



OREGON RESIDENTIAL CARE  
AND ASSISTED LIVING FACILITIES  
*Abuse reporting and investigation*  
GUIDE FOR PROVIDERS

Effective November 1, 2008



Independent. Healthy. Safe.



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AND ASSISTED LIVING FACILITIES  
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## Introduction

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The Abuse Reporting Guidelines for Assisted Living and Residential Care Facilities provides an overview of how to report to the local Adult Protective Services (APS) office incidents of abuse or suspected abuse and investigate such incidents.

**Incidents involving suspected physical, sexual, verbal, or mental abuse; neglect of care; involuntary seclusion; corporal punishment; and illegal or improper use of resident resources must be reported and subsequently investigated by the facility to determine causal factors so that, if needed, interventions are implemented for the protection of the resident.** State regulations require the immediate reporting of those incidents if abuse is suspected or alleged.

The facility must immediately investigate injuries of unknown cause and report those incidents if abuse cannot be ruled out. It is expected that a determination about injuries of unknown cause can be made within 24 hours of the incident and if abuse can not be ruled out, the incident has been reported within that timeframe.

This guide is intended for use by facility management and professional staff, and is available for review by Department of Human Services (DHS) partners and the public. Facility personnel will find resources and tools in this guide to successfully use the State's abuse reporting system. In an effort to provide easy access to the system, this guide describes the reporting process.

Adult Protective Services staff process and triage each reported incident to determine if an on-site investigation is warranted. The Administrator will be verbally informed by the investigator when an on-site investigation begins. A written report outlining the findings of the APS investigation will be issued to the facility along with the Notification of Findings (NOF).

Working in partnership and using this guide, Assisted Living and Residential Care Facilities, and APS will not only fulfill state requirements, but will also maintain professional standards and meet the goal of resident protection and prevention of abuse.

Regulatory authority can be found at Oregon Administrative Rules - Chapter 411, Division 54 - Licensing of Assisted Living and Residential Care Facilities.

## Definitions

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### **Date of Discovery**

The calendar date (month/day/year) and time that the first facility staff observed, found, or learned of an incident or injury.

### **Date of Incident**

The calendar date (month/day/year) that an incident or injury occurred.

### **Incident**

For the purpose of this guide, an occurrence involving a resident in which abuse is alleged or suspected, and in the case of injuries of unknown cause, where an immediate facility investigation cannot rule out abuse. Abuse can include physical, sexual, verbal or mental abuse; neglect of care; corporal punishment; involuntary seclusion; and exploitation of resident resources.

### **Injuries of Unknown Cause**

Any injury should be classified as an “injury of unknown cause” when the source of the injury was not observed by any person and the source of the injury could not be credibly explained by the resident.

### **Notification of Findings**

a document issued for each allegation of wrongdoing in a community-based care facility. The document identifies:

- the nature of the allegation and outcome of the investigation;
- a brief description of the incident;
- whether wrongdoing was substantiated, not substantiated or inconclusive;
- which, if any, Oregon Administrative Rules were violated;
- if wrongdoing was substantiated, the level of harm that resulted;
- whether the finding constituted abuse;
- whether there is a sanction related to the finding;
- and a statement of appeal rights including, as applicable, the right to submit additional information, the right to petition for reconsideration, the right to judicial review, and the right to request a contested case hearing on any related sanction.

### **Self-Reported Incident**

A mandated notification of abuse or suspected abuse (including injuries of unknown cause, if abuse cannot be ruled out) to the state agency from a provider (i.e., the administrator or authorized official).

