

## Substantiated allegations of abuse related to medication or ingested objects

### 2016 through Q3 2022

Source: ODHS Quarterly reports of all substantiated allegations of abuse of Oregon children in residential care (CCAs and other CCLP licensed entities and ODDS kids' residential)

*Notes: The abuse definitions and processes imposed by SB 1515 did not impact allegations of abuse PRIOR to July 1, 2016. Allegations substantiated under the pre-SB 1515 standards are in blue text.*

*Quarterly reports reference the month the allegation was substantiated, not the quarter the allegation occurred. This list includes the date the abuse occurred. Please also note that the abuse is not always substantiated against an individual staff person, but is often substantiated against the program OR an unknown person.*

#### **Homestead Youth and Family Services, CCP16010, 1/16/16**

Two allegations of Negligent treatment as defined in OAR 407-045-0820 (14) were substantiated, one each for two children, because a staff member dropped off the two children receiving care from the program at a store and did not supervise the children as required. The children shoplifted over-the-counter medications and may have ingested some of them. Law enforcement was subsequently involved.

#### **Chehalem Youth and Family Services, CCP16011, 1/12/16**

Two allegations of Negligent treatment as defined in OAR 407-045-0820 (14) were substantiated. Allegation 1 was substantiated because a staff member was determined to have neglected a child receiving care from the program by working under the influence of alcohol and/or controlled substances, as well as tampering with the child's prescribed medication. Allegation 2 was substantiated because the responsible manager failed to take action to protect the child in care by allowing the staff to remain at work while under the influence.

#### **2016 Generally, CCP17015 Allegation A Allegation B Allegation E Northwest Behavioral Healthcare Services**

Three allegations of maltreatment as defined in OAR 407-045-0820 (CCP) were substantiated against Northwest Behavioral Healthcare Services based on the use of: wrongful chemical restraints, wrongful physical restraints, involuntary seclusion, neglect of mental health needs and the failure to adequately evaluate and address self-harm and suicidal ideation.

#### **Trillium Youth and Family Services, Farm Home, CCA160060 8/1/2016**

Four allegations of Neglect as defined in OAR 407-045-0820(14) were substantiated, because staff failed to provide supervision to four children receiving care from the program, resulting in the children accessing alcohol on the premises and becoming intoxicated.

#### **Trillium Youth and Family Services, Farm Home, CCA160132 8/23/2016**

One allegation of Neglect as defined in OAR 407-045-0820(14) was substantiated, because program staff failed to provide supervision to a child receiving care from the program, placing the child at significant risk of harm when she left the program and consumed medications unsupervised.

#### **8/23/16, CCA160132 Allegation 2 Trillium Family Services – Children’s Farm Home**

One allegation of Neglect as defined in OAR 407-045-0820(14) was substantiated, because program staff failed to provide supervision to a child. The investigation of this incident revealed that the neglect was the result of a collective failure on the part of the Trillium Family Services receiving care from the program, placing the child at significant risk of harm when she left the program and consumed medications unsupervised. The neglect was not attributable to a particular employee or group of employees.

#### **5/2/16, CCP16163 Allegation 1 Trillium Family Services – Children’s Farm Home**

One allegation of Negligent Treatment as defined in OAR 407-045-0820 (14) was substantiated because a staff member failed to provide appropriate supervision to a child receiving care from the program, resulting in the child gaining access to and ingesting medication and leading to hospitalization.

#### **2017 Generally, CCA170140 Allegation A Allegation D Allegation E Allegation F Allegation G Northwest Behavioral Healthcare Services**

Five allegations of maltreatment as defined in OAR 407-045-0820 were substantiated against Northwest Behavioral Healthcare Services because they wrongfully chemically restrained multiple youth at the program through the involuntary injection of Geodon. Despite the Geodon being prescribed by the program’s physician, the medication was not an approved treatment activity in the youth’s treatment plan or in connection with a court order.

