

**COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM –  
INTENSIVE SERVICES**

**Name of person served:** Robert (Bob) Bronner

**Date of development:** 10/09/2020                      **For the annual period from:** October 2020 to October 2021

**Name and title of person completing the *CSSP Addendum*:** Beth Blackorbay, Designated Coordinator

**Legal representative:** Katie Schultz

**Case manager:** Lisa Topps, Ramsey County

Dates of development:

- Within 15 days of service initiation, the license holder must complete the preliminary *CSSP Addendum* based upon the *CSSP*.
- Within 45 calendar days of service initiation, the license holder must meet with the support team and make determination regarding areas listed in this addendum.
- Annually, the support team reviews the *CSSP Addendum*.

**Services and supports**

The license holder must provide services in response to the person’s identified needs, interests, preferences, and desired outcomes. Services will be provided according to MN Statutes, chapter 245D and the applicable waiver plan for the person served. The following information will be assessed and determined by the person served and/or legal representative and case manager and other members of the support team.

The **scope of the services** to be provided to support the person’s daily needs and activities include: The scope of services for Bob is intensive support services in a community DTH program and community environment. The program works with Bob to develop and implement achievable outcomes that support his goals and interests including meeting quality of life indicators, health, and safety. PAI supports this by working with Bob to encourage activities, outings, and visiting with peers. Staff support Bob in doing activities of daily living (ADLs), outcome implementation, supervisions, medication administration, data tracking, and daily support related to his health, safety, and well-being as needed by Bob. Support is provided in the most integrated and least restrictive environment.

The person’s **desired outcomes** and the methods or actions that will be used to support the person and to accomplish the service outcomes (Service Outcomes and Supports):

Outcome #1: Daily, Bob will choose which lunch item he would like first 80% of all trials over a 12-month period.

Outcome #2: Daily, Bob will accept a hand massage for 1 minute or more in 95% of all trials over a 12-month period.

# PAI

A discussion of how **technology** may be used to meet the person's desired outcomes has occurred:  Yes  No

Provide a summary that describes decisions made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made:

- Bob can utilize an iPad to make choices and listen to music in his program room.
- Bob and his peers have a computer connected to a television monitor in the program room that is used to watch sensory videos, play interactive games, and listen to music. There is also a Smartboard that resides in another program room within the building. Bob has the opportunity to participate in various groups and activities that are being run utilizing the Smartboard such as games and art exploration when he visits the program room where the Smartboard resides. The Smartboard is used for similar purposes as the computer, but with a much larger screen.
- Further technology exploration is not needed at this time.

Describe the **general and health-related supports** necessary to support this person based upon the *Self-Management Assessment (SMA)* and the requirements of person centered planning and service delivery. For each area a person is not able to self-manage as assessed in the SMA, please write a description of how staff will support them:

**Allergies:** Bob is allergic to Amoxicillin and Penicillin (Amoxicillin). He is also allergic to Baby Powder. Bob is administered only medications and treatments prescribed by his physician. Bob's allergies are listed on his Medication Administration Record (MAR) and on his Face sheet.

**Seizures:** Bob has a seizure disorder that is partially controlled with medication. Staff will monitor Bob for seizure activity. Staff are trained on Bob's seizure protocol. Staff will follow his protocol and provide support and comfort as needed.

**Choking:** Bob is on a physician ordered diet. His diet consists of pureed food with thin liquids, with a 1500 Calorie restriction. Bob is at a risk of choking if these guidelines are not followed. Bob does not attempt to eat food that is not within his dietary guideline. Bob is served foods for lunch that is sent prepared from his residence. Bob is diagnosed with Schatzki's Ring, which is a narrowing of the esophagus and can cause gagging issues and difficulty swallowing. Bob is supported by ensuring that his food is pureed.

**Special Dietary needs (State specific need):** Bob is on a physician ordered diet. His diet consists of pureed food with thin liquids, with a 1500 Calorie restriction. PAI will follow Robert's physician orders.

**Self-administration of medication or treatment orders:** Bob requires assistance in the administration of his medications. Staff have received training on medication administration and complete medication administration record review to ensure no medication errors have occurred. Concerns or issues regarding medication will be communicated by staff to Bob's guardian and any orders or instructions will be followed.