## Oregon administrative rules and interpretive guides

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### 411-054-0005(2) "Abuse" means:

***(a) Any physical injury to a resident that has been caused by other than accidental means. This includes injuries that a reasonable and prudent person would be able to prevent, such as those resulting from hitting, pinching, striking, rough handling or corporal punishment. These instances of abuse are presumed to cause physical injury, including pain, to all residents, including those in a coma or those who are otherwise incapable of expressing injury or pain.***

#### Interpretive Guide:

- Properly trained staff should be able to respond appropriately to resident behavior. Striking a combative resident is not considered an appropriate response in any situation. Retaliation by staff against a resident is considered abuse.
- The staff action is evaluated to determine if it meets the definition of abuse whether or not an injury is evident. An injury is presumed if the act is abusive.
- Corporal punishment includes physical actions used for the purpose of punishing, penalizing or retaliating against a resident.

***411-054-0005(2)(b) Failure to provide basic care or services to a resident that results in physical harm, unreasonable discomfort or serious loss of human dignity. Abuse under this definition includes abandonment and improper use of restraints.***

#### Interpretive Guide:

- Physical harm, as used in this definition, includes: physical injury of any severity;

avoidable decline in condition; and failure to maintain or improve physical condition.

- Unreasonable discomfort and serious loss of dignity require significant negative outcomes. For residents unable to recognize the abuse or respond appropriately, the severity of the outcome will be evaluated using the reasonable and prudent person test. Lesser outcomes are generally considered resident rights issues.
- This definition includes miscellaneous facility categories of abuse, such as abandonment and improper use of restraints, if they resulted in physical harm, unreasonable discomfort or serious loss of dignity.
- Facility failure to assess and intervene in inappropriate resident-to-resident behavior is also included in this definition. Non-consensual sexual contact between residents when foreseeable and predictable, is considered to be a failure to provide appropriate care and services on the part of the facility. The residents are both considered Reported Victims.
- Inappropriate sexual contact by a cognitively intact resident against other residents must be reported to APS as well as referred to law enforcement.
- This definition includes medication errors that result in a change in the resident's baseline functional status, such as, level of consciousness, vital signs or a reaction requiring medical intervention.

***411-054-0005(2)(c) Sexual contact with a resident, including fondling, by an employee or agent of a facility by: physical force; physical or verbal threat of harm or deprivation to the resident or others; use***

***of position, authority or misinformation to compel a resident to do what the resident would not otherwise do; or where the resident has no reasonable ability to consent. For the purpose of this rule, consent means a voluntary agreement or concurrence of wills. Mere failure of the resident to object does not, in and of itself, constitute an expression of consent.***

#### **Interpretive Guide:**

- Without credible evidence of consent, in cases of staff/resident sexual contact, it is considered to be abuse.

***411-054-0005(2)(d) Theft or diversion of a resident's property, including money, personal property and medications; illegal or improper use of a resident's resources for the personal benefit, profit or gain of another person; borrowing resident funds; spending resident funds without the resident's consent; if the resident is not capable of consenting, spending resident funds for items or services that the resident cannot benefit from or appreciate; or spending resident funds to acquire items for use in common areas when such purchase is not initiated by the resident.***

#### **Interpretive Guide:**

- Theft or diversion of a resident's property, including money, personal property and medications. Nothing in this rule shall be construed to prevent an owner, administrator or employee from acting as a representative payee for the resident.
- When the evidence supports a finding of substantiated wrongdoing, abuse will be found regardless of the amount and type of resource or property involved and facility action before, during or after the exploitation.

***411-054-0005(2)(e) Verbal or mental abuse that includes, in extreme forms: the use of oral, written or gestured communication that willfully includes disparaging and derogatory terms to the resident, or within their hearing distance, regardless of their age, ability to comprehend or disability; humiliation; intimidation; harassment; threats of punishment or deprivation directed toward the resident; and unwanted or inappropriate crude or sexual language, questions, comments, or other communication. Examples of verbal and mental abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that the resident will never be able to see the resident's family again; and making unwanted sexual comments. Verbal and mental abuse are distinguished from resident rights violations by the extreme or offensive nature of the communication.***

