHS will continue to monitor the program's performance in this area.		

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Restraint and Involuntary Seclusion Report

Reporting time frame (indicate which quarter in months and year):	July, August, September 2024
The total number of restraints used in programs that quarter.	1848
The total number of programs that reported the use of restraints of children in care that quarter.	37
The total number of individual children in care who were placed in restraints by programs that quarter.	168
The number of reportable injuries to children in care that resulted from those restraints.	382
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.	2
The number of incidents that were reported for potential inappropriate use of restraint.	284