Central Safety Committee Meeting
May 28, 2014 @ 1:00 pm

AGENDA:

- Call to order
- Reviews:
  - Injury Reports
  - Vehicle Accidents
  - Safety Checklist
- New Business
  - Review what Safety Representatives should/should not do?
- Next Meeting – 6/25/14
- Adjourn

OLD BUSINESS:	Assigned To:	Result:
○ None to report on		

NEW BUSINESS:		
• Safety Representative responsibility discussion: ○ Like more people which means more representation ○ Things are getting done faster ○ Increased dialog between staff and management and concerns are getting relayed to the Safety Representative	Michelle	
• Communication ○ Excellent communication style. ○ Shared with committee what is does and how he is excited about the meetings	David Chung	
○ Important to include those who are on expanded OT	Michelle	Notified Brad Heath
• When Brad came to meeting spoke about 4 digit code. Hampden and Turner had incidents and when tried to use their 4 digit code it didn't work. Dispatch/police didn't know what the code was		
• OSHA conversation ○ Staff have heard "OSHA is coming" and want to know their responsibilities. ○ Karla shared her experience during the OSHA walk around ○ All items OSHA looks for are on the Safety Checklist that is looked at monthly by the Safety Representative and signed off by the Site Manager		
• Safety Representatives would like to know more about: ○ Incident/Accident reporting and what their role is ○ Do not feel Expanded OT people get specialized training or a refresher when they come to the house on important safety topics such as gas/electric shut offs	Michelle	Email to Brad H asking if BVS2's could begin to point this out during their training
• Discussion around Safety vs Facility meeting ○ Do not feel it is needed as issues should be dealt with before it is brought to the committee level. If they are not being dealt with then it is important all know why ○ Members would like and outstanding work order list.	ALL	

Central Safety Committee Meeting
May 28, 2014 @ 1:00 pm

Maybe this would cut down on confusion ○ Meetings should be solution/resolution based so want to talk about everything together. • Discussed what Safety Representatives should do: ○ Liaison between staff and management ○ Resource for staff regarding injuries and safety concerns ○ Part of the Accident Investigation Team ○ Should be on the Emergency Call list ○ Support for house in Emergency • Discussed what Safety Representatives should not do: ○ Be the Maintenance Man ○ Staff should not redirect care. If they need to go to dr then we DO NOT drive them. Only call 911, taxi or staffs own family to take them if they are unable to drive. ○ Should NOT show up to Safety Meetings without being present and positive. ○ Should NOT talk to staff about injuries only about what happened ○ Should NOT talk to other staff about injuries • Discussion around staff that are unable to do the job: ○ Testing for lifting capabilities? Like OYA/Bus drivers? ○ In house training with BVS2 isn't retained – Need to make more effective ○ Can we retrain staff that are not capable of performing duties of the job?	ALL ALL ALL	Michelle to discuss at CMT and report back

NEXT MEETING: 6/25/13 @ 1:00 pm at Central Office – Subject – Hazard Identification

Leadership Academy

1:00 pm Central Safety 5/28/14

Name	House
Michelle Patten	Admin
Mike Padilla MHR	James St.
Jeromy Bathke MHP	Charles St
Michael Bales MHP	Hampton Cove
Bill Tellez	MADISON
Jason Benson	Halsey
Jerry Foulkner	DNA
Karla Vinson	Charles St.
Scott Taylor	Flint 1,2,3.
Justin George	Forsythia
Carl Tiller	Dem
Josh Neufeld	Turner
Maggie Whitefeather	Weirich
Ron Chastain	Oak St
James Kammerre	Brooks

1:40 pm

HOLIDAY RETIREMENT

Leadership Academy

Becky Swerkegar	House
Tessa Baston	Cath
	Eliot

HOLIDAY RETIREMENT

DHS
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: Cade | Date: 5-7-14 | Inspector: David Anderson MH-4

+ = 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 for clients	+
1.7 Security alarms/motion detectors ☑ Windows ☑ Doors ☑ Maglocks	+
1.8 Stained/soiled couches or carpeting (where?)	+
1.9 Mold present (where?)	+
1.9 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)	N/A
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) WC MB SB AJ RS ___ ___	+
MEDICAL ONLY HOMES	
M1 Adaptive equipment brakes/safety straps in good repair	
M2 No rough/sharp edges on adaptive equipment	
M3 Generator upkeep schedule current	
M4 Other (list):	

4.0 Other Requirements	
4.1 Current Safety Committee minutes posted	+
4.2 Eyewash station operational needs new caps	+
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	+
6.4 Ladders in good repair	+
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 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 Cell phones accounted for, working, undamaged:	+
8.5 Other (list):	

Item #	Comments/Action Taken (use additional page if necessary)
6.6	gates need repaired to shut properly
1.2	Driveway - tree roots coming up thru
1.9	Road to house - huge potholes will damage State Personal Vehicles

Site Manager Signature: Sue Villone Date: 5/7/14

Policy #5.008 Attachment A

Revised 09/12

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

SOCP Safety Checklist

DHS 4577

Facility: Charles Date: 5-19-14 Inspector: Jeromy Bathke mbtt

+ = 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	+	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 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	N/A
4.2 Eyewash station operational	+	9.2 No rough/sharp edges on adaptive equipment	N/A
4.3 Other (list):		9.3 Generator upkeep schedule current	N/A
		9.4 Other (list):	

Item #	Comments/Action Taken

Site Administrator signature: Karla Hutson Date: 5/21/14

Original filed at house; Copy to Safety Office

Policy #5.008 Attachment A Mandatory

RECEIVED
MAY 14 2014
DHS SOCP

DHS 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: 5-13-14 | Inspector: Justin George

+ = 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 for clients	+
1.7 Security alarms/motion detectors ☒ Windows ☒ Doors ☒ Maglocks	
1.8 Stained/soiled couches or carpeting (where?)	+
1.9 Mold present (where?)	+
1.9 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) KB SF EH MR ___ ___ ___	+
MEDICAL ONLY HOMES	
M1 Adaptive equipment brakes/safety straps in good repair	N/A
M2 No rough/sharp edges on adaptive equipment	N/A
M3 Generator upkeep schedule current	+
M4 Other (list): Propane levels! 80%	+

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	+
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):	
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 Cell phones accounted for, working, undamaged;	+
8.5 Other (list):	

Item #	Comments/Action Taken (use additional page if necessary)

Site Manager Signature: [signature] Date: 5-14-14

Policy #5.008 Attachment A

Revised 09/12

DHS
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:	Hampton Lane	Date:	5/28/14	Inspector:	Mike Bates

