

STAFF ORIENTATION TRAINING PLAN - PERSON SPECIFIC

Staff name: Shelly Niwaa
 Date of background study submission:
 Ongoing annual training period:
 Date of first supervised contact:

Date of hire: 1-24-2022
 Date of background study clearance:
 Date of first unsupervised contact:

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

Initials of person(s) served:

TC, SF, TH, MH, KJ, SK, RM, KS, TR, DS, DW

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
CPR, if required by the CSSP or CSSP Addendum	<u>2.4.2022</u>	<u>Course</u>	<u>5.5</u>	<u>Health Counseling</u>
CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person	<u>1.27.2022</u>	<u>COMP QUIZ</u>	<u>5.5</u>	<u>N/A</u>
Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans	<u>1.27.2022</u>	<u>COMP QUIZ</u>	<u>5.5</u>	<u>N/A</u>
Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person	<u>3.2.2022</u>	<u>Demonstrated</u>	<u>.5</u>	<u>Toni Anderson, RN</u>

Handwritten notes:
 on other
 2/11/22
 2/11/22

The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative	N/A	N/A	N/A	N/A
Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness	1-27-2022	COMP quiz	S.S	N/A
Other topics as determined necessary according to the person's <i>Coordinated Service and Support Plan</i> or identified by the company: Topic: Topic: Topic:	N/A	N/A	N/A	N/A

Sully Viced.
Staff signature

03-14-2022
Date

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

Staff: Shelly Nierad

Date: 01.26.2022



Service Recipient: Theresa Casey

Service Span: 2/11/13 →
(Terri)

Outcomes:

Outcome #1: <u>Identify Emotion Daily using Ipad 80% trials over next 12 mths.</u> Summarize Steps: <u>Identify appropriate emotion on an Ipad</u>
Outcome #2: <u>Choose someone to sit by during Activity 80% trials next 12 mths</u> Summarize Steps: <u>To socialize with peers, choosing who she wants to spend time with by communicating + advocating for self.</u>
Communication Style: <u>Vocalizing, Ipad, Smart Board</u>
Learning Style: <u>Vocalizing & Technology</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 checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Terri has Angioedema - histamine build up. Rapid swelling or itching. Airway may become obstructed - Give Benedryl or Antihistamine</u>
Seizures: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Follow seizure protocol</u>
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Dysphagia - Swallowing difficulties, Strong bite reflex</u>
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Soft bite sized diet, firm meat, thin liquids - sits at 30° angle</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Cerebral palsy spastic Quadriplegia, Femoral Osteotomy, Left hip dysplasia, scoliosis w/ Harrington Rods, Dysphagia, constipation, urine & bowel retention.</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Piazepam, 2 prns - Tylenol or diphenhydramine</u>
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full Support</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>2 people transfer, wheelchair</u>
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Staff provide supervision & support</u>
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Give Terri plenty time to focus.</u>
Behavior Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Some SIB - scratching skin to bleed. Redirect her.</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>
Important to:	<u>Know her & her communication well, include in activities & engage w/ peers. Humor in her daily life</u>
Important for:	<u>Know her & communication well. include in activities & engage w/ peers, sense of humor, encourage her to eat.</u>
Likes:	<u>Socializing, activities, outings, animals, being sung to. Joke, wig, sensory massages, hairbrushes.</u>
Dislikes:	<u>doesn't get enough attention. or doesn't say hi when entering room. pain - hip & teeth. emotional music, getting bored</u>

Staff: Shelly Nierad

Date: 01.26.2022



Service Recipient: Sara Felling

Service Span: 6/3/2008 ->

Outcomes:

Outcome #1: Visit another program Room 80% trials until next review

Summarize Steps:

let her choose who she wants to visit

Outcome #2: Use switches during lunchtime 80% trials until next review

Summarize Steps:

Use switches to strengthen communication & advocacy

Communication Style:

Switches & technology

Learning Style:

Interactions, Sensory, Playing wii

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

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: KNA
Seizures: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: partially controlled tonic-clonic tonic seizures follow protocol
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: bite sized foods pockets food in cheeks.
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Bite sized food, regular utensils, sports bottle Drink
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: Congenital lack of Myelin, microcephaly DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Seizure med, Boost Supp. Lif eats >75%
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: full support of personal cares, briefs;
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: ambulatory-wears helmet, transfer belt, or hold hand, may require 2 people or hoist lift
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Staff provide full supervision & support.
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: Place objects close to eyes, assisted w/ walking, quit belt, hand.
Behavior Support: <input checked="" 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: N/A
Important to:	Family, hugs, comfy place to rest, preferred foods/beverages, hair brushing, walk & 1:1 time.
Important for:	drinking, brushing teeth, taking meds, engage in activities with others.
Likes:	hugs, ranch dressing, sandwiches, music, 1:1 time, music, sunny place
Dislikes:	having to wait, dislikes taking meds, having seizures, being ill brushing teeth.

Lead Review Completed: _____

Outcome 3 - work with staff to wipe face after lunch.

Staff: Shelly Nierad
 Date: 01-26-2022



Service Recipient: Tyrel Horning
 Service Span: 9/15/2003 ->

Outcomes:

Outcome #1: Answer yes or no using Adaptive Signs 95% trials next 12 months.
 Summarize Steps:
 use yes/no adaptive signs - try getting him to trust more people/staff

Outcome #2: Plan Group experiences using yes/no adaptive signs. 80% trials - 12 mths.
 Summarize Steps:
 Explore new areas of interest. allow time to watch activities before deciding if he chooses to participate.

Communication Style:
 Adaptive Signs, iPad (music) (games) Painting, eye direction.
Learning Style:
 eye pointing, Signs, Vocalization.

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

Allergies: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: Augmentin, Latex, Morphine, Red etc.
Seizures: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: follow seizure protocol
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Nothing by Mouth - use g-tube
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: fluids via G-J-tube
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: Dandy Walker Syndrome, Constipation, hip flexor spasms, Hydrocephalus w/ shunt, Mod. Intellectual Disability, Pressure Ulcer DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Per G-tube
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Disposable Brief, Full support needed.
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Shoulder straps, waist belt, lap tray. full physical assistance
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Staff provide full physical support & supervision.
Sensory Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports:
Behavior Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: SIB - bites hand, bangs head, can bite/hit staff, yelling
Unsupervised Time: <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: if needed for calming or less stimuli
Important to:	express preferences & comm is honored, relax & nap, people watch, books/movies.
Important for:	provided w/ options & encourage use of his communication.
Likes:	van rides, fun patient staff, books, bowling exploding science experiments. Rest.
Dislikes:	having to wait, doesn't like picture taken, hates center of attention.

Staff: Shelly Nicrad
 Date: 01.26.2022



Service Recipient: Marv Jo Huberty
 Service Span: 11.28.16 →

Outcomes:

Outcome #1: Choose Sensory Activity to participate in 75% next 6 months.
 Summarize Steps:
Choose Activity.

Outcome #2: Use gait trainer 75% next 6 months.
 Summarize Steps:
walk with her using gait trainer.

Communication Style:
verbal, technology

Learning Style:
choosing and use of technology

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>NKA - sensitive to 2nd hand smoke, latex band-aids, gloves.</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No</u>
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Does not have teeth, pockets food</u>
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Pureed w/ honey thickened liquids.</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Anemia, GERD, constipation/Bowel obstruction</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>Stroke, BP protocol in place, ventral hernia, Ear infections.</u>
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>w/ pudding or Applesauce - Pill Crashed.</u>
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>bracts, uses toilet when transferred to it - do not leave alone</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>wheelchair, chest strap, pushes self out of chair, assist in transfers.</u>
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full support & supervision</u>
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>approach f/ left side, tactile cues, weighted blankets,</u>
Behavior Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety issues.</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports:
Important to: <u>relationships w/ family/friends. talking & being in presence of other people. Swing & garden.</u>	
Important for: <u>Repositioned often, active & walking daily, brief in analts ASAP beverages throughout the day.</u>	
Likes: <u>princes, Jo-Jo, MJ, Disney movies, music, hogs, bowling, shopping, butters apple.</u>	
Dislikes: <u>larvae groups, sit in same position for periods of time, tuna & Peanut Butter.</u>	

