PLEASE POST

SOCP SAFETY COMMITTEE
Meeting Minutes – July 24, 2013

I. Call to order @ 1:00 pm
   Attendees: Sign in attached
II. Minutes to last meeting approved as is
III. Review of accidents/injuries
   a. Review of last months injuries
IV. Safety Check Review:
   a. Review of all houses safety checks.
V. Review of Vehicle Accidents
   a. No accidents to report
VI. Old Business Review:
   a. Cade – Refrigerator isn't staying cold – Work Order submitted by Michelle Patton
   b. Discovery – Can the sprinklers all be flush mounted so clients can't hit them. Michelle Patton will discuss with Site Manager and Program Manager, if this is a issue at the home we can look at flush mount.
   c. Eliot – House 1 A/C is broke and will be fixed by housing. House 2 received gurney chair and House 3 has shower gurney. – Work Order submitted by Michelle Patton for Brian to come and ensure proper installation.
   d. Forsythia –
      i. Breaker box still needs labeled – Work Order submitted by Michelle Patton.
      ii. Is the 18" clearance needed everywhere? Per Michelle Patton, must keep 18" clearance in all areas that have sprinklers.
   e. Halsey – Still several items that need repaired – Housing working on flooring, A/C, etc.
   f. Ina – Screws on front gate brackets are not completely in – Work Order submitted by Michelle Patton
   g. Milton –
      i. Lights in parking lot would be nice due to client wanting to "play" outside at night. – Work Order submitted by Michelle Patton
      ii. Living room on SG side has some outlets that need replaced– Work Order submitted by Michelle Patton

h. Oak St – Ron Chastain is new Safety Officer
i. River Rd – Light switch 3 bed kitchen is broke– Work Order submitted by Michelle Patton
j. Turner –
    i. Stove on 3 bed side has 2 burned out burners – Work Order submitted by Michelle Patton
    ii. Fax machine doors need to be unscrewed still
    iii. Front fence won't lock or engage – Work Order submitted by Michelle Patton
k. Weirich –
    i. Wasp nest issue. Recommendation of using spray foam in the areas to shut them off completely. – Work Order submitted by Michelle Patton
    ii. Washer isn't spinning - – Work Order submitted by Michelle Patton

VII. New Business:
a. Cade
    i. Would like more security bracelets
b. Jody
    i. Fire drills – Quarterly or monthly?
        1. Need to perform one fire drill per quarter per shift.
c. Ina
    i. Screws still need in at front gate
    ii. Fire extinguishers in vehicles – do we need?
        1. Michelle advised not a DAS or Motor pool requirement. If a house has them in the vehicles then they must properly maintain them.
d. Turner and Milton
    i. Have cell phones that have long distance numbers.
    ii. Michelle to work with Donna to get this remedied
e. Oak
    i. Need arm closures for doors
        1. Michelle advised Brian was there that day to fix
    ii. Have two vents where nothing comes out. Ron C to look at vent to see if anything is blocking
f. Turner
    i. Gate is still broken. Fence company has not shown up
    ii. Bees are in the compost pile again

VIII. Adjournment 2:00 pm
a. Next meeting August 28, 2013 1:00pm Central Office

SOCP
CENTRAL SAFETY MEETING
WednesdayJuly 24, 2013 1:00 pm

Staff Name (print)	Represented House	Signature
Patton, Michelle	**Admin**	[signature]
Orser, Matt	Admin *Current SC President	[signature]
Kammerer, James	Brooks	Absent
~~**Vittone, Sue**~~	✓ ~~**Cade**~~	
Jordan, Darla	Cade	Darla Jordan MHT II
Anderson, David	✓ Charles	on vacation
Vinson, Karla	**Charles**	Karla Vinson [signature]
Chung, David	✓ Discovery	Present - Did not sign
Baston, Tessa	Eliot 1, 2, 3	[signature] Baston
Taylor, Scott	✓ Eliot 1, 2, 3	- sick -
Geroge, Justin	✓ Forsythia	Justin George MHT II
Fears, Jamie	✓ Gath	Absent
Benson, Jason	✓ Halsey	J Benson
Chase, Michael	Hampden	Absent
Bill Tellez	Hawthorne	[signature]
Foultner, Jerry	Ina	[signature]
Padilla, Mike	✓ James	Vacation
Moore, Rebecca	✓ Jody	Rebecca Moore [illegible]
Wood, Michael	✓ Macleay	Michael Wood MHT II
Tellez, Bill	✓ Madison	[signature]
Deless, Diana	✓ Milton	[signature] MHTT
Kennedy, Paula	Nursing	Paula Kennedy RN
Chastain, Ron	✓ Oak	On phone
Boes, David	✓ River	Absent - call-in
Colling, Joyce	✓ **Turner**	Joyce Colling [illegible]
Neufeld, Josh	Turner	Absent
Whitefeather, Maggie	Weirich	On phone
Schiable, Jean	✓ Dean	Absent - call-in

SAIF CORPORATION
400 High Street, S.E., Salem, OR 97312-1801

For SAIF Customer Use
Area
Dept.
Shift CC

CLAIM NO.
SUBJECT DATE
CLASS
DEFAULT DATE
EMPLOYER'S ACCOUNT NO.

Toll Free Phone: 1-800-285-8525
Toll Free FAX: 1-800-475-7785

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line. Your employer will give you a copy.

1. Date of injury or illness: 6-27-2013
2. Date you left work: 6-27-2013
3. Shift on day of injury: swing (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.
4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☑ S ☑ S
5. Time of injury or illness: 5:30 ☐ a.m. ☑ p.m.
6. Time you left work: 10 ☐ a.m. ☑ p.m.
7. Check here if you are employed by more than one employer: ☐
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) Kneck, Face, Shoulder ☐ Left ☑ Right
9. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials)

client in behavior in the bathroom, staff called for back up and asked me tro obtain key to paper towel dipenser to remove towels that where being used,by client, to clog sink in an effort for client to over flow and do damage to bathroom. I obtained the key removed the remainder of paper towels and locked it. client immediately swung and hit me , full force, on right side in crease of kneck ,slighty on right side of face, shoulder

11. Name of witnesses: [redacted]
12. Have you previously injured this body part? ☑ Yes ☐ No
13. Your legal name: [redacted]
14. Birthdate: [redacted]
15. Gender: ☐ M ☑ F
16. Mailing address, city, state and zip: [redacted]
17. Home phone: [redacted]
18. SSN (See #25): [redacted]
19. Occupation: habilitative tech 2
20. [redacted]
21. Name of physician or health-care professional: Kathy Harris-Hobbs
22. If medical treatment was given away from [redacted] name and address of facility:
23. Were you hospitalized overnight as an inpatient? ☐ Yes ☑ No
24. Were you treated in the emergency room? ☐ Yes ☑ No
25. By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

I authorize the use of my SSN in the processing of this claim. (Authorizing the use of your SSN will ensure prompt processing of your claim and that your medical records are not released to unauthorized parties. If you do not authorize the use of your SSN, check here ☐.)

26. Worker signature: [redacted]
27. Completed by (please print): [redacted]
28. Date: 6-27-2013

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

29. Employer legal business name: SOCP EMP #5849294
30. Phone: (503) 378-5952 ext. 232
31. FEIN: 93-0710952
32. If worker leasing company, list client business name: N/A
33. Client FEIN: N/A
34. Address of principal place of business (not P.O. box): 4494 River Road N, Keizer, OR 97303
35. Insurance policy no.: 312146
36. Street address from which worker is/was supervised: 4914 Ina SE Milwaukie ZIP: 97267
37. Nature of business in which worker is/was supervised: Social Services
38. Street address, city, and state where event occurred: Same
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☒ Yes ☐ No
40. Class code: 9499
41. Were other workers injured? ☐ Yes ☒ No
42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No
43. OSHA 300 log case #:
44. Date employer knew of claim: 6/27/13
45. Worker's monthly wage: $
46. Date worker hired:
47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☐ Regular Date: ☐ Modified Date:
49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: Susan L. Phillips
51. Name, title, and phone (please print): Susan Phillips Site Manager 503-513-5961
52. Date: 7/1/13

801

X801 1/05

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 922-2689, (503) 378-3272, or Oregon Emergency Response (800) 452-0311, on nights and weekends.

801

SPD - State Operated Community Program

Employee Incident/Accident Report

EMPLOYEE SECTION

[redacted] [redacted] [redacted]

Address

Home P [redacted] Worksite and Phone: RIVER RD 689-1185

Regularly Assigned Shift Hours: M-F 7-3 Days Off: SAT, SUN.

Date of Incident: 6-28- Time of Incident: 245p.

