



In-Service Training Log – Linden

Date:

2-1-2022

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

Training Time	Trainer Name	Training ID	Area	Content/Description
.50	Tristen Lorsung Designated lead			CSSPA for Jenny L.
.25	Emily Elsenpeter Program supervisor			Semiannual review new outcomes: CB, SK
.25	Maddie Kessler Program Supervisor			Misc.-Parking and setting up training with Toni RN, <i>Phone Policy</i>

Make up Date	Initial	EE ID	Last Name
	<i>BA</i>		Ailport, Betsy
	<i>CAJ</i>		Anderson-Jones, Celeste
	<i>KB</i>		Bauch, Kia
	<i>MB</i>		Bradshaw, Morgan
	<i>SC</i>		Christenson, Suzie
	<i>AK</i>		Cox, Alice
	<i>MB</i>		Gagner, Megan
	<i>OH</i>		Harris, Ocla
	<i>HA</i>		Her, Bao
	<i>MA</i>		Hetchler, Maria
	<i>NG</i>		Johnson, Natalie
	<i>FK</i>		Kalu, Festus

Make up Date	Initial	EE ID	Last Name
	<i>LN</i>		Larson, Nancy
	<i>DL</i>		Lepley, Deanne
	<i>SM</i>		Mafi, Sommer
	<i>KM</i>		Mason, Kanya
	<i>DM</i>		Mendez, Danielle
	<i>CR</i>		Rice, Colette
	<i>ES</i>		Sandstrom, Erin
	<i>LS</i>		Stacken, Laura
	<i>JT</i>		Trimble, Jenny
	<i>TH</i>		Hampton, Tony
	<i>HP</i>		Kathy Perry on oakdale

Make Up Date	Initial	EE ID	Admin Staff
<i>2/3/22</i>	<i>HL</i>		Hiland, Lindsay
	<i>MK</i>		Kessler, Madeline

Make up Date	Initial	EE ID	Admin Staff
	<i>AS</i>		Shirley, Ashleigh

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In-Service Training Log - Oakdale

Date:

2-1-2022

Type of Meeting:

All-Staff

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

Training Time	Trainer Name	Training ID	Area	Content/Description
.50	Tristen Lorsung Designated lead			CSSPA for Jenny L.
.25	Emily Elsenpeter Program supervisor			Semiannual review new outcomes: CB, SK
.25	Maddie Kessler Program Supervisor			Misc.-Parking and setting up training with Toni RN, <i>Phone Policy</i>

Make up Date	Initial	EE ID	Last Name
	<i>MBP</i>		Basurto-Poferl, Mari
	<i>SB</i>		Berglund, Sara
	<i>TB</i>		Bongard, Tyler
	<i>AD</i>		Diaz, Amanda
	<i>Pd</i>		Dyer, Paris
	<i>AFM</i>		Fierro-Montes, Alfredo
	<i>TG</i>		Gould, Trey
	<i>LT</i>		Hartman, Lisa
	<i>on Linden</i>		Larson, Nancy

Make up Date	Initial	EE ID	Last Name
	<i>TL</i>		Lorsung, Tristen
	<i>SN</i>		Nierad, Shelly
	<i>JP</i>		Pratt, Jalysa
	<i>DSM</i>		St. Martin, Deb
	<i>MS</i>		Sweeney, Maurita
	<i>KE</i>		<i>Perry, Kathy</i>

Make Up Date	Initial	EE ID	Managers/Admin
<i>2/3/21</i>	<i>HL</i>		Hiland, Lindsay
	<i>EM</i>		Elsenpeter, Emily

Make up Date	Initial	EE ID	Other Attendees
	<i>JC</i>		<i>Jess Cunderson</i>



Competency Tracking Form Linden Site

Participant: Jennifer (Jenny) Lofboom **Annual Service Span:** January 2022-January 2023

Annual Meeting Date: 1.20.2022 **Date Assigned to Lead:** 1.21.2022 **Quiz Due:** 1.27.2022

Documents Reviewed: CSSPA, IAPP, SMA, One-Page Profile, Outcomes

*Your initials below indicate you have reviewed and understand all assigned documents and have completed a competency quiz on the individual. This document is to be done in conjunction with on-site instruction on how to implement the reviewed plans and your demonstration of the understanding of the person as a unique individual.

Date Completed	Initials	Full Name
	BA	^{Airport} Airport, Betsy
	KB	Bauch, Kia
	MB	Bradshaw, Morgan
	SC	Christenson, Suzie
	SC	Cox, Alice
	MB	Gagner, Megan
	OH	Harris, Ocla
	BA	Her, Bao
	MH	Hetchler, Maria
	JLH	Hiland, Lindsay
	NG	Johnson, Natalie
	fe	Kalu, Festus
	MR	Kessler, Madeline
	RL	Larson, Nancy

Date Completed	Initials	Full Name
	DL	Lepley, Deanne
	SM	Mafi, Sommer
	KM	Mason, Kanya
	DM	Mendes, Danielle
	CR	Rice, Colette
	ES	Sandstrom, Erin
	AS	Shirley, Ashleigh
	LB	Stacken, Laura
	JT	Trimble, Jennifer
	AH	Hampton, Tony
on oakdale	RP	Penny, Kathy
	CA	Celeste Anderson Jones

Date Uploaded to LMS: _____



Competency Tracking Form Oakdale

Participant: Jennifer (Jenny) Lofboom Annual Service Span: January 2022-January 2023

Annual Meeting Date: 1.20.2022 Date Assigned to Lead: 1.21.2022 Quiz Due: 1.27.2022

Documents Reviewed: CSSPA, IAPP, SMA, One-Page Profile, Outcomes

*Your initials below indicate you have reviewed and understand all assigned documents and have completed a competency quiz on the individual. This document is to be done in conjunction with on-site instruction on how to implement the reviewed plans and your demonstration of the understanding of the person as a unique individual.

Date Completed	Initials	Full Name
2-1-22	PD	Paris Dyer
2-1-22	LH	Lisa Hartman
2/1/22	MS	Maurita Sweeney
2/1/22	TL	Tristen Lorsung
2/01/2022	AD	Amanda Diaz
2/3/2022	SB	Sara Berglund
2/1/22	JP	Jalysa Pratt
2.1.2022	EE	Emily Elsenpeter
2/1/22	TG	Trey Gould
2.1.22	AFM	Alfredo Fierro-Montes
		Kathryn Perry
2/1/22	MBP	Mari Basurto Poferi
on Linden		Nancy Larson
HL		Lindsay Hiland

Date Completed	Initials	Full Name
2/1/22	TB	Tyler Bongard
2/1/22	<u>DSM</u>	Deb St. Martin
	SN	Shelly Nierad
	KP	Kathryn Perry

Date Uploaded to LMS: _____

Staff: Kanya m
 Date: 2-1-22



Service Recipient: Jennifer LoBarn
 Service Span: Jan. 22 - Jan 23.

Outcomes:

Outcome #1: Choose an activity
 Summarize Steps: Present 3 Sensory activities Go through each option 1 by 1 allow time to Respond
Present 3 Staff to assist with Sensory activities

Outcome #2: Choose a community outing with cards and Jennifer will choose
 Summarize Steps: Staff Show and describe Community integration Cards
ASK if She is interested with option 1 by 1 Time to respond yes/no

Communication Style: Eye gazing and reaching and Pushing away
Facial expressions, body language, vocalizations "Tab" for yes and "Niff" for no

Learning Style: Repetition, Routine, Responds best when encouragement is delivered in an UP beat tone of voice Paired with Physical Cues

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>	
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Parshly control, no pattern, 1-2 sec, arms might go up</u>	
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Open her mouth when she's ready for another bite</u>	
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Food sent from home temp controlled bowl</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration</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>take meds orally</u>	
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>2 Staff, 1 Staff</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheelchair, head rest, Chest Straps,</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff physical support</u>	
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>CORTICAL VISUAL IMPAIRMENT Sees best Peripherally</u>	
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>	
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A No time alone</u>	
Important to: <u>1-1 interaction, time outside her chair</u>		
Important for: <u>Social, Gate trainer,</u>		
Likes: <u>music 1-1 sensory time</u>		
Dislikes: <u>wait for food-drink</u>		

Lead Review Completed: Jenaton Kelly

Staff: Nancy Larson
 Date: 2-1-22



Service Recipient: Jenny Lofstrom
 Service Span: Jan. 2022 - 2023

Outcomes:

Outcome #1: Daily Jenny will choose a staff to assist her in a
 Summarize Steps: Chosen activity

Outcome #2: Monthly Jenny will pick her outing
 Summarize Steps: Use picture cards
Yes/No

Communication Style: Facial expressions, body language, Tan for ups, eye gazing
 Learning Style: routine & repetition - upbeat tone of voice

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>partially controlled seizures, eyes rolling back, arms up</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>opens mouth for another bite, takes water in between</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet sent from home, full assistance</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>Chronic Dehydration, ear infections, w/o bowel constructions</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Orally, cut up in foods</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support, female when available</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheelchair; seat belt, head rest, Gait trainer</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff will supervise in community, visual impairment</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A visual impairment</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no alone time</u>

Important to: 1:1 interactions time outside of chair, music

Important for: offered fluids, to be social, using gait

Likes: Music, hugs, 1:1 time

Dislikes: waiting for things, cold food or drinks

Lead Review Completed: Tristen Sealey

Staff: Kesha K
 Date: 2/1/22



Service Recipient: JL
 Service Span: 2021-2022

Outcomes:

Outcome #1: <u>Daily she will choose a staff for her daily activities</u>
Summarize Steps: <u>Present 3 sensory activities</u> <u>Present 3 staff to assist with sensory activities</u>
Outcome #2: <u>choose a community activity</u>
Summarize Steps: <u>Staff show and describe community recreation cards</u> <u>Time to respond Yes/No</u>
Communication Style: <u>facial expression, vocalization for Yes or No</u> <u>eye gazing</u>
Learning Style: <u>Rehearsal & repetition</u>