#### **Jan 2017 CW #311561 Safe Haven**

This referral is substantiated/founded for two allegations of Neglect, Lack of Supervision and Protection of two children in the CCA by a staff member. A staff member admitted to leaving medication sitting out unlocked which was accessible by children residing at Safe Haven. A child got into the medication and ingested some while his mother was trying to start a load of laundry. He was hospitalized for a night to undergo observation for seizures and tachycardia. This same staff member also admitted to putting a vehicle in gear and moving the vehicle while a resident stood behind the vehicle and another resident holding a child in a car seat was standing beside the vehicle attempting to get in. This could have caused significant injuries to the child had the car seat been knocked out of her mother’s hand. This incident was clearly described by the staff and multiple residents of Safe Haven who were present during the incident. Multiple residents have also described this staff driving erratically and speeding while transporting residents and their children due to talking or texting on her cell phone, including directly after this incident while the child was in the van. This assessment was unfounded regarding additional allegations of neglect by two additional staff persons. While there are some concerns about the way these two additional staff deal with clients and children at times, there was no information collected that indicated child abuse or neglect had occurred by either staff member.

### **03/23/2017 CCA170056 Allegation 1 Allegation 2 Allegation 3 On Track – Teens Program**

Three allegations of Neglect as defined in OAR 407 -045 -0820(1)(b) and (14)(a) were substantiated, because a program staff allowed three children receiving care from a drug and alcohol oriented treatment program to skip a therapeutic meeting and, instead, go to the staff's private home, where the staff pretended to smoke marijuana using a pipe in the home and offered the children chocolate candies containing alcohol, all of which was detrimental to the children's treatment goals.

### **Looking Glass Community Services, CCA210078, 10/2017**

Three allegations of sexual abuse, and three allegations of neglect were substantiated against one former staff member for three alleged victims. In this case, the respondent had sexual contact with three youth by kissing and groping them and allowing the youth to kiss and grope the staff. The staff member also provided the youth with marijuana and *smoked it with them while on community outings.*

### **Youth Progress Association, CCA180048 ,3/12/2018**

Three allegations of neglect as defined in OAR 407 -045 -0820 were substantiated against a Youth Progress Association staff who had marijuana edibles in his personal backpack in the staff office and confronted the youth after they discovered the youth had taken them. The staff failed to take appropriate action or to notify other staff and program management after learning that the youth were in the possession of the edible marijuana.

### **3/22/2018- 3/27/2018 CCA180067 Allegation A Redemption Ridge: Grace House**

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.

### **4/15/2018 CDD18051 Allegation A Center for Continuous Improvement**

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 reported by the physician assistant these medications could have caused the youth to go in to a coma or it could have been fatal.

### **2018 Generally, CDD18146 Allegation A/B Renew Consulting**

Two allegations of neglect as defined in ORS 418.257(1)(b) and OAR 407-045-0887(3)(d) substantiated on the program after multiple staff over a period of months allowed two youth with keys on an ongoing basis allowing them access to sharps, chemicals, the staff office, the medication cart and confidential information. Both youth

have Behavior Support Plans indicating they are not allowed access to these areas due to health and safety reasons.

#### **2018 Generally, CDD18148 Allegation A, Renew Consulting**

One allegation of neglect as defined in ORS 418.257(1)(b) and OAR 407-045-0887(3)(d) substantiated on an unknown staff after a youth was able to acquire multiple sharps, over the counter medications, cigarettes, razor blades and other items that were located when staff noted a foul smell, bugs and moldy food in the youth's room. The youth reported acquiring these items over a period of months although according to her Positive Behavior Support Plan staff are to ensure her room is cleaned weekly. The plan also states this youth has behaviors of physical aggression, self-injurious behavior and suicidal behavior. Due to this occurring over an unknown period of time a specific staff could not be identified as being responsible.

#### **Haag Home for Boys, CCA190056 One Allegation, 3/30/2019**

One allegation of Neglect was substantiated against an unknown staff after a youth ingested an unknown amount of Coriciden and Mucinex, was exhibiting signs of being under the influence and staff did not seek medical attention for several hours. The youth was ultimately hospitalized and although none of the staff who were on shift over the time of the incident were medically trained, none felt the incident rose to the level of the youth needing medical intervention. Because the incident crossed over two shifts with multiple staff, all of which played a part in monitoring the youth, no single staff could be identified as the staff responsible.

#### **Boys and Girls Aid, CCA190068 2019**

One allegation of Neglect was substantiated against a specific proctor parent after the proctor parent provided the youth with a full bottle of acetaminophen and the youth overdosed on the medication. The youth has a history of self-harm and suicidal ideation and requires sight and sound supervision. The youth was hospitalized for two days because of this suicide attempt. Consultation with the Oregon Poison Center revealed the approximated amount the youth ingested was five times the potentially fatal dosage, had the youth not received immediate medical care it could have resulted in liver failure or death.