Witness (es): Rob HESTER

Exact Location of Incident: STEVENS Shed

Body Part Injured (L/R): (L) EAR / Temple

Nature of Injury: BEE STING (yellow Jacket)

Describe the incident fully: Went out with Rob to look for a file cabinet in STEVENS Shed Opened the door and a bee flew straight out with about 7-8 coming out after and stung me on the EAR

What caused the incident? yellow Jacket

How could the incident have been prevented? HAVE PEST CONTROL CHECK FOR HIDDEN NESTS

[redacted] -28-13

Date

SUPERVISOR SECTION: SEE BACK FOR IDENTIFYING FACTORS WHICH CONTRIBUTED TO OR CAUSED ACCIDENT

Analysis of the incident: (Why did it happen – i.e. hazardous condition, unsafe behavior, system weakness, etc.) Opening a shed / Bees nest was hidden / pest control was called.

Action taken to prevent a similar incident: have pest control inspect this area on annual inspection.

Employee: Went back to work: ☒ Y ☐ N Went home: ☐ Y ☐ N Went to Doctor: ☐ Y ☐ N

[signature] HSS

Supervisor Signature Date

OVER

(If yes, need 801 within five (5) days of your knowledge of doctor treatment)

Safety Program 503-378-5952 X232
503-378-5915 fax

Original to Safety Office

SOCP-Safety-001
Rev. 5/08

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

Employee Incident/ Accident Report

001

SOCP Safety Program:
503-378-5952 ext 232
FAX: 503-378-5917

Address:

Worksite: RIVER ROAD SOCP Worksite p

Regularly assigned shift hours: 3pm-11pm Days off: WED/THUR

Accident information:

Date of incident: 7-1-13 Time of incident: 6pm Exact location of incident: OLD MARTHA CT. HOME

Witness(es):

Body part injured (R/L): L SHOULDER LOWER BACK Nature of the injury: POSSIBLE STRAIN

Describe the incident fully: I FELT A PAIN IN MY (L) SHOULDER AND A PULLING IN MY LOWER BACK.

What caused the incident? LIFTING CLIENT'S FURNITURE FROM ONE HOUSE TO HIS CURRENT RESIDENCE.

How could the incident have been prevented: POSSIBLY MORE HELP

Employee signature: Date: 7-18-13

SUPERVISOR ... ors which contributed to or caused the accident)

Analysis of the incident

Why it happened – Hazardous condition ☐ Unsafe behavior ☐ System weakness ☐ Other ☐

Explain:

Action taken to prevent a similar incident:

Employee - Went back to work: Yes ☒ No ☐ | Went home: Yes ☐ No ☐ | Went to Doctor*: Yes ☐ No ☒

Sharon Freeman 7/2/13
Supervisor signature Date

*NOTE: If yes, need 801 within five (5) days of your knowledge of doctor treatment.) OVER >

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

Employee Incident/ Accident Report

001

SOCP Safety Program:
503-378-5952 ext 232
FAX: 503-378-5917

Address: Home phone:

Worksite: Oak St Worksite phone:

Regularly assigned shift hours: 6 AM 2 PM Days off: Sat/Sun

Accident information:

Date of incident: 7/3/13 Time of incident: 9 30 AM Exact location of incident: dining rm 2 bedside

Witness(es):

David Staggs

Ron Chastain

Body part injured (R/L): Right upper arm Nature of the injury: human bite

Describe the incident fully:

client attacked another staff - I went into area to get client to stop - he turned on me, hit me, pulled my hair and bit my (R) upper arm.

What caused the incident?

Client behavior.

How could the incident have been prevented:

can not be prevented

Employee signature: Date: 7-3-13

SUPERVISOR SECTION: (see back for identifying factors which contributed to or caused the accident)

Analysis of the incident

Why it happened – Hazardous condition ☐ Unsafe behavior ☒ System weakness ☐ Other ☐

Explain: client behavior

Action taken to prevent a similar incident:

unsure

Employee - Went back to work: Yes ☒ No ☐ | Went home: Yes ☐ No ☐ | Went to Doctor*: Yes ☒ No ☐

Lyn Hickman SM — *Supervisor signature*

7/3/13 — *Date*

*NOTE: If yes, need 801 within five (5) days of your knowledge of doctor treatment.) OVER >

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Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

Employee Incident/ Accident Report

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001

SOCP Safety Program:
503-378-6952 ext 232
FAX: 503-378-5915

Name: [redacted] Employee ID #:

Address: [redacted] (city, state, zip code) [redacted]

Regularly assigned shift hours: 3-11 Days off: Sun-Mon

Accident information:

Date of incident: 7/5/13 Time of incident: 4:00pm Exact location of incident: Backyard

Time shift began: 3:00 Was a Client involved? Yes ☒ No ☐ Client initials: AC

Witness(es): *Do not list clients as witnesses.*

Body part injured (R/L): L foot Nature of the injury: Big toe Swollen & bruised

Describe the incident fully: me and client playing Soccer and we both went to kick ball and we ended up kicking each others foot. His foot hitting my toe (Big)

What caused the incident?
missed kick of ball

How could the incident have been prevented:
Watch better when playing Soccer

Employee signature: [redacted] Date: 7/5/13

SUPERVISOR SECTION: (see back for identifying factors which contributed to or caused the accident)

Analysis of the incident

Why it happened – Hazardous condition ☐ Unsafe behavior ☐ System weakness ☐ Other ☒

Explain: Accident playing Soccer

Action taken to prevent a similar incident: Be more careful

Client involved? Yes ☒ No ☐ Entered into THERAP? Yes ☒ No ☐

Employee - Went back to work: Yes ☒ No ☐ | Went home: Yes ☐ No ☒ | Went to Doctor*: Yes ☐ No ☒

[signature] 7-7-13
Supervisor signature *Date*

*NOTE: If yes, need 801 within five (5) days of your knowledge of doctor treatment.) OVER >

Received Time Jul. 7. 2013 6:09PM No. 2600

SOCP Employee Incident/Accident Analysis

System challenges:

Management - Do we have:
Policy enforcement
Hazard recognition
Accountability
Supervisor training
Corrective action
Production priority
Proper resources
Job safety training
Hiring practices
Maintenance
Adequate staffing

Employee - Was the employee:
Following procedure
Training
Previous injury
Mental ability
Physical capacity
Equipment use
Short cuts
PPE Worn
Safety attitude

Equipment - Do we have:
Proper tool selection
Tool availability
Maintenance
Visual warnings
Guarding

Environmental - What about:

Plant layout	Vibration
Chemical	Lighting
Temperature	Ventilation
Noise	Housekeeping
Radiation	Biological
Weather	Ergonomics
Terrain	

Additional casual factors:
- ☐ Faulty equipment
- ☐ Non-employee
- ☐ Prior injury
- ☐ Late reporting
- ☐ Off-the-Job injury

Explain any checked boxes >>>>

Employee name: [redacted]

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JUL 08 2013
DHS SOCP
Human Resources

Identify factors which contributed to or caused accident
(refer to list on left side of page):

Management:

Employee:

Equipment:

Environment: Accident playing soccer

Counter measures/best practices to prevent reoccurrence:

Be more careful

Who: All Staff & clients

By when: on Going

Explain any checked boxes for "Additional casual factors":

Safety Program Phone: 503-378-5952 ext 232
Safety Program FAX: 503-378-5915

SPD - State Operated Community Program

Employee Incident/Accident Report

EMPLOYEE SECTION

Na[redacted]

Ad[redacted]

Hc[redacted]

Regularly Assigned Shift Hours: 7-3 Days Off: Sat / Sun

Date of Incident: 7-5-13 Time of Incident: 7:49

Witness (es): Eileen LaRiccia Josh Pierzina

Exact Location of Incident: Living Room

Body Part Injured (L/R): Ⓛ Knee / thigh

Nature of Injury: Client behavior

Describe the incident fully: Was trying to get a pulse so I could pass meds and another staff (w/trying to get him to comply) he grabbed the wrist monitor and threw it across the room striking me in the left knee / thigh

What caused the incident? Client threw a BP monitor across the room

How could the incident have been prevented? I tried to avoid / Nothing because it happened to fast

Employee Signature Date

SUPERVISOR SECTION: SEE BACK FOR IDENTIFYING FACTORS WHICH CONTRIBUTED TO OR CAUSED ACCIDENT

Analysis of the incident: (Why did it happen – i.e. hazardous condition, unsafe behavior, system weakness, etc.) ________

Action taken to prevent a similar incident: ________

Employee: Went back to work: ☐ Y ☐ N Went home: ☐ Y ☐ N Went to Doctor: ☐ Y ☐ N

Supervisor Signature Date **OVER**

(If yes, need 801 within five (5) days of your knowledge of doctor treatment)

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Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

Received Time Jul. 10. 2013 3:24PM No. 2621

Employee Incident/ Accident Report

001

SOCP Safety Program:
503-378-5952 ext 232
FAX: 503-378-5917

Name [redacted]

Worksite: Gath Rd Work [redacted]

Regularly assigned shift hours: Swing Days off: Tue / Wed

Accident information

Date of incident: 7-7-13 Time of incident: 4pm Exact location of incident: Bathroom of Gath

Witness(es):

Sandra Stevens

Body part injured (R/L): Left Shoulder & Hip Nature of the injury: Pulled muscles

Describe the incident fully: Client (BP) was in shower. He began hitting himself, Staff attempted Limb PPI. He was flailing around, and trying to hit his head on the wall. He was pushing and pulling at staff. Staff was attempting to get him seated on the shower seat so they could dry him off and dress him.

