Oregon
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**Legislative Report**
**Department of Human Services**
**Child-Caring Agency Licensing Investigation Quarterly Report**
**to Interim Legislative Committees on Child Welfare**
Reporting period: July 1, 2016-September 30, 2016
Submitted November 4, 2016

Senate Bill 1515, Effective April 4, 2016 following enacted from 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.

The quarterly reports are for the purposes of legislative and public review and oversight of the quality and safety of child-caring agencies that are licensed, certified or authorized by the department in this state and of proctor foster homes that are certified by the child-caring agencies.

Information provided in this report contains:

(a) The name of any child-caring agency or proctor foster home where the department conducted an investigation pursuant to section 37 of this 2016 Act that resulted in a finding that the report of abuse was substantiated during that quarter;

(b) The approximate date that the abuse occurred;

(c) The nature of the abuse and a brief narrative description of the abuse that occurred;

(d) Whether physical injury, sexual abuse or death resulted from the abuse; and

(e) Corrective actions taken or ordered by the department and the outcome of the corrective actions.

**Reporting Period:** July 1, 2016 through September 30, 2016 (abuse investigation reports closed during that time)

**Summary:** 15 OAAPI investigations with 37 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).
- Reports are listed in order of investigations closing during the reporting period

| Report # Allegation # (substantiated) | Provider | 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 |
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| CCP16009 Allegation 2 | Youth Progress Association | 1/1/16 | One allegation of Negligent treatment as defined in OAR 407-045-0820 (14) was substantiated because staff engaged in romantic email and telephone contact with a child receiving care from the program. | No | The perpetrator was placed on administrative leave at the point YPA became aware of the allegations and is no longer employed with YPA at this time. She had no further contact with the victim after allegations where known. No further corrective actions imposed by DHS. |
| CCP16010 Allegation 1 Allegation 2 | Homestead Youth & Family Services | 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 | No | The perpetrator was terminated from employment after Homestead Youth and Family Services learned of the allegations, and he had no further contact with |

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| | | | 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. | | Homestead residents after the incident of neglect occurred. No further corrective actions were imposed on Homestead Youth and Family Services by DHS. |
| CCP16011 Allegation 1 Allegation 2 | Chehalem Youth & Family Services | 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 | No | DHS was in the process of revoking Chehalem Youth and Family Service's license when the allegations were substantiated in August, and there were no longer any children in care at any Chehalem facilities at that time. A hearing on the license revocation is pending. |

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| | | | 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. | | |
| CCP16120 Allegation 1 Allegation 2 Allegation 3 Allegation 4 Allegation 5 Allegation 6 | Trillium – Children's Farm Home | 4/1/16 | Six allegations of Negligent treatment as defined in OAR 407-045-0820 (14) were substantiated for incidents involving three staff members and two children receiving care from the program. All six allegations, naming separate children and | No | Trillium was notified that the three employees had been substantiated for neglect within a few days of the date DHS imposed conditions on Trillium's license. Among the conditions was a requirement to re-train all employees of the Farm Home in supervision requirements and protocols. |

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| | | | staff, were substantiated because the three staff members failed to conduct night checks as required on the two children, who left the facility overnight and used drugs including marijuana, methamphetamine and intravenous heroin. | | Another one of the conditions was an indefinite suspension of admissions of children to any Farm Home facilities. Both of these conditions, as well as other conditions, were imposed to address overarching concerns about the Farm Home's supervision and care of children in general. The three perpetrators of neglect identified in this report were prohibited from having further contact with children pending the outcome of a new background check and fitness determination by the DHS Background Check Unit. In the meantime they were re-trained in supervision expectations and nighttime check procedures along with the rest of Farm Home employees. The DHS |

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| | | | | | background check unit conducted new background checks fitness determinations for all three employees, and all three were recently approved to return to work. |
| CCP16159 Allegation 1 | Maple Star Oregon | 4/28/16 | One allegation of Maltreatment as defined in OAR 407-045-0820 (12) was substantiated because a proctor foster parent slapped a child receiving care from the program. | No | Upon learning of the allegation, Maple Star removed the victim from the home. No other children were in the home, and none were placed during the course of the investigation. Maple Star closed the home and terminated its contract with the perpetrator shortly before the investigation was complete. No additional corrective actions were imposed by DHS. |
| CCP16171 Allegation 1 | Albertina Kerr Centers | 5/8/16 | One allegation of Negligent treatment as defined in OAR 407-045-0820 (14) was | No | Upon learning of the lapse in supervision, Albertina Kerr Centers revised their supervision protocol and re- |

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| | | | substantiated because program staff left a child receiving care and supervision from the program unattended and unsupervised for a period of time in a subacute unit, while the staff and the other children left the unit. | | trained facility staff in the new procedures. No further corrective actions were imposed by DHS in response. |
| CCP16188 Allegation 1 Allegation 2 | KAIROS | 1: 2015 2: 2/27/16 | Two allegations of Negligent treatment as defined in OAR 407-045-0820(14) were substantiated. In two separate instances, a proctor foster parent failed to secure the medications of a child in care. In the first instance the child accessed and stockpiled enough medication to cause harm, but did not | Yes | Upon learning of the allegations, KAIROS terminated their contract with the perpetrator, and the perpetrator ceased caring for children. No additional corrective actions were imposed on Kairos by DHS. |

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| | | | ingest them. In the second, the child ingested the medications and required extensive hospitalization as a result. | | |
| CCP16199 Allegation 1 Allegation 2 | Maple Star Oregon | 6/16/16 | Two allegations of Negligent treatment as defined in OAR 407-045-0820(14) were substantiated, because two respite providers allowed a child receiving care from the program and requiring a high degree of supervision to go to the swimming pool in their apartment complex unsupervised for up to an hour on more than one occasion. | No | The foster parents identified as perpetrators of neglect in the report provided respite care to children placed with other Maple Star foster parents. Upon learning of the allegations Maple Star ceased placing children for respite with the foster parents pending the outcome of the investigation. Shortly after the investigation was initiated, the foster parents notified Maple Star that they were voluntarily terminating their relationship with Maple Star and would no longer be |

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| | | | | | certified to provide foster care. DHS did not impose any additional corrective actions on Maple Star. |
| CCA160015 Allegation 1 | KAIROS | 7/5/16 | Verbal abuse as defined in OAR 407-045-0820(1)(h) was substantiated, because a staff member initiated a derogatory conversation about a child receiving care from the program, stating that the child was "creepy" and "…going to be a rapist when (the child) grows up." The conversation was held in a place where it could be overhead by other children and other staff. The child overhead the | No | The Office of Licensing and Regulatory Oversight (OLRO) followed up with Kairos to determine the employment status of the individual substantiated for verbal abuse. Kairos indicated the employee was disciplined and put on a return-to-work plan that included a requirement to review Kairos policies on abuse/neglect reporting and client boundaries. The employee was also required attend specific trainings: Ethics, Transference and Countertransference and Identifying and Preventing Child Abuse and Neglect. She doesn't work unsupervised and has 2 |

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| | | | conversation and reported being upset by it, stating that (the child) felt "heartbroken" and no longer able to trust anyone. Child has abuse history that includes emotional abuse and displacement trauma. Child's therapist confirmed the negative impact on the resident. | | hours of clinical supervision per month with the Program Manager. Kairos has requested a new background check and fitness determination for the employee from the DHS Background Check Unit. OLRO supports the actions taken by Kairos and has not imposed additional requirements beyond those described here. |
| CCP15133 Allegation 5 Allegation 6 Allegation 7 Allegation 8 Allegation 9 Allegation 10 Allegation 11 Allegation 12 | Chehalem Youth & Family Services | 11/29/2015 | Eight allegations of Negligent treatment as defined in OAR 407-045-0820(14) were substantiated, because an identified program manager – and the CYFS program as a whole – failed to | Yes | On 1/6/2016 OLRO conducted an unannounced visit to Chehalem Youth and Family Services (CYFS), which included a visit to the site where this incident occurred. Interviews with staff and residents at the facility revealed that |