**Chronic medical conditions:**

- **Polymyalgia rheumatica (PMR)** is an inflammatory disorder that causes muscle pain and stiffness, especially in the shoulders and hips. Staff are aware of the conditions and will report any changes of the condition to his residence.
- **Cerebral Palsy**, a group of disorders that affect movement and muscle tone or posture. Staff are aware of the conditions and will report any changes of the condition to his residence.
- **Spastic Quadriplegia**, difficulty in controlling movements in the arms and the legs. Staff are aware of the conditions and will report any changes of the condition to his residence. Staff will assist Bob with hand over hand activities, as tolerated.

**Other Health and Medical Needs:**

- **Personal Cares:** Bob can use the toilet with reminders to go to the restroom. He will not use the restroom, independently. Bob wears pull-up briefs for occasional incontinence. Bob receives full assistance in changing his brief when needed. Bob utilizes the Arjo for transferring while in the restroom.
- **Sun sensitivity:** Bob is at a high risk of sunburn due to medications that he is taking. Sun exposure should be limited. Bob is supported by PAI staff applying sunscreen if he is going to be in the sun for a longer period of time. If in a sunny area, staff will encourage Bob to spend time in the shade.

**Risk of falling:** Bob wears a helmet, at all times, to protect his head on the event of a fall. Bob is able to bear weight. He transfers via the Arjo or in-ceiling track system if he is refusing to bear weight. Bob, when agitated, will throw his weight back in his wheelchair, which can cause it to tip. Bob's wheelchair is equipped with anti-tip bars. Staff will make sure they are down and in the proper position. When Bob is agitated, staff will help problem solve or redirect to another activity.

**Mobility issues:** Bob relies on his wheelchair for mobility. Bob can self-propel his chair over short distances using his legs and feet. Staff will assist Bob propelling his wheelchair for long distances and in the community.

**Regulating water temperature:** Staff will physically check the water temperature by placing their own hand in the water and adjust to a safe and comfortable temperature if need be prior to exposing Bob to the water.

**Community survival skills:** Bob is accompanied by staff while in the community. Staff model appropriate social behavior and follow pedestrian safety rules.

**Water safety skills:** PAI does not offer community outings that are focused around a needed demonstration of water safety skills. PAI may offer outings to local parks with water. Bob is 1:1 and uses his wheelchair for mobility while in the community. Staff will propel his chair when near bodies of water to ensure that he remains a safe distance from the water.

### **Sensory disabilities:**

- **Vision Impairment:** Bob had cataract surgeries in November of '05 and Jan of '06. He has vision difficulties as a result. Robert refuses the use of corrective lenses. Staff will support Robert as needed if he is walking or propelling his wheelchair in and around obstacles.
- **Overstimulation:** If Bob is agitated by loud noises or environment, staff will offer him a different environment to be in. Staff will try to limit the stimulation in Bob's environment, as he prefers.

### **Self-injurious behavior:**

- **Hitting head with hand or throwing himself back in the wheelchair:** If Bob hits his head with his hand or throw himself back in his wheelchair staff will try to redirect him and problem solve. Staff would offer Bob a different environment or adjust the environment he is in. Staff can offer him alternative activities.

### **Person Centered Information**

- **Important To:** It is important to Bob to have the opportunity to go for walks with staff or caregivers, both while in his wheelchair. He enjoys mealtime, as he will independently move his chair towards the lunch table during lunch time at PAI. Bob enjoys drums and maracas and other percussive instruments. He will turn his head towards these instruments during music therapy and other music groups.
- **Important For:** It is important for Bob to have his needs met by his caregivers. It is important for him to have staff and caregivers knowledgeable of his needs, to provide him the best care.
- **Good Day:** A good day for Bob would be having the ability to navigate in the hallways. Having a lunch he enjoys. Being able to rest and having his own space. Having the opportunity to rest. Being able to participate in activities of his choosing.
- **Bad Day:** A bad day for Bob would ne being in a loud environment and not being able to have quiet time. Having a lunch that he dislikes. Not being able to navigate in the halls.

