

In-Service Training Log – Oakdale

Date: 02-26-2020

Type of Meeting:

IAPP, SMA, CSSPA/CSSP Review

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

| Training Time | Trainer Name | Training ID | Area | Content/Description |
|---------------|---|-------------|---------|---|
| 1.0 | Stephanie Borscheid Designated Manager | P119/P129 | Primary | Review the following documents IAPP, SMA, CSSPA, Outcomes: CA, WA, RS CSSP/CSP/ISP: Responsibilities and where applicable the person's IAPP (or any other appropriate plan) to achieve an understanding of the person as a unique individual & how to implement these plans as they relate to the staff's job functions. |
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| Make up Date | Initial | EE ID | Last Name |
|--------------|---------|-------|--------------|
| | RB | e0180 | Anderson, R. |
| | JB | e0678 | Beltz, J. |
| | SB | e0849 | Berglund, S. |
| | AD | e0798 | Diaz, A. |
| | PT | e0656 | Dyer, P. |
| | VF | e0539 | Fielden, K. |
| | UA | e0751 | Hartman, L. |
| | TK | e0841 | King, T. |
| | | | |
| | | | |

| Make up Date | Initial | EE ID | Last Name |
|--------------|---------|-------|---------------|
| | TL | e0793 | Lorsung, T. |
| | JM | e0463 | Muellner, J. |
| | | e0727 | Nichols, A. |
| | SO | e0795 | Otto, S. |
| | KP | e0835 | Perales, K. |
| | JP | | Pratt, J. |
| | HSS | e0846 | Safford, H. |
| | SS | e0741 | Shabaiash, S. |
| | MS | e0752 | Sweeney, M. |
| | | | |
| | | | |

| Make Up Date | Initial | EE ID | Managers/Admin |
|--------------|---------|-------|----------------|
| | SB | e0446 | Borscheid, S. |
| | MD | e0389 | Duffy, M. |
| | KL | | Lind, K. |

| Make up Date | Initial | EE ID | Other Attendees |
|--------------|---------|-------|-----------------|
| | | | |
| | | | |
| | | | |

Staff: Roseann Anderson



Service Recipient: CA

Date: 2/20/2020

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

| Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|--|--|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>Unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 <u>Communicating</u> | <u>actual choice</u> | Outcome #2 <u>Choice</u> | |
| Technology Use: <u>IPad, Computer, TV in Room, smartboard</u> | | | |

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

| | |
|---|---|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensitivity to foods</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>1-2 per year partial</u> | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: <u>Call 911 75 minutes</u> |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>purced, regular liquids, resistant to eating / spits out food</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>anxiety, low urine output</u> | <u>microcephaly to home all continents</u> |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Tylenol - seizure</u> | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>all personal care - full assist - clean clothing protectors - change during the day when needed</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Argo for transfers + reverse basket for stairs</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input checked="" type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input checked="" type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>back massage & wears gloves for oral sensory needs</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>pull hair out - change scenery / redirect may grab others - verbal (oral aggression)</u> | |
| Important To: <u>moving around music therapy, pet therapy</u> | Important For: <u>starchy, coating, drinking</u> |
| Likes: <u>Engaged in abusive outings 1:1 with technology</u> | Dislikes: <u>over stim eating & drinking being in one place too long</u> |
| Describe Communication Style: <u>eye contact + gestures, pushing, pulling away</u> | |

66

Staff: Roseann Anderson



Service Recipient: WA

Date: 2/26/2020

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

| Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|---|--|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other: <u>Unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 <u>music or audio choice daily</u> | | Outcome #2 <u>group or community choice</u> | |
| Technology Use: <u>Ipad & TV</u> | | | |

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

| | |
|--|---|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Bee sting</u> <u>sensitive skin (ie: lavender)</u> <u>insects</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Blind - cuts with hands</u> <u>plate guard</u> <u>4-oz cup - cups to slow down</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Constipation</u> <u>osteoporosis</u> <u>Cleft LP & Palate</u> <u>UTI's</u> | |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>orally meds if needed - 0 at PAI</u> | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tooth brushing</u> <u>DNR/DNI</u> <u>PALST</u> <u>personal care's assist</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>wheelchair if needed</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind - always explain - cues needed before assisting</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>may overstimulate - head rub</u> <u>swing</u> <u>& redirect with music & space</u> | |
| Important To: <u>routine, swing, family</u> | Important For: <u>Non Care</u> |
| Likes: <u>Swing</u> | Dislikes: <u>Fluids, teeth brushing</u> |
| Describe Communication Style: <u>music, chocolate milk, sauce</u> <u>over stimulation & changes to routine</u> <u>Vocals, short words & phrases</u> | |

(signature)

Staff: Roseann Anderson



Service Recipient: RS

Date: 2/26/2020

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

| Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|---|--|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 <u>Unable to report</u> <u>music choice with switches</u> | | Outcome #2 <u>Weekly community outings</u> | |
| Technology Use: <u>Ipod, TV, switches</u> | | | |

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

| | |
|--|---|
| Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Childhood seizures</u> | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Orange crush - only drink</u> <u>enjoys eating - pureed, section, plate, mother care spoon</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP, scoliosis, psoriasis, constipation</u> | |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>with food if needed</u> | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>personal care needs</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>wheelchair & top tray</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tactile need (ripping shirts, sheets, pillowcases)</u> <u>overstim - loud noises (activity)</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>verbal & emotional aggression due to stress (late bus)</u> | |
| Important To: <u>Shamia Turin, music</u> <u>(foods) Orange crush</u> Likes: <u>Food (snacks - preferred)</u> | Important For: <u>drinking</u> <u>independence</u> Dislikes: <u>over stim</u> <u>changes in routine</u> <u>encourage communication</u> |
| Describe Communication Style: <u>eye contact, switches, facial expressions, vocals</u> | |

SB

Staff: _____



Service Recipient: _____

Date: _____

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

| Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Self-Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Financial Exploitation <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|--|---|
| <input type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other: | <input type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Inability to care for self-help needs <input type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 | | Outcome #2 | |
| Technology Use: | | | |

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

| | | | |
|--|--|---|--|
| Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List: | | Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location: | |
| Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe : | | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location: | |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports : | | | |
| Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes – List: | | | |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports : | | | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – List: | | | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed | | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List: | | | |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports: | | | |
| Important To: | | Important For: | |
| Likes: | | Dislikes: | |
| Describe Communication Style: | | | |