***411-054-0005(2)(f) Involuntary seclusion for convenience or discipline. Involuntary seclusion is defined as the separation of a resident from other residents or from their room or confinement to their room (with or without roommates) against the resident's will or the will of the resident's legal representative. Emergency or short-term, monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention until professional staff can develop a plan of care to meet the resident's needs, or as part of an inter-disciplinary care plan after other interventions have been attempted.***

***411-054-0028 Abuse Reporting and Investigation***

## ***Abuse reporting and investigation provider guide***

1. The facility must identify methods of preventing and responding to incidents such as injury loss of property and abuse.
2. ABUSE REPORTING. Abuse is prohibited. The facility employees, agents and licensee must not permit, aid, or engage in abuse of residents who are under their care.
  - a. STAFF REPORTING. All facility employees are required to immediately report abuse and suspected abuse to the local SPD/AAA office, the facility administrator, or to the facility administrator's designee.
  - b. FACILITY REPORTING. The facility administrator or designee must immediately notify SPD/AAA office of any incident of abuse or suspected abuse, including events overheard or witnessed by observation.
  - c. LAW ENFORCEMENT AGENCY. The local law enforcement agency must be called first when the suspected abuse is believed to be a crime (i.e. rape, murder, assault, burglary, kidnapping, theft of controlled substances, etc.).
  - d. INJURY OF UNKNOWN CAUSE. Physical injury of unknown cause must be reported to the SPD/AAA office as suspected abuse, unless an immediate facility investigation reasonably concludes and documents that the physical injury is not the result of abuse.
3. FACILITY INVESTIGATION. In addition to immediately reporting abuse or suspected abuse to SPD, or AAA, or the law enforcement agency, the facility must promptly investigate all reports of abuse and suspected abuse and take measures necessary to protect residents and prevent the reoccurrence of abuse.
  - a. Investigation of suspected abuse must include:
    - (A) Time, date, place and individuals present;
    - (B) Description of the event as reported;
    - (C) Response of staff at the time of the event;
    - (D) Follow-up action; and
    - (E) Administrator's review.
4. IMMUNITY AND PROHIBITION OF RETALIATION.
  - a. The facility licensee, employees and agents must not retaliate in any way against anyone who participates in the making of an abuse complaint, including but not limited to restricting otherwise lawful access to the facility or to any resident, or if an employee, dismissal or harassment.
  - b. Anyone who, in good faith, reports abuse or suspected abuse shall have immunity from any liability that might otherwise be incurred or imposed with respect to the making or content of an abuse complaint.



## Facility reporting and investigative process

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### Protect

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The first priority must be the immediate protection of residents from further harm. Protecting residents from further harm means keeping the residents safe. Each situation will be different, but here are some examples of actions that might be implemented:

- Ensure the reported perpetrator is kept away from the resident and/or other residents.
- Have a trusted person stay with the resident(s).
- Have the resident(s) stay in a supervised area.
- Safeguard the resident(s)' well-being and property.
- Implement other interventions as appropriate.

### Report

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Two types of incidents must be reported to Adult Protective Services (APS):

- **Abuse or suspected abuse** (physical, sexual, verbal or mental abuse, neglect of care, involuntary seclusion, illegal or improper use of resident resources), must be reported immediately, **BEFORE** initiating an investigation, and
- **Physical injuries of unknown cause**, must be reported **unless** an immediate facility investigation concludes that the physical injury is not the result of abuse.

Incidents involving a criminal act must be reported first to law enforcement, then immediately to APS.

For APS investigations, an APS Specialist (APSS) will visit the facility, interview relevant parties, review relevant documentation, and assure that the reported victim is safe. The APSS will make a determination based on a preponderance of the available evidence as to whether wrongdoing occurred, and that report is to be completed and forwarded to DHS Central Office within 60 days. The DHS Corrective Action Unit then determines whether there was abuse or neglect and applies sanctions as appropriate. The provider receives notification and has a right to dispute the finding(s). A non-confidential copy of the report and the Notification of Findings is sent to the provider as well as made available in public files in the local office and in Salem.

