



Service Training Log - Linden

Date:

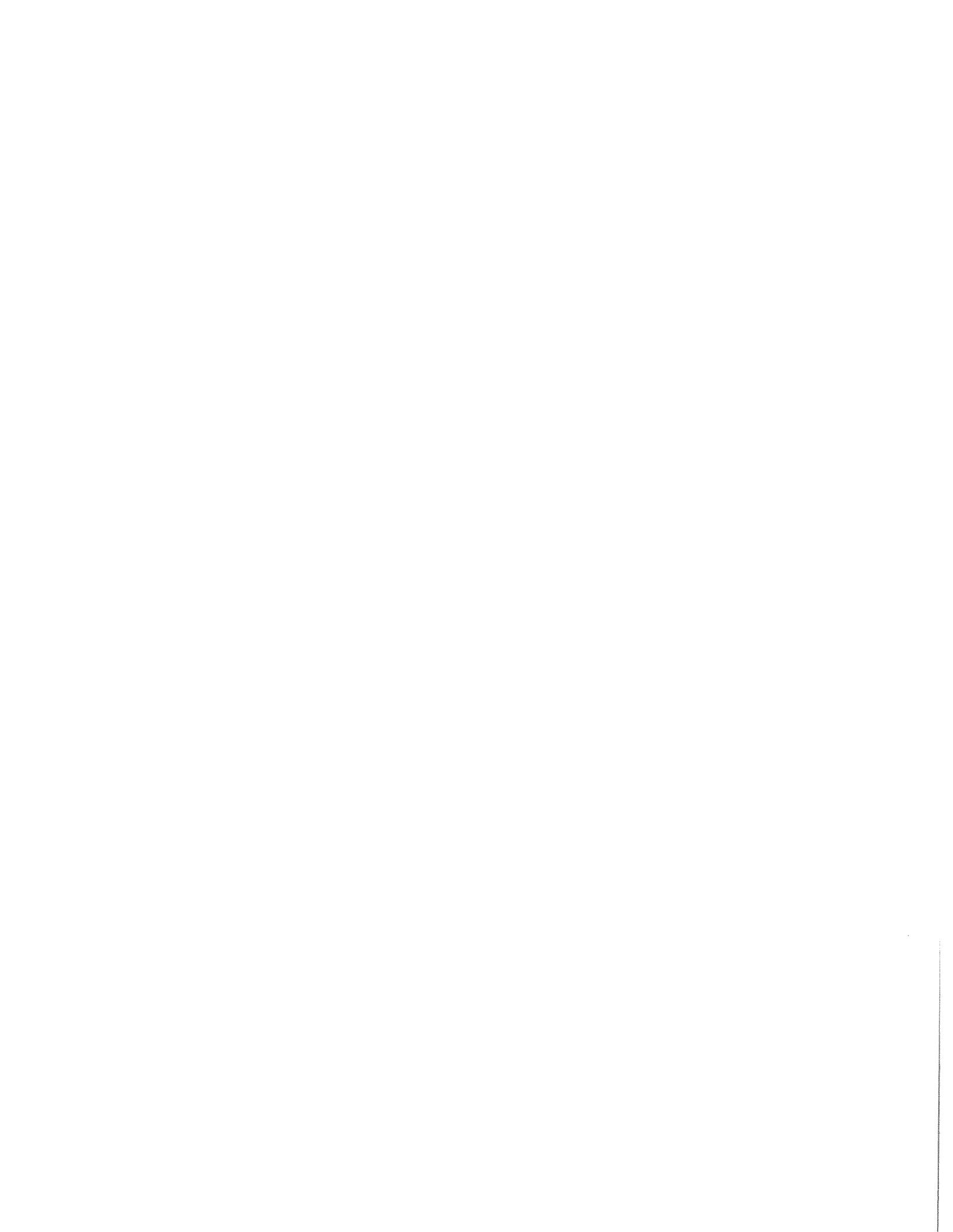
8/26/21

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

Training Time	Trainer Name	Training ID	Area	Content/Description
1.5	Morgan Bradshaw, Direct Service Professional		Primary	Review the following documents IAPP, SMA, CSSPA: NP, JD NM

Make up Date	Initial	EE ID	Last Name	Make up Date	Initial	EE ID	Last Name
	NB		Bradshaw, Morgan				

Make Up Date	Initial	EE ID	Managers /Admin	Make up Date	Initial	EE ID	Other Attendees



Staff: Morgan B.



Service Recipient: Nicky Milligan

Date: 8/26/2024

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 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 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 music to listen to</u>		Outcome #2 <u>Walk left while bearing her weight</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>MSG, Latex, seasonal allergies</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input 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>dysphagia, Pureed</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>osteoporosis, scoliosis, Rhetts syndrome</u>	
Medication Administration/Treatment Orders <input checked="" 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>Rhetts syndrome, osteoporosis, scoliosis</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input checked="" type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input checked="" type="checkbox"/> Support straps/belts needed	<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>fabric to hold in hand</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Parents</u> <u>reading group</u>	Important For: <u>HOH assistance</u>
Likes: <u>having choices playing games</u> <u>art projects</u>	Dislikes: <u>not being included</u>
Describe Communication Style: <u>vocalizations</u>	

Staff: Margann B.



Service Recipient: John D.

Date: 8/26/2024

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 checked="" 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 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 music genre</u>		Outcome #2 <u>Choose instrument</u>	
Technology Use: <u>pad, 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>tegretol, felbamate, pertussis vaccine, depakote, mold, dust</u>		Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Pollen</u>		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>NPO</u>		
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Lenoxgastrot syndrome, static encephalopathy, chronic pancreatitis, hypertonia, Klein-Levin syndrome (drowsiness)</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>unsteady gait</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 checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<input checked="" type="checkbox"/> Support straps/belts needed		
Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes		
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:		
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:		
Important To: <u>being comfortable</u> <u>fresh paper</u> <u>going on outings</u>	Important For: <u>new activities daily</u>	
Likes: <u>1:1 w/ staff</u> <u>being outside</u> <u>music therapy</u>	Dislikes:	
Describe Communication Style: <u>Smiling, lifting eyebrows, vocalizations</u>		

Staff: Morgan B



Service Recipient: Tasha P.

Date: 8/26/2024

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 checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" 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>Choose job</u>		Outcome #2 <u>Choose group 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>None</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>bite size</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cerebral palsy</u> <u>dislocated hips</u> <u>spastic quadraparesis, scoliosis, spinal fusion, hydrocephalus, acid reflux</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input checked="" 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>Spastic quadraparesis</u> <u>cerebral palsy</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 checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>hitting</u>	
Important To: <u>family, music, dancing being social</u>	Important For: <u>Making choices</u>
Likes: <u>Mom, food choices</u>	Dislikes:
Describe Communication Style: <u>vocal, body language</u>	