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	O
1.4 No bee/wasp/hornet nests	O
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/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) CB PZ KW SK JT ___ ___	+

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

5.0 First Aid/Bloodborne Pathogens	
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 Maintenance/Kitchen	
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	+
6.5 Ladder's top step labeled "Not a Step"	+
6.6 Check fences/gates for repair	O
6.7 Other (list):	

7.0 Chemical Information	
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 Vehicle	
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 Wheelchairs	
9.1 Adaptive equipment brakes/safety straps in good repair	
9.2 No rough/sharp edges on adaptive equipment	
9.3 Generator upkeep schedule current	
9.4 Other (list):	

Item #	Comments/Action Taken
1.3	one outside light needs replaces / there is a parking lot light post that is unstable and needs replaced
1.4	Orkin has been notified in bees nest that are in defence
4.2	only have one station and it is always covered
6.6	fences boards are slowly being worked on by staff

Site Manager Signature: _____ Date: _____

Policy #5.008 Attachment A

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

SOCP Safety Checklist

DHS 4577

Facility: INA Date: 5/21/14 Inspector: JERRY FOUTNER

+ = 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	+		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 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
3.5	WINDOW ALARMS NEED TO BE MOVED TO TOP OF WINDOW (INSIDE) SO CLIENTS CAN'T TURN THEM OFF OR BREAK THEM

Site Administrator signature: Susan Phillips SM Date: 5/27/14

Original filed at house; Copy to Safety Office

Policy #5.008 Attachment A Mandatory

DHS 4577 (3/11)

DHS
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: James St | Date: 6-3-14 | Inspector: M. Padilla

+ = 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 for clients	+
1.7 Security alarms/motion detectors ☒ Windows ☒ Doors ☐ Maglocks	+
1.8 Stained/soiled couches or carpeting (where?)	+
1.9 Mold present (where?)	+
1.9 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	+
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)	NA
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) JV SN CR SG MB ___ ___	
MEDICAL ONLY HOMES	
M1 Adaptive equipment brakes/safety straps in good repair	NA
M2 No rough/sharp edges on adaptive equipment	NA
M3 Generator upkeep schedule current	NA
M4 Other (list):	NA

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	+
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):	
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 Cell phones accounted for, working, undamaged:	+
8.5 Other (list):	

Item #	Comments/Action Taken (use additional page if necessary)
2.1	2 Broken outlet covers - will purchase OT

Site Manager Signature: Dawn Taylor Date: 6/10/14

Policy #5.008 Attachment A

Revised 09/12

DHS
Oregon Department of Human Services
State Operated Community Program

House Evacuation / Fire Drill Record

Indicated if: **Quarterly** ☒ or **New Client Entrance Drill** ☐

Home: Jody Place **Date:** 5 / 2 / 2014 (Mo / Day / Year) **Time:** 9 : 10 ☒ AM ☐ PM

Client name: _____
Client name IF Drill is an "Entrance Drill"

House Evacuation / Fire Drills must vary location / route on each drill. Swing and Night Shifts.

Reasonable evacuation time:	*Location of simulated fire:
(Awake) or sleeping: 3 Minutes	Managers office
	*Exit route: front door
	*Must vary location/route each quarter.

Client's name (Last name, first initial)	Evacuation time in minutes										Comments
	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Knutson, Brian	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	2people needed to assist
Lugo, Kristian	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	Successful
Rebeka Parker	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	Successful
Mihajlich, Vincent	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	Successful

Indicate client's level of assistance

Client's name	Level of assistance as identified on RTR/safety plan:	Level of assistance needed today:
Knutson, Brian	Verbal & Physical - Simulated Fire Drill Protocol	High level of assistance needed 2 people assist and redirect to ground good
Lugo, Kristian	Independent	good
Parker, Rebecca	Independent	good
Mihajlich, Vincent	Independent with verbal cues	Good no cues needed

Magnetic door test

Door checked:	Door status *(describe problem & submit DHS 4612 Work Order Form / Contact Contract Provider)*
Front door: Yes ☐ No ☒	Not Mag Locked
Back door: Yes ☐ No ☒	Not Mag Locked
Side door: Yes ☐ No ☐	
Other (1): Yes ☐ No ☐	
Other (2): Yes ☐ No ☐	

Staff present *(All staff on premises must participate in drill and sign below:)*

J.N.	S.C. Caldwell MHT	
B.M. Brandy DSP II	B.A. Jacobsen BS2	
D.R.	L.H. D. Williams BS1	
P.N. Smith		

Signature of staff conducting drill: _____

Signature of site manager: _____

"Follow up Actions Taken" (in response to today's drill) describe details below: Brian Sumary—
Brian was not in a good ~~mood~~ mood before drill so he was unwilling to cooperate and was very ~~com~~ combative with staff to the point that once outside he layed on the ground and had to be helped up.

Follow-up Manager signature: _____ **Date:** _____

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

SOCP Safety Checklist

DHS 4577

Facility: Macleay SOCP Date: 5-7-14 Inspector: M Woolman

+ = 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 ~~☐ Keyblocks~~	+			
1.8 Other (list):	O		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 Check fences/gates for repair	+
2.6 Other (list):	+		6.7 Other (list):	+
3.0 Fire and evacuation safety			7.0 Hazard communication	
3.1 No items in 18" plane of fire sprinkler head	+		7.1 All chemical containers labeled	+
3.2 Extinguishers charged/tagged (current tag)/available	+		7.2 All MSDS's for industrial-use chemicals in book/staff trained	+
3.3 Dryer and furnace filters are clean	+		7.3 Combustible/corrosive/poisonous chemicals stored properly	+
3.4 Exits are not blocked	+		7.4 Personal Protection Equipment for chemical use available	+
3.5 Smoke detectors/alarms working	+		7.5 Other (list):	
3.6 Exit lights are working (if applicable)	+		8.0 Vehicles	
3.7 Exhaust fans are clean and operational	+		8.1 All shift inspections done	+
3.8 Other (list):	+		8.2 Seat belts operational	+
4.0 OSHA Requirements			8.3 Other (list):	+
4.1 Current SOCP Safety Committee minutes posted	+		9.0 Medical homes	
4.2 Eyewash station operational	+		9.1 Adaptive equipment brakes/safety straps in good repair	NA
4.3 Other (list)	+		9.2 No rough/sharp edges on adaptive equipment	NA
			9.3 Generator upkeep schedule current	+
			9.4 Other (list):	+

Item #:	Comments/Action Taken
1.8	Flooring North, South side house still needs repaired
	Having Aware