Physical injuries of unknown cause are considered to be suspected abuse and reported to APS, **unless** facility investigation concludes the injury was not the result of abuse. In that case, it is not necessary to report to APS.

If a facility investigation concludes that abuse did occur, or it is not possible to rule out abuse, it must be reported as soon as that determination is made. **Typically, such a determination is expected to be made within 24 hours.** The facility's determination about the injury of unknown cause must be documented in the resident's record. Additionally, the facility must be able to explain to the APSS the facility's investigative process that evidences the facility's determination.

Following are some examples of situations involving physical injury of unknown cause:

*Example A:* A resident with mild dementia is heard calling for help and is found on the floor next to his bed. He has a skin tear and a bruise

on his arm. No one witnessed the apparent fall. Staff check the resident for other injuries, level of consciousness, vital signs, etc., treat the skin tear, make sure the resident is comfortable and safe, and begin an investigation.

It is determined that although the resident was evaluated/assessed to be at risk for falls, he had never fallen before and had never tried to get out of bed without assistance. He was not ill and had not had an obvious change in cognition level. Staff had provided care, and assisted the resident to the bathroom and back to bed only ten minutes before the incident. The resident could not remember exactly what happened, but said something about going to the bathroom.

Evidence supports that all service planned interventions were in place. Interviews were conducted and support that no other staff/residents were in the area. Because the investigation found that no abuse occurred, this incident would not need to be reported to APS. However, the facility would be expected to document the investigation, re-assess the resident's cognitive status and other relevant areas, and update the service plan with measures to prevent recurrence, and follow any other facility policies as appropriate.

*Example B:* A resident with moderate dementia and a history of falls is found on the floor in her room. She had a nosebleed and a bruise on her forehead. No one witnessed the incident. Staff had assisted her to bed earlier. Staff immediately evaluated/assessed the resident's physical condition, performed appropriate treatment, and assured her comfort and safety. The resident's service plan directed that a personal alarm was to be in place when in bed. No staff remembered hearing the alarm sound. The alarm was found to be attached to the bed, but not to the resident's clothing, and was determined to be in working order. The aide who had assisted the resident to bed stated that she had

properly attached the alarm, and did not know how it could have come off and not sounded. The investigation could not clearly determine whether abuse in the form of neglect of care had occurred or not. This incident would need to be reported to APS as soon as it was determined that abuse could not be ruled out.

*Example C:* A resident with advanced dementia is found on the floor in his room, next to a tipped-over commode and has sustained a cut on the head. No one witnessed the incident.

In the immediate investigation, it was found that a staff person acknowledged helping the resident onto the commode earlier, stating that she told the resident to push his call bell when he was finished. The resident's service plan directed that he required the assistance of one-person for transfers, and that he was not to be left alone on the commode. The staff person stated she had been in a hurry, did not remember that directive, and thought he was capable of remembering to use the call bell.

Because neglect of care resulting in an injury, which is considered abuse, occurred, this incident would be reported to APS immediately upon obtaining the above information.

To report to APS, the attached *Assisted Living and Residential Care Facilities Incident Self-Report Form* is recommended to be completed and faxed to the local APS office or the report may be phoned in. *Please see Appendix C for a list of APS contact information by county.* In reporting the incident, provide as much detailed information as possible, answering who, what, where, when, why and how. Then immediately begin a thorough investigation.

## ***Investigate***

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All incidents require a thorough investigation to determine what occurred and to implement measures, as needed, to prevent recurrence.

A thorough investigation is a systematic (consistent and ordered) collection of information that describes and explains an incident or series of incidents. The investigation seeks to determine if abuse (including failure to provide basic care and services resulting in injury) occurred, how the incident occurred, and how to prevent further occurrences. Critical components of any investigation include:

- the timely initiation of the investigation;
- the objectivity of the investigator;
- the preservation of evidence; and
- the thoroughness of the investigation.

