

INSTRUCTIONS FOR COMPLETING RESIDENT SUPPORT PLAN FORM

NOTE: THE RESIDENT SUPPORT PLAN FORM SHOULD BE REVIEWED ON A QUARTERLY BASIS AND MODIFIED AS NECESSARY TO MEET THE RESIDENT'S NEEDS

RESIDENT INFORMATION:

Questions 1 through 6 are self-explanatory.

For questions 7 through 23, include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.

7. **Medical.** Include any special medical care the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
8. **Ability of the resident to Self-Administer Medications/Need for Medication Reminders/ Medical Administration.** Include any special assistance with medication administration the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
9. **Dental.** Include any special dental care the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
10. **Care Services/Activities of Daily Living.** Include any special care services or assistance with activities of daily living the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
11. **Personal Hygiene.** Include any special assistance with personal hygiene the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
12. **Mobility.** Include any special assistance with mobility the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
13. **Vision.** Include any special vision care the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
14. **Hearing.** Include any special assistance with hearing the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
15. **Dietary.** Include any special diet or meal requirements the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
16. **Communication/Understanding Instructions.** Include any special communication or assistance in understanding instructions the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
17. **Cognitive.** Include any cognitive assistance the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
18. **Mental Health.** Include any special mental health assistance the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
19. **Other Behavioral Care Services.** Include any special behavioral care services needs the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.

- 20. Instrumental Activities of Daily Living.** Include any assistance with instrumental activities of daily living the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
- 21. Social/Recreational.** Include any special social or recreational needs the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
- 22. Other Services.** Include any other service needs the individual requires not addressed in the previous categories. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
- 23. Referrals to Outside Services.** Include any referrals to outside services the individual requires. Include the plan of action, frequency or schedule to be followed and who is responsible for completing this requirement.
- 24. Strategies that Promote Interactive Communication on the Part of and Between Direct Care Staff and Individual Resident.** Include any strategies needed to establish or improve communication between staff and the individual. Examples might include how to communicate with a non-verbal resident or a resident that does not speak the same language as the direct care staff.
- 25. Indicate if the individual is able to safely operate key-locking devices.**
- 26. Indicate if a copy of the support plan was provided to the resident and the resident's designated person.** A copy of the support plan must be provided to the resident and the resident's designated person.
- 27. Indicate who participated in the development of the support plan.** Individuals who participate in the development of the support plan must sign and date the plan. If the assisted living residence staff who completed the support plan is someone other than an RN or an LPN (under the supervision of an RN), an RN or an LPN (under the supervision of an RN) must review and approve the support plan.
- 28. Quarterly Review of Support Plan.** A resident's final support plan must be reviewed on a quarterly basis and modified as necessary to meet the resident's needs. An RN or an LPN (under the supervision of an RN) must sign and date when the review occurred.