Staff: Shelly Nierad

Date: 01-27-2022



Service Recipient: Kay Juske

Service Span: 7/8/2019-7

Outcomes:

Outcome #1: <u>Appropriate Boundaries 2 or less prompts 80% - 12 months.</u>
Summarize Steps: <u>Verbally redirect.</u>
Outcome #2: <u>Participate in Chosen Activity.</u>
Summarize Steps: <u>Loves to sign up but loses motivation when time comes. Verbally redirect her</u>
Communication Style: <u>Verbal</u>
Learning Style: <u>Visual, Verbal, Technology</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:
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports:
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Can eat too quickly though.</u>
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>has type 2 diabetes. (Doesn't say)</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Edema, Intellectual Disability, Type 2 Diabetes.</u> DNR/DNI: <input type="checkbox"/> No <input type="checkbox"/> Yes
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Takes whole w/ Beverage.</u>
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Disposable Brief, usually Independent - Some Assist needed</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>History of falls, - needs verbal reminders.</u>
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full Supervision</u>
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Hearing Aids, visually impaired - Glasses - may need prompts</u>
Behavior Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Physical & verbally - Redirection needed - like to "Joke"</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>—</u>
Important to: <u>her brothers, socialize and joke with others. Also likes to have her own quiet time, and 1:1 conversations.</u>	
Important for: <u>maintain Boundaries, give her opportunities to discuss how she is feeling.</u>	
Likes: <u>Joke Around, go for walks, Gardening, taking care of plants. stay active and go for bike rides.</u>	
Dislikes: <u>Being Rushed</u>	

Staff: Shelly Nierad
 Date: 01.27.2022



Service Recipient: Sue Kazmierczak
 Service Span: 06/04/2018 →

Outcomes:

Outcome #1: <u>use picture cards to choose peer to greet while in gait trainer. 85% - 6 mths.</u> Summarize Steps: <u>let her decide and follow through by helping her.</u>
Outcome #2: <u>Place shirt protector in laundry bin after lunch. 85% - 6 mths.</u> Summarize Steps: <u>Shows sense of accomplishment in completing task - uses skills needed to be independent</u>
Communication Style: <u>Verbal.</u>
Learning Style: <u>Socializing and doing.</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 checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Amoxicillin</u>
Seizures: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Breakthrough Seizures - Follow Protocol 15sec to 1.5 min</u>
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Bite size diet</u>
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>bite size - may require assistance.</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>UTI, Spas., cerebral palsy, GERD, Urine Retention/Bladder Spasms. Uses bricks occasionally</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>- Does have history of gallstones</u>
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full support</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>uses wheelchair, can walk w/ gait trainer, safety straps on wlk.</u>
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full supervision & support</u>
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>VISION impaired - hates glasses.</u>
Behavior Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Full supervision, No SIB's noted.</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>
Important to: <u>family, socializing, walking, swimming, participating in activities.</u>	
Important for: <u>Stay healthy & well, communicate her wants & needs.</u>	
Likes: <u>walkins, swimming, cheeseburgers, family trips, coloring, jokes, puzzles. Likes to try new things - singing & dancing.</u>	
Dislikes: <u>loud noises, hungry, ill, tired, in pain. seizure pain, or not being included.</u>	

Staff: Shelly Nierand
 Date: 01-27-2022



Service Recipient: Rick Mitchell
 Service Span: 7/27/2009-

Outcomes:

Outcome #1: <u>Make Group Choices</u> <u>80% in 12 mts.</u>
Summarize Steps: <u>give verbal description, let him choose</u>
Outcome #2: <u>Communicate wants & needs.</u>
Summarize Steps: <u>let him to communicate w/o flailing arms, screaming or kick kicking his legs.</u>
Communication Style: <u>Non-verbal - can use technology</u>
Learning Style:

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

Allergies: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Latex, Keppra, Kiwi fruit</u>
Seizures: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Follow Protocol</u>
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Does not use teeth effectively</u>
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>pureed diet w/ thickened liquids.</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Scoliosis, Spastic Quad.</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full Support</u>
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full Support</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Wheelchair, can scoot himself along floor.</u>
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full Supervision & support.</u>
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>tactile defensive, legally blind, not like having feet/body off ground</u>
Behavior Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Verbal cues, sib's, high pitch when upset. Hit or bump other WC.</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports:
Important to: <u>personal space, transition time, preferred Manipulatives. food & beverages.</u>	
Important for: <u>Communicate in safe manner, bear weight & cont. walking.</u>	
Likes: <u>tactile / auditory sensory - Massagers, keyboards, bowling, food out,</u>	
Dislikes: <u>disorganization - needs routine, getting cleaned up after lunch or during cares-</u>	

Staff: Shelly Nierad
 Date: 01-27-2022



Service Recipient: Katie Sauter
 Service Span: 6/19/2006 →

Outcomes:

Outcome #1: use iPad to answer YES/NO questions
 Summarize Steps:
ASK questions, she uses iPad to answer.

Outcome #2: walk w/ staff member
 Summarize Steps:
Katie will choose who she wants to go on walk with.

Communication Style:
IPad. - Non-verbally

Learning Style:
Visual. ~~Verbal~~ technology.

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

Allergies: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Dust, Mold, Morphine, Seasonal.</u>
Seizures: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Follow seizure protocol.</u>
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>bite sized pieces - Monitor while eating.</u>
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Physician ordered, nutrition by 6-10 PRN</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Polymyalgia Rheumatica, Scoliosis, Sever ID, Thrombocytopenia</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full support.</u>
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>disposable brief, full support</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Not able to walk w/o assistance. Full support & wheelchair</u>
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full support & supervision.</u>
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Alert to her surroundings.</u>
Behavior Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>SIBS - buzzing sound, biting her hand, hitting herself, crying.</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>—</u>
Important to: <u>Cozy, comfy & looking cute, good music, beads to spin, 1:1 attention.</u>	
Important for: <u>Drink fluids, keep hands out of mouth, use communication skills.</u>	
Likes: <u>Chocolate, milk or hot chocolate, m&M's. Sweets, PB & Mayo Sammies. Music & dance, Shopping for clothing, jewelry, hair Accessories and Snacks.</u>	
Dislikes: <u>big crowds, No music on, hair too tight, or waiting for something she wants or needs, being in WC too long, or being Willy, teeth, hair brushed</u>	

Staff: Shelly Nicrad

Date: 01.27.2022



Service Recipient: Tish Rogowski

Service Span: 3/8/21 →

Outcomes:

Outcome #1: Sign "Restroom" when needing cares 80% 12 mts.
Summarize Steps:
Use sign language

Outcome #2: Plan Activity for following week 80% 12 mts.
Summarize Steps:
Shows excitement to pick Activity, but doesn't always participate.

Communication Style:
Sign language, technology

Learning Style:
Sign language or pictures, technology.

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

Allergies: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Mosquitoes, Seasonal Allergies.</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Does have seizure like episodes.</u>
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Bite size pieces, mostly when consuming liquids. use thickit</u>
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>bite size, thickened liquids.</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>Anxiety, Cerebral Palsy, Neurogenic Bladder - Catheter</u>
Medication at PAI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>possible PRN's though.</u>
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Catheter - needs emptying, can be on toilet, wears briefs</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>uses wheelchair, can bear weight.</u>
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>full support & supervision.</u>
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Needs glasses,</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>NO SIB's indicated - verbal aggression.</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>N/A</u>
Important to: <u>Socializes w/ staff/friends/family, Music & Art.</u>	
Important for: <u>have time to respond, be patient w/ her, prompts shortly before a task. Staff know & honor her communication.</u>	
Likes: <u>music, walks, food, sleeping, signing, all painting, hugs, bowling, community,</u>	
Dislikes: <u>being bored, someone too close or close to her face.</u>	

Staff: Shelly Nierad

Date: 01-27-2022



Service Recipient: Destiny Smith

Service Span: 7/19/2017 ->

Outcomes:

Outcome #1: Clean up area after lunch 80% 12 mths.