### ***Timeliness***

Staff must immediately report and investigate all incidents in accordance with State regulations, and facility policy. To help organize and allow the investigative process to proceed with speed and efficiency, staff training and written policies are required of the facility. Policies should define the responsibilities of staff who conduct investigations. A prompt response to an incident is critical for protection of the resident(s), treatment of injury or adverse effects, and the collection of accurate data.

### ***Objectivity of the Investigator***

The investigator of any incident must remain objective and maintain neutrality during the course of the investigation. Investigations should not begin with a presumption of guilt or innocence of individual(s) reported as perpetrator(s). The investigator's approach should be from an impartial perspective to collect accurate, appropriate data and come to a conclusion. Conclusions should not be made based on incomplete information.

### ***Preservation of Evidence***

Evidence collected during the investigation may

include, but is not limited to, some or all of the following:

- Testimonial evidence: witness statements, telephone notes, e-mails, faxes;
- Documentary evidence: alert charting/24 hour report, change of shift log, staffing log, medication and treatment sheets, chart notes, x-rays, lab results, flow charts, orders, interview notes, post-its, medical records, service plans, incident reports, internal investigation, hospital records, maintenance logs, work documents, personnel records, contact information, financial records, police reports, in-service/training records, etc.;
- Pictorial evidence: drawn diagrams, photographs; and/or
- Direct or physical evidence: clothing, personal effects, linens, tissues, side rails, wheelchairs, foot rests, equipment, oxygen tanks, furniture. Preservation of evidence is especially important when dealing with criminal or other serious incidents. Evidence identified during the course of an investigation must be preserved and made available upon request to APS, Client Care Monitoring Unit (CCMU), local law enforcement and other authorities as appropriate. If a criminal act, such as physical or sexual assault is suspected, contact laws enforcement immediately and ask for guidance on preservation of evidence. Note that bathing a resident, changing linens or emptying trash may destroy critical evidence.

### ***Thoroughness of Investigation***

A thorough investigation will enable the facility to identify and document who, what, where, when, why and how the incident happened, including the cause or source of the incident. The key issue for an investigation is to determine whether the incident was

## ***Abuse reporting and investigation provider guide***

foreseeable and preventable as well as determine causal factors to prevent recurrence.

Each investigation must answer who, what, where, when, why and how, through interviews, documentation review, and observations. Interviews may include but are not limited to: reported victim(s), reported perpetrator(s), staff in immediate area or who provided services, roommate(s), visitors and/or family. The sample questions below are not all-inclusive and should be used as they relate to the facts and circumstances of the incident that is being investigated. Each investigation must be documented.

### ***Who:***

- Who is/are the reported victim(s)?
- Who is/are the reported perpetrator(s)?
- Who witnessed the incident?
- Who first spoke to the reported victim(s)/perpetrator(s) regarding the incident?
- Who has information related to the incident?
- Who reported the incident?

### ***What:***

- What happened?
- What is the chronology of actions leading up to the alleged incident?
- What are the injuries or negative consequences to the resident(s)?
- What was done to protect the resident(s) from further harm?
- What information can the reported victim(s) share?
- What did the discovering person(s) or witness(es) see, hear or smell?

- What was done upon discovery of the incident?
- What information do other staff members have surrounding the incident?
- What was the functional, mental and cognitive status of the reported victim(s)/perpetrator(s) before and after the incident?
- What is the resident's current medical condition (labs, progress notes, service plan, injury trends)?
- What diagnoses may have contributed to the incident, if any?
- What recent changes in treatment and physician's orders may have contributed to the incident?
- What is the resident's current physical status?
- What is the impact of the environment to the incident?
- What is the history of the resident(s)?
- What is the resident's condition/need?
- What is the assessment and service plan and are they reflective of the resident's needs?
- What were the requirements of the service plan? Was the service plan followed?
- What training/orientation was provided to staff involved?
- What was the staffing level/pattern and did that contribute to the incident?