# PAI

The person's **preferences** for how services and supports are provided including positive support strategies and how the provider will support the person to have control of their schedule:

Bob enjoys his independence, whenever able.

Bob likes to be a part of the group during activities and participating at a level he is comfortable with.

Bob prefers a quiet environment.

Is the current service setting the **most integrated setting available and appropriate** for the person?

Yes  No

If no, please describe what action will be taken to address this:

N/A

# PAI

How will services be **coordinated across other 245D licensed providers and members of the expanded/support team serving this person** to ensure continuity of care and coordination of services?

- Bob's guardian and PAI staff will share necessary information as it relates to his services and care. Needed supplies and medications will be provided by his residential provider. Meetings and reports are shared and the team works together to ensure the continuity of service. In person conversations, phone calls, emails, and faxes may be used to discuss information.
- Lisa Topps, Bob's county case manager and guardian, will create the Coordinated Service and Support Plan, participate in meetings, and assist Bob in other supports as requested.

If there is a **need for service coordination** between providers, include the name of service provider, contact person and telephone numbers, services being provided, and the names of staff responsible for coordination:

Beth Blackorbay, PAI Designated Coordinator  
3595 Linden Ave. White Bear Lake, MN 55117  
651-777-5622 Ext 201  
[bblackorbay@paimn.org](mailto:bblackorbay@paimn.org)

Lisa Topps, Case Manager  
160 East Kellogg Blvd #7800  
651-266-4274  
[Lisa.topps@co.ramsey.mn.us](mailto:Lisa.topps@co.ramsey.mn.us)

Katie Schultz, Guardian  
160 East Kellogg Blvd #7800  
651-266-4268  
[Katie.Schultz@co.ramsey.mn.us](mailto:Katie.Schultz@co.ramsey.mn.us)

Melissa Leonard, Residential Contact  
ACR-Bicentennial  
2234 Bicentennial Ct  
New Brighton, MN 55112  
651-567-0709  
[melissa.leonard@acrhomes.com](mailto:melissa.leonard@acrhomes.com)

Does the person require the **presence of staff** at the service site while services are being provided?

Yes  No

If no, please provide information on when staff do not need to be present with this person (include community, home, or work) and for the length of time. If additional information regarding safety plan is needed, also provide:

N/A

# PAI

Does the person require a **restriction of their rights as listed in 245D.04, subdivision 3** as determined necessary to ensure the health, safety, and well-being of the person?

Yes  No

**If yes, please indicate what right(s) are restricted:**

N/A

If rights are being restricted the Rights Restrictions form must be completed.

Does this person use **dangerous items or equipment**?

Yes  No

**If yes, address any concerns or limitations:**

N/A

Has it been determined by the person's physician or mental health provider to be **medically or psychologically contraindicated to use an emergency use of manual restraint** when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety?

Yes  No

If yes, the company will not allow the use of the behavioral intervention/manual restraint to be used for the person.

## Health needs

Indicate what **health service responsibilities** are assigned to this license holder and which are consistent with the person's health needs. If health service responsibilities are not assigned to this license holder, please state "NA."

- Observation of signs of injury or illness and provision of first aid or care to treat the concern
- Request medical supplies and medication refills from residential provider
- Administration of medications to Bob
- Provide first aid and CPR, as needed

If health service responsibilities are assigned to this license holder, the case manager and legal representative will be promptly notified of any changes in the person's physical and mental health needs affecting the health service needs, unless otherwise specified here: N/A

If the license holder is assigned responsibility for medication assistance or medication administration, the license holder will provide medication administration or assistance (including set up) according to the level indicated here:

Medication set up     Medication assistance     Medication administration

The following information will be reported to the legal representative and case manager as they occur, unless otherwise indicated here.

- Any report made according to 245D.05, subdivision 2, paragraph (c), clause (4)
- The person's refusal or failure to take or receive medication or treatment as prescribed.
- Concerns about the person's self-administration of medication or treatments.

## Psychotropic medication monitoring and use

Is this person prescribed psychotropic medication?

