

Staff: Juan Bonilla



Service Recipient: Elizabeth Jantzen

Date: 9.30.21

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 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 Elizabeth cannot consistently recall the new addresses for her house yet & would like to learn. Will practice new home address daily by copying it down in writing & reading it aloud.		Outcome #2 Elizabeth enjoys eating & shopping in the community, doesn't typically help make transactions or carry her own money but would like to learn, will help make transactions in the community.	
Technology Use: She'll occasionally use an iPad for an activity.			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>morphine, difficulty coming out of anesthesia</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Generalized tonic seizures</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Cutting food into nickel sized pieces, lactase</u> into her unit.	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>would not remember to take medication herself</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>likes to climb</u>	<input type="checkbox"/> Verbal Cues <input 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 checked="" type="checkbox"/> Yes - List: <u>should wear glasses daily to correct her myopia, staff should clean her glasses as needed & report any vision concerns to Elizabeth's residence & guardian.</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>spending time w/ her parents, have good food to eat, work on cards</u>	Important For: <u>having staff support to eat healthy & safe & have opportunities to incorporate in her community.</u>
Likes: <u>animals, salads, joking with others, affirmations & attention, puzzles & Uno.</u>	Dislikes: <u>being rushed, people arguing, the dentist.</u>
Describe Communication Style: <u>verbal</u>	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Brown

Date of hire: 9.20.21

Date of background study submission:

Date of background study clearance:

Ongoing annual training period:

Date of first supervised contact: 9/20/2021

Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Elizabeth Santzen

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
* Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specific:	NA	9.30.21	Paper Quiz	
* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	9.30.2021	Paper quiz	50 hours total	Catherine Kelly, OS
* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specific:	✓	✓	✓	✓
CPR, if required by the CSSP or CSSP Addendum	✓	✓	✓	✓

<p><i>CSSP, CSSP Addendum, and Self-Management Assessment</i> to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p><i>Individual Abuse Prevention Plan</i> to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's <i>Coordinated Service and Support Plan</i> or identified by the company: Topic: Topic: Topic:</p>				

Staff signature 

Date 11-17-21

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Shan Basilla



Service Recipient: Liz Bourke

Date: 9-29-21

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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input 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 type="checkbox"/> Dresses inappropriately <input checked="" 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 checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1		Outcome #2	
Technology Use:			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input 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 type="checkbox"/> Yes - Describe :	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : Elizabeth carries a water bottle w/ her & if she purchases food in the community staff will encourage her to make a healthy choice	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: hypertension, frequent sinus or ear infections, chronic pain GERD, migraines, IBS, asthma, COPD & multiple joint osteo arthritis.	
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 type="checkbox"/> Yes - Describe primary mobility & supports unsteady gait & often experiences pain in her knees, back & right foot Elizabeth has also diagnosed with osteoarthritis. uses a walker, would rather sit than stand	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" 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 type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: meeting new people, health, friends, keeping in touch w/ daughter.	Important For: Maintaining her health, having a part time job.
Likes: Reading, word searches, watching movies, being friends w/ her fiance coloring, journaling, time w/ her cats, writing, walking.	Dislikes:
Describe Communication Style:	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Bonilla

Date of background study submission:

Date of hire: 9.20.21

Ongoing annual training period:

Date of background study clearance:

Date of first supervised contact: 9/20/2021

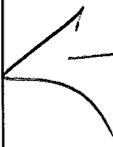
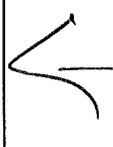
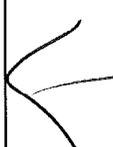
Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

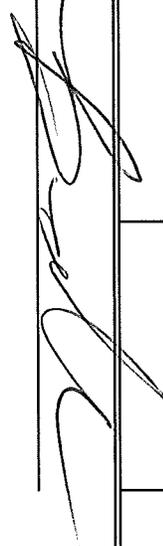
Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Elizabeth Bonilla

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
* Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA ↓	9.20.21 ↓	Paper Quiz ↓	↓
* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	9/20/2021 ↓	Paper quiz ↓	50 mins ↓	Courtney Kelly, PS ↓
* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify: CPR, if required by the CSSP or CSSP Addendum	↓	↓	↓	↓

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: Topic: Topic:</p>				

Staff signature



Date

11.17.21

Staff: Juan Bonilla



Service Recipient: Sara Grahn

Date: 9.29.21

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>Social Boundaries</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 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 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>When participating in a community outing involving money Sara will hand her own cash to the cashier to obtain the receipt which she will give to staff members with her</u>		Outcome #2 <u>When attending PAI Sara will practice counting money with staff</u>	
Technology Use: <u>Using phone to text/call family, ipod, ipad at commerce when needed/wants to watch tv/movies at home</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 :		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 :			
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports		<input type="checkbox"/> Verbal Cues <input 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
Important To: <u>obtaining a job in the community being as independent as possible, having supports to help her, feeling safe, staying healthy by making healthy choices. Being a good friend, going over for coffee, but not eating. Making friends, positive encouragement</u>		Important For: <u>having the people around her be supportive, being healthy & making better eating choices. Being a good friend, going over for coffee, but not eating. supports to talk through concerns. choices & making the decisions.</u>	
Likes: <u>Coffee, bowling, playing games, Dollar tree, going to 5 below, talking on the phone, listening to music, Arts & crafts.</u>		Dislikes: <u>Mushrooms, Spicy food, Taking out the trash, being disrupted while working, being told what to do.</u>	
Describe Communication Style: <u>Verbal</u>			

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Bonilla

Date of background study submission:

Date of hire: 9.20.21

Ongoing annual training period:

Date of background study clearance:

Date of first supervised contact: 9/20/2021

Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

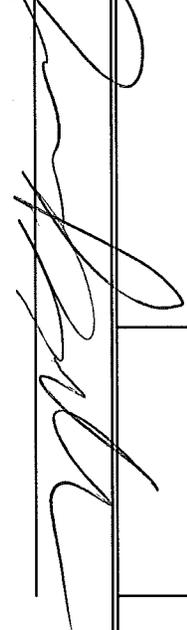
Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Sara Braha

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
* Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	N/A	9.24-21	Paper Quiz	
* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	9/29/2021	Paper Quiz	50 mins	Anthony Kelly, RS
* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify: CPR, if required by the CSSP or CSSP Addendum	↓	↓	↓	↓

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>	✓	✓	✓	✓
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: Topic: Topic:</p>				

Staff signature



Date

11.17.21

Staff: Juan Bonilla



Service Recipient: Sameera Flower

Date: 9-22-21

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 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 <i>participating in at least one new community activity per month until next year.</i>		Outcome #2 <i>Journaling from a provided list of journal every morning in homeroom, 75% of all trials until next review</i>	
Technology Use:			

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:		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: <i>She can chew & swallow her food independently, no staff support needed in this area. May not always make healthy food choices. Staff are required according to the CSSP Addendum. * Avoids pork, Gelatin for religious reasons</i>			
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <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 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: <i>Friends people, Family & Friends, Disney movies, The Beatles, to have money & a job, shopping (especially at Kohls.) going out to eat (Taco Bell)</i>		Important For:	
Likes: <i>Working on cards, relaxing in her room, playing on her computer, music, her friends at PAI & spending time with her family</i>		Dislikes: <i>Bad weather, changes to her schedule without people letting her know, some peers at PAI, some classes at PAI, closed in spaces.</i>	
Describe Communication Style: <i>Verbal</i>			

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Ramirez

Date of hire: 9-29-21

Date of background study submission:

Date of background study clearance:

Ongoing annual training period:

Date of first supervised contact: 9/20/2021

Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Suzette Howe

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
* Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	9-29-21	Paper Quiz	
* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	9/28/2021	Paper Quiz	50 mins	Century Valley PS
* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify: CPR, if required by the CSSP or CSSP Addendum	✓	✓	✓	✓

<p><i>CSSP, CSSP Addendum, and Self-Management Assessment</i> to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p><i>Individual Abuse Prevention Plan</i> to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>	✓	✓	✓	✓
<p>Other topics as determined necessary according to the person's <i>Coordinated Service and Support Plan</i> or identified by the company: Topic: Topic: Topic:</p>				

Staff signature



Date

11.17.21

Staff: Juan Bonilla



Service Recipient: Jhan'ne Durham

Date: 9-28-21

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 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 Jhan'ne will personally hand her money to the cashier when purchasing items in the community at least once a month w/ or less hand prompts		Outcome #2 Jhan'ne will practice once a day writing her phone number with one verbal cue.	
Technology Use:			

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 :		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 :			
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe primary mobility & supports <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 type="checkbox"/> Yes			
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List: <u>N/A</u>			
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:			
Important To: <u>doing some art projects, playing games, hanging out with family & friends.</u>		Important For: <u>having access to work & leisure activities, & having the appropriate supports needed w/ those opportunities.</u>	
Likes:		Dislikes:	
Describe Communication Style:			

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Sven Boellke
 Date of background study submission: _____

Date of hire: 9-20-21
 Date of background study clearance: _____

Ongoing annual training period:
 Date of first supervised contact: 9/20/2021

Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Shawne Durham

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
* Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	9-28-21	Paper Quiz	
* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	9/28/2021	Paper Quiz	50 hours	Century Kuby, R-
* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify: CPR, if required by the CSSP or CSSP Addendum	✓	✓	✓	

<p><i>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</i></p>	✓	✓	✓	✓
<p><i>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</i></p>	✓	✓	✓	✓
<p><i>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</i></p>	✓	✓	✓	✓
<p><i>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</i></p>	✓	✓	✓	✓
<p><i>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</i></p>	✓	✓	✓	✓
<p><i>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</i></p> <p>Topic:</p> <p>Topic:</p> <p>Topic:</p>				
<p>Staff signature</p> 	<p>Date</p> <p>11.17.21</p>			

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla
 Date: 9.29.21



Service Recipient: Robert Dean (Fred)

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 type="checkbox"/> Yes <input checked="" 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 type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input 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 type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input 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>NA</u>		Outcome #2 <u>NA</u>	
Technology Use: <u>NA</u>			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Rantidine, seasonal</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 type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :		
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>GFRD, asthma</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 type="checkbox"/> Yes - Describe primary mobility & supports	<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 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>Knowing his schedule ahead of time to help control his anxiety, his independence staying healthy</u>	Important For: <u>Self determination assistance with setting up appointments & medications, encouragement to stay active in his community, continuing to learn & work on personal relationships with the</u>	
Likes: <u>Spending time with close friends, fishing, camping, going on trips, working, spending time at home alone</u>	Dislikes: <u>People not returning his calls or answering the phone, feeling anxious, not knowing about schedule changes ahead of time.</u>	
Describe Communication Style:		

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Jwen Bonilla

Date of background study submission:

Ongoing annual training period:

Date of first supervised contact: 9/20/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the Coordinated Service and Support Plan.

Name of person served: Robert 'Fred' Dean

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specific:	NA	9-29-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	9/29/2021	Paper quiz	50 hours	Century Valley, B
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specific:	✓	✓	✓	✓
CPR, if required by the CSSP or CSSP Addendum	✓	✓	✓	✓

<p><i>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</i></p>				
<p><i>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</i></p>				
<p><i>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</i></p>				
<p><i>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</i></p>				
<p><i>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</i></p>	✓	✓	✓	✓
<p><i>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</i></p> <p>Topic:</p> <p>Topic:</p> <p>Topic:</p>				

Staff signature



Date 11-17-21

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla



Service Recipient: Karen Loven

Date: 9.30.21

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 type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input 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 wants to work on staying calm in the moment & asking staff to speak privately. Karen wants to avoid becoming upset in front of her peers.		Outcome #2 Karen wants to work on both building strong relationships with the staff in her room & courtly using coping skills	
Technology Use: Uses phone at home & at PAI to keep in contact with family & friends. used iPad at work for leisure activities			

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>Penicillin, Sulfa, lactose intolerant, cats, scasna</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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: _____	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Heart Murmur, Williams Syndrome</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>No time management & _____ skills. Need staff to help administer inhaler.</u>	
Specific Health & Medical Needs <input checked="" 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"/> 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Needs hearing aids & glasses to help navigate surroundings</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>family, dogs, having her niece back in MN</u>	Important For: <u>Maintaining good health, being happy & continuing to have opportunities in the community.</u>
Likes: <u>Coming to PAI, her staff, dogs, her family, shopping & watching TV</u>	Dislikes: <u>rude people or when people use the phrase "you gmys?"</u>
Describe Communication Style: <u>Verbal</u>	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Sven Bonilla Date of hire: 9.20.21
 Date of background study submission: _____ Date of background study clearance: _____

Ongoing annual training period: _____ Date of first unsupervised contact: 9/20/2021 Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: <u>KAREN LOVEN</u>				
Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
* Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify: _____	<u>NA</u>	<u>9.30.21</u>	<u>Paper</u>	
* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	<u>9/30/2021</u>	<u>Paper quiz</u>	<u>.50 hours</u>	<u>Cathary Kelly, RS</u>
* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify: _____	<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>
CPR, if required by the CSSP or CSSP Addendum				

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>	✓	✓	✓	✓
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>	✓	✓	✓	✓
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>	✓	✓	✓	✓
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>	✓	✓	✓	✓
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>	✓	✓	✓	✓
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p>				
<p>Topic:</p>				
<p>Topic:</p>				
<p>Staff signature</p>				
<p>Date</p>	<p>11-17-21</p>			

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla



Service Recipient: Mac Meron

Date: 9-30-21

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 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 <i>wants to become independent in making purchases in the community & wants to work on handy skills,</i>		Outcome #2 <i>working on math skills & wants to work on addition & subtraction. Applying this to the real world. Mac would like to be more confident using money.</i>	
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: <i>Alternaria, mold, grass, hair, some farm animals & Pets</i>	Epi Pen/Treatment <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location: <i>he carries his own</i>
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: <i>some foods need to be cut</i>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <i>asthma, hydrocephalus, hypotonia, Klinefelter Syndrome, osteopenia, history of pica-</i>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <i>lack of time management skills</i>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <i>low muscle tone, may require assistance in restroom after BM.</i>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <i>low endurance & muscle tone.</i>	<input type="checkbox"/> Verbal Cues <input 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <i>wears glasses needs a reminder to wear glasses daily. may not realize his vision has declined or recognize his glasses need to be cleaned.</i>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <i>Working & making a paycheck, family & friends</i>	Important For: <i>Having opportunities to work & stay involved in his community</i>
Likes: <i>working on greeting cards, playing games (skippo, connect 4, bean bag toss) country music, hanging out w/ friends, spending time w/ family, the Vikings</i>	Dislikes: <i>peers who are unkind & start drama, being sick, being bored</i>
Describe Communication Style: <i>Verbal</i>	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Jan Ballie Date of hire: 9-20-21
 Date of background study submission: _____ Date of background study clearance: _____

Ongoing annual training period: _____
 Date of first supervised contact: 9/20/21 Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Mr. Nelson

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specific:	NA	9:30-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	9/30/2021	Paper Quiz	50 hours	Catherine Kelly, PS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specific:	✓	✓	✓	✓
CPR, if required by the CSSP or CSSP Addendum	✓	✓	✓	✓

<p><i>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</i></p>				
<p><i>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</i></p>	✓	✓	✓	✓
<p><i>Medication set up or medic ation administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</i></p>	✓	✓	✓	✓
<p><i>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</i></p>	✓	✓	✓	✓
<p><i>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</i></p>	✓	✓	✓	✓
<p><i>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</i></p> <p>Topic:</p> <p>Topic:</p> <p>Topic:</p>				

Staff signature



Date 11-17-21

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla



Service Recipient: Daniel Petersdorf

Date: 10-1-21

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 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 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 Dan will learn PAI's address by copying it four times a week		Outcome #2 Dan will learn his place of employment Culver's address & phone numbers by copying it daily at PAI.	
Technology Use: uses phone to text, Dan uses iPads at PAI commerce when he needs to. plays video games during down time.			

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>Tomatoes (whole)</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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: PAI staff members are responsible for the sensory needs of the residents <u>Dan has vision lost; Dan wears glasses</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>His many family/friends, his house, working, the PAI staff, positivity</u>	Important For: <u>Remaining busy, having the opportunity to work at his job, interacting w/ friends & family, having support to remain as independent as possible.</u>
Likes: <u>Music, attending classes at PAI (Cooking), going for walks in the neighborhood, taking dog for walks, playing video games, Imagine Dragons, spiritz, pizza, filming hot chests, going to apple orchard, exercising to Lifetime fitness.</u>	Dislikes: <u>Tomatoes, Negativity. When peers mess w/ him or others</u>
Describe Communication Style: <u>Verbal</u>	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Benilla Date of hire: 01-20-21

Date of background study submission: _____ Date of background study clearance: _____

Ongoing annual training period: _____

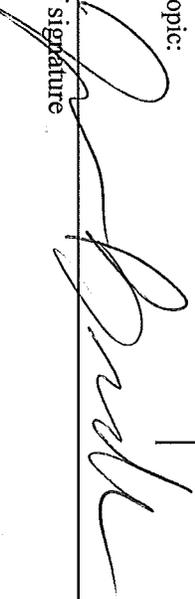
Date of first supervised contact: 9/20/2021 Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Daniel Petersdorf

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
* Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	10-1-21	Paper Quiz	
* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	10/11/2021	Paper quiz	50 mins	Catherine Kelly, PS
* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:				
CPR, if required by the CSSP or CSSP Addendum	✓	✓	✓	✓

<p><i>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</i></p>	✓	✓	✓	✓
<p><i>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</i></p>	✓	✓	✓	✓
<p><i>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</i></p>	✓	✓	✓	✓
<p><i>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</i></p>	✓	✓	✓	✓
<p><i>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</i></p>	✓	✓	✓	✓
<p><i>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</i></p> <p>Topic:</p> <p>Topic:</p> <p>Topic:</p>				
<p>Staff signature: </p>	<p>Date: <u>11-17-21</u></p>			

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bosilla



Service Recipient: Roland Missing

Date: 10-1-21

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 type="checkbox"/> Likely to seek/cooperate in an abusive situation <input 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 type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input 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 Roland directs on things causing him pain, bothering him or that he finds annoying. Roland is receptive to more positive subjects & enjoys socializing w/ peers & staff.		Outcome #2 Roland works a mix of jobs at PAI w/ varying levels of pay. Going over his paycheck & work list prior to work will help Roland understand more about the rate he earns doing each job.	
Technology Use: Roland does not wish to pursue more technology use, including to not learn more about, to not complete an outcome & not learn a new skill.			

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>Sulfa & Penicillin</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>Roland knows & understands he has a seizure disorder, but hasn't had one in years. Roland takes medication daily. Roland knows the importance of wearing his medical ID bracelet.</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>Roland does not have strong impulse control when it comes to eating junk food. Roland chooses to eat whatever he wants, including high fat & high salt foods even though it may impact his health negatively.</u>			
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Prone to Blood Clots, Diabetes, Subdermal Hematomas</u>			
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Roland understands the importance of taking medication to stay healthy. Roland can take the correct medication dose when handed to him.</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 <input type="checkbox"/> Support straps/belts needed		<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 checked="" type="checkbox"/> Yes			
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>When Roland is annoyed, Roland may raise his voice, call others names & tease others</u>			
Important To:		Important For: <u>to maintain health for his diabetic diet enough to avoid further health concerns, opportunities to work.</u>	
Likes: <u>Working at Dynamic Air, going out for dinner, music & when he used to work on the farm.</u>		Dislikes: <u>taking classes, working on piece rate work, & not being busy/ having something to do.</u>	
Describe Communication Style: <u>Verbal</u>			