### ***Where:***

- Where did the incident happen? Be specific: room number, wing, hall, floor, or other specific location.
- Where were the witnesses in relationship to the incident or residents?

### **When:**

- When did the incident happen? (date, time, shift)
- When was facility supervisory/management staff first contacted about the incident?

### **Why/How:**

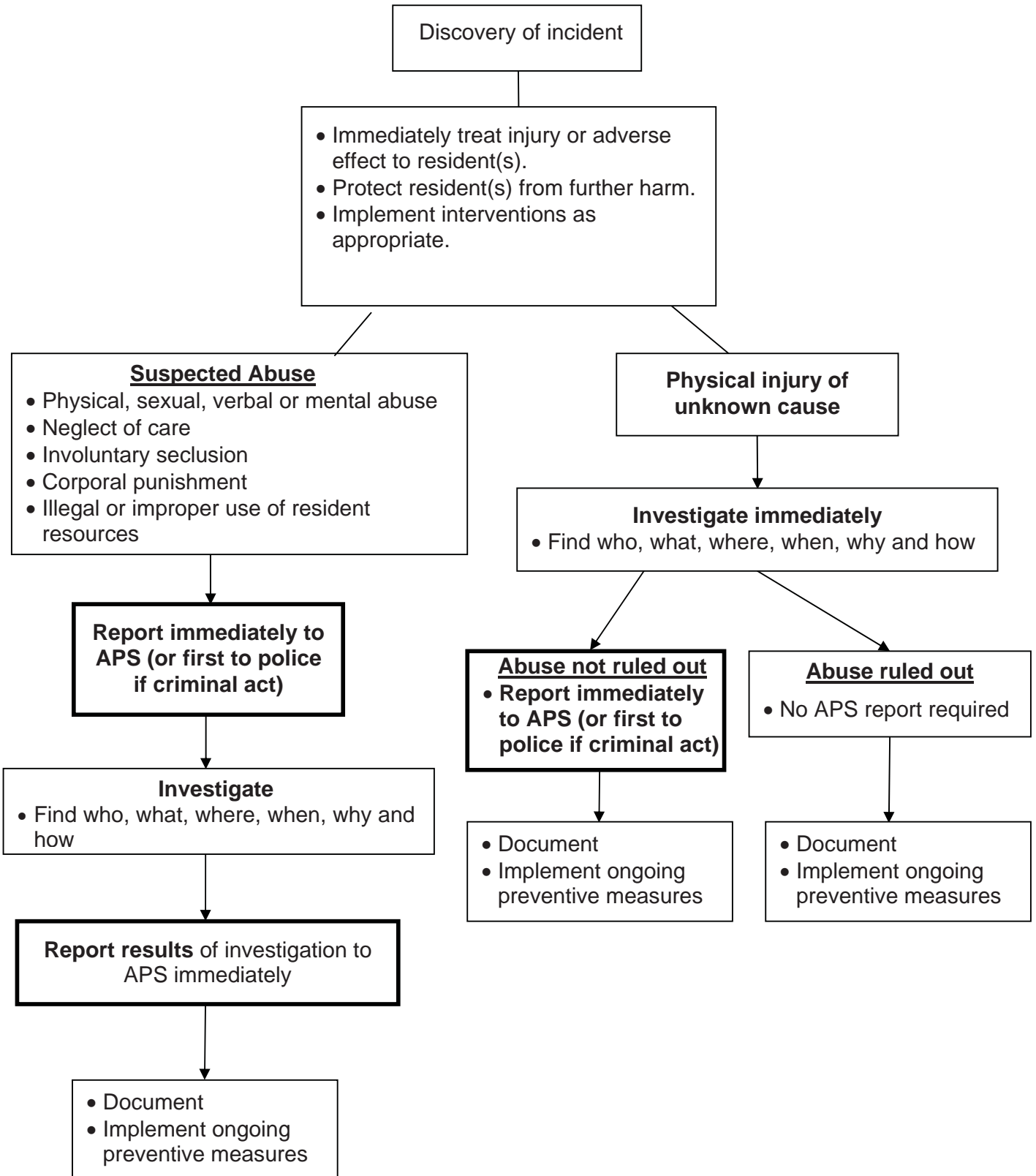
- How did the incident occur?
- How could it have been prevented?
- Why did the incident and/or injury occur?

