



# In-Service Training Log – Oakdale & Linden

Date: 12/20/2021

Type of Meeting: [Redacted]

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

Training Time	Trainer Name	Training ID	Area	Content/Description
1.00				Linden CSSPA's-AS & GB
4.00				Oakdale's CSSPA's-TJ, TH, TM, AF, KV, CW, JW, NK, KB, CA, LB, SG, TJ, JL, SV, MS
				Cross training to other rooms

Make up Date	Initial	EE ID	Last Name

Make up Date	Initial	EE ID	Last Name
			Alfredo Fierro-Montes

Make Up Date	Initial	EE ID	Managers/Admin

Make up Date	Initial	EE ID	Other Attendees

Staff: Alfredo Fierro-Montes



Service Recipient: Alexander Subiaga

Date: 10/5/21

Reviewed by: \_\_\_\_\_

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP) Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>Inaccurate self-reporter</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Daily, Alex will greet his peers using a pre-recorded message.</u>		Outcome #2 <u>Weekly, Alex will choose a video to watch.</u>	
Technology Use: <u>Ipad, Computer, TV, SMARTBoard</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>Amoxicillin, Ceftriaxone Sodium.</u>	Epi Pen/Treatment <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location: <u>PAI</u>
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Drop Seizures, Tonic Clonic.</u>	Seizure PRN <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location: <u>PAI</u>
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Bite sized diet.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Atypical Rett Syndrome, Hypotonia.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Assistance w/administration.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Personal Cares.</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Manual wheelchair, Arjo, pivot transfers.</u>	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> Arjo <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
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>Vision Impairment, Tactile Defensive.</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Train videos, Music, recliner, group activities, socializing and mealtime.</u>	Important For: <u>Care from staff trained in how best to serve him, bear weight in Arjo - transfers, encourage to eat independently.</u>
Likes: <u>Train videos, Music, being part of the group, SMARTBoard games</u>	Dislikes: <u>Hand over hand support, being tired, being touched too much.</u>
Describe Communication Style: <u>Hand gestures, vocalizations, body language.</u>	

Staff: Alfredo Fierro-Montes



Service Recipient: Gary Bayne

Date: 10/5/21

Reviewed by: \_\_\_\_\_

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP) Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>Inaccurate self-reporter</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Daily, Gary will choose which lunch item he would like to eat first.</u>		Outcome #2 <u>Weekly, Gary will choose an art project to participate in.</u>	
Technology Use: <u>Ipad, Computer, TV, SMARTBoard</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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Epilepsy, only had one seizure in 2014.</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>Physician ordered diet (Bite sized)</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Osteoarthritis, Finger, Atrophy, Diabetes - Insipidus, Migraines, Pressure sores, deaf Intermittent Explosive Disorder, Hepatitis B, Bruxism, Edema</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Requires assistance in the administration of his medication.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Spinal Fusion, Pressure sores on bottom, foot + ankle.</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Wheelchair</u>	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> Arjo <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
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>Gary is deaf.</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Group activities w/peers, Board/Card games, arts/crafts projects, eating food he enjoys.</u>	Important For: <u>Needs are being met, staff knowledgeable about his needs/communication style, be active/propel wheel chair.</u>
Likes: <u>Relaxing in recliner, being part of the group.</u>	Dislikes: <u>Pain/discomfort, thirst, didn't eat enough food.</u>
Describe Communication Style: <u>Facial Expressions, vocalizations, hand gestures/body language.</u>	

Staff: Alfredo Fierro-Montes



Service Recipient: Tévon Joseph

Date: 9/28/21

Reviewed by: \_\_\_\_\_

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>unable to report</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 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:
<b>Outcome #1-</b> Will inform staff when he needs to use cares room in 70% of all opportunities.		<b>Outcome #2-</b> Will choose a 1:1 activity in 90% of all opportunities the next 6 months.	
<b>Technology Use:</b> <del>IPAD</del> <u>IPad, SMART Board, Television/Computer</u>			

**Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)** Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:		<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Has a pronounced underbite which can lead to choking. Should that occur then staff will administer abdominal thrusts and call paramedics. Bite size diet.</u>			
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>ADHD- difficult to pay attention and control impulsive behaviors. He is encouraged to stay on task and pay attention. Cerebral Palsy limits his muscle control.</u>			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Tévon takes his medication w/water or soft food. Cannot self-medicate so he needs staff.</u>			
<b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Requires a disposable brief and can not complete his cares. He will get squirmy when experiencing gas or prior to having a bowel movement.</u>			
<b>Fall Risk/Mobility Supports</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>IS able to bear weight but is at risk of falling. Staff need to help with foot rest &amp; wheelchair.</u> <input checked="" type="checkbox"/> Support straps/belts needed <u>Uses AFO + E-Z stander.</u>		<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> Arjo <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____	
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff stay within arms reach near water.</u>			
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Wears glasses but still has limited vision out of his right eye.</u>			
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Tactile defensiveness to his hands. Doesn't like having his hands wet or sticky. May be hesitant to touch anything during group activities.</u>			
<b>Important To:</b> <u>Musie/Musical activities, access to technology, socializing &amp; singing.</u>		<b>Important For:</b> <u>Freedom of preference and to do things w/as much independence as possible.</u>	
<b>Likes:</b> <u>Video games, Ipad, Musie, concerts, food, going out in the community and bowling.</u>		<b>Dislikes:</b> <u>Jello or anything sticky, water sprayed on his face, loud noises, warm environments, sometimes his stander.</u>	
<b>Describe Communication Style:</b> <u>Verbally 1-3 words at a time, "yes or no", sometimes points his wheelchair towards something.</u>			

Staff: Alfredo Fierro-Montes



Service Recipient: Tyrel Horning

Date: 9/30/21

Reviewed by: \_\_\_\_\_

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>Unable to report abuse</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 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 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 Will answer yes or no using adaptive signs when asked if he would like to visit friends or staff in other programs.

Outcome #2 3x weekly Tyrel will plan his group experience using adaptive signs.

Technology Use: IPad, Television, Wii and SMART Board.

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>Augmentin, Morphine, Latex</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>Partially controlled Tonic Clonic/Grand Mal</u>	Seizure PRN <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location: <u>PAI</u>

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: NPO, Suction Machine. Physician's order diet.

Chronic Medical Conditions  No  Yes - List: Dandy Walker Syndrome, Constipation, Hip flexor spasms, Hydrocephalus, Moderate Intellectual Disability, Pressure Ulcer.

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports: G-tube with 30 cc's water flush

Specific Health & Medical Needs  No  Yes - List: Personal Care Hygiene.

Personal Cares/Toileting, Fatigue/Sleeping, Wrist Hand Orthotic.

Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Seizure Disorder, uses wheelchair.</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> Arjo	<input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
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Community & Water Safety Skills  No  Yes

Sensory Disabilities  No  Yes - List: \_\_\_\_\_

Self-Management of Behaviors  No  Yes - Describe supports: Self-injurious behaviors, physical/verbal aggression, Mental/Emotional health symptoms/crises.

Important To: <u>allowed to express preference, napping, people watching, preferred staff</u>	Important For: <u>provided with options, encouraged to communicate, staying awake &amp; time to nap.</u>
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Likes: <u>Picture books, elevators, bowling, movies, stretching on mat table.</u>	Dislikes: <u>Having to wait, others in his personal space, strangers doing his cares, his picture taken.</u>
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Describe Communication Style: Non-verbally using gestures, facial expressions and vocalizations.

Staff: Alfredo Fierro-Montes



Service Recipient: Terrell Monjeau

Date: 9/30/21

Reviewed by: \_\_\_\_\_

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>unable to report.</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 <u>unable to</u> <input checked="" type="checkbox"/> Other: <u>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 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 Daily, staff will model an ASL Sign/Terrell will use flashcards to identify which emotion he feels on the ipad.

Technology Use: Ipad, computer, TV, SMART Board.

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>Cigarette Smoke.</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>Possible Seizures</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports :

Physicians order diet, Limited intake of caffeine (sugary drinks).

Chronic Medical Conditions  No  Yes - List: Inattentive ADHD, Baclofen Pump, Cerebral Palsy, Constipation, Spinal Stenosis.

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports : Staff administer the medication orally in soft foods.

Specific Health & Medical Needs  No  Yes - List:

Personal Cares.

Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>wheelchair, sometimes knee pads</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> Arjo	<input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
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Community & Water Safety Skills  No  Yes

Sensory Disabilities  No  Yes - List: Deaf

Self-Management of Behaviors  No  Yes - Describe supports:  
Self-injurious behaviors, Physical aggression

Important To: <u>snack everyday, relax in recliner, fun people, supportive staff, new things.</u>	Important For: <u>support in taking medication, physically active, form friendships, communicating.</u>
Likes: <u>Wii, tetherball, eating, 1:1, socializing, art projects, sports, movies, sensory activities.</u>	Dislikes: <u>waiting to eat, bananas, eggs, veggies, apples, plain water.</u>

Describe Communication Style: Non-verbal ASL, facial expressions, vocalizations, pointing, eye gazing.

Staff: Alfredo Fieno-Montes



Service Recipient: Andrew Farris

Date: 10/1/21

Reviewed by: \_\_\_\_\_

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>unable to report to appropriate person.</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>unable to report.</u>	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Daily, Andy will put away his puzzle.</u>		Outcome #2 <u>weekly, Andy will use a door switch to open a door to go out.</u>	
Technology Use: <u>IPad, TV, Computer, SMARTBoard.</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>Spring Seasonal, Antibiotics, Penicillin, Sulfa.</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>Partially controlled Tonic Clonic and Myoclonic, VNS.</u>	Seizure PRN <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location: <u>PAI</u>
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Physician's ordered bite size diet. Thickened liquids.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Autism Spectrum Disorder, Cerebral Palsy, Herpes Simplex 1, Scoliosis.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Takes PRN orally in the cheek.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Personal cares / Toileting, Raynaud's Disease.</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>wheelchair w/ chest strap, padded lap tray, safety belt.</u> <input checked="" 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 checked="" type="checkbox"/> Arjo <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: <u>2</u> <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Hearing Impairment, Tactile Defensiveness.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Seasonal Affective Disorder,</u>	
Important To: <u>using his puzzles daily, people watching, milk w/ lunch, no unnecessary touching.</u>	Important For: <u>consistent and patient staff, uses fine motor skills, that he be encouraged to socialize.</u>
Likes: <u>To be called "Andy", shape puzzles, outings, Wii, sensory activity.</u>	Dislikes: <u>Hard to chew food, sweets (cookies), being touched, humility, Arjo handles, loud noises, angry/upset peers.</u>
Describe Communication Style: <u>Vocalizations, eye gazing, facial expressions, body language, eye-contact or reaching out.</u>	

Staff: Alfredo Fierro-Montes

Date: 12/20/21



Service Recipient: Kimberly Varness

Service Span: Sep 2021 - Sep 2022

**Outcomes:**

**Outcome #1:** Daily, Kim will hand her drink to staff when she is done.  
Summarize Steps:

**Outcome #2:** Daily, Kim will take off shirt protector after lunch.  
Summarize Steps:

**Communication Style:**

Non-verbally, vocalizing, waving, spitting

**Learning Style:**

ALS, iPad, Smartboard.

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Sulfa Medications, Seasonal Allergies, Bug Spray/Sunscreen</u>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Epilepsy</u>
<b>Choking:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Reminders to slow down, grabs peers food.</u>
<b>Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Dime sized diet, sippy cup</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <span style="float: right;">DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</span> <u>cerebral Palsy, cervical spine Spondylosis, constipations</u>
<b>Medication at PAI:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Takes meds w/soft foods.</u>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Uses a brief, toilets.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Chronic Medical Conditions increase risk. Visual impairment.</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff observe/intervene on her behalf.</u>
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Visual impairment, Trichotillomania</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Hit, pinch, spit/bite others.</u>
<b>Unsupervised Time:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>

**Important to:**

Be engaged in meaningful interactions, socializing, oral manipulatives.

**Important for:**

Walk daily w/good posture, sensory activities, comm skills.

**Likes:**

Being called "Kim" or "Kimmy", sensory activities, eating, dancing, music.

**Dislikes:**

To be rushed, demanding/stern tones, being bored, washing hands.