Site Administrator signature: [signature] Date: 5-7-14

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

DHS 4577 (2/11)

DHS
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

FAXED 5/14/14 1-503-378-5917

House:	MADISON	Date:	5/14/14	Inspector:	Bill Tellez

1.0 Outdoor Environment	OK	5.0 First Aid/Emergency Equipment	OK
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 Bloodborne 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 for clients	+	5.6 Other (list):	
1.7 Security alarms/motion detectors ☑ Windows ☒ Doors ☑ Maglocks	+	**6.0 Yard/Maintenance Equipment**	**OK**
1.8 Other (list):		6.1 Guards on mowers, edgers, etc. in place	N/A
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	N/A	6.4 Ladders in good repair	+
2.3 Electrical cords not frayed/cracked	N/A	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 (lists):		**7.0 Hazard Communication**	**OK**
3.0 Fire/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 chemicals in book	+
3.2 Extinguishers within "Green" charged area	+	7.3 Combustible/corrosive/poisonous chemicals properly stored	+
3.3 Extinguishers initialed on back of tag monthly	+	7.4 Personal Protection Equipment for chemical use available	+
3.4 Dryer and furnace filters are clean	+	7.5 Other (list):	
3.5 Exits are not blocked	+	**8.0 Vehicles**	**OK**
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 Smoke detectors/alarms working	+	8.3 Garbage/debris removed from inside vehicle	+
3.9 Emergency Plan in place for all clients (Place clients initials below) ✓ ✓ ✓ ✓ ✓ ___ ___ ___	+	8.4 Other (list):	
4.0 Other Requirements		**9.0 Medical Equipment**	
4.1 Current 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 Eyewash station checked as tested for month	+	9.3 Generator upkeep schedule current	+
4.4 Other (list):		9.4 Other (list):	

Item #	Comments/Action Taken

Site Manager Signature: _____ Date: _____

Policy #5.008 Attachment A

DHS
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: Oak St | Date: 5-28-14 | Inspector: Ron Chastain

+ = 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	+	**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) AA DM TO JR BT ___ ___	+	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)
1	Need Some kind of Light In Back yard
	2 Red Side and Some kind in the Back Parking
	~~Front~~ Lot - talk to Housing

Site Manager Signature: Lyn Hickman SM Date: 5/29/14

Policy #5.008 Attachment A

Revised 09/12

DHS
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: Weitzel | Date: 6-1-14 | Inspector: Maggie Gilstrap

+ = OK - = Not OK NA = Not Applicable

1.0 General Environment		**4.0 Other Required Items**	
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 ☒ Meglocks	+	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 Hazards		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	+	6.4 Ladders in good repair	+
2.6 Other (lists):	+	6.5 Ladder's top step labeled "Not a Step"	+
3.0 Fire Hazard Control		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 Vehicle**	
3.9 Emergency Plan in place for all clients (Place clients initials below) AC AE KD JE ___ ___ ___	+	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):	N/A		

Item #	Comments/Action Taken (use additional pages if necessary)
hot water	it's too small for all the baths + dishwasher ran on
water	pressure it's low - not enough water pressure

Site Manager Signature: Brenda Rodriguez-Jones Date: 6/2/14

Policy #5.008 Attachment A

Revised 09/12

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

SOCP Vehicle Incident Report and Supplement to DMV

735-32

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

Employee / volunteer report of incident
Employee or volunteer:
Complete the followi... ...our supervisor.
In addition, comple... equired by law (as outlined on the form),
also submit the 735

Your name: J[redacted] 2 Date of incident: 5-23-14

Normal work hours: 6 ☒ am To: ☐ am Days off: ☐ Mon ☐ Tues ☒ Wed ☒ Thurs
☐ pm 2 ☒ pm ☐ Fri ☐ Sat ☐ Sun

Office name: Hawthorne Group Home
Office address/city: 9355 SE Hawthorne BLVD
Supervisor's name: Krystal Lyon Supervisor's phone: 503-255-2925 Haw House #
Date reported to supervisor: 5/23/2014 cell office 503-200-... 503-254-1359
This incident was in a: ☒ State vehicle #: E 7362368 ☐ Private vehicle ☐ Rental vehicle

Describe the purpose of this trip:
This staff and staff Amaya Taina MHTT had just picked up client from Pathways school and were headed back to the group home. Client was escalated, this staff was helping to calm with verbal cues. When slowing to a stop, tapped car in front. No Damages were noted.

Did police respond to the incident? ☐ Yes ☒ No

☒ I was not injured If Injured: Indicate body part(s) injured: N/A
☐ I was injured Describe injuries: N/A

Action required:
☐ Rest break only ☐ First Aid* ☐ Medical care* ☐ Hospitalization*
* If seeking medical treatment, complete Form 801.pdf N/A

Describe recommendations that could have prevented this incident or a similar incident in the future:
Ideally, driver should never avert eyes from road.

Employee signatur[redacted] e: 5-23-14

DHS
Oregon Department of Human Services
State Operated Community Program

Employee Incident/ Accident Report

001

SOCP Safety Program:
503.378.5952 ext 232

Name: [redacted]

Address: [redacted] 97304

Regularly assigned shift hours: 10PM to 6AM Days off: SAT / SUN

Accident information:

Date of incident: 4/21/2014 Time of incident: 4:AM Exact location of incident: Cedar House WK Bedroom

Time shift began: 10PM Was a Client involved? Yes ☒ No ☐ Client initials: [redacted]

Witness(es): *Do not list clients as witnesses.*
Patty Wittaker
Chuck Peterson

Body part injured (R/L): Lower back Nature of the Injury: Pull - strain

Describe the incident fully:
lifting weak individual who could not assist, had circumstances for lift, no something to lift client up in bed. correct way to safely do it in space provided!

What caused the incident?

How could the incident have been prevented:
appropriate lift for client of his girth & elevated bed more room so body mechanics could prevent injury

Employee signature: [redacted] Date: 5/1/2014

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: Bed does not raise / lower; so staff must adjust to bed height

Action taken to prevent a similar incident: Looking into getting resident a bed that has adjustab. height.

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 ☒

[redacted] 5/23/14
Supervisor signature *Date*

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

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:
- Placed draw sheet on bed
- Gait belt to assist with transfers and ambulation
- Bedside commode made available
- Wheelchair available if necessary

Employee:
- Bed had wheels; could have been moved to create a larger space for staff manuverability

Equipment:
- Bed with wheels not moved
- Bed does not have mechanism to raise and lower height; will look into getting new hospital bed with those features.