An investigation may be expanded to determine how widespread abuse is/was, and to identify other potential affected residents and/or perpetrators. It is important that conclusions not be reached without adequate information.

The following elements may be included in an expanded investigation, as appropriate:

- Further examine events which preceded and followed the incident. Repeat interviews to clarify information.
- Interview additional potential witnesses, such as: medical personnel, contract personnel, volunteers, family, visitors, clergy, vendors, etc.
- Interview additional residents who may have had contact with the reported perpetrator.
- Conduct follow-up investigation of newly discovered information. Consult with other professionals.

## Appendix A: Reporting and investigation of incidents




## Appendix B: Self-report form

The DHS 0810A Assisted Living and Residential Care Facilities Incident Self-Report Form can be accessed through the Web and downloaded as either a Microsoft Word \*.doc or an Adobe Acrobat \*.pdf file. To access the form, please visit the following Web site:



[www.oregon.gov/DHS/spd/provtools/index.shtml#manuals](http://www.oregon.gov/DHS/spd/provtools/index.shtml#manuals)

(See page 14-15 for full size sample of the DHS 0810A form.)

 Oregon Department of Human Services Seniors and People with Disabilities	<b>Assisted Living and Residential Care Facilities Incident Self-Report Form</b>
Facility name: _____ Phone: (____) _____ Address: _____	
Person reporting the incident: _____ Title: _____	
<b>Incident:</b> Date: _____ Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm Date discovered: _____ Location of incident: _____ Residents involved in incident: <i>(Attach additional pages if necessary.)</i> Name: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No Relevant diagnoses: _____ Name: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No Relevant diagnoses: _____	
<b>Reported Perpetrators:</b> (Not residents) <i>(Attach additional pages if necessary.)</i> Name: _____ Title: _____ Phone: (____) _____ License or certificate #: _____ Name: _____ Title: _____ Phone: (____) _____ License or certificate #: _____	
<b>Witnesses:</b> <i>(Attach additional pages if necessary.)</i> Name: _____ Relationship / Title: _____ Phone: (____) _____ Name: _____ Relationship / Title: _____ Phone: (____) _____ Name: _____ Relationship / Title: _____ Phone: (____) _____	
Continued on next page Page 1 of 2 <span style="float: right;">DHS 0810A (REV 8/07)</span>	

*(Attach additional pages to answer the questions below, if necessary.)*  
 Describe the incident and any injury or adverse effect to the resident(s):

What immediate measures were taken to protect the resident(s)?

Has this happened before to the same resident(s) or others?  Yes  No If yes, describe:

Who else was contacted (such as law enforcement, ombudsman, licensing board, etc.)?

Name of person completing this report: \_\_\_\_\_ Date: \_\_\_\_\_  
 Facility name: \_\_\_\_\_ Date of incident: \_\_\_\_\_

<b>APS OFFICE USE ONLY</b>		Branch office: _____	
Date rec'd: _____	Time rec'd: _____	Rec'd by: _____	Log #: _____
Disposition: Local unit investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Investigator's name: _____	
Response priority: <input type="checkbox"/> 2-hour <input type="checkbox"/> Next day <input type="checkbox"/> Other: _____		_____	

Page 2 of 2 DHS 0810A (REV 8/07)