Yes  No

Has the license holder been assigned responsibility for the medication administration of the psychotropic medication?

Yes  No

If yes, the following information will be maintained by the company:

1. Describe the target symptoms the psychotropic medication is to alleviate:

N/A

2. Does the prescriber require documentation to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medications?

Yes  No

If yes, please indicate the documentation methods to be used to collect and report on medication and symptom-related data according to the prescriber's instructions:

N/A

**Permitted actions and procedures**

On a continuous basis, does the person require the **use of permitted actions and procedures** that includes physical contact or instructional techniques:

1. To calm or comfort a person by holding that person with no resistance from the person.

Yes  No If yes, explain how it will be used: N/A

2. To protect a person known to be at risk of injury due to frequent falls as a result of a medical condition.

Yes  No If yes, explain how it will be used: N/A

3. To facilitate a person's completion of a task or response when the person does not resist or it is minimal:

Yes  No If yes, explain how it will be used: Bob may need assistance from staff with his fine motor skills. Staff can assist Bob with hand over hand or hand under hand as tolerated.

4. To block or redirect a person's limbs or body without holding or limiting their movement to interrupt a behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.

Yes  No If yes, explain how it will be used: N/A

5. To redirect a person's behavior when the behavior does not pose a serious threat to self or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

Yes  No If yes, explain how it will be used: N/A

6. To allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment.

Yes  No If yes, explain how it will be used: N/A

# PAI

7. Assist in the safe evacuation or redirection of a person in an emergency and they are at imminent risk of harm.  
 Yes  No If yes, explain how it will be used: Bob may not respond appropriately to emergency situations. Staff will assist him in transferring or evacuating during an emergency as needed.
8. Is a restraint needed as an intervention procedure to position this person due to physical disabilities?  
 Yes  No If yes, explain how it will be used: Bob wears a seat belt while in his wheelchair to keep him safely secured.
9. Is positive verbal correction specifically focused on the behavior being addressed?  
 Yes  No If yes, explain how it will be used: N/A
10. Is temporary withholding or removal of objects being used to hurt self or others being addressed?  
 Yes  No If yes, explain how it will be used: N/A
11. Are adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition being used?  
 Yes  No If yes, explain how it will be used: Bob wears a helmet due to his seizure disorder.

## Staff information

Are any **additional requirements** requested for staff to have or obtain in order to meet the needs of the person?  
 Yes  No

If yes, please specify what these requirements are: N/A

Does a staff person who is **trained in cardiopulmonary resuscitation (CPR)** need to be available when this person is present and staff are required to be at the site to provide direct service?  Yes  No

## Staff ratio: For facility-based day services only

NA for residential services

For facility-based day services only – please indicate the staff ratio required for this person. Additional information on how this ratio was determined is maintained in the person’s service recipient record:

1:4  1:8  1:6  Other (please specify):

## Frequency of reports and notifications

\*Information received regarding the frequency of reports and notifications is completed with the person served and/or legal representative and case manager.

1. Frequency of *Progress Reports and Recommendations*, at a minimum of annually:

Quarterly  Semi-annually  Annually

2. Frequency of service plan review meetings, at a minimum of annually:

Quarterly  Semi-annually  Annually

# PAI

3. Frequency of receipt of *Psychotropic Medication Monitoring Data Reports*, this will be done quarterly unless otherwise requested:  
 Quarterly       Other (specify):       NA
4. Frequency of medication administration record reviews, this will be done quarterly or more frequently as directed (for licensed holders when assigned responsibility for medication administration):  
 Quarterly       Other (specify):       NA
5. The legal representative and case manager will receive notification within 24 hours of an incident or emergency occurring while services are being provided or within 24 hours of discovery or receipt of information that an incident occurred, or as otherwise directed. Please indicate any changes regarding this notification:  
N/A
6. Request to receive the *Progress Report and Recommendation*:  
 At the support team meeting       At least five working days in advance of the support team meeting
7. Frequency of receiving a statement that itemizes receipt and disbursements of funds will be completed as requested on the Financial Authorization form (also stated here).  
 Quarterly       Semi-annually       Annually       Other (specify):  NA