Environment:
- Bed not flattened to make resident repositioning easier

Counter measures/best practices to prevent reoccurrence:

Staff will use draw sheet when repositioning; bedside commode for nightly toileting; ~~gait belt to support ambulation and~~ wheelchair for resident use if needed

Who: Management

By when: Already completed 5/22/14

Explain any checked boxes for "Additional casual factors":

SPD - State Operated Community Program

Employee Incident/Accident Report

EMPLOY

Name: [redacted]

Addres[redacted]

Home Phone: 541-570-9987 Worksite and Phone:

Regularly Assigned Shift Hours: Vacation Relief Days Off: Not consistent -

Date of Incident: 4-25-14 Time of Incident: 2:30 pm

Witness (es): Kim Huson & Rebecca SM Assistant

Exact Location of Incident: Bedroom of resident/client

Body Part Injured (L/R): Right temple

Nature of Injury: red, swollen, painful small lumb on right temple

Describe the incident fully: client Rm - I was holding plexy glass cabnit door open and positioned myself between client and staff who was trying to fix DVD player - client swung, I deflected & my left arm, client reach past it slaping my left cheek and pushing my right temple into sharp plexy glass

What caused the incident? client hitting staff

How could the incident have been prevented? rounded corners on plexy glass and better DVD player set up

[redacted] 4/25/14

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.) Unsafe behavior -

Action taken to prevent a similar incident: more aware of possible unsafe issues.

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

Lyn Hickman SM 4/30/14

Supervisor Signature Date

OVER

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

Staff did not report this to me -

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

Employee Incident/ Accident Report

001
SOCP Safety Program:

Name [redacted]

Address [redacted]

Worksite: 650 Dean Ave, Eugen, OR Worksite phone: 541-344-1887

Regularly assigned shift hours: 2-10p Days off: Sun/Mon.

Accident information:

Date of incident: 4.26.14 Time of incident: 8:30p Exact location of incider [redacted]

Witness(es):
Gail Smith, Cyndi Felton, Bob Penegor, Julie Hodges
He bite M. Tiller's

Body part injured (R/L): Lt. side of bod Lt. Forearm Nature of the injury: Lt. Forearm with his tooth and drew Blood & Bruising
Knees, leg, Lt hip, neck, hurt allover body

Describe the incident fully:
G. Smith and M. Tiller tried to put John into a 2 person PPI standing. John started to thrash around. When he got close to his bed he pushed all of us on the bed, causing us to twist a the bodies, He bite M. Tiller with his tooth on Lt. forearm causing bruising, drew blood

What caused the incident?
Client went into behavior

How could the incident have been prevented:

Employee signature: [redacted] Date: 4.26.14

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:

Action taken to prevent a similar incident:

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

Shawn Freeman 4/28/14
Supervisor signature *Date*

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

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

Employee Incident/ Accident Report

001
SOCP Safety Program:

Name: [redacted]

Addr

Worksite: 650 Dean Ave Eugene, OR 97405 Worksite phone: 541-344-1887

Regularly assigned shift hours: 2pm-10pm Days off: Tue-Wed

Accident information:

Date of incident: 4-26-14 Time of incident: 8:30pm Exact location of incident: [redacted] Bedroom

Witness(es):
Margret Tiller / Cyndi Felton / Bob Penegar / Julie Hodges

Body part injured (R/L): Right-Hand/neck Nature of the injury:

Describe the incident fully: Lower Back/right arm/middle back/
Client John Crenshaw went into a behavior because his staff was busy in the office redoing her (Therap) the John spit at her and then made the gesture to kick her. I got up when I heard him spit and seen him kick at her the kicked the door, when I came to see what was going

What caused the incident?
Impatients on Johns part.

How could the incident have been prevented:

Employee signature: [redacted] Date: 4-26-14

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: John has intermittent explosive disorder & when

Action taken to prevent a similar incident: he gets upset he explodes

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

Marion Freeman 4/28/14
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

Incident Report (IR) Part 5
Continuation page

Name: _____ Date: _____ Time: _____

Section:	☐ Site Manager ☐ Program Manager ☐ Person completing form ☐ Behavior Specialist
continued →	on and [redacted] was walking down the Hall way quickly then turned and spit on me then spit on Cyndi and kicked at me, then I backed up and [redacted] came towards me aggressively and I evaded but he still he hit my right hand. Margret and T. then tried to put [redacted] into a 2 person PPI Standing and [redacted] started thrashing around and when he got close to his bed he pushed all of us onto his bed causing us to twist our bodies and he also head butted me in the neck and tried biting me. He did bite Margret in the right forearm and we held him for 10 min.

Distribution: Original – SOCP Central Office, Canary copy- House; Pink copy – Client files

SPD - State Operated Community Program

Employee Incident/Accident Report

EMPL(

Name [redacted]

Add. [redacted]

Home Phone: 5417607684 Worksite and Phone:

Regularly Assigned Shift Hours: 6AM - 2pm Days Off: Tues & Weds

Date of Incident: 4/27/14 Time of Incident: 10:23 AM

Witness (es):

Exact Location of Incident: Dining Room table on 3 bed side

Body Part Injured (L/R): Right wrist

Nature of Injury: Swollen painful wrist

Describe the incident fully: I was at the kitchen table with a client eating. He was hyper-excited and trying to grab me. I scooted away from him. I had to move my hands to keep a safe distance.

What caused the incident? While scooting away from him I bumped my wrist on the table.

How could the incident have been prevented? Client could have kept his hands to himself

[redacted] 4/28/14

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.) Unsafe behavior for both individuals

Action taken to prevent a similar incident: undetermined

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

Lyn Hickman SM 4/28/14

Supervisor Signature Date

OVER

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

DHS
Oregon Department of Human Services
Seniors and People
State Operated C

Employee Incident/

001
SOCP Safety Program:

Name: [redacted]

Address:

Regularly assigned shift hours: 2p r 10pm Days off: wed thur Fri

Accident information:

Date of incident: 4/27/2014 Time of incident: 6pm Exact location of incident: 1105 Samas St back yard

Time shift began: 2pm Was a Client involved? Yes ☑ No ☐ Client initials: ____

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

Body part injured (R/L): face chest ARM Nature of the injury: Scratches

Describe the incident fully:

client attacked staff Scratching NOSE Left cheek Right chest+ARM

What caused the incident?

Behavior

How could the incident have been prevented:

unpreventable

Employee signature: [redacted] Date: 4/28/2014

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 attacked without warning

Action taken to prevent a similar incident:

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 ☒

David Taylor 4/29/14

Supervisor signature *Date*

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

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:
Try to defeat better although with unexpected attack it would be difficult.

