ASSISTED LIVING PLAN

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

Resident Information

First Name _____

Last Name _____

Date of Birth _____

Assisted Living Home Information

Address _____

City _____ State AK

Zip Code _____

Facility Contact _____

Facility Phone _____

Date of this Plan _____

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 _____

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

Section 2 Resident Preferences

Roommates

Living environment

Food

Recreational activities

Religious affiliation

Relationships/visitation with friends, family members, and other

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

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

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

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)

Date Review Required	Date Completed	Signature of Administrator	*Signature of Resident or Representative

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

Resident Name _____