

# ASSISTED LIVING PLAN

(Must be completed within 30 days of admission of Resident)

## Resident Information

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Date of this Plan \_\_\_\_\_

## Assisted Living Home Information

Address \_\_\_\_\_

City \_\_\_\_\_ State AK

Zip Code \_\_\_\_\_

Facility Contact \_\_\_\_\_

Facility Phone \_\_\_\_\_

## Resident Contacts

### Care Coordinator/Case Manager/Program Specialist

Name \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

Alt Telephone \_\_\_\_\_

### Legal Representative

Name \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

Alt Telephone \_\_\_\_\_

### Resident's Emergency Contact

Name \_\_\_\_\_

Agency \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

Alt Telephone \_\_\_\_\_

Resident Name \_\_\_\_\_

**Section 1 Resident Strengths/Limitations/Conditions/Diagnosis**

Primary Diagnosis

Secondary Diagnosis

Hospice/DNR/Comfort One

Wound Care

Physical Disabilities and Impairments that are Relevant to the Resident's Service Needs

Resident's Strengths/Abilities and Limitations in Performing the Activities of Daily Living

Resident Name \_\_\_\_\_

**Section 2 Resident Preferences**

Roommates

Living environment

Food

Recreational activities

Religious affiliation

Relationships/visitation with friends, family members, and other

Resident Name \_\_\_\_\_

**Section 3 Service Needs**

**Activities of Daily Living**

***Dressing***

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

***Eating***

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

***Walking/Ambulation/Transfers***

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

***Toileting***

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

***Hygiene/Bathing***

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Resident Name \_\_\_\_\_

## Medication and Health Services

Applicant requires the following assistance with medication, (check all that apply)

- No Assistance
- Reminder to take
- Reading Label
- Opening Bottle
- Observing the Self Administration of Medication
- Directing or guiding the hand of the resident as the self-administer medication
- Administration of Medication

If administration of medication is required describe the task

**If administration of medication is provided by staff attach special instructions, resident/representative permission, and delegation**

### Other Health services provided by the Home

Health Service	How it will be met

**If the health service requires a nurses delegation please attach**

Resident Name \_\_\_\_\_

## Instrumental Activities of Daily Living

### *Laundry*

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

### *Cleaning*

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

### *Food/Meals (include diet restrictions/needs)*

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

### *In Home Supervision (bed checks, turning schedule, type/frequency of monitoring)*

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

### *Wandering or Elopement Risk/Interventions*

Activity/Plan for Care	Frequency of Care/Assistance	Expected Outcome

Resident Name \_\_\_\_\_

Mental/Emotion Health Summary

Behavioral Health Interventions

**Use of Restraints**

(Includes bedrails, self-releasing safety belts, lap-top trays, wedge cushions, concave mattress).

Type	Frequency	Use	Safety

**If restrains are used Attach Physician's recommendations/orders**

Resident Name \_\_\_\_\_

Training for Independent Living

Legal Situation

Financial Assistance/Resident money Management Agreement

**If the home is assisting the resident with managing money attach the residential money management agreement and authorization.**

Transport/Escort Services

Day Care or Day Activities

Ability to Navigate Community Independently

Other Personal Assistance Needs

Resident Name \_\_\_\_\_



## Risk Assessment

The Resident (or the resident's guardian/representative) and the Home have identified the following risks associated with specific interventions identified in this plan, have evaluated such risks, and have agreed to this plan recognizing these risks.

## Signatures

**I have participated in the planning of my own care; and have read, or had read to me, in a language that I can understand the foregoing plan of care; and agree with my plan of care.**

Resident or Resident's Representative

Signature \_\_\_\_\_ Date \_\_\_\_\_

Care Coordinator/Case Manager/ Program Coordinator

Signature \_\_\_\_\_ Date \_\_\_\_\_

Service Providers (as appropriate)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Assisted Living Home Representative

Signature \_\_\_\_\_ Date \_\_\_\_\_

Licensed Nurse (If Health Services Provided)

Signature \_\_\_\_\_ Date \_\_\_\_\_

Resident Name \_\_\_\_\_

**ATTACHMENTS (Indicate if the Plan includes any of following)**

- Physician’s statement
- Separate Nurse Review of Health Services
- List of Residents Current Medication
- DNR/Comfort One/Advanced Health Care Directives

**QUARTERLY EVALUATIONS OF ASSISTED LIVING PLAN**

(If Health Related Services are provided, an evaluation is required every three months)

<b>Date Review Required</b>	<b>Date Completed</b>	<b>Signature of Administrator</b>	<b>*Signature of Resident or Representative</b>

***\*NOTE Signature signifies that a copy of revisions, if any, have been received and a copy is attached to this plan.***

Resident Name \_\_\_\_\_