Equipment:

Environment:

Counter measures/best practices to prevent reoccurrence:

Staff be anticipating possible threat

Who:
Staff

By when:

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

Name: [redacted]

Address [redacted]

Home Phone: 5417602684 Worksite and Phone: _____

Regularly Assigned Shift Hours: 6Am - 2pm Days Off: Tues & Weds

Date of Incident: 4/27/14 Time of Incident: 10:23 Am

Witness (es): _____

Exact Location of Incident: Dining Room table on 3 bed side

Body Part Injured (L/R): Right wrist

Nature of Injury: Swollen painful wrist

Describe the incident fully: I was at the kitchen table with a client eating. He was hyper-excited and trying to grab me. I scooted away from him. I had to move my hands to keep a safe distance.

What caused the incident? While scooting away from him I bumped my wrist on the table.

How could the incident have been prevented? Client could have kept his hands to himself

[redacted] 4/28/14

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.) unsafe behavior for both individuals

Action taken to prevent a similar incident: undetermined

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

Lyn Hildman SM 4/28/14

Supervisor Signature Date

OVER

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

SPD - State Operated Community Program

Employee Incident/Accident Report

EMPLO

Name: [redacted]

Addres [redacted]

Home Phone: 541-570-9099 Worksite and Phone: [redacted] 3889

Regularly Assigned Shift Hours: 10pm - 6am Days Off: Thurs Fri

Date of Incident: 4-28-14 Time of Incident: 1:50pm

Witness (es):

Exact Location of Incident: couch - living room

Body Part Injured (L/R): Right eye

Nature of Injury: Bruch

Describe the incident fully: Sitting next to client, holding his hand (at his request) attempting to keep him calm. He asked for a outting that couldn't happen until the next shift. After ~~[illegible]~~ giving him of that fact, he quickly struck me in the eye with other hand (closed fist)

What caused the incident? Client escalating do to not being to do what he wanted.

How could the incident have been prevented? sit farther away.

[redacted] 4-28-14

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.) Unsafe behavior - unexpected. This is the first time he has done this.

Action taken to prevent a similar incident: Give client more space when he's upset.

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

[redacted] 4/28/14

Supervisor Signature Date

OVER

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

SPD - State Operated Community Program

Employee Incident/Accident Report

EMPLOYEE S

Name: [redacted]

Address: [redacted]

Home Phone: [redacted] Worksite and Phone: OAK 541-451-3889

Regularly Assigned Shift: 10pm - 6am Days Off: Thurs Fri.

Date of Incident: 4-28-14 Time of Incident: 1:50pm

Witness (es):

Exact Location of Incident: couch - Living room

Body Part Injured (L/R): Right eye

Nature of Injury: Bruch

Describe the incident fully: Sitting next to client, holding his hand (at his request) attempting to keep him calm. He asked for a outting that couldn't happen until the next shift. After ~~cuing~~ telling him of that fact, he quickly struck me in the eye with other hand (closed fist)

What caused the incident? Client escalating do to not being to do what he wanted.

How could the incident have been prevented? sit farther away.

[redacted] 4-28-14

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.) Unsafe behavior - unexpected. This is the first time he has done this.

Action taken to prevent a similar incident: Give client more space when he's upset.

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

Supervisor Signature Date 4/28/14

OVER

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

SPD - State Operated Community Program

Employee Incident/Accident Report

EM

Nr

/

Home Phone: _____ Worksite and Phone: Oak St. 541 451-3889
Regularly Assigned Shift Hours: 10AM - 8PM Days Off: Wed/Thurs/Fri
Date of Incident: 4/29/14 Time of Incident: 1:55 pm
Witness (es): Lyn. Hickman, Sara Andrews, Richard Andrews
Exact Location of Incident: Living room 3 bd. side
Body Part Injured (L/R): Right shoulder
Nature of Injury: not sure, strain / dislocated?
Describe the incident fully: client behavior, trying to anchor hair, client was attempting to bite my ear - was

What caused the incident? client behavior

How could the incident have been prevented? can't. client has behaviors weekly. Restraints sometimes take 5 people.

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.) Unsafe behaviors - (client)

Action taken to prevent a similar incident: Client has behaviors weekly. At this point we are looking at medication.

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

Lyn Hickman sm 4/29/14
Supervisor Signature Date

OVER

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

SPD - State Operated Community Program

Employee Incident/Accident Report

EMPI

Nam [redacted]

Address:

Home Phone: _____ Worksite and Phone: Oak St. 541 451-3889

Regularly Assigned Shift Hours: 10 AM - 8 PM Days Off: Wed / Thurs / Fri

Date of Incident: 4/29/14 Time of Incident: 1:55 pm

Witness (es): Lyn Hickman, Sara Andrews, Richard Andrews

Exact Location of Incident: Living room 3 bd. side

Body Part Injured (L/R): Right shoulder

Nature of Injury: not sure, strain / dislocated ?

Describe the incident fully: client behavior, trying to anchor hair client was attempting to bite my ear - was

What caused the incident? client behavior

How could the incident have been prevented? can't client has behaviors weekly. Restraints sometimes take 5 people.

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.) Unsafe behaviors - (client)

Action taken to prevent a similar incident: Client has behaviors weekly. At this point we are looking at medication.

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

Lyn Hickman SM 4/29/14

Supervisor Signature Date

OVER

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

DHS
Oregon Department of Human Services
State (

Employee Incident/

001
SOCP Safety Program:

Name: [redacted]

Add...

(city, state, ZIP code) 97302

Regularly assigned shift hours: Alternate 16 weds i Thurs Friday 8 Days off: SAT, Sun, Mon, Tues

Accident information:

Date of incident: 4/30/14 Time of incident: 2:30 Exact location of incident: McKay highschool

Time shift began: 0700 Was a Client involved? Yes ☒ No ☐ Client Initials:

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

Cathy Lafournaise

Body part injured (R/L): left Knee Nature of the injury: Kicks to Knee

Describe the incident fully:

Client was in full blown behavior & kicked staff in knee twice & staff came down & landed on knee on ground trying to prevent client from injury herself or others

What caused the incident?

client behavior

How could the incident have been prevented:

N/A

Employee signature: [redacted] Date: 4/30/14

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:

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 ☐

[redacted] *Supervisor signature* 5/1/14 *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 Peo
State Operated

Employee Incident/

001
SOCP Safety Program:

Name: [redacted]

Address: [redacted] -9
(city, state, zip code)

Regularly assigned shift hours: 7am - 3pm Days off: Sat/Sun

Accident information:

Date of incident: 5/1/14 Time of incident: 10:44am Exact location of incident: couch - living room

Time shift began: 7am Was a Client involved? Yes [X] No [ ] Client initials:

Witness(es): *Do not list clients as witnesses.*
Kathy Urzak
Genine Lieder

Body part injured (R/L): (R) cheek/ top molar tooth Nature of the injury: punch

Describe the incident fully: Staff and I were performing a PPI on client. Client was able to manuver out of PPI and were going to abort just as she punched me in the right cheek. I felt stinging burn and noticed my tooth had broken

What caused the incident? punch to face. Client had mauvered out of other staff's grip.