Seniors and People with Disabilities

### Assisted Living and Residential Care Facilities Incident Self-Report Form

Facility name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_

Person reporting the incident: \_\_\_\_\_

Title: \_\_\_\_\_

#### Incident:

Date: \_\_\_\_\_ Time: \_\_\_\_\_  am  pm Date discovered: \_\_\_\_\_

Location of incident: \_\_\_\_\_

#### Residents involved in incident: *(Attach additional pages if necessary.)*

Name: \_\_\_\_\_ Gender:  M  F

Medicaid?  Yes  No

Relevant diagnoses: \_\_\_\_\_

Name: \_\_\_\_\_ Gender:  M  F

Medicaid?  Yes  No

Relevant diagnoses: \_\_\_\_\_

#### Reported Perpetrators: (Not residents) *(Attach additional pages if necessary.)*

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) License or certificate #: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) License or certificate #: \_\_\_\_\_

#### Witnesses: *(Attach additional pages if necessary.)*

Name: \_\_\_\_\_ Relationship / Title: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship / Title: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship / Title: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

*Continued on next page*



(Attach additional pages to answer the questions below, if necessary.)

Describe the incident and any injury or adverse effect to the resident(s):

What immediate measures were taken to protect the resident(s)?

Has this happened before to the same resident(s) or others?  Yes  No If yes, describe:

Who else was contacted (such as law enforcement, ombudsman, licensing board, etc.)?

Name of person completing this report: \_\_\_\_\_ Date: \_\_\_\_\_

Facility name: \_\_\_\_\_ Date of incident: \_\_\_\_\_

<b>APS OFFICE USE ONLY</b>	Branch office: _____
Date rec'd: _____	Time rec'd: _____
Rec'd by: _____	Log #: _____
Disposition: Local unit investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No Investigator's name: _____	
Response priority: <input type="checkbox"/> 2-hour <input type="checkbox"/> Next day <input type="checkbox"/> Other: _____	
_____	

## Appendix C: Contacts for reporting facility incidents

COUNTY	FAX NUMBER	PHONE NUMBER
Baker	541-523-5667	541-523-5846
Benton	541-967-6423	541-967-8630 or 541-924-8418
Clackamas	503-650-5645 APS 503-650-5722 Main Fax	503-650-5751
Clatsop	503-304-3465	800-846-9165
Columbia	503-397-0389	503-397-5863
Coos	541-756-1861	541-756-2017
Crook	541-388-6118	541-693-2707
Curry	541-247-5938	541-247-4515
Deschutes	541-388-6118	541-693-2707
Douglas	541-440-3599	541-440-3580
Gilliam	541-298-1251	541-298-4114
Grant	541-575-2910	541-575-0255
Harney	541-567-4893	541-567-2274
Hood River	541-298-1251	541-298-4114
Jackson	541-776-6215	541-776-6222
Jefferson	541-388-6118	541-693-2707
Josephine	541-474-3125	541-474-3110
Klamath	541-883-5652	541-883-5551
Lake	541-883-5652	541-883-5551
Lane	541-682-2461	541-682-4038
Lincoln	541-336-1517	800-282-6194 (Toll Free) 541-336-7744 (Local) 888-414-7991 (Main Reception)
Linn	541-967-6423	541-967-8630 or 541-924-8418
Malheur	541-889-2485	541-889-7553
Marion	503-304-3465	800-846-9165
Morrow	541-567-4893	541-567-2274
Multnomah	503-988-4012	503-988-4450 503-988-3646 (24 hour line)
Polk	503-304-3465	800-846-9165
Sherman	541-298-1251	541-298-4114
Tillamook	503-304-3465	800-846-9165
Umatilla	541-567-4893	541-567-2274

<b>COUNTY</b>	<b>FAX NUMBER</b>	<b>PHONE NUMBER</b>
Union	541-523-7698	541-963-7276
Wallowa	541-426-3878	541-426-3155
Wasco	541-298-1251	541-298-4114
Washington	503-846-1529	503-640-3489
Wheeler	541-298-1251	541-298-4114
Yamhill	503-304-3465	800-846-9165



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