Summarize Steps:
verbal cues

Outcome #2: Put blanket away 80% 12 mths.

Summarize Steps:
verbal cues

Communication Style:
verbal cues, sign.

Learning Style:
verbal, hands on, 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 checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Bee sting, Contrast Dye, Iodine, Iohexol</u>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>No</u>
Choking: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Cannot use back teeth to chew</u>
Specialized Diet: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Pureed - visually monitored, May eat slow</u>
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>Trisomy 9</u> DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>Aortic Valve disorder, Intellectual Disability, Osteoporosis, Scoliosis</u>
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>orally - liquid.</u>
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>independently uses toilet, needs help w/ menses & BM cleanup.</u>
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>walks independently, needs supervision & support</u>
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: <u>Full support & supervision.</u>
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: <u>hearing aids - Both Ears, use glasses to see - visually impaired.</u>
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>No SIB's</u>
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>—</u>

Important to: games, matching & sorting, being out in community, opportunities to be helpful, or tasks to do on own, pictures/books of parents.

Important for:
use communication skills, consume appropriate # of fluids.

Likes: Games, buttons or touchscreens, card games, sort & match, color, hair & makeup done

Dislikes: being told no, taking away pamphlets or picture books, large groups, tv, music, movies, dogs or anything that can put her off balance.

Staff: Shuly Nirad

Date: 01-27-2022



Service Recipient: Davis Wolf

Service Span: 6/3/19 ->

Outcomes:

Outcome #1: Use voice to communicate w/ Staff	70% 12 mts.
Summarize Steps: Use voice more often.	
Outcome #2: Choose 2 staff or peers to visit.	
Summarize Steps: Use voice.	
Communication Style: Verbal, reaching, move towards.	
Learning Style: Repetition, routine, verbal.	

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

Allergies: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: Vancomycin.
Seizures: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Absent & tonic seizures - Follow Protocol
Choking: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Independent - bite size pieces - may eat quickly.
Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: visually monitor eating.
Chronic Medical Conditions: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: DNR/DNI: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes F72 - Severely multiply impaired, physically Impaired. Seizures, DD.
Medication at PAI: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: offer on spoon with food - beverage to follow.
Personal Cares: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Brits - does not use toilet - Full care
Mobility/Fall Risk: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: due to seizures. Staff provide support for wc.
Community Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe Supports: Full support & supervision.
Sensory Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: Head - limit any touch.
Behavior Support: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	List & Describe Supports: SIB's - May hit himself in head, may throw items.
Unsupervised Time: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: N/A
Important to: participate in singing, music, coloring/drawing, Arts + crafts. time in community	
Important for: Communicate his needs, in safe appropriate way.	
Likes: friends, shopping, cartoons. Camp friendship	
Dislikes: people taking things away from him, hearing word no,	

OBSERVED SKILL ASSESSMENT

Name of staff member Shelly Nierad

The staff member has successfully demonstrated the ability to administer medications by the following routes, according to facility procedures:

Route	Date	Nurse Signature
Oral	<u>3/2/22</u>	<u>3/2 J Anderson RN</u>
Skin/topical	<u>3/2/22</u>	<u>J Anderson RN</u>
Ear drops	<u>3/2/22</u>	<u>J Anderson RN</u>
Eye drops	<u>3/2/22</u>	<u>J Anderson RN</u>
Buccal	<u>3/2/22</u>	<u>J Anderson RN</u>
Sublingual	<u>3/2/22</u>	<u>J Anderson RN</u>
Transdermal	_____	_____
Rectal	_____	_____
Vaginal	_____	_____
Inhaler	_____	_____
Nasal Spray	<u>3/2/22</u>	<u>J Anderson RN</u>
Gastrostomy	<u>3/2/22</u>	<u>J Anderson RN</u>
Subcutaneous Injection	_____	_____
Other	_____	_____
Other	_____	_____
Other	_____	_____

File in staff member's personnel file.