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>NA</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>chronic seizure partially controlled</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>keep open mouth when ready for another bite</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet from home</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>chronic dehydration ear infections</u> <u>Bowel obstruction</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>Take medication by mouth</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses briefs</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses wheelchair with hand support</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff provide supervision & support in community</u>
Sensory Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Visual impairment</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>NA</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no time alone</u>
Important to:	<u>low / no risk, time outside for class and recreation</u>
Important for:	<u>to be social, engage in activity. Goal for more 3x/week</u>
Likes:	<u>giving her hugs, food</u>
Dislikes:	<u>waiting for processed food/drink, and being hungry or thirsty</u>

Lead Review Completed: Erin Brady

Staff: Betsy
 Date: 2/1/2022



Service Recipient: Jennifer
 Service Span: 2022 - 2023

Outcomes:

Outcome #1: Daily, Jennifer will choose a staff to assist her in a sensory activity
 Summarize Steps: Present 3 sensory activities review each opt to allow time to respond

Outcome #2: Monthly, community outing
 Summarize Steps: staff show + describes community outing

Communication Style:
vocalization, facial expressions, body language

Learning Style:
routine, repetition, upbeat voice

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>partially clonic - eyes going back</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>when ready will eat or spits it out</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet from home, full assistance food kept warm.</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic history of ear infection</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 orally whole or cut</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full assistance</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>wheelchair, headrest, seat belt, 2 staff using a</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff will supervision</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>partial visual</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff No time alone</u>
Important to:	<u>1:1 interaction with upbeat staff</u>
Important for:	<u>options, social engaging</u>
Likes:	<u>music, 1:1, sensory time</u>
Dislikes:	<u>waiting for things, cold food,</u>

Lead Review Completed: Tristen Young

Staff: Celeste Anderson Jones



Service Recipient: Jennifer Lofiboom

Date: 2.1.22

Service Span: ~~Jan 22~~ - Jan 2023

Outcomes:

<p>Outcome #1: Daily, Jennifer will choose a staff to assist her in a chosen sensory activity</p> <p>Summarize Steps: Present 3 sensory activities, review each option 1 by 1 allow time to respond</p> <p>Present 3 staff to assist with sensory activities, review each option 1 by 1 allow time to respond, follow through on choices</p>
<p>Outcome #2: Monthly, Jennifer will choose a community integration trip to participate in</p> <p>Summarize Steps: Staff show & describe community integration events, ask if she is interested with each option 1 by 1 allow time to respond</p>
<p>Communication Style: facial expressions vocalizations, "Aah" for yes "Tiff" for no eye gazing, reaching or pushing away</p>
<p>Learning Style: routine & repetition responds best when encouragement is given delivered</p>

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

<p>Allergies:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports:</p> <p>N/A</p>
<p>Seizures:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Partially controlled Clonic Tonic Seizures infrequent don't follow a pattern unless dehydrated clusters 1-20 seconds may last 1-4 mins</p>
<p>Choking:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: She'll open her mouth when ready for another bite, will spit out food if</p>
<p>Specialized Diet:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Ketogenic diet - keep food warm, use spoon</p> <p>spouted cup</p>
<p>Chronic Medical Conditions:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: Chronic dehydration DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>history of ear infections history of bowel obstruction pyruvate dehydrogenase!</p>
<p>Medication at PAI:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: orally whole or cut up into foods as tolerated</p>
<p>Personal Cares:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Full support female staff, briefs</p>
<p>Mobility/Fall Risk:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: wheel chair with headrest, foot rest, chest strap</p> <p>lunge strap, & seat belt, mal table</p>
<p>Community Support:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: staff provide supervision, physical support while in the community</p>
<p>Sensory Support:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: visual impairment</p>
<p>Behavior Support:</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports:</p> <p>N/A</p>
<p>Unsupervised Time:</p> <p><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports:</p> <p>no time alone</p>
<p>Important to:</p> <p>offered fluids frequently, social engage engagement gait trained</p> <p>minimum 3 time weekly</p>	
<p>Important for:</p> <p>interaction with up next staff being able to have time outside of her wheel chair</p>	
<p>Likes:</p> <p>listening to music 1:1 sensory time & hugs</p>	
<p>Dislikes:</p> <p>waiting for things, being hungry or thirsty, cold food or drinks</p>	

Lead Review Completed: *Justin Bailey*

Staff: Kia L. Bauch

Date: 2/1/22



Service Recipient: Jenny Lofboom

Service Span: Feb 22 → 23

Outcomes:

Outcome #1: Choose a staff to assist in sensory activity
 Summarize Steps:
Present 3 choices, present 3 & staff

Outcome #2: choose an outing
 Summarize Steps:
give options

Communication Style:
facial expressions, body language, vocalizations, eye gazing

Learning Style:
routine + repetition

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>	
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>clonic/tonic</u>	
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>open mouth when ready, small drinks</u>	
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Keto-genic, water, full assist</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>chronic dehydration, chronic ear infection</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 orally</u>	
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full support</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>wheelchair w/ footrests</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>provide supervision</u>	
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>visual impairment</u>	
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>	
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no alone time</u>	
Important to: <u>1:1, time outside her chair, music</u>		
Important for: <u>offered fluids, gait trainer 3x weekly</u>		
Likes: <u>music, 1:1, hugs</u>		
Dislikes: <u>want waiting, cold foods,</u>		

Lead Review Completed: Fiston Wray

Staff: Morgan B.
 Date: 2/1/22



Service Recipient: Jennifer L.
 Service Span: Jan 2022-2023

Outcomes:

Outcome #1: Choose staff to assist her in a chosen sensory activity.
 Summarize Steps:
3 sensory activities review each option 1 by 1 allow response time

Outcome #2: Monthly, choose community integration trip to participate in.
 Summarize Steps:
Show integration cards of what outing looks like

Communication Style:
Tah is yes and niff for no, facial expressions, reaching/push away

Learning Style:
routine and repetition with encouragement w/ physical ques

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>none</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled clonazepam 1-2 min</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>open mouth for another bite, small drinks</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Keto, keep food warm, too cool will just pocket it</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, ear infections, bowel obstructions</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>med orally, keto cal</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>female staff, brief, reverse bucket to mat table</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full assist w/ w/c gait trainer w/ posey belt</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff provide supervision</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>cortical visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no time alone</u>
Important to: <u>1:1 interactions, being out of chair, music</u>	
Important for: <u>fluids frequently, being social</u>	
Likes: <u>hugs, music, sensory</u>	
Dislikes: <u>waiting, cold food/drink,</u>	

Lead Review Completed: Foster Young

Staff: Suze Christensen
 Date: February 1, 2022



(Jenny)
 Service Recipient: Jennifer Hofbom
 Service Span: Jan 2022 - Jan 2023

Outcomes:

Outcome #1: <u>Jennifer chooses staff to assist her in a chosen sensory activity</u> Summarize Steps: <u>Present 3 sensory activities, review each option (by) allow time to respond, present 3 staff to assist with sensory activities, review each option (by) allow time to respond, follow through on choices.</u>
Outcome #2: <u>Manually, Jenny will choose a community integration trip to participate in.</u> Summarize Steps: <u>Staff show and describe community integration cards, ask if she's interested in each option (by) 1, allow time to respond.</u>
Communication Style: <u>Facial expressions, body language, vocalizations. a "yah" for "yes" and "NA" for "no"</u>
Learning Style: <u>routine / repetition, encouragement in positive way.</u>

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>partially controlled clonic tonic seizures. Clonus 1-20 seconds.</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>she'll spit out food she doesn't like. Accepting of small sips between bites of food</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>ketogenic diet sent from home. Spouted up, regular spoon, insulated bowl.</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, history of ear infections, history of bowel obstructions</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>meds are taken whole (orally) or cut & tolerated soft foods.</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Fall supports female staff when available, briefs, may be some weight is transferred by 1 staff pivot or 2 staff reverse pivot.</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff provide supervision and physical support to her while in the community.</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses wheel chair.</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Critical visual impairment</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>
Important to: <u>meaningful 1:1 with upstart staff time outside, music</u>	
Important for: <u>Being offered fluids often, support to be social & engaged in activities</u>	
Likes: <u>music, 1:1 sensory time, hugs</u>	
Dislikes: <u>waiting, cold food/drinks, being hungry/thirsty.</u>	

Lead Review Completed: Faaton Berry

Staff: Alice L. Cox
 Date: 2/1/22



Service Recipient: Jennifer L
 Service Span: 1/22 - 1/23

Outcomes:

Outcome #1: Staff to assist w sensory activity
 Summarize Steps: Present 3 activities Review them + give time to choose

Outcome #2: Choose Outcome Monthly
 Summarize Steps: Give per option cards

Communication Style: Facial Expressions, Vocalizations, Pushing + Pushing ^{Eye} Going

Learning Style: Repetition Upbeat tone + Verbal Cues

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>NA</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially Controlled ^{cause of dehydration} 3-4 mins Eyes roll, Snore after</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Open mouth on sips between bites</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Keto Genic / Water in warm insulated bowl ^{Req cup asst}</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic Dehydration Ear Injections Bowel Obstruction</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>Orally w soft foods</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full Support female staff 1 staff Stand assist ^{1-2 person back}</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheelchair - brakes + straps Posey Bell</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Supervision + Support</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Visual Impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>NA</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>None - always supervised</u>
Important to:	<u>Meaningful 1-1, time out of chair</u>
Important for:	<u>Fluids, Social, Engaged Caretakers</u>
Likes:	<u>Sensory, Music</u>
Dislikes:	<u>Cold food or drink, Being hungry or thirsty</u>

