



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.

Make up Date	Initial	EE ID	Last Name
	RA	e0180	Anderson, R.
	JB	e0678	Beltz, J.
	SB	e0849	Berglund, S.
	AD	e0798	Diaz, A.
	PD	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.
	SD	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: Jessica Mueller



Service Recipient: CA

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 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>make activity choice w/ 4 options</u>		Outcome #2 <u>3x per week plan group experience</u>	
Technology Use: <u>IPad, TV, Smartboard, Wii</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>Sensitivities - 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>one to two a year, crys out Partial</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>pureed, thin liquids, eat only foods sent from home, if she spits out food we honor her refusing, sports bottle</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Anxiety pms, microcyfali, not voiding all day, low urine output</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Tylenol, small cup</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Personal cares, clean clothing protecters</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Propel wheelchair, Arjo, reverse basket when in standler</u> <input checked="" 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 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>proprioceptive input, wears gloves</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>pull hair out, change sensory grab or spit at people. Verbal emotional vocals</u>	
Important To: <u>music + pet therapy familiar environments</u>	Important For: <u>eat + drink standler</u>
Likes: <u>one to one games outings</u>	Dislikes: <u>being in one place too long over stim. eating + drinking</u>
Describe Communication Style: <u>gestures, eye gazing, facial expressions vocals</u>	

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Staff: Jessica Mueller



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 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 checked="" 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>Daily choose group</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>sensitive skin, insect + Bee stings</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>Plate guard, Spoon, 4oz cup, slow down "don't choke"</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>constipation, osteoporosis, cleft lip + palate UTI's</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>orally whole in food w/ drink</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tooth brushing after eating DNR + DNI PUIS personal cares,</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Blind, staff walk w/ her arm in arm verbal</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" 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 checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind tell her who you are + what you will be doing,</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>overstimulated loud environments, flicks under chin + Pound on her chest</u>	
Important To: <u>Routine, Rocking + Swinging family</u>	Important For: <u>nail care, fluids,</u>
Likes: <u>Choc. milk + sauce, music Therapy Swing</u>	Dislikes: <u>loud environments changes in routine</u>
Describe Communication Style: <u>vocalizations, short words,</u>	

SB

Staff: Jessica Mueller



Service Recipient: RS

Date: 2/26/2020

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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 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 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 choice w/switches</u>		Outcome #2 <u>choosing community experience</u>	
Technology Use: <u>IPad, TV, smart board, Comm. 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 type="checkbox"/> Yes - Describe: <u>History of seizures in childhood</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>pureed thin liquids sectioned plate, mother care spoon, slip mat sippy cup</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP, spina scoliosis, psoriasis, constipation</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>with food</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>personal cares</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>wheelchair, staff propel, laptray Hoyer</u> <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 checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: <u>1</u> <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>tactial sensory - ripping shirts, pillows, sheets over stimulated</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>verbal emotional aggression very stress when bus is late routine</u>	
Important To: <u>music, preferred food & drinks choc. pudding, people watching</u>	Important For: <u>drinking, repositioning making a choice</u>
Likes: <u>pudding, orange crush</u>	Dislikes: <u>change in routine lunch being done waiting</u>
Describe Communication Style: <u>facial expression, vocals</u>	

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