Staff: Alfredo Fierro-Montes



Service Recipient: Christina Wagner

Date: 12/20/21

Service Span: Mar 2021 - Mar 2022

Outcomes:

Outcome #1: Daily, Christina will choose a sensory activity  
Summarize Steps:

Outcome #2: Daily, Christina will choose a staff to assist w/activity  
Summarize Steps:

Communication Style:  
Vocalizations, Body Motions, reaching for hand, facial expressions.  
Learning Style:  
Repetition, iPad,

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

Allergies: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Seasonal</u>
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Reminders to slow down.</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite sized diet, uses teaspoon. 3-4oz of her drink at a time.</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>GERD</u> <u>Cerebral Palsy, Spasticity, Hypertension.</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Takes meds w/soft foods, Baclofen.</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Uses briefs, sling/Mat table.</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Chronic Medical Conditions increase risk.</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Communicates options, Staff observe/intervene on her behalf.</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Sensorineural hearing loss</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Pulling hair, hitting forehead, Anxiety, SAD</u>
Unsupervised Time: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>

Important to:  
Anticipate day by routine, have nails painted, hair done, snack/lunch on time.

Important for:  
Use comm skills when upset/anxious, take meds as scheduled, wheel herself far around.

Likes:  
Nails painted, hair done, recliner, eating, painting, music.

Dislikes:  
Waiting, change in routine, ice tea/flavored teas, in her space, bump her chair.

Staff: Alfredo Fierro-Montes

Date: 12/20/21



Service Recipient: Jerome Welch

Service Span: Nov 2021 - Nov 2022

Outcomes:

Outcome #1: Weekly, Jerome will choose a staff to assist w/sensory bottle.  
Summarize Steps:

Outcome #2: Weekly, Jerome will create a sensory bottle.  
Summarize Steps:

Vocalizations, reaching, eye gazing, adaptive switching.  
Communication Style:

Learning Style:  
Repetition, iPad, adaptive switches, wii.

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Penicillin, Polio vaccine, Seasonal.</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Tonic Clonic / Grand Mal</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Mother care spoon, divided plate, pureed foods / nectar-thick liquids.</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Pureed foods / nectar-thickened liquids.</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Gibbus Deformity, lower leg vascular, Osteopenia, Hypothyroidism, cellulitis, obstructive sleep apnea.</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Fibercon, Calcium Carbonate, Baclofen.</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Briefs, sling / Mat table.</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Chronic Medical conditions increase risk.</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Cannot propel wheelchair, Staff observe / intervene on his behalf.</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Astigmatism, overstimulation.</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Scratching head, hands/arms, Yelling / loud vocalizations.</u>
Unsupervised Time: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>W/A</u>

Important to:  
Spicy foods, sweet treats, bottles, phones, nap time.

Important for:  
Be repositioned, to be independent, be social, balanced meals.

Likes:  
People watching, sensory activities, holding bottles, wii games.

Dislikes:  
waiting for activities, activities requiring bottle be put away.

Staff: Alfredo Fierro-Monares

Date: 12/20/21



Service Recipient: Nicholas Kessler

Service Span: Jan 2021 - Jan 2022

**Outcomes:**

**Outcome #1:** Daily, Nich will turn on the water in the restroom.  
Summarize Steps:

Important to build independence.

**Outcome #2:** Daily, Nich will identify activities on the ipad.  
Summarize Steps:

Enjoys using tech in picking his activities.  
Communication Style:

**Learning Style:**

Ipad, SmartBoard, Computer.

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Hay fever/seasonal, possibly allergic to latex</u>
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>
<b>Choking:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Reminders to slow down</u>
<b>Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite sized diet</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <span style="float: right;">DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</span> <u>Intellectual Disability, Hypotonia, Autism.</u>
<b>Medication at PAI:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Uses briefs.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Visual Impairment.</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff observe/intervene on his behalf.</u>
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Vision Impairment</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Biting finger, Pulling hair, charging at people, pushing away</u>
<b>Unsupervised Time:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>

**Important to:**  
Socializing, meeting new people, swimming, classical music, crunchy food.

**Important for:**  
To slow down + chew, reminders to use restroom, others be patient.

**Likes:**  
Swimming, trampoline, friends/family, car rides, music.

**Dislikes:**  
Low environments screeching.

Staff: Alfredo Fierro-Montes

Date: 12/20/21



Service Recipient: Keith Buchman

Service Span: June 2021-2022

Outcomes:

Outcome #1: Daily, Keith will choose a staff/peer to visit.  
Summarize Steps:

Outcome #2: Weekly, Keith will participate in music therapy.  
Summarize Steps:

Communication Style:

Vocalizations, eye gazing, touching item he wants.