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Bonilla
 Date of background study submission:

Date of hire: 9.20.21
 Date of background study clearance:

Ongoing annual training period:
 Date of first supervised contact: 9/20/2021

Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

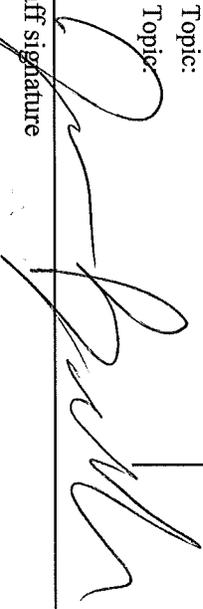
Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Roland Myslins

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specific:	NA	ID-1-21	Paper QUIZ	Century Valley, RS
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	10/1/2021	Paper Quiz	50 mins	Century Valley, RS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specific:	↓	↓	↓	↓
CPR, if required by the CSSP or CSSP Addendum	↓	↓	↓	↓

<p><i>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</i></p>	✓	✓	✓	✓
<p><i>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</i></p>	✓	✓	✓	✓
<p><i>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</i></p>	✓	✓	✓	✓
<p><i>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</i></p>	✓	✓	✓	✓
<p><i>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</i></p>	✓	✓	✓	✓
<p><i>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</i></p> <p>Topic: _____</p> <p>Topic: _____</p> <p>Topic: _____</p>	✓	✓	✓	✓

Staff signature



Date

11.17.21

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Beaulac



Service Recipient: Mary Jo Otley

Date: 10.1.21

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 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 Maintaining her mobility & good health. During lunch Mary Jo will independently stand up, walk around, stretch her legs or elevate her legs for a few minutes. If she doesn't independently stand up, staff will remind her.		Outcome #2 Participating in the community. Each month staff will approach Mary Jo with a list of planned outings that month & Mary Jo will choose one that interests her & when the day comes she'll attend.	
Technology Use: Telephone at home to stay in contact with friends/family, iPad for class activities/learning.			

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 :	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: None to support her swallowing & eating crunch foods. Mary Jo has dentures & may have difficulties chewing some foods. Mary Jo also forgets to slow down when eating at times. Avoid very hard, chewy, sticky, dry &		
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: Mary Jo doesn't have the time or self management skills to take medication independently correctly & consistently.		
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 <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" 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: Mary Jo wears glasses everyday & can wear them independently put them on & care for them Vision impairment in both eyes		
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:		
Important To: to continue living with her husband, to find another place to live, for her & her husband to stay healthy	Important For: to continue eating healthy & staying active in her community & to have work opportunities.	
Likes: going out to lunch w/ friends, pizza, spaghetti baked salmon, shopping at Dollar Tree, cooking & baking.	Dislikes: scary movies, cleaning, exercising, activities on/near large bodies of water, arguing.	
Describe Communication Style: Verbal		

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Benilla Date of hire: 9-20-21
 Date of background study submission: Date of background study clearance:

Ongoing annual training period: Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

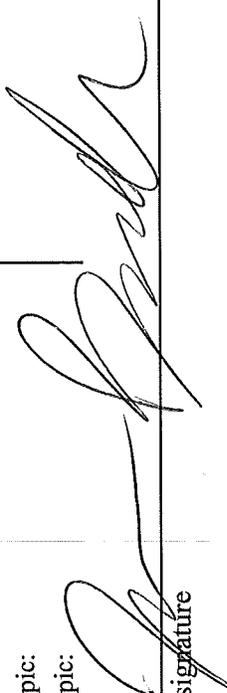
Name of person served: Mary Jo Otley

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	10-1-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	10/11/2021	Paper quiz	.50 hours	Courtney Kelly, PS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	→	→	→	→
CPR, if required by the CSSP or CSSP Addendum	→	→	→	→

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>						
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>						
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>						
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>						
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>						
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p>						
<p>Topic: Topic:</p>						

Date

11.17.21



Staff signature

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla



Service Recipient: Melanie Nyvold

Date: 10-1-21

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 checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input 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 Melanie will ask for more work 70% of all trials		Outcome #2 Melanie will get <u>get</u> a person of her choice 70% of all trials	
Technology Use: phone to keep in touch w/ family & friends, iPad at PAI Commerce when she wants/needs to.			

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:	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>No MSG, Soda or Juice</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>doesn't demonstrate the skills needed to administer her own treatment orders or medication.</u>	
Specific Health & Medical Needs <input checked="" 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"/> 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Melanie is able to be redirected when she needs it - Engages in self-talk, pinch others, gissle or laugh at inappropriate times, touch her breasts in front of others, or repeatedly flap the sleeve of her coat or mittens when she is anxious.</u>	
Important To: <u>Job at US Bank, Family, laptop, being able to go outside for 20 minutes when it's too loud around me.</u>	Important For: <u>Go outside, going to work every day at PAI & US Bank, following a routine & schedule</u>
Likes: <u>Yoga, going to church, spending time w/family, Bob Dylan, fish, chicken</u>	Dislikes: <u>Mayonnaise, ranch, dressing, when peers are having loud or disruptive beh. disor.</u>
Describe Communication Style: <u>Verbal</u>	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Benitez **Date of hire:** 9-20-21
Date of background study submission: _____ **Date of background study clearance:** _____
Ongoing annual training period: _____ **Date of first unsupervised contact:** 11/17/2021
Date of first supervised contact: 9/20/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Melanie Nyvold

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	10-1-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	10/1/2021	Paper Quiz	50 hours	Catherine Kelly, PS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:				
CPR, if required by the CSSP or CSSP Addendum				

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p> <p>Topic: _____</p> <p>Topic: _____</p>				<p>11-17-21</p> <p>Date</p>

Staff signature: 

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Boonina



Service Recipient: Anthony Qualley

Date: 10.4.21

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 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 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 Learning & practicing ASL via flash cards w/ cartoon phrases on them. Anthony picks one card every morning & demonstrate to staff how to sign the phrase or question in ASL.		Outcome #2 Wants to stay active & enjoys getting out & spending time w/ friends. Open to try an outing once a month. Staff will provide Anthony a list of outings at the beginning of each month & ask Anthony to pick one. Anthony wants to continue learning to do so but does not wish to have this as a formal outcome at this time. Anthony likes using the iPad.	
Technology Use: None at this time. Anthony likes using the iPad.			

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 :	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 :	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: doesn't have the skills to independently schedule & attend appointments. Wouldn't be able to answer complex questions about his medical history or concerns	
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 <i>None</i>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" 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: Needs glasses & hearing aids daily. Anthony can put these items on himself.	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: living w/ his brothers watching TV (cartoons) & coming to PAI to see his friends	Important For: continuing to stay active & maintain mobility, having opportunities to work & interact w/ friends, having support of his family to continue living with them
Likes: working on levels at PAI, music from the 50s, watching TV, pirates & pirate ships, Cindy Lauper	Dislikes: Spinach snow, rain
Describe Communication Style: Verbal (speaks very softly)	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: *Jwan Beall* **Date of hire:** *9-20-21*
Date of background study submission: **Date of background study clearance:**
Ongoing annual training period:
Date of first supervised contact: *9/20/2021* **Date of first unsupervised contact:** *11/17/2021*

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterisk (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: *Anthony Qualley*

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	10-4-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	10/4/2021	Paper quiz	50 hours	Catherine Kelly MS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:				
CPR, if required by the CSSP or CSSP Addendum				

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>	<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>	<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>	<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>	<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>	<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p>
<p>Topic: _____ Topic: _____</p>					
<p>Staff signature _____ Date 11/17/21</p>					

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla



Service Recipient: Hollie Schuette

Date: 10.11.21

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 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 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 When on an outing where Hollie needs to make a purchase, Hollie will hand the cash to the cashier & receive change & receipt		Outcome #2 Money skills on the iPad	
Technology Use: <u>iPad</u>			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies No Yes - List: Seasonal

Epi Pen/Treatment No Yes
Location:

Seizures No Yes - Describe:

Seizure PRN No Yes
Location:

Choking/Specialized Dietary Needs No Yes - Describe Equipment/Supports: if Hollie's food were not properly cut up, Hollie would take too big of a bite at a time

Chronic Medical Conditions No Yes - List: GERD, Megacolon, Chronic Constipation, scoliosis, Obsessive compulsive disorder, cerebral palsy

Medication Administration/Treatment Orders No Yes - Describe Equipment/Supports: lacks the skills to take medication consistently & correctly on her own - Doesn't know which medication she's taking or it's purpose.

Specific Health & Medical Needs No Yes - List:

Mobility Supports Fall Risk No Yes - Describe primary mobility & supports

Verbal Cues
 Physical Assistance
 Posey / Gait Belt
 Walker

2 Person Hoyer
staff in care room: _____
 1 Person Hoyer / Track
 Arjo

Support straps/belts needed

Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List: prescription glasses to correct her vision but may still try to wear her reading glasses that she has purchased from the store Dollar Tree. This could negatively impact Hollie's vision.

Self-Management of Behaviors No Yes - Describe supports: if Hollie is picking at her hair staff will ask her to stop & try to redirect her & find a new activity to do. Hollie is not feeling well or upset staff will ask Hollie what is wrong & try to take a few minutes to herself to calm down, though staff will give her space & let her take a few minutes to calm down.

Important To: spending time w/ family & friends, eating good food, electronics, a looking nice, getting out.

Important For: Having the opportunity to work, having new & varied opportunities to incorporate into her community.

Likes: listening to music (especially Lady Gaga & country), snacks, watching the Simpsons, going out to eat, going shopping.