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Lead Review Completed: Jennifer L

Staff: Megan Gagner
 Date: 2/1/2022



Service Recipient: Jennifer Lofboom
 Service Span: Jan 22 - Jan 23

Outcomes:

Outcome #1: <u>Daily Jennifer will choose a staff to assist her in a chosen sensory activity.</u> Summarize Steps: <u>present 3 sensory activities, review each one on one, allow time to respond</u>
Outcome #2: <u>Monthly, Jennifer will choose a community integration trip to participate in.</u> Summarize Steps: <u>staff show and describe community integration cards, ask if interested in each option</u>
Communication Style: <u>Facial expressions, body language, vocalizations, eye gazing</u>
Learning Style: <u>Routine and repetition, responds best when encouragement is delivered in an upbeat tone</u>

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>No allergies N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled Clonic tonic seizures, infrequent</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>open mouth when ready for a bite, will spit at food if too much</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet sent from home, full assistance, no cold food will packet if not warm enough</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, history of ear infections, history of bowel obstruction</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 medication orally or in soft food</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Receives full support – female staff when available,</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses wheelchair with support of seatbelt and straps</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff will provide supervision and support while in the community</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No time alone</u>
Important to: <u>meaningful 1:1 interactions with upbeat staff, being able to have time outside of chair</u>	
Important for: <u>Being offered fluids frequently, uses gait trainer 3 times a week</u>	
Likes: <u>listening to music, hugs, 1:1 sensory time</u>	
Dislikes: <u>cold food/drink, being hungry/thirsty</u>	

Lead Review Completed: Erin Brady

Staff: DELG HARRIS
 Date: 2/1/22



Service Recipient: Jennifer Lofboom
 Service Span: JAN 22 - JAN 23

Outcomes:

Outcome #1: Daily, Jennifer will choose a staff to assist in a chosen sensory activities
 Summarize Steps: Present 3 Sensory Activities
 Go through each option 1 by 1 Allow time to respond / Present 3 Staff go through each option

Outcome #2: Monthly, Jennifer will choose a Community Integration Trip to participate in.
 Summarize Steps: ~~Staff~~ Staff show and describe community integration cards
 ASK if she is interested with each option 1 by 1 Time to respond Yes/No follow through on choice

Communication Style: facial expressions, body language, vocalizations & "TAH" for yes or no and N/A for no, eye gazing, and Reaching or Pushing away

Learning Style: Routine & Repetition. Responds best when encouragement is delivered in an upbeat tone of voice paired with physical cues

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: N/A
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Partially controlled Clonic Tonic Seizures. infrequent, don't follow a pattern unless dehydrated clusters of 1-20 seconds and may last 1-4 minutes Present as eyes rolling back, tongue may protrude, arm may go
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Will open mouth when ready for another bite if too much food/drink she will spit it out she accepting of small drinks between bites of food to prevent pocketing food
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Ketogenic diet, sent from home. Water with Sugar Free Flavoring water full assistance in eating & drinking. her food/drink are kept warm if to cool she will pocket if instead, spouted cup, Reg. spoon, insulated cup bawl For Temp control
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: Chronic dehydration - encourage and DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Chronic dehydration - encourage and support in drinking, history of ear infections - cover ears when outside, history of bowel obstruction Report BH'S
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Takes her medication whole or cut orally as tolerated in soft food. Jenny currently takes Ketocal po with lunch per Family Request
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Receives full support, female staff when available uses bras
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Use wheel chair with support of a headrest, foot rest chest straps, pelvic straps & seat belt may bear weight and transferred by one staff stand pivot or two staff ^{power} hoist
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Staff provide supervision and physical support to her while in the community
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: cortical visual impairment see best peripherally
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: N/A
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: No Alone time
Important to:	1-1 interactions with upbeat staff, being to have time outside of her chair & music
Important for:	Be offered fluids frequently, have support to be social and engaged in activity
Likes:	Listening to music 1-1 sensory time, and hugs
Dislikes:	waiting for things, cold food/drinks, and being hungry/thirsty

Lead Review Completed: Justin Keeney

Staff: BAO HNK
 Date: 2/1/22



Service Recipient: J.I.
 Service Span: 1/27/23

Outcomes:

Outcome #1: <u>Choose staff to assist her in sensory activity</u> Summarize Steps: <u>3 sensory activities review each by 1 allow</u>
Outcome #2: <u>Will choose community integration trip to Portofino</u> Summarize Steps: <u>staff show & describe community integration cards</u>
Communication Style: <u>facial, body language, vocal, eye gaze</u> <u>reach/rush away</u>
Learning Style: <u>routine & repetition / physical cues</u>

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>clock tonic, parthall</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>open mouth for another bite</u> <u>too much food/water spill out</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet sent from home</u> <u>water w/ sugar instead of sweet</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>dehydration, ear infections, bowel obstruction, Bms, pyruvate dehydrogenase</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>oral cut or whole w/ soft food</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full support / female staff, bare weight</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses wheelchair w/ support of a helper</u> <u>rail will be engaged on mat. 2 feet w/ gait</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff are supervision/physical support</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>cortical visual impairment</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Restrain alone</u>
Important to: <u>1:1 upheld staff, outside chair, music</u>	
Important for: <u>Offered financial support to be social. was gait trainer 3x weekly</u>	
Likes: <u>music, hugs, 1:1 fun</u>	
Dislikes: <u>cold food/drink/water/hungry or thirsty</u>	

Lead Review Completed: Tristen Brady

Staff: Maria Hetchler

Date: 2/1/2022



Service Recipient: Jennifer

Service Span: Jan. 22 - Jan. 23

Outcomes:

<p>Outcome #1: <u>Biweekly, Jennifer will choose a staff to assist her in a chosen sensory activities.</u> Summarize Steps: <u>Present 3 activities option 1 by 1 give time to responds</u></p>
<p>Outcome #2: <u>Monthly, Jennifer will choose a community integration trip to participate in.</u> Summarize Steps: <u>Staff show and describe community cards ask if she interest 1 by 1 allow time respon yes/no</u></p>
<p>Communication Style: <u>facial expression, body language, vocalization a "Ta" for yes and "Nff" for no</u></p>
<p>Learning Style: <u>Routine and repetition</u></p>

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

<p>Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>N/A</u></p>
<p>Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Partially controlled clonic tonic seizures, infrequent cluster of 1-20 second convulsions may last 1-4 min</u></p>
<p>Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Will open mouth when ready other bite, will spit if too much food</u></p>
<p>Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Ketogenic diet, water w/sugar free</u></p>
<p>Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>chronic dehydration - support in DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes drinking, report BM's</u></p>
<p>Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>take orally whole or cut as tolerated in soft food ketocal PO w/winch</u></p>
<p>Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Full support, female staff available, breast</u></p>
<p>Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>used wheelchair w/support the head, footrest</u></p>
<p>Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>staff provide supervision and physical support</u></p>
<p>Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>cortical visual impairment</u></p>
<p>Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>N/A</u></p>
<p>Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>No time alone</u></p>
<p>Important to: <u>morning full 1:1 interaction, music, time outside her chair</u></p>	
<p>Important for: <u>over fluids frequently, being social activities w/others, use gait trainer 3 times a week</u></p>	
<p>Likes: <u>music, 1:1 sensory and hugs</u></p>	
<p>Dislikes: <u>waxing, cold food/drinks and being hungry</u></p>	

Lead Review Completed: Justin Young

Staff: Natalie Johnson
 Date: 2-1-2022



Service Recipient: Jennifer Johnson
 Service Span: Jan 2022 - 2023

Outcomes:

- Outcome #1:** Daily Jennifer will choose a Staff to assist in sensory activity?
 Summarize Steps: Present 3 sensory activities, go 1 by 1 and give Jennifer 4 time to respond. Present 3 Staff, go 1 by 1, give her time to respond
- Outcome #2:** Monthly, Jennifer will choose a Community integration trip to participate in
 Summarize Steps: Staff show her and describe community integration cards ask if she is interested with each option 1 by 1 allow time to respond
- Communication Style:** facial expressions, vocalizations "tah" for yes, "hiff" for no, eye gazing, reaching or pushing away?
- Learning Style:** Routine and repetition. Responds best when encouragement is delivered.

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled tonic clonic seizures?</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>She'll open her mouth when ready for another bite. Will spit out food if too much.</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet - Keep food warm. Peg spoon Spouted cup</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, history of ear infections, history of bowel obstruction, pyruvate dehydrogenase,</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>Ketocal PO - Whole or cut up into food as tolerated</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support, female staff when available, briefs</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheel Chair</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff provide supervision and physical support to her while in community?</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>NO alone time</u>
Important to: <u>1:1 interactions with upbeat staff, being able to have time out of her chair</u>	
Important for: <u>Be offered fluids often, have support to be social and engaged in activity w/ others.</u>	
Likes: <u>listening to music - Justin timberlake, sensory time and hugs</u>	
Dislikes: <u>Waiting for things, cold food or drink, being hungry or thirsty</u>	

Lead Review Completed: Fawn Mandy

Staff: Deanne Lepley
 Date: 2-1-22



Service Recipient: Jennifer Coffboom
 Service Span: Jan 2022-Jan 2023

Outcomes:

<p>Outcome #1: <u>Daily Jennifer will choose a staff to assist her in a chosen sensory activity</u> Summarize Steps: <u>present 3 sensory activities activities review each option 1 by 1 allow time to respond, present 3 staff to assist w/ sensory activities, review each option by 1 allow time to respond, follow through on choices</u></p>
<p>Outcome #2: <u>Monthly, Jennifer will choose a community interaction trip.</u> Summarize Steps: <u>Staff show + describe community interactions, code ask if interested</u></p>
<p>Communication Style: <u>social expressions, body language, vocalizations are going + reaching or pushing away</u></p>
<p>Learning Style: <u>Routine + repetition responds best when encouragement delivered in an upbeat tone of voice paired w/ physical cues</u></p>

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

<p>Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>N/A</u></p>
<p>Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>partially controlled clonic-tonic seizures clusters of 1-20 seconds</u></p>
<p>Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>opens mouth when leader to eat another bites ab two much food or drink she will spit out</u></p>
<p>Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Keto-genic diet sent home. Water w/ sugar free flavoring food assistance, food kept warm. Spouted cups</u></p>
<p>Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>dehydration, ear infections, bowel obstruction, PIV VAC, Dehydraguard</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Medication at PAI: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>takes her medications orally</u></p>
<p>Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>full support - jernal staff when available</u></p>
<p>Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Uses wheelchair, foot strap, chest strap, pelvic strap, seat belt, gait trainer w/ 2 staff while wearing a posey belt</u></p>
<p>Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>supervision while in community</u></p>
<p>Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>Cortical visual impairment - sees best peripherally</u></p>
<p>Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>N/A</u></p>
<p>Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>NO alone time</u></p>
<p>Important to: <u>Meaningful 1 on 1 interaction w/ staff, time out of chair (recliner, gait trainer)</u></p>	
<p>Important for: <u>Friends, Being Social, Uses gait trainer min 3x weekly</u></p>	
<p>Likes: <u>Justin Timberlake, music, hugs</u></p>	
<p>Dislikes: <u>waiting for things, cold food/drink, being hungry or thirsty</u></p>	

Lead Review Completed: Deanne Lepley

Staff: Summer
 Date: 1/1/21



Service Recipient: Jennifer L. Loomis
 Service Span: Jan. 22 - Jan. 23

Outcomes:

Outcome #1: <u>Jenny will choose a staff to assist her in choosing sensory.</u> Summarize Steps: <u>- present 3 sensory activities. Let her choose 3 staff options. Let her choose</u>
Outcome #2: <u>Monthly Jenny will choose community integration trip.</u> Summarize Steps:
Communication Style: <u>Body lang, facial expression, Tan-lys, eye gazing, teaching, pushing</u>
Learning Style: <u>Reinforced resp responds best when encouraged w/ upbeat tone of voice</u>

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>partially clonic tonic seizures - infrequent,</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Will open mouth when ready, small drinks between bites</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Keto diet, water w/ sugar free - full assistance - kept CSOI</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, ear infection, bowel obstruction</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>Orally, cut. in soft food, Keto Cal PD</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support, brkts, may wear some underwear</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheel chair, chest/ pelvic strap, need assistance w/ walker</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff provides support in community</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical visual impairment - sees best peripherally</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No time alone</u>
Important to:	<u>1:1 interaction, time outside of chair, music</u>
Important for:	<u>Offered fluids, gait trainer 3x weekly</u>
Likes:	<u>music, hugs, sensory</u>
Dislikes:	<u>Cold food, being hungry/thirsty</u>

Lead Review Completed: Tristen Kelley

Staff: Danielle Mendez



Service Recipient: Jenny Loftum

Date: 2.2.22

Service Span: 1.22 - 1.23

Outcomes:

<p>Outcome #1: <u>daily choose staff to assist with sensory activity</u></p> <p>Summarize Steps: <u>Present 3 sensory activities, review each option 1 by 1 allow time to respond, Present 3 staff to assist with sensory activities, Review each 1 by 1 allow time to respond, follow through on choice.</u></p>
<p>Outcome #2: <u>Monthly choose outing.</u></p> <p>Summarize Steps: <u>Staff show and describe community integration cards. Ask if she is interested w/ each option 1 by 1 allow time to respond y/n follow through w/ choice</u></p>
<p>Communication Style: <u>facial expressions, body language, vocalizations TAT/yes N/A/NO eye gazing</u></p>
<p>Learning Style: <u>Routine & repetition. responds best when encouragement is delivered in upbeat tone</u></p>

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

<p>Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>NA</u></p>
<p>Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>partially controlled. follow seizure protocol</u></p>
<p>Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>will open mouth when ready for bite. If too much will spit out. Pockets food.</u></p>
<p>Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Ketogenic diet, sent from home. Sparked cup water with no sugar. Full assistance per. span</u></p>
<p>Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>Chronic dehydration, encourage drinking, ear infections, DM obstruction</u></p> <p>DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Takes meds orally with food.</u></p>
<p>Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>Full support, female staff when available. Diets priv staff, reverse basket.</u></p>
<p>Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>WC, head rest, feet rest, mat table bars, genit trainer.</u></p>
<p>Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>provide supervision & physical support</u></p>
<p>Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>Cortical visual impairment - sees best peripherally</u></p>
<p>Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: <u>NA</u></p>
<p>Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: <u>NO Time Alone</u></p>
<p>Important to: <u>interactions w/ upbeat staff, time out of her chair and music.</u></p>	
<p>Important for: <u>be offered fluids, be social and engage in activities, use genit trainer</u></p>	
<p>Likes: <u>Music, sensory time, hugs</u></p>	
<p>Dislikes: <u>waiting, cold drink/food being hungry/thirsty</u></p>	

Lead Review Completed: Tristen Deery

Staff: Colette Rice

Date: 2.1.22



Service Recipient: Jennifer Lofboom

Service Span: Feb. 22 → 2023

Outcomes:

Outcome #1: Choose a Staff to assist in Sensory activity
Summarize Steps: Present 3 choices, Presents 3 staff

Outcome #2: Choose an outing
Summarize Steps: give ~~many~~ options

Communication Style:
Facial expressions, body language, vocalizations

Learning Style:
routine, repetition

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partial controlled clonic/tonic</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Open mouth when ready for food, drinks</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Water, Sugar free, full assistance</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, ear infection</u> bowel upstruction 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>orally</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full support</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>wheel chair with foot rest</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Provide supervision</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no alone time</u>

Important to:
one on one upbeat staff, music

Important for:
offer liquids, gait trainer, 3x weekly

Likes:
music lol, hugs

Dislikes:
waiting, cold food/drink,

Lead Review Completed: Fertin Kelly

Staff: ERIN SANDSTROM
 Date: 2.1.2022



Service Recipient: JENNIFER LOFBOM
 Service Span: JAN 2022-DEC 2022

Outcomes:

Outcome #1: <u>DAILY, JENNIFER WILL CHOOSE A STAFF TO ASSIST HER IN A CHOSEN SENSORY ACTIVITY.</u> Summarize Steps: <u>1- PRESENT 3 SENSORY ACTIVITY. 2- REVIEW EACH OPTION 1 BY 1. ALLOW TIME TO RESPOND.</u>
Outcome #2: <u>MONTHLY, JENNIFER WILL CHOOSE A COMMUNITY INTEGRATION TRIP TO ATTEND.</u> Summarize Steps: <u>1- STAFF SHOW CARDS, ASK IF SHE IS INTERESTED. 2- ALLOW TIME TO RESPOND.</u>
Communication Style: <u>"TAH" - YES MEAN "NO"</u> <u>FAZIAL EXPRESSIONS, BODY LANGUAGE, EYE GAZING</u>
Learning Style: <u>ROUTINE/REPETITION - RESPONDS BEST W/ UPBEAT ENCOURAGEMENT</u>

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PARTIALLY CONTROLLED CLONIC TONIC SEIZURES/CLUSTERS</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>WILL OPEN MOUTH WHEN READY FOR FOOD.</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>SPROUTED WP, REGULAR SPOON</u> <u>KETOGENIC DIET, WATER W/ FLAVORING, POKETS FOOD</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>CHRONIC DEHYDRATION, EAR INFECTIONS, BOWEL OBSTRUCTIONS</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>TAKES MEDS WHOLE OR CUT AS TOLERATED IN SOFT FOODS</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>FULL SUPPORT FEMALE STAFF, 1 PERSON STAND PIVOT 2 PERSON REVERSE BASKET.</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>W/C, GAIT TRAINER W/ 2 STAFF, ASSIST WITH PROPPELLING</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>PROVIDE SUPERVISION AND PHYSICAL SUPPORT</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>CORTICAL VISION IMPAIRMENT - SEES BEST PERIPHERALLY</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>NO TIME ALONE</u>
Important to: <u>1:1 INTERACTIONS, UPBEAT STAFF, MUSIC, PEELMER</u>	
Important for: <u>OFFER FLUIDS, SUPPORT TO BE SOCIAL AND ENGAGED GAIT TRAINER</u>	
Likes: <u>FLUIDS, SOCIAL, ENGAGED, HUBS, SENSORY</u>	
Dislikes: <u>WAITING, HUNGER, THIRSTY,</u>	

Lead Review Completed: Erin Sandstrom

Staff: Laura Stacken

Date: Feb 1, 2022



Service Recipient: Jenny Lofboom

Service Span: Jan 2022 - 2023

Outcomes:

Outcome #1: Daily, Jenny will choose a staff her in a chosen sensory activity

Summarize Steps:

Present 3 sensory activities

Outcome #2: Monthly, Jenny will choose a community integration trip to participate in

Summarize Steps:

Staff show & describe community integration cards.

Communication Style:

Facial Expression, body Lang, Vocalizations a "Tah" for yes and "Nif" No

Learning Style:

Routine & repetition responds best when encouragement is delivered in an upbeat tone

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled Clonic Tonic Seizures</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>will open mouth when ready for another bite. Too much food/drink she will spit it out</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet, sent from home, water with sugar free flavoring. Full Assist.</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration ear infection, history of bowel obstruction</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>brally whole or cut as tolerated in soft food</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full Support, Female Staff when available, briefs.</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses wheel chair with support of a headrest, footrest, chest straps, seat belt, gait trainer two staff.</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff will provide support in community</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No time alone</u>
Important to:	<u>1:1 interactions with upbeat staff, being able to have time outside other chair & music</u>
Important for:	<u>Be offered fluids, have support to be social, engaged in activity</u>
Likes:	<u>Music, 1:1 time sensory & hugs</u>
Dislikes:	<u>Waiting for things, cold/food/drinks & being hungry/thirsty.</u>

Lead Review Completed: Justin Yodanis

Staff: Jenny Trimble

Date: 2-1-2022



Service Recipient: Jennifer Loftman

Service Span: 1-2022-1-2023

Outcomes:

Outcome #1: Daily, Jennifer will choose a staff chosen sensory activity
Summarize Steps: Present 3 sensory activities, review each option (by) allow time to respond. staff present 3 staff to assist

Outcome #2: monthly, choose a community outing
Summarize Steps: staff show & describe community cards

Communication Style: facial expression, body language, vocalizations

Learning Style: Routine, repetition. Responds best when encouraged in upbeat tone of voice paired w/ physical cues

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>partially clonic-tonic seizures infrequent, 1-4 min</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>open mouth when ready</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet sent from home full assistance fluid w/ sugar free flavor</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>chronic dehydration history of ear infections & bowel obstruction</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 orally whole or cut</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full support, female staff as available 1-2 staff pivot</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>w/c waistrest, chest strap pelvic and seatbelt, gait trainer 2-staff using a rosey belt</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff supervision & physical support</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical visual</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no time alone</u>

Important to: 1:1 interactions w/upbeat staff, outside of chair, music

Important for: offered fluids, social & engaging, gait trainer

Likes: listening to music, 1:1, sensory time & hugs

Dislikes: waiting for things, cold food/fluid & being hungry

Lead Review Completed: Forrest Whaley

Staff: Anthony H



Service Recipient: Jenny L.

Date: 2-4-22

Service Span: Jan. 22 - Jan. 23

Outcomes:

<p>Outcome #1: Jennifer is allowed to pick who she wants to assist her daily activities.</p> <p>Summarize Steps: Present 3 sensory activities 1 by 1 and Review along with who Jennifer chooses to assist her with her choice</p>
<p>Outcome #2: every month Jennifer gets to choose a community integrated trip to attend.</p> <p>Summarize Steps: Show the and explain integration cards see if she is interested in any and Review</p>
<p>Communication Style: Tah = yes nff = no facial expressions body language eye gaze Reach out or pull away</p>
<p>Learning Style: Love encouragement Troninward and Repition Like upbeat tones Paired with Physical Cues</p>

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

<p>Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: N/A</p>
<p>Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Clonic-Tonic Seizures partially 1-2 seconds up to 1-4 minutes eyes roll back arms may raise S hear sound after seizure protocol</p>
<p>Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: will open mouth when ready for another bite spit out if it's too much she accepts primary inbetween bites</p>
<p>Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Ketogenic diet zero from home water with sus or free flavor fully assist keep warm</p>
<p>Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: Chronic Dehydration history of Coring <small>CDNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</small> History of bowel obstruction Keto Diet</p>
<p>Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Take orally whole or cut in soft food Takes Ketocal PO with Lunch</p>
<p>Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Full Support Female staff breaks may be heavier May need 2 staff assistance</p>
<p>Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Uses wheelchair with head Rest foot Rest Chest straps pelvic straps and seat belt Use Rail when staff assist with all wheel chair safety straps</p>
<p>Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Staff provide supervision and physical support</p>
<p>Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: Cortical visual impairment - sees best Peripherally</p>
<p>Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: N/A</p>
<p>Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: no alone time</p>
<p>Important to: music being out of chair meetings upbeat happy staff</p>	
<p>Important for: offer fluids frequently support in activities and interactions Uses gate trainer 3x weekly</p>	
<p>Likes: Hugs sensory time hugs</p>	
<p>Dislikes: Cold food/drinks waiting on others being hungry and thirsty</p>	

Lead Review Completed: Justin Kelly

Staff: Ashleigh Shirley
 Date: 2/1/22



Service Recipient: 1/22-1/23
 Service Span: Jenny Lotboom

Outcomes:

Outcome #1: Choose staff to assist her in chosen activity daily.
 Summarize Steps:
3 activities - review 1 by 1 - allow time to respond
present staff options 1 by 1

Outcome #2: monthly - choose eating
 Summarize Steps:
present activities of the month allow time to choose
~~no eye gazing - eye gazing - reaching/AV~~

Communication Style: facial expressions, body language, Tan-yes
no - nff - nose puff - eye gaze reaching push

Learning Style:
ROUTINED REP, responds best w/ encouragement - upbeat tone paired w/ physical cues

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>infrequent TC seizure clusters + has protocol</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>open mouth when ready - spit out if too much in mouth</u> <u>sips between</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet - sent from home - full assistance</u> <u>- warm water & food</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>chronic dehydration - ear infection</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>bc of bowel obstructions, keto diet supports a disease</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>orally in soft foods ketocal w/ lunch</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>receives full support - pref female staff - 1 staff pivot</u> <u>report skin body</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>w/c w/ headrest, feetrest, seat, chest belt</u> <u>posy belt 2 staff</u> <u>matt table + things</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Provide supervision</u> <u>staff train</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>selective visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no time alone</u>
Important to:	<u>upbeat interact w/ 1:1 staff out of chair + music loves JT</u>
Important for:	<u>distored fluid frequently - bait trainer 3 weeks @ least</u>
Likes:	<u>MUSIC 1:1 sensory hugs</u>
Dislikes:	<u>waiting cold food/drink hungry or thirsty</u>

Lead Review Completed: Fairsten [signature]

Staff: Maddy K

Date: 2/1/22



Service Recipient: Jennifer Hofboom

Service Span: Jan 22 - Jan 23

Outcomes:

Outcome #1: Daily, Jennifer will choose a staff to assist her in a chosen sensory activity

Summarize Steps: Give 3 sensory activities, review each option 1 by 1, allow time to respond, Give 3 staff, review, give time to respond.

Outcome #2: Monthly, Jennifer will choose a community integration trip to participate in.

Summarize Steps: staff show + describe community integration cards, ask if she is interested 1 by 1, allow time to respond yes/no

Communication Style: Facial expressions, body language, Vocalizations "Yah" for yes + "nff" for no, eye gazing, pushing away

Learning Style: Routine + repetition, Encouragement delivered in positive way

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled clonic tonic, clusters of 1-20 sec, Eye rolling, tongue out, arms may go up</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>will open mouth when ready for another bite. If too much, she will spit it out. Small drinks between food</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet, water w/ sugar free flavoring</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration - encourage drinking fluids, History of ear infections</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>orally, whole or cut in soft foods. Ketocal</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support- female staff when available, May bear some weight-transferred using stand pivot</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses wheel chair with head rest, foot rests, chest straps, pelvic straps + seat belt</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff provide supervision + physical support while in community</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical Visual Impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No time alone</u>
Important to:	<u>1:1 interactions with upbeat staff, time out of chair, music</u>
Important for:	<u>offered fluids frequently, support to be social + engage, gait trainer 3x/day</u>
Likes:	<u>1:1, Music, sensory time, hugs</u>
Dislikes:	<u>waiting, cold food/drinks, being hungry/thirsty</u>

Lead Review Completed: Feather McAlley

Staff: Paris Dyer
 Date: 2/1/22



Service Recipient: Jenny Gottb/0217
 Service Span: Jan. 22 - Jan. 23

Outcomes:

Outcome #1: Jenny will chose a staff to assist her in choosing sensory

Summarize Steps: Present 3 sensory activities
 review each option 1 by 1
 allow response time

Outcome #2: Jenny will use a monthly community integration trip.

Summarize Steps: Staff show and describe community integration cards.

Communication Style: Body language, vocalizations "Tah", Facial expressions
 eye gazing, reaching or pulling away

Learning Style:
routine and repetition

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled tonic clonic</u>
Choking: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Open mouth when ready, small bites</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Keto sent from home, learn fluid in sponged cup</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>car infections, bowel obstruction</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>med orally whole</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>female staff when available, uses briefs</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheel chair with headrest foot and chest straps ^{posey} w/ belt</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Provide supervision and sensory supports</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A Visual impairment</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff supervision</u>
Important to: <u>1 on 1 interactions with staff</u>	
Important for: <u>offered fluids, social time, gait trainer, sensory time, hugs</u>	
Likes: <u>waiting, being thirsty, cold food</u>	
Dislikes: <u>✓</u>	

Lead Review Completed: Fisher [signature]

Staff: Trey Gouid
 Date: 02/01/22



Service Recipient: Jenny L
 Service Span: 01/22 - 01/23

Outcomes:

Outcome #1: Jenny will choose a staff to assist her in a
 Summarize Steps: Chosen Sensory Activity

Outcome #2: Jenny will choose a Community Integration
 Summarize Steps: trip to participate in

Communication Style: Facial expressions, Body language,
Tah = Yes N/A = NO

Learning Style: routine and repetition, upbeat

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>NO Allergies</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially Controlled tonic Clonic,</u> <u>Clusters 1-20 seconds</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>will open mouth when ready 4</u> <u>Bite</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic, water sugar free flavor,</u> <u>warm food/drink, Spouted Cup, reg Spoon</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration,</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>Bowl obstruction,</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketocal PO</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support, female staff when</u> <u>Available</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>wheel chair, head rest, foot rest,</u> <u>Chest Strap</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Supervision and physical</u> <u>Support</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical Visual Impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>not alone time.</u>
Important to:	<u>meaningful 1:1, upbeat staff, music, Time</u> <u>Outside of Chair</u>
Important for:	<u>Offered fluids, support in social Sit, Gait</u> <u>trainer 3x weekly</u>
Likes:	<u>music, 1:1 Sensory, hugs</u>
Dislikes:	<u>waiting, Cold food/drink, being hungry/thirsty</u>

Lead Review Completed: Fisher Perry

Staff: Maurita Sweeney

Date: 2/1/22



Service Recipient: JL

Service Span: Jan 2022 - Jan 2023

Outcomes:

Outcome #1: <u>Will choose a staff to assist her in sensory activity.</u>
Summarize Steps: <u>present 3 activities give time to respond</u> <u>present 3 staff choices give time to respond.</u>
Outcome #2: <u>Monthly choose community integration cards for activity.</u>
Summarize Steps: <u>Present activities - give time to respond</u>
Communication Style: <u>facial expressions</u> <u>noise s</u> <u>body language</u> <u>vocalization s</u>
Learning Style: <u>Routine repetition. Use upbeat voice.</u>

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partial tonic clonic</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Will spit out too much food. give small drinks.</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet, insulated bowl</u> <u>spouted w/</u> <u>water + sugar-free drink.</u> <u>regular spoon</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>chronic dehydration, keto diet</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>E. coli infection, bowel obstruction s</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>oral, whole, soft foods, may cut.</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support, female staff when available, stand pivot</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>gait trainer</u> <u>wheel chair, headrest, pelvic strap</u> <u>seat belt, seat belt, shoulder straps</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Provide supervision, physical support</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>NO alone time.</u>
Important to:	<u>1:1 interaction with upbeat staff, music. Time out of chair</u>
Important for:	<u>offer drinks frequently</u> <u>3x week use gait trainer</u>
Likes:	<u>music, hugs, 1:1 sensory time with staff.</u>
Dislikes:	<u>waiting, cold food or drink, being hungry or thirsty.</u>

Lead Review Completed: Justin Barry

Staff: Lisa Hartman
 Date: 2-1-22



Service Recipient: Juniper Softblow
 Service Span: Jan 20 - Jan 23

Outcomes:

Outcome #1: <u>Daily choose a staff to assist chosen sensory activity.</u>
Summarize Steps: <u>3 sensory activities presented - time to respond, present 3 staff choices to help follow thru</u>
Outcome #2: <u>Monthly choose a community integration trip to participate in.</u>
Summarize Steps: <u>pick card options - is interested, time to respond follow thru</u>
Communication Style: <u>facial exp, vocal, body language, smart NO, Tah, Yes</u> <u>Eye gazing, push things away</u>
Learning Style: <u>repetition, upbeat & physical cues</u> <u>routine</u>

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>NKA</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>partial control tonic/clonic - dehydrate & cluster 1-20 sec shw</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>small bites of food drinks pockets food</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Keto genic from home tho & sugar free ^{blowing} warm food - sported cup, insulated ^{good} bowl</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>dehydration by lab infection DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</u> <u>bowel obstructions Ketodiet</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>oral cat as tol. & keto celt & food</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>brief, 1 staff pivot full female support &</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>w/c head vest, foot rest, seat belt chest strap assist mobility quit trainer & posey delt mat table - side rail up ^{when staff direct contact}</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>physical/supervision</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical Visual impairment peripheral vision</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>NA</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>0 time alone</u>
Important to:	<u>meaningful 1:1 interactions time out of chair music</u>
Important for:	<u>frequent fluids being social quit trainer x 3 wk</u>
Likes:	<u>music 1:1 sensory time giving hugs</u>
Dislikes:	<u>hungry/thirsty cold food/drink waiting for things</u>

Lead Review Completed: Justin Young

Staff: Amanda Diaz
 Date: 02/01/2022



Service Recipient: Jenny Lofboom
 Service Span: July 2021 - Feb 2022
 2022 2023

Outcomes:

Outcome #1: Daily, Jenny will choose a staff to assist her in chosen sensory
 Summarize Steps: Present ^{sensory} 3 choices

Outcome #2: Monthly, Jenny will choose a community integration trip
 Summarize Steps: staff will show & describe outing

Communication Style: yes NO
Body language, Ta, niff, eye gazing, reaching pushing

Learning Style: Physical cues
routine with someone who has upbeat tone of voice

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>NA</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled tonic-clonic seizure (dehydration)</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>She will open mouth when ready to eat or drink</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full assistance, warm food & drink</u> <u>Ketogenic sent from home, spouted cup</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, chronic ear infections</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>Oral medication</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support, briefs, 1 person pivot transfer</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>gait trainer</u> <u>Wheelchair: head rest, chest strap, lap ^{strap} strap, gait-belt</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff will provide supervision</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>NA</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No time alone</u>
Important to: <u>meaningful 1:1, reciever time, music, gait trainer</u>	
Important for: <u>offered fluids, 3 times weekly gait-trainer-hugs</u>	
Likes: <u>waiting, cold food or drinks, hugs</u>	
Dislikes: <u>waiting, cold food/drinks</u>	

PEEK!

Lead Review Completed: Justin Walsh

Staff: Sara B
 Date: 2/4/2022



Service Recipient: Jenny
 Service Span: Jan. 22 - Jan. 23

Outcomes:

Outcome #1: <u>Only Jenny will choose staff to assist in sensory</u>
Summarize Steps: <u>3 sensory activities review each option 1 by 1 allow the to respond. present 3 staff to assist with activity. review 1 by 1 give time to response.</u>
Outcome #2: <u>monthly Jenny will choose a community</u>
Summarize Steps: <u>trip to go to describe community outing cards ask 1 by 1 allow time to response</u>
Communication Style: <u>Facial expressions body language "Tah" for yes "Nah" for no, eye gazing reaching & pushing away.</u>
Learning Style: <u>Routine & repetition regards best to upbeat tone of voice paired with physical cues.</u>

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>per Haley control tonic-clonic seizures. frequent tonic clonic pattern unless dehydrated. 1-2 sec clusters may last 1-4 min eye rolling arms go up "drop"</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>open mouth when ready for a bite too much food or water will spit out. small drinks before bites to prevent pocketing food.</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Keto diet sent from home. water sugar free flavoring. full assistance. warm spiced cup veg spread. insulalief bowl</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>chronic dehydration support DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes drinking ear infection cover ears outside history of bowel obstructions Pyruvate D-hydroxyphenyl support keto diet.</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>orally whole or cut up in soft food. keto PD w/ lunch here family.</u>
Personal Cares: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full support female staff, briefs. many lightweight transfer one staff pivot 2 staff never basket sun bread down communicated to home.</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>headrest foot rest chest strap pelvic straps & seat belt mat table raise wheel be up chest properly. wheel chair apply & remove safety belts 2 staff seat transfer.</u>
Community Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Support visit & physical support for whole community.</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical visual impairment sees best peripherally</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>NO time alone</u>
Important to:	<u>meaningful 1:1 upbeat staff outside of her chair music</u>
Important for:	<u>friends support to be social & to do activities with others good trainer 3 times</u>
Likes:	<u>music 1:1 sensory time & hugs</u>
Dislikes:	<u>waiting, cold food or drink being hungry/thirsty</u>

Lead Review Completed: Erin Young

Staff: Jahysa Pratt

Date: 2-1-2022



Service Recipient: Jenny Lofboom

Service Span: Jan 22 - Dec 22
Jan. 23

Outcomes:

Outcome #1: <u>Jenny will choose a staff to assist her in a chosen</u> Summarize Steps: <u>Present 3 sensory activities</u> sensory
Outcome #2: <u>Monthly Jenny will choose a intergration activity.</u> Summarize Steps: <u>show and describe intergration choice cards</u>
Communication Style: <u>Face expression, vocalization, Ta noise for "yes" and a Nff for "no"</u>
Learning Style: <u>Routine + repetition</u>

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>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Partially controlled seizures. Drop seizures 1-20 secs. When dehydrated.</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Open her mouth base for Food. spippy cup</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Drink mix comes from home. Insulated spoon. Keto diet. Full assist.</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, DNR/DNI: <input type="checkbox"/> No <input type="checkbox"/> Yes bowel obstruction. Chronic ear</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Takes orally, keto diet. small cut up ^{meds} in food.</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support. Female staff when available</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full assist. when propelling a wheel chair. ^{posy belt} engaged when on ^{mat} gait trainer. side bar</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Provide full support.</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Visual Impairment. Cortical</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>/// No time alone.</u>
Important to: <u>MUSIC</u>	<u>1:1 interaction w/ upbeat staff. Outside her chair</u>
Important for: <u>Using her gait trainer</u>	
Likes: <u>Hugs, music, 1:1 interaction</u>	
Dislikes: <u>Cold food/drinks. Being hungry</u>	

Lead Review Completed: Faithen Tracy

Staff: Emily Eldenpeter
 Date: 2.1.2022



Service Recipient: Jan 2022 - Jan 2023
 Service Span: Jenny Lofboom

Outcomes:

Outcome #1: Daily choose staff to assist in chosen sensory activity Summarize Steps: Present 3 activities, review option 1 by 1 allow time to respond, 3 sensory activities, review option 1 by 1 allow time, follow through
Outcome #2: Monthly, choose community trip to participate in. Summarize Steps: Show & describe community trip-cards, ask 1 by 1, allow time to respond y/n, follow through
Communication Style: facial expressions, body language, vocalizations Tah-Yes Nff-no, eye gazing, reaching/pushing
Learning Style: Routine & repetition, upbeat staff with physical cues

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes <u>N/A</u>	List & Describe Supports: <u>No known allergies</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled tonic seizures. No pattern unless dehydrated, 1-4 min. eyes roll back, arms up, body drop</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Open mouth for food - if too much food/drink - spit out small drinks to prevent pocketing</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet Water w/ sugar free flavoring. Full assistance Warm food/drink or will pocket. Spouted cup regular spoon</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration - encourage & support DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes drinking history of ear infections - cover ears out Bowel obstructions - report BM home. Pyruvate dehydrogenase keto diet</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Orally whole or cut in soft food Ketocal as lunch</u>
Personal Cares: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support female staff - Anulaku. Briefs, bear weight 1 staff stand pivot or 2 reverse basket</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheelchair - headrest, footrest, chest straps, pelvic straps, seatbelt rail on mat engaged when no contact. Assistance propelling, something</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff provide supervision and physical support</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical visual impairment, sees best peripherally</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes <u>N/A</u>	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No alone time</u>
Important to: <u>Meaningful 1:1 w/ upbeat staff, time outside of chair, music</u>	
Important for: <u>Offered fluids, support in socialization, gait trainer</u>	
Likes: <u>music, 1:1, sensory, hugs</u>	
Dislikes: <u>waiting, cold food/drink, being hungry/thirsty</u>	

Lead Review Completed: Erin Bradley

Staff: Alfredo Fierro-Montes

Date: 2.1.22



Service Recipient: Jennifer Lofblom

Service Span: Jan. 2022 - Jan. 2023

Outcomes:

Outcome #1: Daily, Jennifer will choose a staff to assist her in a sensory activity.
Summarize Steps:

Present 3 activities, review each option w/her.

Outcome #2: Monthly, Jennifer will choose a community integration trip.
Summarize Steps:

Staff demonstrates community cards.

Communication Style:

Body language, "Ta", "Wiff", eye gazing.

Learning Style:

Routine + repetition, have upbeat tone of voice.

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled Clonie Tonic, "Drop seizures"</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Too much food/drink she will spit, "pockets food"</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Keto diet, full assistance, spouted cup.</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>Chronic Dehydration, Ear infection history,</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Takes meds in soft foods, keto diet</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Full support, utilizes briefs, 1-person pivot</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>wheelchair, chest straps, seatbelt, gait trainer w/belt</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff provide supervision</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Visual impairment.</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Always under supervision.</u>
Important to:	<u>1:1 interactions w/upbeat staff, music, time out of wheelchair</u>
Important for:	<u>Social, constant drink,</u>
Likes:	<u>music, 1:1 time, hugs</u>
Dislikes:	<u>waiting, hungry/thirsty, cold food/drink</u>

Lead Review Completed: Fanton berry

Staff: Tristen Lorsung

Date: 1/27/22



Service Recipient: Jennifer Lofboom

Service Span: January 2022-January 2023

Outcomes:

<p>Outcome #1: Daily, Jennifer will choose a staff to assist her in a chosen sensory activity.</p> <p>Summarize Steps: Present 3 sensory activities Go through each option 1 by 1 allow time to respond Present 3 staff to assist with sensory activities Go through each option 1 by 1 allow time to respond Follow through on choices</p>
<p>Outcome #2: Monthly, Jennifer will choose a community integration trip to participate in.</p> <p>Summarize Steps: Staff show and describe community integration cards Ask if she is interested with each option 1 by 1 Time to respond yes/no. Follow through on choice</p>
<p>Communication Style: Facial Expressions, body language, Vocalizations a "Tah" for yes and "Nff" for no, eye gazing, and reaching or pushing away.</p>
<p>Learning Style: Routine and repetition. Responds best when encouragement is delivered in an upbeat tone of voice paired with physical cues.</p>

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

<p>Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: No allergies. N/A</p>
<p>Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Partially controlled Clonic Tonic seizures. Infrequent, don't follow a pattern unless dehydrated. Clusters of 1-20 seconds and may last 1-4 minutes. Present as eyes rolling back, tongue may protrude, arms may go up, snore sound after, and "drop" forward or to the side. Seizure protocol.</p>
<p>Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Will open mouth when ready for another bite. If too much food/drink she will spit it out. She is accepting of small drinks between bites of food to prevent pocketing food.</p>
<p>Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Ketogenic diet, sent from home. Water with sugar free flavoring. Full assistance in eating/drinking. Her food/drink are kept warm for if it is too cool, she will pocket it instead. Spouted cup, regular spoon, insulated bowl for temp control</p>
<p>Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: Chronic dehydration-encourage and support in drinking, history of ear infections-cover ears outside, history of bowel obstruction-report BM's, Pyruvate Dehydrogenase-supported in keto diet DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Takes her medication orally whole or cut as tolerated in soft food. Jenny currently takes Ketocal PO with lunch per family request for supplement.</p>
<p>Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Receives full support. Female staff when available. Utilizes briefs. May bear some weight and is transferred by one staff stand pivot or two staff reverse basket to mat table. Skin breakdown communicated to home.</p>
<p>Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Uses wheelchair with support of a headrest, footrests, chest straps, pelvic straps, and a seatbelt. When using mat table, rail will be engaged whenever there is no staff direct contact. Assisted in propelling her wheelchair, applying, and removing safety straps and breaks. Gait trainer with two staff while wearing a posey belt.</p>
<p>Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Staff provide supervision and physical support to her while in the community.</p>
<p>Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: Cortical Visual Impairment sees best peripherally.</p>
<p>Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: N/A</p>
<p>Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: No time alone.</p>

Lead Review Completed: *Tristen Lorsung*

Staff: Kathy Perry
 Date: 2-1-22



Service Recipient: Jennifer Lobb
 Service Span: Jan 2021 - 2023

Outcomes:

<p>Outcome #1: Will choose a staff to assist in a chosen sensory act</p> <p>Summarize Steps: Present 3 sensory act, review each option 1 by 1. allow time to respond. Present 3 staff choices to assist</p>
<p>Outcome #2: Monthly will choose Comm. trip</p> <p>Summarize Steps: Show & describe Comm. integration cards ask if 'ah-yes' 'uh-no' ask if interested in each item. allow time to respond</p>
<p>Communication Style: facial expressions, vocalizations, body language eye gazing reaching or pushing away</p>
<p>Learning Style: Routine repetition Deliver Deliver encouragement in upbeat tone & physical cues</p>

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

<p>Allergies: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes</p>	<p>List & Describe Supports: N/A</p>
<p>Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: partially controlled tonic/clonic more when dehydrated.</p>
<p>Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: will open mouth. accepting of small drinks to ↓ pocketing of too much food will spit out</p>
<p>Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: ketogenic diet water & flavouring, warm everything, spouted cup</p>
<p>Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: chronic dehydration, hx of ear infections, hx bowel obstruction DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: takes whole or cut in soft foods</p>
<p>Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: full support, briefs - female when able</p>
<p>Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: w/c headrest, chest strap, pelvic strap, seat belt Dax harness & transfer belt + 2 staff, assist & N/C</p>
<p>Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Supervision & physical support</p>
<p>Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: vision impairment - sees best peripherally</p>
<p>Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: N/A</p>
<p>Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: none</p>
<p>Important to: Meaningful 1:1 interactions Time out of chair. Music</p>	
<p>Important for: offer fluids frequently. Dax harness at least 3x wk be social & engaged in act.</p>	
<p>Likes: Music, 1:1, sensory hugs</p>	
<p>Dislikes: waiting, cold food or drink Being hungry or thirsty</p>	

Staff: Mari
 Date: 2/1/22



Service Recipient: Jenny
 Service Span: 1/22 ~ 1/23

Outcomes:

Outcome #1: <u>Daily, Jenny will choose staff to assist her in sensory activity.</u> Summarize Steps: <u>Present three staff and allow options for activity</u>
Outcome #2: <u>Monthly Jennifer will choose to go on an outing.</u> Summarize Steps: <u>Staff will offer options for outings & honor choice</u>
Communication Style: <u>"uhf" for no, eye gazing, "tah" for yes</u>
Learning Style: <u>repetition, routine, upbeat staff</u>

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>partially controlled tonic clonic seizures.</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>will open mouth for food, given small amounts due to producing</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet, flavored sugar free water, heat up</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration, ear infections, bad constipation, Keto diet</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>takes orally on-in satiford, Ketocal</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>reduces full support - transferred to mat table</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses wheelchair w/ support of chest straps, pelvic strap and gait belt ^{gait} belt ^{belt}</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff will provide supervision & physical support</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no time</u>
Important to: <u>meaningful 1:1, upbeat staff, recliner time, music</u>	
Important for: <u>offered fluids frequently, uses gait trainer 3x weekly</u>	
Likes: <u>hugs sensory, justin timberlike</u>	
Dislikes: <u>waiting, cold food & drinks, being hungry</u>	

Lead Review Completed: Justin Weary

Staff: TYLER BONGARD

Date: 2/1/2022



Service Recipient: JENNY LOFBOOM

Service Span: 1/22 - 1/23

Outcomes:

Outcome #1: DAILY, SHE WILL CHOOSE STAFF TO HELP HER w/ A SENSORY ACTIVITY
 Summarize Steps: PRESENT STAFF CHOICE BOARD ON IPAD

Outcome #2: MONTHLY, SHE WILL CHOOSE A COMMUNITY INTEGRATION ACTIVITY TO
 Summarize Steps: PARTICIPATE IN
 GIVE OPTIONS w/ COMMUNITY INTEGRATION ACTIVITY FLASHCARDS

Communication Style: FACIAL EXPRESSION, VOCALIZATIONS - AH-TAH = YES
 PUSHING/PULLING OBJECTS - BLOWING THROUGH NOSE = NO

Learning Style: REPETITION/ROUTINE, UPBEAT STAFF

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes NA	List & Describe Supports:
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: PARTIALLY CONTROLLED TONIC-CLONIC SEIZURES - MORE SEIZURES WHEN DEHYDRATED
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: ACCEPTS SMALL DRINKS BETWEEN BITES
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: KETO-CAL, FULL ASSISTANCE, WARMED FOOD/DRINK, SPOURED CUP
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: CHRONIC DEHYDRATION, BOWEL OBSTRUCTIONS, NEEDS EARS COVERED WHEN OUTSIDE (HISTORY OF EAR INFECTIONS) 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: KETO CAL FOR LUNCH
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: BRIEFS, FEMALE STAFF WHEN POSSIBLE
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: ASSISTED IN ATTACHING BELTS/STRAPS ON CHAIR, MAT TABLE SIDE PUT UP (IF NEEDED, WHILE ASSISTING w/ CARES)
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: PROVIDED SUPERVISION IN COMMUNITY/IN PROGRAM
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: HAS VISUAL IMPAIRMENT
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes NA	List & Describe Supports:
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: NO ALONE TIME
Important to:	MEANINGFUL 1:1 TIME w/ UPBEAT STAFF, MUSIC, BEING AT HER CHAIR
Important for:	BEING SOCIAL/ENGAGED, GETTING ENOUGH FLUIDS, GAIT TRAINING 3x WEEK
Likes:	HUGS, SENSORY, MUSIC
Dislikes:	COLD FOOD/DRINKS, WAITING, BEING HUNGRY/THIRSTY

Lead Review Completed: *Tristen Garcia*

Staff: Dob & Martin
 Date: 2/1/2020



Service Recipient: Jennifer LaLoun
 Service Span: _____

Outcomes:

Outcome #1: Daily Jennifer will choose a staff to connect her in a chosen.
 Summarize Steps: sensory activity.
 - Present 3 sensory activities review each one by one 2-3 min time to respond. Present 3 staff ~~choices~~ to assist w/ sensory activities, review by alternation tip.

Outcome #2: Monthly Jennifer will choose a community activity.
 Summarize Steps: staff show

Communication Style: Facial expressions, body language. Vocalizations a "Tah" for yes and "off" for no. goeing reaching & pushing away.

Learning Style: Routine & repetition responds best w/ encouragement is delivered in upbeat tone of voice paired w/ physical cues.

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

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>na</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>partially controlled chronic/chronic.</u> <u>Dehydration - 1-20 seconds clusters 1-4 min. Eyes</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>may pocket food - too much will spit out - accepting of small drinks between bites</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic diet from home - water w/ sugar free food warm not cool (pocketing) Spouted cup - no sippy</u>
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Chronic dehydration - ear infections - bowel obstructions</u> <u>Renalate Dehydrogenase (supp)</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>crabby, whole or cut as tolerated - Ketocat PO w/ lunch per family</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>full support - female support when available</u> <u>Skin breakdown communicated to home</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheelchair - headrest, footrests, short straps, pelvic straps, Satchel -</u> <u>Wrist engaged on mad table, Gait trainer w/ proxy strap</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff provide supervision</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Cortical visual impairment - sees best peripherally</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>na</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no time alone</u>
Important to:	<u>Meaningful 1:1 interactions w/ upstart staff - time out side of chair -</u> <u>gait trainer, recliner, Justin Lumbertake</u>
Important for:	<u>gait trainer 3x weekly, offered fluids frequently, had support to be</u> <u>social & engaged w/ others in activity</u>
Likes:	<u>music - 1:1 sensory time - hugs</u>
Dislikes:	<u>waiting, cold food water being hungry or thirsty</u>

Lead Review Completed: Justin Lumbertake

Staff: Shelly
 Date: 2.1.22



Service Recipient: Jenny
 Service Span: 1/22 - 1/23

Outcomes:

Outcome #1: Choose Staff to Assist in Sensory Activities
 Summarize Steps: present activities Respond
1:1 - Follow Arrow

Outcome #2: Choose Community outings
 Summarize Steps: Show pic card give time to respond
ask if interested

Communication Style:
Facial, body lang. Cough, sniff, reaching

Learning Style:
Routine/Repetition encourage (yes) her (no)

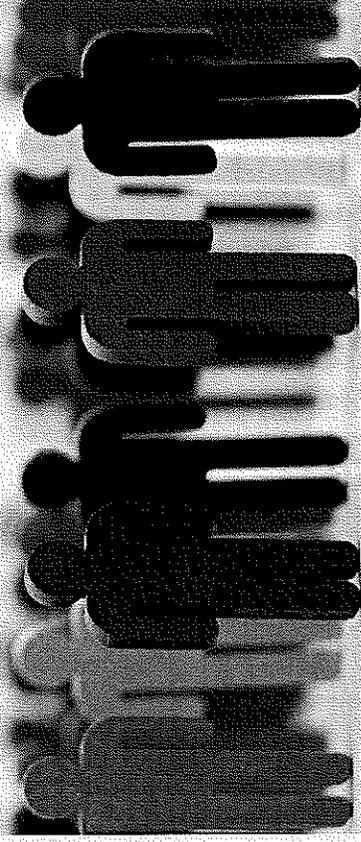
Is this person able to self-manage according to the IAPP, SMA & CSSPA – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Partially controlled tonic clonic</u>
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>open when ready, will spit out, small drinks between bites</u>
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Ketogenic sent from home, full assistance - water</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>dehydration, ear infections, bowel ob., keto diet</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>oral drally, soft foods</u>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Female staff, Diets, staff support, skin-breakdowns</u>
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>wheelchair, all straps, mat table - support by staff</u>
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Staff supervise</u>
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>visual impairment</u>
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>N/A</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>always under supervision</u>
Important to:	<u>1:1 staff, outside of chair, music, J.T.</u>
Important for:	<u>offered foods frequently, gait trainer -</u>
Likes:	<u>Music 1:1 sensory time hugs</u>
Dislikes:	<u>waiting for things, being hungry or thirsty</u>

Lead Review Completed: Justin Brady

**PAI-
Linden/Oakdale
Team Meeting**

2/1/2022



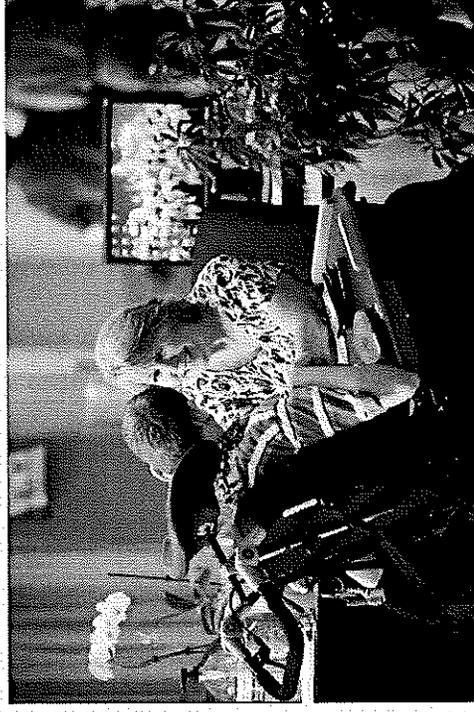


Agenda

- Welcome
 - Site-Specific Updates
 - Employee Handbook Review
 - Competency Reviews
 - Semi-Annual
 - Wrap Up
-

Site-Specific Updates

February Trainings
STAR LMS - Professional Development - Epilepsy & Seizure Disorders
STAR LMS - Professional Development - Communication Skills
On-site Specific Individual Participant Semi/Annual Documents



Competency Reviews

Jennifer (Jenny) Lofboom

Outcome #1: Daily, Jennifer will choose a staff to assist her in a chosen sensory activity.

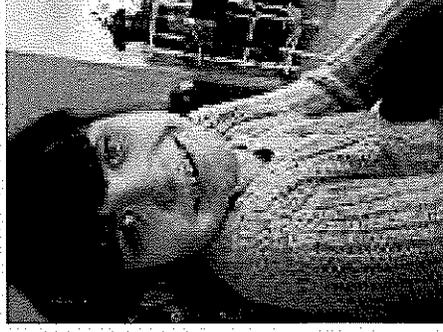
Summarize Steps: Present 3 sensory activities, review each option 1 by 1 allow time to respond, Present 3 staff to assist with sensory activities, review each option 1 by 1 allow time to respond, follow through on choices.

Outcome #2: Monthly, Jennifer will choose a community integration trip to participate in.

Summarize Steps: Staff show and describe community integration cards, ask if she is interested with each option 1 by 1, allow time to respond yes/no, follow through on choice.

Communication Style: Facial Expressions, body language, Vocalizations a "Tah" for yes and "Nff" for no, eye gazing, and reaching or pushing away.

Learning Style: Routine and repetition. Responds best when encouragement is delivered in an upbeat tone of voice paired with physical cues.



Competency Reviews

<p>Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>List & Describe Supports: Chronic dehydration-encourage and support in drinking, history of ear infections-cover ears outside, history of bowel obstruction-report BM's, Pyruvate Dehydrogenase-supported in keto diet</p> <p style="text-align: right;">DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Takes her medication orally whole or cut as tolerated in soft food. Jenny currently takes Ketocal PO with lunch per family request for supplement.</p>
<p>Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Full support, female staff when available, briefs. May bear some weight and is transferred by one staff stand pivot or two staff reverse basket to mat table. Skin breakdown communicated to home.</p>
<p>Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Describe Supports: Uses wheelchair with support of a headrest, footrests, chest straps, pelvic straps, and a seatbelt. When using mat table, rail will be engaged whenever there is no staff direct contact. Assisted in propelling her wheelchair, applying, and removing safety straps and breaks. Gait trainer with two staff while wearing a posey belt.</p>



Competency Reviews

Important to: Meaningful 1:1 interactions with upbeat staff, being able to have time outside of her chair (recliner and gait trainer), and music.

Important for: Be offered fluids frequently, have support to be social and engaged in activity with others, and that she uses her gait trainer minimum of 3 times weekly.

Likes: Listening to music, 1:1 sensory time, and hugs.

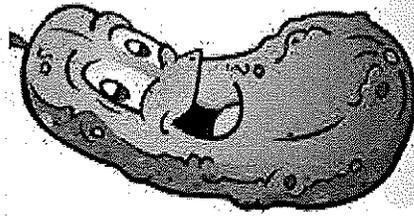
Dislikes: Waiting for things, cold food/drink, and being hungry/thirsty.



Gratitude

Jenny

Lisa



We'd be in a
PICKLE
without you!

Thank you for all of your hard
work and dedication.