Learning Style:

Ipad, SmartBoard, Computer

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Alternaria, Hormodendrum, Aspergillus.</u> <u>Dust mites, Grass, Trees, cats, weeds, Milk/Grape fruit products.</u>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Epilepsy.</u>
<b>Choking:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Will be prompted to slow down.</u>
<b>Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Phycisian's ordered diet. Purced, Tablespoon sized bites.</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Down Syndrome, Gout, Microcephaly, Pica, Spastic Diplegia.</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
<b>Medication at PAI:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Takes medication in soft foods followed by drink.</u>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses briefs. Able to transfer w/minimal assistance.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Chronic Medical Conditions increase risk. uses wheelchair.</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff observe/intervene on his behalf.</u>
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>VISION/hearing impairment. Oral sensory processing.</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Banging head, biting hands, pulling hair, biting others. Property destruction.</u>
<b>Unsupervised Time:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>

Important to:

Greet friends daily, socialize w/favorite peer/staff, sit near windows.

Important for:

opportunity to be active, drink fluids, does not bump his feet, use comm. skills.

Likes:

Dancing, hugs, Sunny spots, Music, Silly noises, vibrations, spicy foods.

Dislikes:

long activities, sitting in one place too long, hats/gloves, waiting for lunch, gout pain.

Staff: Alfredo Fierro-Montes



Service Recipient: Chanel Anderson

Date: 12/20/21

Service Span: Feb 2021 - Feb 2022

**Outcomes:**

**Outcome #1:** Once weekly, Chanel will choose a room to visit.  
Summarize Steps:

She enjoys observing those around her/tracks those she's interested in.

**Outcome #2:** Daily, Chanel will plan her in room group experience on Ipad.  
Summarize Steps:

Chanel likes to be engaged in activities of her preference.

**Communication Style:**

Uses Ipad

**Learning Style:**

Ipad

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Bananas, Apple juice, strawberries, egg/egg noodles, custard, egg food products, MSC, wheat, tomatoes.</u>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Infrequent seizures w/stiffening in body + staring.</u>
<b>Choking:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Not able to chew properly.</u>
<b>Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Pureed / food sensitivities</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety w/PMS, low urine output, microcephaly</u> <span style="float: right;">DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</span>
<b>Medication at PAI:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports:
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Utilizes briefs.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses wheelchair.</u> <u>Limited balance/history of removing safety straps.</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff observe around / Intervene on her behalf.</u>
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Hand mouthing</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Hand mouthing, pulling hair, grabbing at others, spitting, vocalizations</u>
<b>Unsupervised Time:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Not left unsupervised.</u>
<b>Important to:</b>	<u>Being included, choices respected, sensory activities, spending time in the recliner. Pet Therapy.</u>
<b>Important for:</b>	<u>Use stander, eat/drinks daily, limit hand mouthing, Communicate needs/wants</u>
<b>Likes:</b>	<u>To be with people, tactile manipulatives, music, 1:1 projects, hair brushing, Wii, adaptive yantzee, Music Therapy, bowling</u>
<b>Dislikes:</b>	<u>Sitting in one place too long, sensory overload, being bored, being tired/distracted.</u>

Staff: Alfredo Fierro-Montes

Date: 12/20/21



Service Recipient: Libby Broadbent

Service Span: Sep 2020 - Sep 2021

Outcomes:

Outcome #1: Daily, Libby will choose a musical preference.  
Summarize Steps:

Important to make her own choices.

Outcome #2: Daily, Libby will choose a staff/peer to greet/establish eye contact.  
Summarize Steps:

Working on social skills.

Communication Style:

Vocalizations, eye contact (gazing).

Learning Style:

Ipod, Smartboard, Computer

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Seasonal</u>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Epilepsy. Uses VNS.</u>
<b>Choking:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>verbal cues to slow down. History of choking.</u>
<b>Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses regular utensils.</u> <u>Physician's order diet, finger foods, cup w/straw.</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Asthma, Partial Trisomy 4p, Severe intellectual Disability, Hypertonicity, Spastic Quadriplegia, GERD</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
<b>Medication at PAI:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PRN</u>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Uses briefs /Arid for toileting</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Epilepsy /Chronic Medical Conditions. Uses wheelchair.</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Observe her surroundings /intervent on her behalf.</u>
<b>Sensory Support:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
<b>Behavior Support:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
<b>Unsupervised Time:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No unsupervised time.</u>
<b>Important to:</b> <u>meaningful social interactions, to make choices, not feel rushed, participate in sensory activities, tactile sensory.</u>	
<b>Important for:</b> <u>Fun /upbeat people, meaningful connections, staff don't rush, socializing.</u>	
<b>Likes:</b> <u>1:1 time, sensory activities, group activities, visiting friends, Pet Therapy.</u>	
<b>Dislikes:</b> <u>To be rushed, plain water, serious /stern people.</u>	