Dislikes: eating salads vegetables, mispleasing her belongings, going to doctor appointments, when peers tell her what to do, getting hurt or not feeling well.

Describe Communication Style: Verbal

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

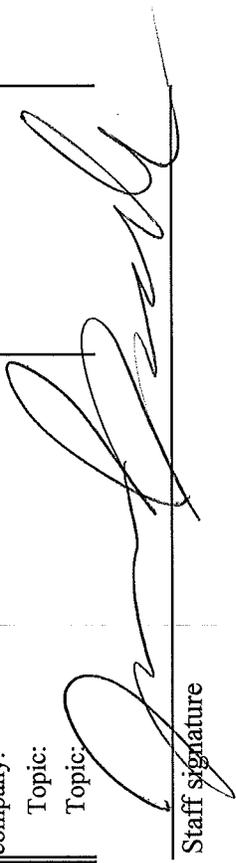
Staff name: Juan Benitez **Date of hire:** 9-20-21
Date of background study submission: _____ **Date of background study clearance:** _____
Ongoing annual training period: _____ **Date of first unsupervised contact:** 11/17/2021
Date of first supervised contact: 9/20/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.
 Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Holly Schwette

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	N/A	10-11-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	10-11-2021	Paper quiz	.50 hours	Catherine Kelly, PS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	↓	↓	↓	↓
CPR, if required by the CSSP or CSSP Addendum	↓	↓	↓	↓

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p>				

Topic: 

Topic: _____

Staff signature: _____

Date: 11-17-21

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bealla



Service Recipient: Meng Yang

Date: 11-15-21

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?

Table with 4 columns: Sexual Abuse, Physical Abuse, Self-Abuse, Financial Exploitation. Includes checkboxes for Yes/No and handwritten notes for Outcome #1 and Outcome #2.

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Form with multiple sections: Allergies, Seizures, Choking/Specialized Dietary Needs, Chronic Medical Conditions, Medication Administration/Treatment Orders, Specific Health & Medical Needs, Mobility Supports Fall Risk, Community & Water Safety Skills, Sensory Disabilities, Self-Management of Behaviors, Important To/For, Likes/Dislikes, Describe Communication Style.

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Panilla **Date of hire:** 9-20-21
Date of background study submission: _____ **Date of background study clearance:** _____
Ongoing annual training period: _____ **Date of first unsupervised contact:** 11/17/2021
Date of first supervised contact: 9/20/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.
 Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterisk (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Meng Yang

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	11-15-21	paper quiz _____	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	11/15/2021	paper quiz	.50 hours	Catherine Kelly, RS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	✓	✓	✓	✓
CPR, if required by the C SSP or C SSP Addendum	✓	✓	✓	✓

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p> <p>Topic: Topic:</p>				<p>11-17-21</p> <p>Date</p>

Staff Signature

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla



Service Recipient: Julie Tint

Date: 11-15-21

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 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 Julie will greet a different staff member or peer each morning using sign language 70% of all trials until next review.		Outcome #2 Julie will work 1:1 with staff on iPad skills once a day, 70% of all trials until next review.	
Technology Use: N/A, the additional use of technology would not be beneficial for Julie at this time.			

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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: Julie has a seizure disorder & used to have seizures	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: Julie is a Hepatitis B carrier. Julie does not understand this diagnosis or the associated risk factors.	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: Julie is a hepatitis B carrier. Julie doesn't understand this diagnosis or the associated risk factors.	
Medication Administration/Treatment Order <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: Julie doesn't take any medication while at PAI. If the need arises, trained staff in medication would administer per a signed physician's order.	
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 <input type="checkbox"/> Support straps/belts needed	<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 checked="" 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:	
Important To: her family, working on greeting cards & staying active	Important For: opportunities to work onsite at PAI & make money, community involvement & monitoring of her health needs
Likes: using iPads, her family, working on cards going for walks, going out to eat (McDonalds) & spending time w/ friends	Dislikes: loud & disruptive behaviors, not following rules & being sick or injured.
Describe Communication Style: Non verbal, sign language	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Bonilla
Date of background study submission: 9-20-21
Date of hire: 9-20-21
Date of background study clearance:
Ongoing annual training period:
Date of first supervised contact: 9/20/2021
Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.
 Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Julie Tint

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
* Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	11-15-21	Paper Quiz	
* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	11/15/2021	Paper quiz	50 mins	Caitery Kelly, PS
* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:				
CPR, if required by the CSSP or CSSP Addendum				

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>	<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>	<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>	<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>	<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>	<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: Topic:</p>
<p>Staff signature  Date 11-17-21</p>					

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla



Service Recipient: Ann Strassburg

Date: 11-10-21

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 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 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 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 Ann will research & find a healthy recipe once a week, 75% of trials until next review.		Outcome #2 Ann will go out into the community w/ PAI's employment specialist at least once per month to work on finding a community job until next review.	
Technology Use:			

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:	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: Ann struggles w/ making healthy food choices consistently & w/ portion sizes. Ann checks her blood sugar continually at home & is aware that if her numbers do not stabilize & improve, she will need to be put on more medicine/insulin.	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: Arm tremors, not diagnosed	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: Ann does not have good time management skills & would forget to take her medication consistently. Ann does not know all the medications & their purposes that she takes.	
Specific Health & Medical Needs <input checked="" 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"/> 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 type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: Ann has mild myopia & has been prescribed glasses but choose not to wear them most of the time.	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: working & trying new jobs, social relationships w/ peers, her family & staying active in her community.	Important For: Maintaining good health through eating well & stabilizing blood sugar levels & continuing to have opportunities in the community to work & do leisure activities.
Likes: Working (especially in the community), spending time w/ family, Asian food, music, cooking & using an iPad.	Dislikes: drama w/ peers/friends, working some of the easier jobs
Describe Communication Style: Verbal	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

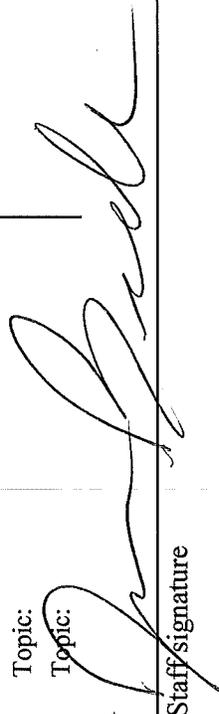
Staff name: Juan Bogler **Date of hire:** 9-20-21
Date of background study submission: **Date of background study clearance:**
Ongoing annual training period:
Date of first supervised contact: 9/20/2021 **Date of first unsupervised contact:** 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.
 Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Ann Strassburg

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	11-10-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	11/10/2021	Paper quiz	50 hours	Courtney Kelly, PS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	✓	✓	✓	✓
CPR, if required by the CSSP or CSSP Addendum	✓	✓	✓	✓

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p> <p>Topic: _____</p> <p>Topic: _____</p>				

Staff Signature: 

Date: 11-17-21

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla
 Date: 9-27-21



Service Recipient: Michelle Bergman

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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Financial Exploitation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<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 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 type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Work on iPad/technology skills once a week, 75% of all trials until next review</u>		Outcome #2	
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>Lisinopril, Seasonal</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 checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Does not like beef, pork, ground turkey, ground chicken or fish. Michelle may not eat nutritionally incomplete meals if alternatives are not provided. Michelle packs & prepares her lunch from home. If she's having additional food at PAI, staff will encourage her to choose healthier options. She chooses what she would eat & avoids what she does not.</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Needs glasses to correct vision</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Family, Art, Education.</u>	Important For: <u>safety, assistance to being as independent as possible, and comfort (pain management).</u>
Likes: <u>Peanut Butter & apple sandwiches, Pringles, going to the YMCA w/ her mom, spending time w/ friends & family, socializing, volunteering, watching TV</u>	Dislikes: <u>Beef, pork, Cottage Cheese & fish</u>
Describe Communication Style:	

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Boalla
Date of hire: 9.20.21
Date of background study submission:
Date of background study clearance:
Ongoing annual training period:
Date of first supervised contact: 9/20/2021
Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Michelle Bergman

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	9-27-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	9/27/2021	Paper Quiz	.50 hours	Cortney Kelly IRS
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:				
CPR, if required by the CSSP or CSSP Addendum				

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>					
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>					
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>					
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>					
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>					
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p> <p>Topic: _____</p> <p>Topic: _____</p>					

11-17-21

Date

Staff signature: 

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.

Staff: Juan Bonilla



Service Recipient: Elissa Fisher

Date: 9-29-21

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 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>False Reporting</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 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>Wants to work at memorizing brother's phone number</u>		Outcome #2 <u>Community activities & is interested in trying new ones out</u>	
Technology Use: <u>Uses iPad at home & at PAI, also uses her phone at home to call family & friends</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:		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:			
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <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 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:			
Important To: <u>Staff at PAI, her mom, her dog & working.</u>		Important For: <u>Staying active in the community & following a healthy diet.</u>	
Likes: <u>Michael Jackson, going shopping, going out to eat, sleeping, & bowling.</u>		Dislikes: <u>Peers passing her around or giving her directions, spicy & greasy foods, new people at work, when people yell & scream</u>	
Describe Communication Style:			

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Juan Bonilla

Date of hire: 9-20-21

Date of background study clearance:

Ongoing annual training period:

Date of first supervised contact: 9/20/2021

Date of first unsupervised contact: 11/17/2021

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. *Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Elisa Fisher

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	NA	9-29-21	Paper Quiz	
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet *Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	9/29/2021	Paper quiz	.50 hours	Catherine Kelly JS
CPR, if required by the CSSP or CSSP Addendum				

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>					
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>					
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>					
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>					
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>					
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:</p>					

Topic: 

Staff Signature

11-17-21

Date

*I understand the information I received and my responsibilities for their implementation in the care of persons served by this program.