What caused the incident? Not really sure. Usually showers calm him down and he is usually good for staff when showering. He is new to the house, and he is non-verbal. We don't know what his triggers are.

How could the incident have been prevented: Not sure.

Employee signature [redacted]

SUPERVISOR SECTION (Look for identifying factors which contributed to or caused the accident)

Analysis of the incident

Why it happened – Hazardous condition ☒ Unsafe behavior ☒ System weakness ☐ Other ☐

Explain: Client is 2:1 for safety due to SIB, staff need to be close to BP for safety

Action taken to prevent a similar incident:

Encourage BP to sit on shower chair, although he refuses usually

Employee - Went back to work: Yes ☒ No ☐ | Went home: Yes ☐ No ☒ | Went to Doctor*: Yes ☐ No ☒

Supervisor signature [signature] Date 7/10/13

*NOTE: If yes, need 801 within five (5) days of your knowledge of doctor treatment.) OVER >

Jul. 10. 2013 3:08PM No. 6285 P. 2

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Received Time Jul. 10. 2013 3:24PM No. 2621

SOCP Employee Incident/Accident Analysis

System challenges:

Management - Do we have:
Policy enforcement
Hazard recognition
Accountability
Supervisor training
Corrective action
Production priority
Proper resources
Job safety training
Hiring practices
Maintenance
Adequate staffing

Employee - Was the employee:
Following procedure
Training
Previous injury
Mental ability
Physical capacity
Equipment use
Short cuts
PPE Worn
Safety attitude

Equipment - Do we have:
Proper tool selection
Tool availability
Maintenance
Visual warnings
Guarding

Environmental - What about:

Plant layout	Vibration
Chemical	Lighting
Temperature	Ventilation
Noise	Housekeeping
Radiation	Biological
Weather	Ergonomics
Terrain	

Additional casual factors:
☐ Faulty equipment
☐ Non-employee
☐ Prior injury
☐ Late reporting
☐ Off-the-Job injury
Explain any checked boxes >>>>

Employee name: [redacted]

Identify factors which contributed to or caused accident (refer to list on left side of page):

Management:

Employee:

Equipment:
Possible mats placed on tile to protect him from injury + bigger mats on floor maybe staff could back away out of his strike zone

Environment:
same

Counter measures/best practices to prevent reoccurrence:
Encourage use of shower chair
Encourage PP to hold rails + shower head
Check into protective mats on tile in shower

Who: Slundy

By when: 7/20/13

Explain any checked boxes for "Additional casual factors":

Safety Program Phone: 503-378-5952 ext 232
Safety Program FAX: 503-378-5917

No. 6285 P. 3 Jul. 10. 2013 3:09PM

SAIF CORPORATION
400 High Street S.E., Salem, OR 97312-1801

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JUL 11 2013
SOCP ADMIN

For SAIF Customer Use
Area
Dept.
Shift CC

CLAIM NO.
SUBJECT DATE
CLASS
DEFAULT DATE
EMPLOYER'S ACCOUNT NO.

Toll Free Phone: 1-800-285-8525
Toll Free FAX: 1-800-475-7785

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line.** Your employer will give you a copy.

1. Date of injury or illness: 7-8-13
2. Date you left work: 7-8-13
3. Shift on day of injury: 2-10 (from) ☐ a.m. ☒ p.m. (to) ☐ a.m. ☒ p.m.
4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☒ T ☒ F ☐ S ☐ S
5. Time of injury or illness: 240 ☐ a.m. ☒ p.m.
6. Time you left work: 300 ☐ a.m. ☒ p.m.
7. Check here if you are employed by more than one employer: ☐ NO
8. What is your illness or injury? What part of the body? Which side? ☒ Left ☐ Right (Example: sprained right foot) left side next to eye an the eye
9. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify): N/A
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials)
I was talking to a client who was yelling at staff. I told her to stop talking so loud and being rude. She then turned to me and punched me on my left eye and next to my left eye
11. Name of witnesses: Josh, Beth
12. Have you previously injured this body part? ☐ Yes ☒ No
13. Your legal name: [redacted]
15. Gender: ☐ M ☒ F
16. Mailing address, city, state and zip: [redacted]
17. Home phone: [redacted]
18. SSN (See #25): [redacted]
19. Occupation: Mental Health Tech II
21. Name of physician or health-care professional:
22. If medical treatment was given away from the worksite, print name and address of facility: Kaiser permente Stark St Portland, ORe
23. Were you hospitalized overnight as an inpatient? ☐ Yes ☒ No
24. Were you treated in the emergency room? ☐ Yes ☒ No

25. **By my signature,** I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

I authorize the use of my SSN in the processing of this claim. (Authorizing the use of your SSN will ensure prompt processing of your claim and that your medical records are not released to unauthorized parties. If you do not authorize the use of your SSN, check here ☒.)

26. Worker signature: [redacted]
28. Date: 7-9-13

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

29. Employer legal business name: SOCP EMP #5849294
30. Phone: (503) 378-5952 ext. 232
31. FEIN: 93-0710952
32. If worker leasing company, list client business name: N/A
33. Client FEIN: N/A
34. Address of principal place of business (not P.O. box): 4494 River Road N, Keizer, OR 97303
35. Insurance policy no.: 312146
36. Street address from which worker is/was supervised: 9352 SE Mddison Portland, OR ZIP: 97216
37. Nature of business in which worker is/was supervised: Social Services
38. Street address, city, and state where event occurred: Same
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☒ Yes ☐ No
40. Class code: 9499
41. Were other workers injured? ☐ Yes ☒ No
42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No
43. OSHA 300 log case #:
44. Date employer knew of claim: 7/8/13
45. Worker's monthly wage: $
46. Date worker hired:
47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☒ Regular Date: 7/9/13 ☐ Modified Date:
49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: [signature]
51. Name, title, and phone (please print): Boston R, RN 503 408 4841
52. Date: 7/9/13

801
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OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 922-2689, (503) 378-3272, or Oregon Emergency Response (800) 452-0311, on nights and weekends.

801

saifcorporation
400 High Street, S.E., Salem, OR 97312-1601

For SAIF Customer Use
Area
Dept.
Shift CC

CLAIM NO.
SUBJECT DATE
CLASS
DEFAULT DATE
EMPLOYER'S ACCOUNT NO.

Toll Free Phone: 1-800-285-8525
Toll Free FAX: 1-800-475-7785

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line. Your employer will give you a copy.