#### **Albertina Kerr, CDD19031, 2019**

One allegation of Neglect was substantiated against a specific staff after the staff (management) failed to have the staff office door repaired for several weeks or take protective measures to ensure youth could not access the office while the door was in disrepair. A youth entered the office and ingested several pills leading to the youth being hospitalized.

**Trillium-Children's Farm Home CCA190136, One Allegation, 08/10/2019**

One allegation of Neglect was substantiated against a specific staff after the staff failed to intervene when a youth on enhanced supervision ingested non-edible objects and further failed to notify appropriate program personnel or follow program protocols.

**Looking Glass Pathways Boys Program, CCA190137, 8/13/2019**

One allegation of Neglect was substantiated against a specific staff after the staff knowingly provided a youth with a serious seafood allergy shrimp resulting in a medical emergency in which the youth was diagnosed with an anaphylactic reaction.

**Trillium-Children's Farm Home, CCA190155, 9/13/2019**

One allegation of Neglect was substantiated against an unknown staff after a youth was able to ingest the ink cartridges of eleven markers as well as four marker caps under the direct supervision of a staff. There were multiple staff involved in this incident, each with a different level of involvement, knowledge of the specific events and unfamiliarity of their own ability/responsibility to direct staff in the situation on what to do. Nobody made the call to have staff physically intervene or remove the markers from her possession which led to the youth having an invasive surgery due to concerns of blockage. Communication between all parties was fragmented and because nobody listened or gathered pertinent information due to many differing factors this youth was neglected.

**Albertina Kerr, 00065315, 1/6/2020**

One allegation of Financial Exploitation was substantiated against an unknown staff after one youth's entire unopened bubble pack of medication was found to be missing as well as an opened bubble pack of medication being tampered with.

**Center for Continuous Improvement, 00082768, 4/20/2020**

One allegation of Neglect was substantiated on a specific staff after that staff brought marijuana into the program in an unsecured backpack, leaving the backpack in a common area. A youth reported ingesting the marijuana.

**Morrison Center, SAGE CCA200145, 9/1/2020**

Two allegations of Neglect were substantiated on an unidentified staff after one youth was found with a second youth's medication. It could not be determined when the youth "cheeked" her medication or which staff was responsible. The investigation didn't determine the identity of the specific employee responsible for administering the medication that the youth successfully avoided ingesting and later giving to another youth in care at the program. Morrison Center. After learning of the incident, Morrison made improvements to its medication administration protocols and re-trained all personnel.

**St. Mary's Home for Boys, CCA200179, 11/18/2020**

Two allegations of Neglect were substantiated on an unidentified staff after a staff left a door unsecured resulting in two youth accessing an over the counter medication and ingesting to the point of intoxication.

**Morrison Youth and Family Services, CCA200105, June 18-July 10, 2020.**

One allegation of Neglect substantiated on a specific proctor parent after that proctor parent failed to properly store the youth's medication leading to several missing pills. Numerous concerns were identified including the medications not being stored or administered as required, leading to the youth snorting his medication. The youth was placed in this program to focus on his substance abuse issues so this incident was counterproductive to the youth's treatment. Additionally, to cover up his error, the proctor foster parent drove the youth to his parent's home two days in a row in an attempt to obtain more medication. Ultimately the youth ran on the second trip to his parent's home and was incarcerated.

**Rimrock Trails, CCA200189, 11/2020**

Two allegations of Neglect were substantiated on two different staff for two incidents in which hand sanitizer was left unsecured and unsupervised allowing a youth to access and consume. This is a drug and alcohol treatment facility with strict protocol on the storage of such items. The youth became intoxicated during the second incident, engaged in aggressive/assaultive behavior, and was arrested for this behavior.

**Albertina Kerr Centers, 130201, 3/20/2021**

One staff was substantiated for financial exploitation after it was discovered the staff stole narcotic medication belonging to a youth.

**Albertina Kerr Centers, 00118980, 1/2021**

Nature of Abuse and Brief Narrative: An unknown staff was substantiated for Neglect after an unknown staff failed to search the youth's belongings upon return from a home visit allowing that youth unrestricted access to the medications. The youth ingested several of those medications and was hospitalized.

**Albertina Kerr Centers, 123088, Date unknown but substantiated in 2021**

An unknown staff was substantiated for Neglect after a youth was found to have several pills in her room which were unaccounted for.

**Albertina Kerr Centers, 121936, 2022**

One allegation of financial exploitation was substantiated against an unknown staff after the youth was missing several medications with no explanation as to what happened to them.