How could the incident have been prevented:
Better executed PPI.

Employee signature: [redacted] Date: 5/1/14

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 [X] System weakness [ ] Other [ ]

Explain: Staff was struck by client during a struggle

Action taken to prevent a similar incident: practice OIS restraint to avoid injury

Client involved? Yes [X] No [ ] Entered into THERAP? Yes [ ] No [ ]

Employee - Went back to work: Yes [X] No [ ] | Went home: Yes [ ] No [ ] | Went to Doctor*: Yes [ ] No [ ]

[redacted] SR
Supervisor signature

5/5/14
Date

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

OVER >

DHS
Oregon Department of Human Services
State Operated Community Program

Employee Incident/ Accident Report

001
SOCP Safety Program: 232 115

Name: [redacted]

Address:

Regularly assigned shift hours: 3-11 PM Days off: S/S

Accident information:

Date of incident: 5/2/14 Time of incident: 5 PM Exact location of incident: Back yd Forsythia House

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

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

N/A

Body part injured (R/L): L Shoulder Nature of the injury: torn rotator muscles

Describe the incident fully: KB was sitting against the fence, I reach down to assist her to stand. She grab my arm & pulled me down

What caused the incident?
KB pulled on my arm as I tried to help her up

How could the incident have been prevented:
I could have refused to help her up

Employee signature: [redacted] Date: 5/5/14

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:

Action taken to prevent a similar incident:

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 ☐

Supervisor signature *Date*

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

SPD - State Operated Community Program

Employee Incident/Accident Report

EMPLO

Name: [redacted]

Address: [redacted]

Home Phon[redacted] Worksite and Phone: 541-481-3887

Regularly Assigned Shift Hours: 8am-4pm M-F Days Off: Sat, Sun

Date of Incident: 5/6/14 Time of Incident: 10:30am

Witness (es): Kim earhart, Ron Chastian, chandel schnicker, sue Riddell, sara Andrews

Exact Location of Incident: Day area 3 bed side

Body Part Injured (L/R): Right ankle

Nature of Injury: Pain & swelling

Describe the incident fully: client was in emergency PPI

What caused the incident? while assisting in Emergency PPI, client repeatitivly ground his shin portion of his leg into my ankle

How could the incident have been prevented? multiple attempts were made to readjust unable to due to safety issues (every attempt made, client would become more violent)

[redacted] 5/6/14

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.) Unsafe behavior

Action taken to prevent a similar incident: Due to clients aggressive and violent nature during PPI's - its difficult to keep everyone safe.

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

Lyn Hickman SM 5/7/14

Supervisor Signature Date

OVER

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

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

Employee Incident/ Accident Report

001
SOCP Safety Program: 12 5

Name: [redacted]

Address: [redacted]

Regularly assigned shift hours: 8A to 5PM Days off: Sat/Sun

Accident Information

Date of incident: 5/8/14 Time of incident: 8:10 Exact location of incident: Hallway Bed Side

Time shift began: 7A Was a Client involved? Yes ☐ No ☒ Client initials: ____

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

Yoon Saetern a staff

Kay Tran a staff

Body part injured (R/L): (R) Knee Nature of the injury: sore neck

Describe the incident fully: I Got the restroom floor was wet after Client took shower. I stepped out into the hallway and my (R) foot slipped and went sideways causing pain in (R) knee.

What caused the incident? wet floor

How could the incident have been prevented: Staff need to ~~Spot~~ clean water up on floor after showers

Employee signature: [redacted] Date: 5/15/14

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: ____

Action taken to prevent a similar incident: ____

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 ☐

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: 503-378-5915

Name: Kala Lusson Employee ID #: OR0020926

Address: 7550 Sawtell Rd Sheridan Ore 97378 Home phone: 503-870-7761
(city, state, zip code)

Regularly assigned shift hours: 8A to 5pm Days off: Sat/Sun

Accident information:

Date of incident: 5/8/14 Time of incident: 8:10 Exact location of incident: Hallway 2 Bed Side

Time shift began: 7A Was a Client involved? Yes ☐ No ☒ Client initials: ____

Witness(es): *Do not list clients as witnesses.*
Yoon Saetern MHT
Koy Tran MHT

Body part injured (R/L): (R) Knee Nature of the injury: torn MCL

Describe the incident fully: I Seen the restroom floor was wet after Client took Shower. I stepped out into the hallway and my (R) foot Slipped and went sideways causing pain in (R) knee.

What caused the incident? wet floor

How could the incident have been prevented: Staff need to ~~Spot~~ clean water up on floor after showers

Employee signature: Kala Lusson Date: 5/15/14

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: ____

Action taken to prevent a similar incident: ____

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 ☐

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

Name: [redacted]

Address: [redacted]

Regularly assigned shift hours: 2pm-10pm Days off: Th - Monday

Accident information:

Date of incident: 5/10/14 Time of incident: 430 Exact location of incident: Neighbors yard

Time shift began: 2pm Was a Client involved? Yes ☒ No ☐ Client initials:

Witness(es): *Do not list clients as witnesses.*
Jeff Bachelor
Mark Damwood

Body part injured (R/L): R Facial Head Nature of the injury: Contusion of face.

Describe the incident fully:
Client went into a behavior and started throwing rocks He went to throw rock at staff I tried a one arm limb restraint he grabbed my pony tail + punch me in the Right face

What caused the incident?
Client has rage issues and attempted PPI while Client had rock weapon

How could the incident have been prevented:
This is the 3rd time he has attacked staff while leaving supervised area

Employee signature: [redacted] Date: 5/9/14

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 is very aggressive.

Action taken to prevent a similar incident: trying medication changes

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 ☐

Lyn Hilburn SM — *Supervisor signature*
5/12/14 — *Date*

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

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

Employee Incident/ Accident Report

001
SOCP Safety Program

Name: [redacted]

Address:

Worksite: Gatu Rd Worksite phone: 503-399-0879

Regularly assigned shift hours: 2-10pm Days off: W/Th

Accident information:

Date of incident: 5/14/14 Time of incident: 2:50-3:5 Exact location of incident: Living Rm

Witness(es):
Nicole Pospeland, Teresa Underwood

Body part injured (R/L): R. Hand Nature of the injury: Bite

Describe the incident fully:

What caused the incident?
was in restrant and clients tooth broke skin before could evade

Restrant

How could the incident have been prevented:
More knowledge of the client.