Staff: Alfredo Fierro-Montes

Date: 12/21/2021



Service Recipient: Susan Gilbertson

Service Span: June 2021 - June 2022

Outcomes:

**Outcome #1:** Daily, Susan will choose an activity to participate/attend in.  
Summarize Steps:  
Participate in activities that are of interest to her.

**Outcome #2:** Daily, Susan will choose a peer/staff to visit in another room.  
Summarize Steps:  
Enjoys interacting with staff/peers.

**Communication Style:**  
Short phrases, yes/no questions, facial expressions.

**Learning Style:**  
Repetition, Ipad, computer, smartboard.

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Ibuprofen, Naproxen</u>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Generalized Tonic Clonic, Drop seizures, Absence seizures.</u>
<b>Choking:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff observe Susan eat.</u>
<b>Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Against Medical Advice, physicians order diet.</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Acute kidney failure, Acute Cystitis, Osteoporosis, Pressure Ulcer, Nutritional anemia, Thrombocytopenia, Encephalopathy.</u> DNR/DNI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
<b>Medication at PAI:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff set up medication per prescribers orders.</u>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wears briefs, mechanical lift/swing.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Osteoporosis, uses wheelchair, has safety strap on recliner.</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Not able to propel wheelchair, staff intervene on her behalf.</u>
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Near sighted</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Hits herself, tip wheelchair, grab/scratch.</u>
<b>Unsupervised Time:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>

**Important to:**  
Personal Space, calm environment, what is happening / who is helping, her doll.

**Important for:**  
to be independent, well-balanced diet, be repositioned.

**Likes:**  
Coloring, sensory videos, silly animal videos, oldies music, Pet Therapy.

**Dislikes:**  
people in her space, surprises, staff who don't tell her how they will help.

Staff: Alfredo Fierro-Montes

Date: 12/20/21



Service Recipient: Tévon Joseph

Service Span: May 2021 - May 2022

Outcomes:

**Outcome #1:** Daily, Tévon will inform staff when he needs the cares room.  
Summarize Steps:  
Personal goal is to use the toilet one day.

**Outcome #2:** Daily, Tévon will choose a 1:1 activity.  
Summarize Steps:  
Enjoys being social with staff/peers.

**Communication Style:**  
Verbally, yes/no.

**Learning Style:**  
Ipad, computer, Smartboard.

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

<b>Allergies:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>
<b>Choking:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite size diet, eats fast &amp; has an underbite.</u>
<b>Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite sized diet</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <span style="float: right;">DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</span> <u>ADHD, Cerebral Palsy.</u>
<b>Medication at PAI:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Does not take meds at PAI</u>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Uses briefs, transfer to toilet, Mat table.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Chronic Medical Conditions increase risk.</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff observe/intervene on his behalf.</u>
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Vision impairment.</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <del>###</del> <u>Tactile defensiveness w/hands.</u>
<b>Unsupervised Time:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>

**Important to:**  
technology, socializing, seeing different people, singing w/staff.

**Important for:**  
To be supported, be independent, indicate preferences.

**Likes:**  
Video games, ipad, music, concerts, eating, being active, wii.

**Dislikes:**  
Jell-o, getting hands dirty, water in face, loud noises, warm environments.

Staff: Alfredo Fierro-Montes

Date: 12/20/21



Service Recipient: Jennifer Loftboom

Service Span: Jan 2021 - Jan 2022

Outcomes:

Outcome #1: Daily, Jennifer will choose a sensory activity.  
Summarize Steps:

Important for her to make choices.

Outcome #2: Daily, Jennifer will choose to use her gait-trainer.  
Summarize Steps:

Jennifer must maintain leg strength.

Communication Style:

Vocalizations, eye gazing, body language, "talk" = yes, "nff" = No.