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| | | | prevent a physical altercation involving four children receiving care from the program. A single new employee with insufficient training had been left with no backup to work with five children requiring a high level of supervision, four of whom became involved in a fight with multiple resulting injuries. | | employees who lacked training in behavior de-escalation and intervention were sometimes scheduled to work alone at the facility and to supervise and care for residents with a history of physical aggression and other dangerous behavior. OLRO issued corrective actions following the visit, including a requirement for CYFS to ensure staff had necessary training before being responsible to supervise residents. Later CYFS voluntarily closed the facility where the incident occurred. The agency as a whole continued to struggle, and ultimately DHS issued a notice of intent to revoke Chehalem's license to operate a child-caring agency and ceased admitting children to the |

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| | | | | | program. CYFS appealed the pending revocation, and a legally binding settlement was reached under which Chehalem agreed to close all of its residential care facilities. |
| CCP16033 Allegation 1 Allegation 2 | St. Mary's Home for Boys | 1/1/16 | Two allegations of Negligent treatment as defined in OAR 407-045-0820 (14) were substantiated, one each for two children receiving care from the program, because a staff member failed to provide adequate supervision which allowed the two children to have sexual contact. | No | The report indicates that the employee who failed to continuously maintain line-of-sight supervision on the two residents involved acted contrary to the training he received. His employment at St. Mary's was already terminated prior to the start of the investigation. No additional corrective actions were imposed on St. Mary's Home for Boys by DHS. |
| CCP16059 Allegation 2 Allegation 3 | Inn Home for Boys | 3/19/16 | Two allegations of Negligent treatment as defined in OAR 407-045-0820 (14) were substantiated, one | No | Shortly after learning of this incident OLRO made an unannounced visit to the facility and observed that staff were struggling to |

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| | | | each for two children receiving care from the program, because a staff member failed to provide adequate supervision. As a result the two children were able to leave the facility unnoticed in the program's vehicle and drive around for several hours before being stopped by police. | | supervise youth and were unable to manage their behavior. The program established a safety plan, which included increasing the number of staff at the facility. OLRO made a subsequent visit the next day, and again observed staff to be struggling and unable to manage resident's behavior. DHS began making plans to move some of the more behaviorally challenging children from the program. On 3/29 the Executive Director of The Inn Home announced that they had decided to close the facility. |
| CCP16162 Allegation 1 | Maple Star Oregon | 5/1/16 | One allegation of Negligent treatment as defined in OAR 407-045-0820(14) was substantiated because a proctor foster parent | No | The foster parent who is the subject of the report has not been caring for children since Maple Star learned of the allegation. Following the substantiation of |

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| | | | failed to administer medications appropriately to a child receiving care from the program. | | neglect, Maple Star submitted a new background check request to the DHS Background Check Unit (BCU), and the BCU's fitness determination resulted in a denial. A decision regarding the foster parent's appeal of the denial is pending. If the appeal results in an approval, and if Maple Star elects to begin placing children with the foster parent again, Maple Star will retrain the Foster Parent in medication administration before doing so. |
| CCP16169 Allegation 1 Allegation 2 | Maple Star Oregon | | Two allegations of Negligent treatment as defined in OAR 407-045-0820(14) were substantiated because a proctor foster parent failed to supervise two | No | Maple Star placed the foster parent on inactive status upon learning of the allegation, meaning she does not have any children placed in her home. She remains on inactive status |

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| | | | children receiving care from the program, and they became involved in a physical altercation. | | at this time. The foster parent is appealing the substantiation of neglect. |
| CCP16173 Allegation 1 Allegation 2 Allegation 3 Allegation 4 | Chehalem Youth & Family Services | 4/22/16 | Four allegations of Negligent treatment as defined in OAR 407-045-0820 (14) were substantiated, one each for four children in the program's care, because CYFS failed to supervise them appropriately and follow up appropriately after the children ran away from the facility for six or more hours overnight. During their time away from the facility the children broke into cars, stole numerous items from multiple individuals, ingested unknown | No | Prior to this incident OLRO had issued a number of corrective actions following an unannounced visit to CYFS in January 2016. The corrective actions were designed to address issues contributing to poor supervision and to improve the overall care and treatment of youth at the program. When the program failed to make necessary improvements, DHS issued a notice of intent to revoke the agency's license to operate as a child-caring agency and ceased placing children at the program. CYFS appealed, and eventually a |

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| | | | substances in an attempt to get “high” and ultimately were all arrested by law enforcement. | | legal settlement was reached under which CYFS agreed to close all of its residential care facilities. |

Please direct questions and any additional requests for information to:

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