Employee signature: [redacted] Date: 5-14-14

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: Restraint related to behavior. Could not evade fast enough.

Action taken to prevent a similar incident:
More training on client specific issues

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

[redacted] 5/14/14
Supervisor signature *Date*

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

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:
Policy Enforcement
Accountability
Client Caused

Employee:
Following Procedure

Equipment:

Environment:

Counter measures/best practices to prevent reoccurrence:
Using OTS pratice

Who:
OM/ASM
BVSR

By when:
May 30th

Explain any checked boxes for "Additional casual factors":

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

ODHS
Oregon Department of Human Services
State Operated Community Program

Employee Incident/ Accident Report

001

SOCP Safety Program:
503-378-5952 ext 232
[illegible]-378-5915

Name: [redacted]

Address: [redacted]

Regularly assigned shift hours: 2:00 - 10:00 Days off: SAT, SUN

Accident information:

Date of Incident: 5/16/14 Time of incident: ~2:50P Exact location of incident: PARKING LOT

Time shift began: 2:00P Was a Client involved? Yes ☒ No ☐ Client initials: [redacted]

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

DONNA SCHMIT-PAULS, MARK DAMEWOOD, ARRIC MUNOZ

Body part injured (R/L): R TRICEP Nature of the injury: 2 BITES

Describe the incident fully:

IN OIS PPI W/ CLIENT ON CLIENT'S LEFT SIDE, CLIENT TURNED HEAD TO LEFT AND BIT MY RIGHT TRICEP TWICE

What caused the incident? ESCALATED CLIENT IN BEHAVIOR IN PPI

How could the incident have been prevented:

NOT BE IN PPI WITH CLIENT WHOSE PHYSICAL STATURE + VIOLENT STRUGGLING INCREASE CHANCE OF INJURY

Employee signature: [redacted] Date: 5/16/14

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 is very violent during PPI's

Action taken to prevent a similar incident: Unable at this time

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 ☐

Lyn Hickman SM
Supervisor signature

5/19/14
Date

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

Oregon Department of Human Services
State Operated Community Program

Employee Incident/ Accident Report

001

SOCP Safety Program:
503-378-5952 ext 232
Fax: 503-378-5915

Name: [redacted]

Address: [redacted]

Regularly assigned shift hours: Vary Days off: Vary

Accident information:

Date of incident: 5/16/14 Time of incident: 2:30pm Exact location of incident: parking lot gravel

Time shift began: 2:00pm Was a Client involved? Yes ☒ No ☐ Client initials: [redacted]

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

Amick Moor, Mark Damwood
Terry Shipley, Donna Schmitt-Paul

Body part injured (R/L): back Nature of the injury: pulled back

Describe the incident fully: Anthony was in an emergency PPT in the back parking lot. I was on his right leg and hurt my back while keeping him safe and controlling his leg.

What caused the incident?
He began throwing log, rocks and hit a staffs car.

How could the incident have been prevented?
Better communication, not being in the parking lot.

Employee signature: [redacted] Date: 5/16/14

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: [redacted] Client is violent during PPT's - area where it happens is not the best.

Action taken to prevent a similar incident: Can not prevent at this time.

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 ☐

Lyn Hickman-Ohm 5/19/14
Supervisor signature *Date*

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

OCP 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: _____

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

Management:

Employee:

Equipment:

Environment:

PPE was done in parking lot on asphalt - not the best place for a PPE -

Counter measures/best practices to prevent reoccurrence:

Who:	By when:

Explain any checked boxes for "Additional casual factors":

Safety Program phone: 503-378-5952 ext 232
Safety Program fax: 503-378-5915

DHS
Oregon Department of Human Services
State Operated Community Program

Employee Incident/ Accident Report

001
SOCP Safety Program:
503-378-5952 ext 232
5

Name: [redacted]

Addres

Regularly assigned shift hours: 2:00 - 10:00 Days off: SAT, SUN

Accident information:

Date of incident: 5/16/14 Time of incident: ~2:50P Exact location of incident: PARKING LOT

Time shift began: 2:00P Was a Client involved? Yes ☒ No ☐ Client initials: [redacted]

Witness(es): *Do not list clients as witnesses.*
DONNA SCHMIT-PAULS, MARK DAMELWOOD, ARRIC MUNOZ

Body part injured (R/L): R TRICEP Nature of the injury: 2 BITES

Describe the incident fully:
IN OIS PPI W/ CLIENT ON CLIENT'S LEFT SIDE, CLIENT TURNED HEAD TO LEFT AND BIT MY RIGHT TRICEP TWICE

What caused the incident? ESCALATED CLIENT IN BEHAVIOR IN PPI

How could the incident have been prevented:
NOT BE IN PPI WITH CLIENT WHOSE PHYSICAL STATURE + VIOLENT STRUGGLING INCREASE CHANCE OF INJURY

Employee signature: [redacted] Date: 5/16/14

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 is very violent during PPI's

Action taken to prevent a similar incident: Unable at this time

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 ☐

Lisa Hickman SM
Supervisor signature

5/19/14
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:

Name: [redacted]

Address: [redacted]

Worksite: bath road Worksite phone: 503-549-0879

Regularly assigned shift hours: VACATION relief Days off: varies

Accident Information:

Date of incident: 5.17.14 Time of incident: 2:00 pm Exact location of incident: kitchen entry

Witness(es):
Betty Fennell (heard it)

Body part injured (R/L): L wrist Nature of the injury: strain/sprain

Describe the incident fully:
holding door to enter kitchen & client kicked door shut

What caused the incident?
client behavior

How could the incident have been prevented:
hold the outside knob instead of actual door but then my hand may have been kicked

Employee signature: [redacted] Date: 5.17.14

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 on Behavior

Action taken to prevent a similar incident:
Tape to mark line clients shouldn't be.

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

[redacted] 5/19/14
Supervisor signature *Date*

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

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:
Policy Enforcement

Employee:
Following Procedure

Equipment:
Maintenance

Environment:

Counter measures/best practices to prevent reoccurrence:
Continue to Train on Unit Issues & Enforce Policies

Who:
SM/ASM

By when:
May 31st

Explain any checked boxes for "Additional casual factors":

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

RECEIVED
DHS MAY 1 2014

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

Employee Incident/ Accident Report

001

SOCP Safety Program: 232 317

Name: SC [redacted] 3

Addrc [redacted]

Worksite: Bath House 3683 Bath Rd Worksite phone: [redacted]

Regularly assigned shift hours: Swing 2p 10pm Days off: Sun, Mon

Accident information:

Date of incident: 5-17-14 Time of incident: 2:05p Exact location of incident: Dining Area of Bath.