Learning Style:

Ipod, Television, Smartboard, Repetition.

Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

<b>Allergies:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled Tonic Clonic.</u>
<b>Choking:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Many "pocket" food items.</u>
<b>Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet (sent from home)</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <span style="float: right;">DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</span> <u>Chronic dehydration, ear infections, bowel obstruction, PDD</u>
<b>Medication at PAI:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Takes meds orally w/soft foods.</u>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Brief dependent, Mat table.</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Seizure disorder, PDD.</u>
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff observe/intervene on her behalf.</u>
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical Visual Impairment.</u>
<b>Behavior Support:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
<b>Unsupervised Time:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>

Important to: meaningful 1:1 interactions, chatting w/ preferred people, music, recliner time.

Important for: be supported in following diet, offered fluids frequently, be involved.

Likes: Music, chatting w/friends, sensory time, hugs, recliner, bowling.

Dislikes: waiting for drinks, personal cares & wearing socks/shoes, being hungry/thirsty.

Staff: Alfredo Fierro-Montes



Service Recipient: Sara Valento

Date: 10/5/21

Reviewed by: \_\_\_\_\_

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP) Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:

Outcome #1 Daily, Sara will independently use a new word/phrase to make a request.

Outcome #2 Weekly, Sara will use yes/no answers to plan a group activity.

Technology Use: Ipad, TV

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  No  Yes - Describe Equipment/Supports:

Bite sized diet.

Chronic Medical Conditions  No  Yes - List: GERD, Neurogenic Bladder,

Cerebral Palsy w/mixed tone quadriplegia, Severe Neuromuscular Scoliosis

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports:

Assistance with medication setup.

Specific Health & Medical Needs  No  Yes - List:

Personal Care.

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

Wheelchair, Chest strap

Support straps/belts needed

- Verbal Cues
- Physical Assistance
- Posey / Gait Belt
- Walker  Arjo

- 2 Person Hoyer # staff in cares room: \_\_\_\_\_
- 1 Person Hoyer / Track
- Manual Lift # staff \_\_\_\_\_

Community & Water Safety Skills  No  Yes

Sensory Disabilities  No  Yes - List:

Oculomotor Apraxia.

Self-Management of Behaviors  No  Yes - Describe supports:

Important To: Certain staff, family, chips / cookies, using hand under hand for projects.

Important For: Eating equipment, making choices.

Likes: Chips / cookies, McDonald's, spending time w/blom, favorite staff.

Dislikes: Wearing chest strap, people touching her w/out warning, when her schedule is not being followed.

Describe Communication Style:

Staff: Alfredo Fierro-Montes



Service Recipient: Mark Snee

Date: 10/5/21

Reviewed by: \_\_\_\_\_

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 checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:

Outcome #1 Daily, Mark will press a Mark Switch requesting to use hand held massager.

Outcome #2 Weekly, Mark will choose to watch a video.

Technology Use: IPad, TV

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: <u>Grand Mal + Petit Mal</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports:

Pureed diet.

Chronic Medical Conditions  No  Yes - List:

Hypotonic Cerebral Palsy, Constipation, Contractures, History of reflux.

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports:

Staff assisted administration.

Specific Health & Medical Needs  No  Yes - List:

Personal Canes, GI Discomfort.

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

Wheelchair

Support straps/belts needed

- Verbal Cues
- Physical Assistance
- Posey / Gait Belt
- Walker  Arjo

- 2 Person Hoyer # staff in cares room: \_\_\_\_\_
- 1 Person Hoyer / Track
- Manual Lift # staff \_\_\_\_\_

Community & Water Safety Skills  No  Yes

Sensory Disabilities  No  Yes - List:

Oculomotor Apraxia, Exotropia, Astigmatism, Sensitivity to loud noises.

Self-Management of Behaviors  No  Yes - Describe supports:

Redirect Mark or offer a different environment.

Important To: HIS family, being active, lots of attention, people around him, laughter, TV / music, wheel of fortune, action movies.

Likes: Walking outside, Wheel of Fortune, Barney, his dogs, going into the community.

Important For: Seizure protocol, family who cares for him, Pureed foods, nutritional supplement, hooyer for transfers.

Dislikes: Pain / discomfort, bowel issues, not being around people, not being engaged with.

Describe Communication Style: