

STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: MOSI

Date of hire: 11/8/2021
 Date of background study clearance:

Ongoing annual training period:

Date of first supervised contact:

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: R.V.

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>12/7/21</u>	<u>12/7/21 assisted with sensory activities</u>	<u>11/17-12/7/21</u> <u>7.5</u>	<u>Frederick survey</u>
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	<u>12/7/21</u>	<u>12/7/21 prep. & assisted with lunch</u>	<u>11/17-12/7/21</u> <u>7.5</u>	<u>Shanika Lab</u> <u>Frederick survey</u>
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	<u>12/7/21</u>	<u>12/7/21 completed in assisting with mail cases</u>	<u>11/17-12/7/21</u> <u>7.5</u>	<u>Shanika Lab</u> <u>Frederick survey</u>
CPR, if required by the CSSP or C SSP Addendum	<u>12/7/21</u>	<u>12/7/21 reviewed</u>	<u>11/17-12/7/21</u> <u>7.5</u>	<u>Shanika Lab</u> <u>Frederick survey</u> <u>Shanika Lab</u>

CPR test — 12/14/2021 Test 7.5 HEALTH COUNSELING

Already added LMS

<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>12/17/21</p>	<p>12/17/21 outcomes</p>	<p>11/17-12/17/21</p>	<p>Triston Learning <i>Amrullah Latif</i></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>12/17/21</p>	<p>12/17/21 reviewed with Triston Learning</p>	<p>11/17-12/17/21</p>	<p><i>Amrullah Latif</i> Triston Learning <i>Amrullah Latif</i></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>12.22.2021</p>	<p>12.22.2021 observed administered</p>	<p>5</p>	<p>Toni Anderson RN</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>12/17/21</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A</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>12/17/21</p>	<p>12/17/21 reviewed with Triston Learning</p>	<p>11/17-12/17/21</p>	<p>Triston Learning <i>Amrullah Latif</i></p>
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: Bathroom routine PICA Topic: Bus routine Topic: Hitting, laughing</p>	<p>12/17/21</p>	<p>12/17/21 reviewed with Triston Learning</p>	<p>11/17-12/17/21</p>	<p>Triston Learning <i>Amrullah Latif</i></p>

[Signature]

Staff signature

1-13-22

Date

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

Staff: Marisol Bagurto

Service Recipient: Kimmy

Date: 11/12/2021



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 checked="" type="checkbox"/> Other: <u>unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>unable to report</u>	<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 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 <u>will hand drink to staff when done. continue to develop skills</u>		Outcome #2 <u>will take shirt protector, after which, continue to develop skills</u>	
Technology Use: <u>utilizes PAI pad, tv, and computer</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sulfate medication, and seasonal, sensitive to bug sprays and sunscreens</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>diagnosed with epilepsy, last seizure 1998</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>has a physician ordered diet to prevent choking, eats rapidly, increasing choking risk</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>CP: limited movement, balance, and posture. chronic constipation, infrequent bowel movements. cervical spine spondylosis - affects joints, origins spine. dysmenorrhea, painful periods</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>takes medication with soft foods, & encouraged to drink, not able to self administer</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>utilizes disposable bricks & requires support if spotting. May clench legs together when being assisted.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>At high risk of falling, unsteady when walking, wears gait belt for assistance</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input checked="" type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>PAI keeps water at safe temperature, needs support in common area</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Astigmatism, blurred vision, Near sighted, difficulty to see far items, overstimulation can become overstimulated in loud environment</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Trichotillomania, hair pulling disorder, communicates nonverbally & communicate frustration w/ actions. Receives treatment for mood disorders</u>	
Important To: <u>being engaged in meaningful interactions & socializing</u>	Important For: <u>walk daily & have sensory activities</u>
Likes: <u>clapping, hand holding, going out to eat, looking in mirrors, music, and walks</u>	Dislikes: <u>being rushed or repeating requests, demanding tone, "Kimberly", being bored.</u>
Describe Communication Style: <u>nonverbally, using facial expressions, or wavying, blows raspberries or spits when angry or frustrated</u>	