Witness(es):
Leah
Betty F

Body part injured (R/L): Head & Back Nature of the injury: Was Assauted (punched) many times in head & Back

Describe the incident fully:
Was getting ready to go on outing, asked the client to wait a minute

What caused the incident?
client just blew up and started punching staff in the head & back

How could the incident have been prevented:
Don't think it could have been.

Employee signature: [redacted] Date: 5-19-14

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: Was an unprovoked attack by a client

Action taken to prevent a similar incident:

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

Supervisor signature 5/21/14 *Date*

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

RECEIVED
MAY 1 2014
COMPLIANCE ADMIN

SOCP Employee Incident/Accident Analysis

Employee name: [redacted]

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 >>>>

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

Management:	Employee:
Policy Enforcement	Following Procedure

Equipment:	Environment:

Counter measures/best practices to prevent reoccurrence:

CRS Training + Update

Who:	By when:
CRS oversight	May 31st

Explain any checked boxes for "Additional casual factors":

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

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

Employee Incident/ Accident Report

001
SOCP Safety Program: 1232 915

Name: [redacted]

Address: [redacted]

Regularly assigned shift hours: 3pm - 11pm Days off: Tue-Wed

Accident Information

Date of incident: 5/18/14 Time of incident: 3:15pm Exact location of incident: kitchen

Time shift began: 3pm Was a Client involved? Yes ☒ No ☐ Client initials: [redacted]

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

Genine Lieder

Body part injured (R/L): left knee Nature of the injury: bruse

Describe the incident fully: Client came into the kitchen grabed the coffee pot and was going to pour it into a cup that already was full of water. Tried to tell him I would get a new cup as he kicked me in the knee the coffee pot was removed as he was asked to leave and he did.

What caused the incident? Larry misunderstood that I was trying to help him.

How could the incident have been prevented: ~~to E Ti~~ not letting him in the kitchen when a worker staff is in.

Employee signature: [redacted] Date: 5/18/14

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 was upset and kicked a staff.

Action taken to prevent a similar incident: Work with staff on identifying pre cursers

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 ☐

Robert Gates SM — *Supervisor signature*

5/19/14 — *Date*

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

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: 5/21/14	2. Date you left work: 5/22/14	3. Shift on day of injury: 2P 10P (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: 2pm ☐ 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) Lower back ☐ Left ☐ Right		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) While working a mandatoned 2nd shift my coworker and I were doing [illegible] @ the table when a residents Oximeter alarm when I stood up I heard a "pop" and pain radiated thru-out my back and down my legs.

11. Name [redacted] This injury? ☐ Yes ☐ No

13. You[redacted] 201[redacted] 6909

16. Mai[redacted] city, sta[redacted]

18. SS[redacted]

21. Name of physician or health-care professional: Dr Matt Leng

22. If [illegible] address of facility: Kaiser Permanente

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. Worke[redacted] signature: [redacted] 28. Date: 5/22/14

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: ZIP:		37. Nature of business in which worker is/was supervised: Social Services
38. Street address, city, and state where event occurred:		
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:	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: 5/28/14		49. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No
50. Employer signature:	51. Name, title, and phone (please print):	52. Date:

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

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: 5/23/14	2. Date you left work: 5/24/14	3. Shift on day of injury: 6:30 (from) ☐ a.m. ☒ p.m. 7:00 (to) ☒ a.m. ☐ p.m.	4. Regularly scheduled days off: ☒ M ☒ T ☐ W ☐ T ☐ F ☐ S ☐ S
5. Time of injury or illness: 12:00 ☒ 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) Neck & back Centered knee ☒ 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) Dealing with a client in behavior, got my hair pulled, got hit in the left cheek and right shoulder and was pulled down onto bed by my shirt

11. Name of witnesses:

13. Your legal name:

16. Mailing address, city, state and zip:

18. SSN (See #25 ↓

21. Name of physician or health-care professional: Dr. Valencia

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:

28. Date: 5/24/14

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: ZIP:		37. Nature of business in which worker is/was supervised: Social Services
38. Street address, city, and state where event occurred:		
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:	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:	51. Name, title, and phone (please print):	52. Date:

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

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: 5-23-14	2. Date you left work: 5-24-14	3. Shift on day of injury: NOC (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: 11:15 ☐ a.m. ☑ p.m.	6. Time you left work: 7:00 ☒ 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) Neck Muscels ☒ 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) KB Was in Behavior. She was trying to eloup from her bedroom window. She took Bedroom Windo off I was holding Iron grate closed so as to contain Behavior in the house.

[redacted] ... previously injured this body part? ☒ Yes ☐ No

21. Name of physician or other medical professional: Jean Lankow

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]	28. Date: 5-24-14

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: ZIP:		37. Nature of business in which worker is/was supervised: Social Services
38. Street address, city, and state where event occurred:		
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:	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:	51. Name, title, and phone (please print):		52. Date:

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

DHS Oregon Department of Human Services
Seniors and I
State Opera

Employee Incident/

001
SOCP Safety Program:

Name: [redacted]

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

Regularly assigned shift hours: Varried Days off: Varried

Accident information:

Date of incident: 5/27/14 Time of incident: 1245 Exact location of incident: Dining Room 3 side

Time shift began: 1200 Was a Client involved? Yes ☒ No ☐ Client initials: [redacted]

Witness(es): *Do not list clients as witnesses.*
Stephanie Thornton (non visual)

Body part injured (R/L): Right elbow Nature of the injury: Swollen Cannot extend fully

Describe the incident fully: SG shoved me into the wall by Kitchen door as I was falling back I hit right elbow on corner of the cabinet on 3 side of house

What caused the incident?
Client behavior

How could the incident have been prevented:
Support staff not turning back while client in behavior

Employee signature [redacted] Date: 5/28/14

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/aggression

Action taken to prevent a similar incident: Staff to try to evade physical contact better.

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 ☐

Supervisor signature 5/29/14 Date

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

SOCP Employee Incident/Accident Analysis

Employee name: [redacted]

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 >>>>

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

Management:	Employee:

Equipment:	Environment:

Counter measures/best practices to prevent reoccurrence:

Unacceptable due to client Behavior

Who:	By when:

Explain any checked boxes for "Additional casual factors":

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