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

<table>
<tr><th>Report/ Allegation</th><th>Provider</th><th>Approximate Date Abuse Occurred</th><th>Did physical injury, sexual abuse or death result?</th></tr>
<tr><td>CCA210047 (1 allegation)</td><td>Bob Belloni Ranch</td><td>03/2021</td><td>No</td></tr>
<tr><td colspan="2">Nature of Abuse and Brief Narrative:

One allegation of neglect was substantiated against a Belloni Ranch staff member after learning the staff member failed to provide the appropriate services and supervision to the youth. The staff member did not follow the youth's Master Service Plan, failed to have appropriate boundaries, and assisted the youth in eloping from the facility.</td><td colspan="2">Corrective Actions Taken or Ordered by the Department, and Outcome:

The identified employee resigned her employment around the time the report was made. ODHS provided feedback and direction to the program concerning the program's initial response the situation, which was hampered by incorrect assumptions and a failure to act decisively. Since the time of the incident, the agency's board appointed a new Executive Director for the agency, and this change is resulting in better control and accountability at the program.</td></tr>
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<tr><td>CCA210102 (1 allegation)</td><td>St. Mary's Home for Boys</td><td>09/26/2021</td><td>No</td></tr>
<tr><td colspan="2">Nature of Abuse and Brief Narrative:

An allegation of Neglect against St. Mary's Home for Boys was substantiated after information was obtained that St. Mary's management, despite being aware of Senate Bill – 710 and its implementation on 09/01/2021, instructed their staff to continue performing restraints as originally trained, which included the use of the floor as a means to reposition a client when the</td><td colspan="2">Corrective Actions Taken or Ordered by the Department, and Outcome:

ODHS worked closely with St. Mary's to ensure the program's management was correctly interpreting and implementing the provisions of Senate Bill 710 governing physical interventions with children in care. ODHS personnel directly observed the training the program provided to their staff after receiving feedback from ODHS, and ODHS was able to confirm that the training aligned with statute and ODHS Licensing rules.</td></tr>
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use of the standard CPI restraint became unstable. Information was also presented that St. Mary's management did not train their staff on modifications to the current curriculum until receiving clarification via email from Oregon State Senator Sara Gelser regarding the exact way in which the bill should be interpreted. Once St. Mary's management received this clarification, they reversed course and modified their practices, which included retraining staff members to be in alignment with the new bill.	There have been no further incidents of a similar nature since the incident that gave rise to the investigation, and it's evident that the program acted decisively in its course correction.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCA210103(1 allegation)	Trillium-Parry Center	04/2021	No

Nature of Abuse and Brief Narrative:	**Corrective Actions Taken or Ordered by the Department, and Outcome:**
One allegation of Wrongful Restraint was substantiated on a temporary staff after that staff used a wall (a solid object) to restrain the youth and later held the youth on the floor while in a supine position. Both of these restraints are prohibited per Senate Bill-710	The employee in question was part of a group of employees brought in from a staffing agency to help alleviate an on-going staffing shortage at the program. The employee had experience working in other residential care settings and had received training from Trillium on the authorized use physical interventions and the parameters surrounding the use of those interventions. When it became clear that the employee was implementing a restraint that is prohibited by the program's policy and contrary to the training the employee had received, a supervisor instructed the employee to release the youth and withdraw from the hold, which the employee refused to do. The employee was instructed not to return to the program following the incident, and he subsequently returned to his place of residence in another state.

Report/ Allegation	**Provider**	**Approximate Date Abuse Occurred**	**Did physical injury, sexual abuse or death result?**
CCP21008 (1 allegation)	Rimrock Trails	Unknown(historical)	Yes

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 former staff after a former resident disclosed having sexual contact with that staff. Although the incident is alleged to have occurred over twenty years ago, there is corroborating information to support the allegation as reported.	From what was learned in the course of the investigation, it's likely that the program was unaware of the sexual contact at the time it occurred approximately 21 years ago. The identified victim did not report the abuse until recently. The identified employee hasn't worked at the site since the year 2000. More recently, when the program became aware of a less severe instance of poor boundaries between a staff person and a youth in care, the program acted quickly and decisively to address the situation and ensured that all employees of the program were clear in their understanding of appropriate boundaries between youth in care and staff.

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

Reporting time frame (indicate which quarter in months and year):	09-01-2021/12-31-2021
The total number of restraints used in programs that quarter.	1130
The total number of programs that reported the use of restraints of children in care that quarter.	26
The total number of individual children in care who were placed in restraints by programs that quarter.	154
The number of reportable injuries to children in care that resulted from those restraints.	203
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.	13
The number of incidents that were reported for potential inappropriate use of restraint.	77