1. Date of injury or illness: 7/11/13
2. Date you left work: —
3. Shift on day of injury: (from) 3 ☐ a.m. ☒ p.m. (to) 11 ☐ a.m. ☒ p.m.
4. Regularly scheduled days off: ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S
5. Time of injury or illness: 4:15 ☐ a.m. ☒ p.m.
6. Time you left work: — ☐ a.m. ☐ p.m.
7. Check here if you are employed by more than one employer: ☐
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) (L) Thumb burn ☒ Left ☐ Right
9. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials) I went into the kitchen to clean things up after shift change. I did not notice that the burner was left on from previous shift & I was wiping the stove down & burned my thumb
11. Name of witnesses:
12. Have you previously injured this body part? ☐ Yes ☒ No
13. Your legal name: [redacted]
14. Birthdate: [redacted]
15. Gender: ☐ M ☒ F
16. Mailing address, city, state and zip: [redacted]
18. SSN (See #25 ...): [redacted]
19. Occupation: HTP2
21. Name of physician or health-care professional: Dr. John Sharrer
22. If medical treatment was given away from the worksite, print name and address of facility: —
23. Were you hospitalized overnight as an inpatient? ☐ Yes ☒ No
24. Were you treated in the emergency room? ☐ Yes ☒ No
25. By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.
26. Worker signature: [redacted]
28. Date: 7/11/13

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

29. Employer legal business name: SOCP River Road Group home
30. Phone: (541) 689-1185
31. FEIN:
32. If worker leasing company, list client business name:
33. Client FEIN:
34. Address of principal place of business (not P.O. box): 350 River Rd, Eugene OR 97404
35. Insurance policy no.:
36. Street address from which worker is/was supervised: 350 River Rd, Eugene, OR ZIP: 97404
37. Nature of business in which worker is/was supervised:
38. Street address, city, and state where event occurred: Same
39. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☒ Yes ☐ No
40. Class code:
41. Were other workers injured? ☐ Yes ☒ No
42. Did injury occur during course and scope of job? ☐ Unknown ☒ Yes ☐ No
43. OSHA 300 log case #:
44. Date employer knew of claim: 7/12/13
45. Worker's weekly wage: $
46. Date worker hired: 10/15/12
47. If fatal, date of death:
48. Return-to-work status: ☐ Not returned ☐ Regular Date: ☐ Modified Date:
49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature: [signature], HSS
51. Name, title, and phone (please print): Robert Hester, HSS (541) 689-1185
52. Date: 7/12/13

801

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 922-2689, (503) 378-3272, or Oregon Emergency Response (800) 452-0311, on nights and weekends.

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DHS
Oregon Department of Human Services
State Operated Community Program

Employee Incident/ Accident Report

001

SOCP Safety Program:
503-378-5952 ext 232

Regularly assigned shift hours: 6AM - 10pm **Days off:** Rotating

Accident information

Date of incident: 7-19-13 **Time of incident:** 1225 **Exact location of incident:** Corner Williams Ave and Stanton

Time shift began: 6AM **Was a Client Involved? Yes** ☒ **No** ☐ **Client initials:** LG

Witness(es): *Do not list clients as witnesses.*

Body part injured (R/L): Rt Knee **Nature of the injury:** Bruised Rt Knee c̄ sm.

Describe the incident fully: Back - pulled abrasion on Rt Knee back when fell
While out on an outing - I was pushing wheel chair crossing street at ramp (sidewalk) incline more than normal item fell off of chair and I fell - while pushing chair

What caused the incident?
guess to maybe tripped over item and or steep ramp incline pushing wheel chair too fast

How could the incident have been prevented?
All happened too fast - find safer area to cross street

Employee signa

SUPERVISOR SECTION: (see back for identifying factors which contributed to or caused the accident)

Analysis of the incident

Why it happened – Hazardous condition ☐ **Unsafe behavior** ☐ **System weakness** ☐ **Other** ☒

Explain: It is unclear whether item falling off chair was the cause of the fall or the incline of the ADA sidewalk.

Action taken to prevent a similar incident: Keep back of WC clear of hazardous items if they were to fall.

Client involved? Yes ☒ **No** ☐ **Entered into THERAP? Yes** ☐ **No** ☒

Employee - Went back to work: Yes ☒ **No** ☐ | **Went home: Yes** ☐ **No** ☒ | **Went to doctor*: Yes** ☐ **No** ☐

Anna Barton — *Supervisor signature* 7/19/2013 — *Date*

***NOTE: If yes, need 801 within five (5) days of your knowledge of doctor treatment.)** **OVER >**

saifcorporation

400 High St. SE, Salem, OR 97312

For SAIF Customer Use
Area ______
Dept. ______
Shift ______ CC ______

CLAIM NO. ______
SUBJECT DATE ______
CLASS ______
DEFAULT DATE ______
EMPLOYER'S ACCOUNT NO. ______

Email: saif801@saif.com
Toll-free phone: 1.800.285.8525
Toll-free FAX: 1.800.475.7785

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. If you do not intend to file a workers' compensation claim with SAIF Corporation, do not sign the signature line. Your employer will give you a copy.

1. Date of injury or illness: 7/13/13 7/14
2. Date you left work:
3. Time you began work on day of injury: 1100 [X] a.m. [ ] p.m.
4. Regularly scheduled days off: [ ] M [X] T [X] W [ ] T [ ] F [ ] S [ ] S
5. Time of injury or illness: 915 [X] a.m. [ ] p.m.
6. Time you left work: didn't [ ] a.m. [ ] p.m.
7. Shift on day of injury: (from) 7 AM [X] a.m. [ ] p.m. (to) 3 pm [X] a.m. [ ] p.m.
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) [ ] Left [ ] Right
Back pain, Shoulder pain (R) side
9. Check here if you have more than one job: [ ]
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing material.)
Yesterday 7/13/13 while helping Larry off and on to the toilet from wheel chair he was dead weight and pulled on my shoulder and back.
Today 7/14/13 while 2 of us were Transfering Larry to bed he fell to bed pulling me down on him and onto the floor.

DEPT USE: Emp / Ins / Occ / Nat / Part / Ev / Src / 2src

20. Names of witnesses: Jennifer Walson, Dana
21. Name and phone number of health insurance company:
22. Name and address of health care provider who treated you for the injury or illness you are now reporting:
23. Have you previously injured this body part? Back [X] Yes [ ] No
24. Were you hospitalized overnight as an inpatient? [ ] Yes [X] No
25. Were you treated in the emergency room? [ ] Yes [X] No

26. By my signature, I am making a claim for worker's compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. Notice: Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF Corporation within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

30. Employer legal business name:
31. Phone:
32. FEIN:
33. If worker leasing company, list client business name:
34. Client FEIN:
35. Address of principal place of business (not P.O. Box):
36. Insurance policy no.:
37. Street address from which worker is/was supervised: ZIP:
38. Name of business in which worker is/was supervised:
39. Address where event occurred:
40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? [ ] Yes [ ] No
41. Class code:
42. Were other workers injured? [ ] Yes [ ] No
43. Did injury occur during course and scope of job? [ ] Unknown [ ] Yes [ ] No
44. OSHA 300 log case no:
45. Date employer knew of claim:
46. Worker's weekly wage: $
47. Date worker hired:
48. If fatal, date of death:
49. Return-to-work status: Not returned [ ] Regular Date: [ ] Modified Date: [ ]
50. If returned to modified work, is it at regular hours and wages? [ ] Yes [ ] No
51. Employer signature:
52. Name and title (please print):
53. Date:

801

OSHA requirements: On the job fatalities and catastrophes must be reported to Oregon OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to Oregon OSHA. Call 800.922.2689, 503.378.3272, or Oregon Emergency Response 800.452.0311, on nights and weekends.

801

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Jul. 17. 2013 3:57PM DHS Junction City No. 0613 P. 3

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

SOCP Safety Checklist

DHS 4577

Facility: Cade / SOCP   Date: 7/3/13   Inspector: Darla Jordan MHS

+ = OK   0 = Not OK   NA = Not Applicable

Item		Item	
1.0 General environment		**5.0 Emergency equipment**	
1.1 All areas are clean and organized	+	5.1 First aid kits/manuals are complete and available	+
1.2 No trip hazards present inside or outside	+	5.2 PPE kits are complete and available	+
1.3 All lights working	+	5.3 Emergency phone numbers are current and posted By phone	+
1.4 No bee/wasp/hornet nests Shed bee + Nest taken care of on shed.	+	5.4 Garbage/laundry for Blood Borne Pathogens are labeled	+
1.5 Knives, scissors, etc., stored correctly In locked areas on 3.5.	+	5.5 Flashlights working and available on each floor/side	+
1.6 Water temperature < 120 All within 120°	+	5.6 Other (list):	
1.7 Security alarms/motion detectors: ☒ Windows ☒ Doors ☒ Maglocks	+		
1.8 Other (list):		**6.0 Yard/maintenance equipment**	
2.0 Electrical safety		6.1 Guards on mowers, edgers, etc. in place	+
		6.2 Eye protection available	+
2.1 Outlet/switch cover plates intact	+	6.3 Ear protection available	+
2.2 Extension cords are not in use	+	6.4 Ladders in good repair	+
2.3 Electrical cords not frayed/cracked	+	6.5 Ladder's top step labeled "Not a Step"	+
2.4 3' clearance in front of breaker box	+	6.6 Check fences/gates for repair	+
2.5 All circuits in breaker box labeled	+	6.7 Other (list):	
2.6 Other (list):		**7.0 Hazard communication**	+
3.0 Fire and evacuation safety		7.1 All chemical containers labeled	+
3.1 No items in 18" plane of fire sprinkler head	+	7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
3.2 Extinguishers charged/tagged (current tag)/available (All within Perimeters)	+	7.3 Combustible/corrosive/poisonous chemicals stored properly	+
3.3 Dryer and furnace filters are clean Filters changed 6/30/13	+	7.4 Personal Protection Equipment for chemical use available	+
3.4 Exits are not blocked	+	7.5 Other (list): gloves, mask, eye shield, gown available	
3.5 Smoke detectors/alarms working	+	**8.0 Vehicles**	
3.6 Exit lights are working (if applicable)	+	8.1 All shift inspections done	+
3.7 Exhaust fans are clean and operational	+	8.2 Seat belts operational	+
3.8 Other (list):		8.3 Other (list):	
4.0 OSHA Requirements		**9.0 Medical homes**	
4.1 Current SOCP Safety Committee minutes posted In sign in book	+	9.1 Adaptive equipment brakes/safety straps in good repair	N/A
4.2 Eyewash station operational (flushed weekly)	+	9.2 No rough/sharp edges on adaptive equipment	N/A
4.3 Other (list):		9.3 Generator upkeep schedule current	+
		9.4 Other (list): Hospital bed, walker brakes, Rails in bedroom, battery for bedside Sensors. portable oxygen machine & cannula changed 5/8/13	

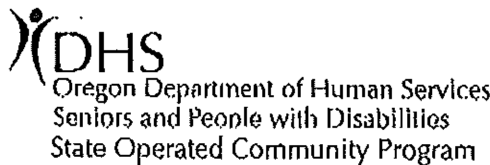
Item #: **Comments/Action Taken**

- Safety brackett missing on North side of House

Therap note to staff to return missing bracelet

Site Administrator signature: [signature]   Date: 7/3/13

Original filed at house; Copy to Safety Office



Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

SOCP Safety Checklist

DHS 4577

Facility: charles st Date: 7-15-13 Inspector: D Anderson

+ = OK 0 = Not OK NA = Not Applicable

1.0 General environment		5.0 Emergency equipment	
1.1 All areas are clean and organized	+	5.1 First aid kits/manuals are complete and available	+
1.2 No trip hazards present inside or outside	+	5.2 PPE kits are complete and available	+
1.3 All lights working	+	5.3 Emergency phone numbers are current and posted	+
1.4 No bee/wasp/hornet nests	+	5.4 Garbage/laundry for Blood Borne Pathogens are labeled	+
1.5 Knives, scissors, etc., stored correctly	+	5.5 Flashlights working and available on each floor/side	+
1.6 Water temperature < 120	+	5.6 Other (list):	
1.7 Security alarms/motion detectors: ☒ Windows ☐ Doors ☒ Maglocks		**6.0 Yard/maintenance equipment**	
1.8 Other (list):		6.1 Guards on mowers, edgers, etc. in place	+
2.0 Electrical safety		6.2 Eye protection available	+
2.1 Outlet/switch cover plates intact	0	6.3 Ear protection available	+
2.2 Extension cords are not in use	+	6.4 Ladders in good repair	+
2.3 Electrical cords not frayed/cracked	+	6.5 Ladder's top step labeled "Not a Step"	+
2.4 3' clearance in front of breaker box	+	6.6 Check fences/gates for repair	+
2.5 All circuits in breaker box labeled	+	6.7 Other (list):	
2.6 Other (list):		**7.0 Hazard communication**	
3.0 Fire and evacuation safety		7.1 All chemical containers labeled	+
3.1 No items in 18" plane of fire sprinkler head	+	7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
3.2 Extinguishers charged/tagged (current tag)/available	+	7.3 Combustible/corrosive/poisonous chemicals stored properly	+
3.3 Dryer and furnace filters are clean	+	7.4 Personal Protection Equipment for chemical use available	+
3.4 Exits are not blocked	+	7.5 Other (list):	
3.5 Smoke detectors/alarms working	+	**8.0 Vehicles**	
3.6 Exit lights are working (if applicable)	N/A	8.1 All shift inspections done	+
3.7 Exhaust fans are clean and operational	+	8.2 Seat belts operational	+
3.8 Other (list):		8.3 Other (list):	
4.0 OSHA Requirements		**9.0 Medical homes**	
4.1 Current SOCP Safety Committee minutes posted	+	9.1 Adaptive equipment brakes/safety straps in good repair	+
4.2 Eyewash station operational	+	9.2 No rough/sharp edges on adaptive equipment	+
4.3 Other (list):		9.3 Generator upkeep schedule current	N/A
		9.4 Other (list):	

Rved 7/24

Item #:	Comments/Action Taken
2.1	lightswitch needs replaced 2 bed side workorder submitted 5-1-13
2.1	outlet cover in clients bedroom (2 bed side) is pushed in.

Site Administrator signature: ______________ Date: ______________

Original filed at house; Copy to Safety Office

DHS
Oregon Department of Human Services
Seniors and People with disabilities

State Operated Community Program
Safety Checklist

Facility: Dean Date: 7-8-13 Inspector: Jean Schaible

+ = OK 0 = Not OK NA = Not Applicable

1.0 General Environment		5.0 Emergency Equipment	
1.1 All areas are clean and organized	+	5.1 First aid kits/manuals are complete and available	+
1.2 No trip hazards present inside or outside	+	5.2 PPE kits are complete and available	+
1.3 All lights working	+	5.3 Emergency phone numbers are current and posted	+
1.4 No bee/wasp/hornet nests	+	5.4 Garbage/laundry for Blood Borne Pathogens are labeled	+
1.5 Knives, scissors, etc., stored correctly	+	5.5 Flashlights working and available on each floor/side	+
1.6 Water temperature < 120	+	5.6 Other (list):	
1.7 Security Alarms/motion detectors	+	**6.0 Yard/Maintenance Equipment**	
1.8 Other (list):		6.1 Guards on mowers, edgers, etc. in place	+
2.0 Electrical Safety		6.2 Eye protection available	+
2.1 Outlet/switch cover plates intact	+	6.3 Ear protection available	+
2.2 Extension cords are not in use	+	6.4 Ladders in good repair	+
2.3 Electrical cords not frayed/cracked	+	6.5 Ladder's top step labeled "Not a Step"	+
2.4 3' clearance in front of breaker box	+	6.6 Check fences/gates for repair	+
2.5 All circuits in breaker box labeled	+	6.7 Other (list):	
2.6 Other (list):		**7.0 Hazard Communication**	
3.0 Fire and Evacuation Safety		7.1 All chemical containers labeled	+
3.1 No items in 18" plane of fire sprinkler head	+	7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
3.2 Extinguishers charged/tagged (current tag)/available	–	7.3 Combustible/corrosive/poisonous chemicals stored properly	+
3.3 Dryer and furnace filters are clean	+	7.4 Personal Protection Equipment for chemical use available	+
3.4 Exits are not blocked	+	7.5 Other (list):	
3.5 Smoke detectors/alarms working	+	**8.0 Vehicles**	
3.6 Exit lights are working (if applicable)	+	8.1 All shift inspections done	+
3.7 Exhaust fans are clean and operational	+	8.2 Seatbelts operational	+
3.8 Other (list):		8.3 Other (list):	
4.0 OSHA Requirements		**9.0 Medical Homes**	
4.1 Current SOCP Safety Committee minutes posted	+	9.1 Adaptive equipment brakes/safety straps in good repair	NA
4.2 Eyewash station operational	+	9.2 No rough/sharp edges on adaptive equipment	NA
4.3 Other (list):		9.3 Generator upkeep schedule current	NA
		9.4 Other (list):	NA

Item #	Comments/Action Taken
3.2	Extinguishers out of Date by one & two years

Site Administrator Signature: Sharon Freeman Date: 7/8/13

Original filed at house; Copy to Safety Office

Policy #5.008 Attachment A Mandatory

DHS 4577 (2/07)

Jul. 8. 2013 12:32PM No. 0580 P. 2

Oregon Department of Human Services

Seniors and People with Disabilities
State Operated Community Program

SOCP Safety Checklist

To be completed monthly
___ faxed to the Safety Office
___ Original filed at house

House: Forsythia	Date: 7-12-13	Inspector: Justin George MHTT

+ = OK 0 = Not OK NA = Not Applicable

1.0 General Environment		4.0 Other Requirements	
1.1 All areas are clean and organized	+	4.1 Current Safety Committee minutes posted	+
1.2 No trip hazards present inside or outside	+	4.2 Eyewash station operational	+
1.3 All lights working	0	4.3 Eyewash station checked as tested for month	+
1.4 No bee/wasp/hornet nests	+	4.4 Other (list):	
1.5 Knives, scissors, etc., stored correctly	+	**5.0 Emergency Equipment**	
1.6 Water temperature < 120 for clients	+	5.1 First aid kits/manuals are complete and available	+
1.7 Security alarms/motion detectors ☒ Windows ☒ Doors ☒ Maglocks	[illegible]	5.2 PPE kits are complete and available	+
1.8 Stained/soiled couches or carpeting (where?)	+	5.3 Emergency phone numbers are current and posted	+
1.9 Mold present (where?)	+	5.4 Garbage/laundry for Bloodborne Pathogens are labeled	+
1.9 Other (list):		5.5 Flashlights working and available on each floor/side	+
2.0 Electrical Safety		5.6 Other (list):	
2.1 Outlet/switch cover plates intact	+	**6.0 Yard/Maintenance Equipment**	
2.2 Extension cords are not in use	+	6.1 Guards on mowers, edgers, etc. in place	+
2.3 Electrical cords not frayed/cracked	+	6.2 Eye protection available	+
2.4 3' clearance in front of breaker box	+	6.3 Ear protection available	+
2.5 All circuits in breaker box labeled	+0	6.4 Ladders in good repair	+
2.6 Other (lists):		6.5 Ladder's top step labeled "Not a Step"	+
3.0 Fire and Evacuation Safety		6.6 Check fences/gates for repair	+
3.1 No items in 18" plane of fire sprinkler head	+	6.7 Other (list):	
3.2 Extinguishers within "Green" charged area	+	**7.0 Hazard Communication**	
3.3 Extinguishers initialed on back of tag monthly	+	7.1 All chemical containers labeled	+
3.4 Dryer and furnace filters are clean	+	7.2 All MSDS's for chemicals in book	+
3.5 Exits are not blocked	+	7.3 Combustible/corrosive/poisonous chemicals properly stored	+
3.6 Exit lights are working (if applicable)	+	7.4 Personal Protection Equipment for chemical use available	+
3.7 Exhaust fans are clean and operational	+	7.5 Other (list):	
3.8 Smoke detectors/alarms working	+	**8.0 Vehicles**	
3.9 Emergency Plan in place for all clients (Place clients initials below) HB SF EH MR ___ ___ ___	+	8.1 All shift inspections done	+
MEDICAL ONLY HOMES		8.2 Seat belts operational	+
M1 Adaptive equipment brakes/safety straps in good repair	N/A	8.3 Garbage/debris removed from inside vehicle	+
M2 No rough/sharp edges on adaptive equipment	N/A	8.4 Cell phones accounted for, working, undamaged:	+
M3 Generator upkeep schedule current	+	8.5 Other (list):	+
M4 Other (list):			

Item #	Comments/Action Taken (use additional page if necessary)
2.5	Breakers request has been made.
1.3	Lights were ordered but didn't arrive

XXX week Giantbulbs 2 G

Site Manager Signature: [signature] Date: 7/17/13

Policy #5.008 Attachment A

Revised 09/12

Received Time Jul. 12. 2013 2:30PM No. 2638

Seniors and People with Disabilities
State Operated Community Program

RECEIVED
JUL 12 2013
DHS SOCP
Human Resources

Safety Checklist

Facility: Gath Road Date: 7/4/13 Inspector: Jamie

+ = OK 0 = Not OK NA = Not Applicable

1.0 General Environment	
1.1 All areas are clean and organized	+
1.2 No trip hazards present inside or outside	+
1.3 All lights working	+
1.4 No bee/wasp/hornet nests	+
1.5 Knives, scissors, etc. stored correctly	+
1.6 Water temperature < 120	0
1.7 Other (list):	
2.0 Electrical Safety	
2.1 Outlet/switch cover plates intact	+
2.2 Extension cords are not in use	+
2.3 Electrical cords not frayed/cracked	+
2.4 3' clearance in front of breaker box	+
2.5 All circuits in breaker box labeled	+
2.6 Other (list):	
3.0 Fire and Evacuation Safety	
3.1 No items in 18" plane of fire sprinkler heads	+
3.2 Extinguishers charged/tagged (current tag)/ available	+
3.3 Dryer and furnace filters are clean	+
3.4 Exits are not blocked	+
3.5 Smoke detectors/alarms working	+
3.6 Exit lights are working (if applicable)	+
3.7 Other (list):	
4.0 OSHA Requirements	
4.1 Other (list):	
4.2 Current SOCP Safety committee minutes posted	+
4.3 Eyewash station operational	+
4.4 Other (list):	

5.0 Emergency Equipment	
5.1 First aid kits are complete and available	+
5.2 PPE kits are complete and available	+
5.3 Emergency phone numbers are current and posted	+
5.4 Garbage/laundry for Blood Borne Pathogens are labeled	+
5.5 Flashlights working and available on each floor/side	+
5.6 Other (list):	
6.0 Yard/Maintenance Equipment	
6.1 Guards on mowers, [redacted] etc. in place	+
6.2 Eye protection available	+
6.3 Ear protection available	+
6.4 Ladders in good repair	+
6.5 Ladder's top step labeled "Not a Step"	+
6.6 Other (list):	
7.0 Hazard Communication	
7.1 All chemical containers labeled	+
7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
7.3 Combustible/corrosive/poisonous chemicals stored properly	+
7.4 Personal Protection Equipment for chemical use available	+
7.5 Other (list):	
8.0 Vehicles	
8.1 All shift inspections done	+
8.2 Seatbelts operational	+
8.3 Other (list):	
9.0 Medical Homes	
9.1 Adaptive equipment brakes/safety straps in good repair	0
9.2 No rough/sharp edges on adaptive equipment	+
9.3 Generator upkeep schedule current	+
9.4 Other (list):	

Item #:	Comments/Action Taken
	Water Need turned down little Bit 122°
	I will ajust Temp on 7/5/13
	Adaptive equipment on New client ~~[illegible]~~ Vest zipper broke

Site Administrator Signature: [signature] SM Date: 7/11/13

Policy #5.008 Attachment A * 9.1 → called orth. co to repair all B.P equip. Mandatory 7/04

V.J. getting pre auth from [illegible]

Jul. 12. 2013 2:14PM No. 6294 P. 2

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

SOCP Safety Checklist

DHS 4577

Facility: Halsey Date: 7/15/13 Inspector: Jason

+ = OK 0 = Not OK NA = Not Applicable

1.0 General environment	
1.1 All areas are clean and organized	+
1.2 No trip hazards present inside or outside	0
1.3 All lights working	+
1.4 No bee/wasp/hornet nests	+
1.5 Knives, scissors, etc., stored correctly	+
1.6 Water temperature < 120	+
1.7 Security alarms/motion detectors: ☑ Windows ☑ Doors ☑ Maglocks	+
1.8 Other (list):	
2.0 Electrical safety	
2.1 Outlet/switch cover plates intact	0
2.2 Extension cords are not in use	+
2.3 Electrical cords not frayed/cracked	+
2.4 3' clearance in front of breaker box	+
2.5 All circuits in breaker box labeled	0
2.6 Other (list):	
3.0 Fire and evacuation safety	
3.1 No items in 18" plane of fire sprinkler head	+
3.2 Extinguishers charged/tagged (current tag)/available	+
3.3 Dryer and furnace filters are clean	+
3.4 Exits are not blocked	+
3.5 Smoke detectors/alarms working	+
3.6 Exit lights are working (if applicable)	+
3.7 Exhaust fans are clean and operational	0
3.8 Other (list):	
4.0 OSHA Requirements	
4.1 Current SOCP Safety Committee minutes posted	+
4.2 Eyewash station operational	0
4.3 Other (list):	

5.0 Emergency equipment	
5.1 First aid kits/manuals are complete and available	+
5.2 PPE kits are complete and available	+
5.3 Emergency phone numbers are current and posted	+
5.4 Garbage/laundry for Blood Borne Pathogens are labeled	0
5.5 Flashlights working and available on each floor/side	+
5.6 Other (list):	
6.0 Yard/maintenance equipment	
6.1 Guards on mowers, edgers, etc. in place	+
6.2 Eye protection available	+
6.3 Ear protection available	+
6.4 Ladders in good repair *Need longer*	0
6.5 Ladder's top step labeled "Not a Step"	+
6.6 Check fences/gates for repair	0
6.7 Other (list):	
7.0 Hazard communication	
7.1 All chemical containers labeled	+
7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
7.3 Combustible/corrosive/poisonous chemicals stored properly	+
7.4 Personal Protection Equipment for chemical use available	+
7.5 Other (list):	
8.0 Vehicles	
8.1 All shift inspections done	+
8.2 Seat belts operational	+
8.3 Other (list):	
9.0 Medical homes	
9.1 Adaptive equipment brakes/safety straps in good repair	N/A
9.2 No rough/sharp edges on adaptive equipment	N/A
9.3 Generator upkeep schedule current	N/A
9.4 Other (list):	N/A

Item #	Comments/Action Taken
1.2	Fence screws and nails (2.1) lose or need to be replaced/Not client safe
2.5	Need labeled for all circuits, Alarm and breaker. One breaker is out.
3.7	In kitchen (4.2) No head room. (5.4) Need 3 for cars/vehicles
6.6	lose nails and screws / warped and cracking.

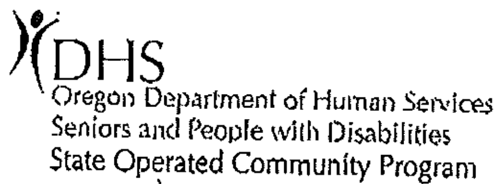
Site Administrator signature: ________ Date: 7/15/13

Original filed at house; Copy to Safety Office

Policy #5.008 Attachment A Mandatory

DHS 4577 (3/11)

JUL. 14. 2013 1:05PM No. 6190 P. 2



DHS
Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

SOCP Safety Checklist

DHS 4577

Facility: Jody Place Date: 7/10/13 Inspector: Rebecca Moore, ltt

+ = OK 0 = Not OK NA = Not Applicable

Item		Item	
1.0 General environment	0	**5.0 Emergency equipment**	+
1.1 All areas are clean and organized	+	5.1 First aid kits/manuals are complete and available	+
1.2 No trip hazards present inside or outside	+	5.2 PPE kits are complete and available	+
1.3 All lights working	+	5.3 Emergency phone numbers are current and posted	+
1.4 No bee/wasp/hornet nests	0	5.4 Garbage/laundry for Blood Borne Pathogens are labeled	+
1.5 Knives, scissors, etc., stored correctly	+	5.5 Flashlights working and available on each floor/side	+
1.6 Water temperature < 120	0	5.6 Other (list):	
1.7 Security alarms/motion detectors: ☐ Windows ☐ Doors ☐ Maglocks	NA	**6.0 Yard/maintenance equipment**	
1.8 Other (list):		6.1 Guards on mowers, edgers, etc. in place	+
2.0 Electrical safety	+	6.2 Eye protection available	+
2.1 Outlet/switch cover plates intact	+	6.3 Ear protection available	+
2.2 Extension cords are not in use	+	6.4 Ladders in good repair	+
2.3 Electrical cords not frayed/cracked	+	6.5 Ladder's top step labeled "Not a Step"	+
2.4 3' clearance in front of breaker box	+	6.6 Check fences/gates for repair	+
2.5 All circuits in breaker box labeled	+	6.7 Other (list):	
2.6 Other (list):		**7.0 Hazard communication**	+
3.0 Fire and evacuation safety	+	7.1 All chemical containers labeled	+
3.1 No items in 18" plane of fire sprinkler head	+	7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
3.2 Extinguishers charged/tagged (current tag)/available Laundry Closet/Supply Rm. Above	+	7.3 Combustible/corrosive/poisonous chemicals stored properly	+
3.3 Dryer and furnace filters are clean	+	7.4 Personal Protection Equipment for chemical use available	+
3.4 Exits are not blocked	+	7.5 Other (list):	
3.5 Smoke detectors/alarms working	+	**8.0 Vehicles**	+
3.6 Exit lights are working (if applicable)	NA	8.1 All shift inspections done	+
3.7 Exhaust fans are clean and operational	+	8.2 Seat belts operational	+
3.8 Other (list):		8.3 Other (list):	
4.0 OSHA Requirements		**9.0 Medical homes**	
4.1 Current SOCP Safety Committee minutes posted	+	9.1 Adaptive equipment brakes/safety straps in good repair	NA
4.2 Eyewash station operational	+	9.2 No rough/sharp edges on adaptive equipment	NA
4.3 Other (list):		9.3 Generator upkeep schedule current	NA
		9.4 Other (list):	

Item #:	Comments/Action Taken
1.0	Bathroom #2 Door is getting too loose — work order submitted
1.6	Water gauge is missing thermometer → Heat Xform
1.4	Three Hornets nest in the steeples on the outside of the house

Site Administrator signature: Brenda Roadhouse/SM Date: 7/10/13

Policy #5.008 Attachment A Mandatory Original filed at house; Copy to Safety Office

Seniors and People with Disabilities
State Operated Community Program

Safety Checklist

Facility: Macleay SOCP Date: 7-3-2013 Inspector: MWood MATT

+ = OK 0 = Not OK NA = Not Applicable

Item		Item	
1.0 General Environment		**5.0 Emergency Equipment**	
1.1 All areas are clean and organized	+	5.1 First aid kits are complete and available	+
1.2 No trip hazards present inside or outside	+	5.2 PPE kits are complete and available	+
1.3 All lights working	+	5.3 Emergency phone numbers are current and posted	+
1.4 No bee/wasp/hornet nests	+	5.4 Garbage/laundry for Blood Borne Pathogens are labeled	+
1.5 Knives, scissors, etc. stored correctly	+	5.5 Flashlights working and available on each floor/side	+
1.6 Water temperature < 120	+	5.6 Other (list):	+
1.7 Other (list):	0	**6.0 Yard/Maintenance Equipment**	
2.0 Electrical Safety		6.1 Guards on mowers, edgers, etc. in place	+
2.1 Outlet/switch cover plates intact	+	6.2 Eye protection available	+
2.2 Extension cords are not in use	+	6.3 Ear protection available	+
2.3 Electrical cords not frayed/cracked	+	6.4 Ladders in good repair	+
2.4 3' clearance in front of breaker box	+	6.5 Ladder's top step labeled "Not a Step"	+
2.5 All circuits in breaker box labeled	+	6.6 Other (list):	+
2.6 Other (list):	+	**7.0 Hazard Communication**	
3.0 Fire and Evacuation Safety		7.1 All chemical containers labeled	+
3.1 No items in 18" plane of fire sprinkler heads	+	7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
3.2 Extinguishers charged/tagged (current tag)/ available	+	7.3 Combustible/corrosive/poisonous chemicals stored properly	+
3.3 Dryer and furnace filters are clean	+	7.4 Personal Protection Equipment for chemical use available	+
3.4 Exits are not blocked	+	7.5 Other (list):	+
3.5 Smoke detectors/alarms working	+	**8.0 Vehicles**	
3.6 Exit lights are working (if applicable)	+	8.1 All shift inspections done	+
3.7 Other (list):	+	8.2 Seatbelts operational	+
4.0 OSHA Requirements		8.3 Other (list):	+
4.1 Other (list):	+	**9.0 Medical Homes**	
4.2 Current SOCP Safety committee minutes posted	+	9.1 Adaptive equipment brakes/safety straps in good repair	NA
4.3 Eyewash station operational	+	9.2 No rough/sharp edges on adaptive equipment	NA
4.4 Other (list):	+	9.3 Generator upkeep schedule current	+
		9.4 Other (list):	+

Item #	Comments/Action Taken
1.7	Southside Rm # [illegible], Heat vent needs to be re-attached

Site Administrator Signature: [signature] Date: 7-3-13

Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

1-503-378-5917

SOCP Safety Checklist

To be completed monthly
___ faxed to the Safety Office
___ Original filed at house

House: MADISON	Date: 7/4/13	Inspector: BILL Tellez

+ = OK / = Not OK NA = Not Applicable

1.0 General Environment	
1.1 All areas are clean and organized	+
1.2 No trip hazards present inside or outside	+
1.3 All lights working	+
1.4 No bee/wasp/hornet nests	+
1.5 Knives, scissors, etc., stored correctly	+
1.6 Water temperature < 120 for clients	+
1.7 Security alarms/motion detectors ☐ Windows ☐ Doors ☐ Maglocks	+
1.8 Other (list):	

2.0 Electrical Safety	
2.1 Outlet/switch cover plates intact	+
2.2 Extension cords are not in use	+
2.3 Electrical cords not frayed/cracked	+
2.4 3' clearance in front of breaker box	+
2.5 All circuits in breaker box labeled	+
2.6 Other (lists):	

3.0 Fire and Evacuation Safety	
3.1 No items in 18" plane of fire sprinkler head	+
3.2 Extinguishers within "Green" charged area	+
3.3 Extinguishers initialed on back of tag monthly	+
3.4 Dryer and furnace filters are clean	+
3.5 Exits are not blocked	+
3.6 Exit lights are working (if applicable)	+
3.7 Exhaust fans are clean and operational	+
3.8 Smoke detectors/alarms working	+
3.9 Emergency Plan in place for all clients (Place clients initials below) ___ ___ ___ ___ ___ ___ ___	+

4.0 Other Requirements	
4.1 Current Safety Committee minutes posted	+
4.2 Eyewash station operational	+
4.3 Eyewash station checked as tested for month	+
4.4 Other (list):	

5.0 Emergency Equipment	
5.1 First aid kits/manuals are complete and available	+
5.2 PPE kits are complete and available	+
5.3 Emergency phone numbers are current and posted	+
5.4 Garbage/laundry for Bloodborne Pathogens are labeled	+
5.5 Flashlights working and available on each floor/side	+
5.6 Other (list):	

6.0 Yard/Maintenance Equipment	
6.1 Guards on mowers, edgers, etc. in place	+
6.2 Eye protection available	+
6.3 Ear protection available	N/A
6.4 Ladders in good repair	+
6.5 Ladder's top step labeled "Not a Step"	+
6.6 Check fences/gates for repair	+
6.7 Other (list):	N/A

7.0 Hazard Communication	
7.1 All chemical containers labeled	+
7.2 All MSDS's for chemicals in book	+
7.3 Combustible/corrosive/poisonous chemicals properly stored	+
7.4 Personal Protection Equipment for chemical use available	+
7.5 Other (list):	

8.0 Vehicles	
8.1 All shift inspections done	+
8.2 Seat belts operational	+
8.3 Garbage/debris removed from inside vehicle	+
8.4 Other (list):	

9.0 Medical Home	
9.1 Adaptive equipment brakes/safety straps in good repair	N/A
9.2 No rough/sharp edges on adaptive equipment	N/A
9.3 Generator upkeep schedule current	+
9.4 Other (list):	

Item #	Comments/Action Taken

Site Manager Signature: ______________________ Date: __________

DHS
Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

SOCP Safety Checklist

DHS 4577

Facility: Milton   Date: 7-15-13   Inspector: DDelesmHtt

+ = OK   0 = Not OK   NA = Not Applicable

Item		Item	
1.0 General environment		**5.0 Emergency equipment**	
1.1 All areas are clean and organized	+	5.1 First aid kits/manuals are complete and available	+
1.2 No trip hazards present inside or outside	+	5.2 PPE kits are complete and available	+
1.3 All lights working	0	5.3 Emergency phone numbers are current and posted	+
1.4 No bee/wasp/hornet nests	+	5.4 Garbage/laundry for Blood Borne Pathogens are labeled	+
1.5 Knives, scissors, etc., stored correctly	+	5.5 Flashlights working and available on each floor/side	+
1.6 Water temperature < 120	+	5.6 Other (list):	
1.7 Security alarms/motion detectors: ☒ Windows ☒ Doors ☒ Maglocks	+	**6.0 Yard/maintenance equipment**	
1.8 Other (list):		6.1 Guards on mowers, edgers, etc. in place	+
2.0 Electrical safety	0	6.2 Eye protection available	+
2.1 Outlet/switch cover plates intact	+	6.3 Ear protection available	+
2.2 Extension cords are not in use	+	6.4 Ladders in good repair	+
2.3 Electrical cords not frayed/cracked	+	6.5 Ladder's top step labeled "Not a Step"	+
2.4 3' clearance in front of breaker box	+	6.6 Check fences/gates for repair	+
2.5 All circuits in breaker box labeled	+	6.7 Other (list):	
2.6 Other (list): x2 Pluggs need replaced		**7.0 Hazard communication**	
3.0 Fire and evacuation safety		7.1 All chemical containers labeled	+
3.1 No items in 18" plane of fire sprinkler head	+	7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
3.2 Extinguishers charged/tagged (current tag)/available	+	7.3 Combustible/corrosive/poisonous chemicals stored properly	+
3.3 Dryer and furnace filters are clean	+	7.4 Personal Protection Equipment for chemical use available	+
3.4 Exits are not blocked	+	7.5 Other (list):	
3.5 Smoke detectors/alarms working	+	**8.0 Vehicles**	
3.6 Exit lights are working (if applicable)	+	8.1 All shift inspections done	+
3.7 Exhaust fans are clean and operational	+	8.2 Seat belts operational	+
3.8 Other (list):		8.3 Other (list):	
4.0 OSHA Requirements		**9.0 Medical homes**	
4.1 Current SOCP Safety Committee minutes posted	+	9.1 Adaptive equipment brakes/safety straps in good repair	NA
4.2 Eyewash station operational	+	9.2 No rough/sharp edges on adaptive equipment	NA
4.3 Other (list):		9.3 Generator upkeep schedule current	+
		9.4 Other (list):	

Long distance phone calls only - #97

Item #:	Comments/Action Taken
1.3	8 Lites burnt out.
2.6	x2 Pluggs Loose (old need replaced) south side
☆	x2 cell phone old (2006) no camera need new phones

Site Administrator signature: ______________________ Date: ____________

Policy #5.008 Attachment A   Mandatory   Original filed at house; Copy to Safety Office   DHS 4577 (3/11)

A/C broke - N. Side - Johnathan Graf

JUL. 15. 2013 3:46PM   No. 8936 P. 1

Oregon Department of Human Services
Seniors and People with Disabilities
State Operated Community Program

SOCP Safety Checklist

To be completed monthly
___ faxed to the Safety Office
___ Original filed at house

House:	River Road	Date:	7-8-13	Inspector:	DAVID BOES

+ = OK 0 = Not OK NA = Not Applicable

1.0 General Environment		4.0 Other Requirements	
1.1 All areas are clean and organized	+	4.1 Current Safety Committee minutes posted	+
1.2 No trip hazards present inside or outside	+	4.2 Eyewash station operational	+
1.3 All lights working	+	4.3 Eyewash station checked as tested for month	+
1.4 No bee/wasp/hornet nests	+	4.4 Other (list):	
1.5 Knives, scissors, etc., stored correctly	+	**5.0 Emergency Equipment**	
1.6 Water temperature < 120 for clients	+	5.1 First aid kits/manuals are complete and available	+
1.7 Security alarms/motion detectors ☐ Windows ☐ Doors ☐ Maglocks	+	5.2 PPE kits are complete and available	+
1.8 Stained/soiled couches or carpeting (where?)	+	5.3 Emergency phone numbers are current and posted	+
1.9 Mold present (where?)	+	5.4 Garbage/laundry for Bloodborne Pathogens are labeled	+
1.9 Other (list):		5.5 Flashlights working and available on each floor/side	+
2.0 Electrical Safety		5.6 Other (list):	
2.1 Outlet/switch cover plates intact 3 bd K switch	0	**6.0 Yard/Maintenance Equipment**	
2.2 Extension cords are not in use	+	6.1 Guards on mowers, edgers, etc. in place	+
2.3 Electrical cords not frayed/cracked	+	6.2 Eye protection available	+
2.4 3' clearance in front of breaker box	+	6.3 Ear protection available	+
2.5 All circuits in breaker box labeled	+	6.4 Ladders in good repair	+
2.6 Other (lists):		6.5 Ladder's top step labeled "Not a Step"	+
3.0 Fire and Evacuation Safety		6.6 Check fences/gates for repair	+
3.1 No items in 18" plane of fire sprinkler head	+	6.7 Other (list):	
3.2 Extinguishers within "Green" charged area	+	**7.0 Hazard Communication**	
3.3 Extinguishers initialed on back of tag monthly	+	7.1 All chemical containers labeled	+
3.4 Dryer and furnace filters are clean		7.2 All MSDS's for chemicals in book	+
3.5 Exits are not blocked	+	7.3 Combustible/corrosive/poisonous chemicals properly stored	+
3.6 Exit lights are working (if applicable)	+	7.4 Personal Protection Equipment for chemical use available	+
3.7 Exhaust fans are clean and operational	+	7.5 Other (list):	
3.8 Smoke detectors/alarms working		**8.0 Vehicles**	
3.9 Emergency Plan in place for all clients (Place clients initials below) SE SH VB LL		8.1 All shift inspections done	+
MEDICAL ONLY HOMES		8.2 Seat belts operational	+
M1 Adaptive equipment brakes/safety straps in good repair		8.3 Garbage/debris removed from inside vehicle	+
M2 No rough/sharp edges on adaptive equipment		8.4 Cell phones accounted for, working, undamaged:	+
M3 Generator upkeep schedule current		8.5 Other (list):	
M4 Other (list):			

Item #	Comments/Action Taken (use additional page if necessary)
	NEED A NEW IN-GROUND CONTROL VALVE BOX (BROKEN)

Site Manager Signature: ______________________ Date: __________