



Service Training Log – Linden

Date: 05/19/2021

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

Training Time	Trainer Name	Training ID	Area	Content/Description			
1	Morgan Bradshaw, Direct Service Professional		Primary	Review the following documents IAPP, SMA, CSSPA: MB, GJ			
Make up Date	Initial	EE ID	Last Name	Make up Date	Initial	EE ID	Last Name
	MB		Bradshaw, Morgan				
Make Up Date	Initial	EE ID	Managers /Admin	Make up Date	Initial	EE ID	Other Attendees

Staff: Morgan



Service Recipient: Mary B.

Date: 5/19

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 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 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>Choose between 2 music genres</u>		Outcome #2 <u>Choose pillow blanket w/ her in recliner</u>	
Technology Use:			

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>seasonal allergic allergies big bites</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:	Seizure PRN <input 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>ground/chopped diet thin liquids low cholesterol</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Scoliosis, dementia, hypothyroidism constriction hyperlipidemia high cholesterol</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sun sensitivity, eye redness</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>blind needs assistance walking</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 # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>blind, tactile defensiveness</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>looking well / put together warm baths spicy food</u>	Important For: <u>using chair on outings</u>
Likes: <u>people are descriptive when supporting her</u>	Dislikes: <u>bland food</u>
Describe Communication Style: <u>Nonverbal</u>	

Staff: Morgen



Service Recipient: Greg J.

Date: 5/19

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:	<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 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>Grab morning snack daily</u>		Outcome #2 <u>indicate group wants to join</u>	
Technology Use: <u>iPad/computer</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>grass, pollen, ragweed, mold</u>	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 checked="" type="checkbox"/> Yes - List: <u>PKU, asthma, GERD, gastric ulcer, eczema pruritus</u>	
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 checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>may be unsteady at times</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 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 checked="" type="checkbox"/> No <input checked="" 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: <u>bite/scratch himself</u>	
Important To: <u>daily routine</u> <u>snacks/eating personal space</u>	Important For: <u>honoring his choices</u> <u>holding someone's hand/arm walking</u>
Likes:	Dislikes:
Describe Communication Style:	