



Service Training Log – Linden

Date:

6/30/21

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

Training Time	Trainer Name	Training ID	Area	Content/Description			
2:5	Morgan Bradshaw, Direct Service Professional		Primary	Review the following documents IAPP, SMA, CSSPA: LT, KP, BG, AS, JV			
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 B.



Service Recipient: Andy S.

Date: 6-30

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>inaccurate</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 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>4 wks</u> <u>choose sensory item</u>		Outcome #2 <u>Greet peers on MAC switch</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:	Epi Pen/Treatment <input 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>bite size</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cerebral palsy, developmental delay, GERD</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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>family, reading books</u> <u>going to PAI</u> <u>having manipulative</u>	Important For: <u>allow space</u> <u>explore room</u> <u>verbally explain</u> <u>mirrors</u>
Likes: <u>Mirrors, being read to</u>	Dislikes:
Describe Communication Style: <u>non verbal</u>	

Staff: Morgan B.
 Date: 6-30



Service Recipient: Brittney G.

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>Weekly listen to music from different rock band</u>		Outcome #2 <u>Daily, indicate lotion message</u>	
Technology Use: <u>iPad, TV in room</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>Cipro, ceftriaxone, suprad, latex, cetamine</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>Partially controlled</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>Choking, NPO</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>static encephalopathy, scoliosis w/ O2 spinal fusion, dysmenorrhea, constipation</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Cooperative</u>	
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>Scoliosis</u>	<input 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 type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Something is too loud may cry</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>family, outside, hair being done 1 on 1 time</u>	Important For: <u>VNS, NPO, knowing her allergies</u>
Likes: <u>music, relaxing in recliner</u>	Dislikes:
Describe Communication Style:	

Staff: Morgan B.



Service Recipient: Kelly P.

Date: 6-30

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>trust strangers non verbal</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 checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" 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>Making choices 80% of day</u>		Outcome #2 <u>tour a place virtually</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>seasonal</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>none</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>May eat too quickly</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cerebral palsy, neurogenic bladder, scoliosis, right hip dysplasia</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Can take independently</u>	
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>Cerebral palsy, scoliosis</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>myopic</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>throws items</u>	
Important To: <u>have a schedule, mom, arts/crafts, privacy, summer camp</u>	Important For: <u>15 min in AM for time around building</u>
Likes: <u>price is right.</u>	Dislikes: <u>Storms, rain, lightning</u>
Describe Communication Style: <u>verbal</u>	

Staff: Morgan B

Service Recipient: Larry T

Date: 6 30



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 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 checked="" type="checkbox"/> Other: <u>unable to remove himself</u>	<input 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 type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" 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 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 group to join</u>		Outcome #2 <u>Play checkers</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:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>epilepsy</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite size</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>ataxia</u> <u>failure to thrive, cerebral palsy, osteoporosis, rosacea, depression</u>	
Medication Administration/Treatment Orders <input 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>Cerebral palsy</u> <u>ataxia</u> <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input checked="" 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>alternating esotropia, hypermetropia, vitreous floater, sensorineural</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>depression</u>	
Important To: <u>checkers music therapy</u> <u>Making announcements being involved</u>	Important For: communication <u>doing things independently 10 min alone time</u>
Likes: <u>checkers</u> <u>visiting others</u> <u>out to eat</u>	Dislikes:
Describe Communication Style: verbal <u>verbal</u>	

Staff: Morejean B.



Service Recipient: Sara V.

Date: 6-30

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>daily, use new word/phrase</u>		Outcome #2 <u>answer yes/no questions</u>	
Technology Use: <u>iPod/computer/TV</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>NKA</u>	Epi Pen/Treatment <input 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>bite size pieces</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cerebral palsy w/ mixed tone quadriplegia severe neuromuscular scoliosis, GERD, neurogenic bladder</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" 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>Able to support trunk</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
<input type="checkbox"/> Support straps/belts needed	
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>nothing needed</u>	
Important To: <u>family friends certain staff music baking joking around</u>	Important For: <u>hand under hand NO unexpected noises</u>
Likes: <u>Certain staff Schedule initiate contact</u>	Dislikes: <u>unexpected noises wearing chest strap</u>
Describe Communication Style: <u>verbal/vocalizations/facial expressions</u>	

