APD Care Plan Version
ACHP Classification Level Worksheet for Adult Care Home Operators

See MCAR'S 023-800-400 through 023-080-425: Operators shall complete this worksheet as part of the Care Plan once the resident has been in the home for up to 14 days. (Initial class worksheet is completed as part of the screening). Care Plans rewritten annually.

Resident Name:_____ **DOB:** _____ **Date:** _____

Definition	Independent	Assist	Full Assist
Eating Feeding and eating; may include using assistive devices	Needs no assistance Considered independent even if set-up, cutting up food, or special diet needed. ☐	Requires another person to be immediately available and within sight. Requires hands-on feeding or assistance with special utensils, cueing while eating, or monitoring to prevent choking or aspiration ☐	Requires one-on-one assist for direct feeding, constant cueing, or to prevent choking or aspiration. Includes nutritional IV or feeding tube set-up by another person. *Needs assistance through all phases, every time.* ☐
Dressing and Grooming Dressing and undressing; grooming includes nail care, brushing and combing hair.	Needs no assistance ☐	Needs assist in dressing, or full assist in grooming (cannot perform any task of grooming without the assistance of another person.) ☐	Needs full assist in dressing. (cannot perform any task of dressing without the assistance of another person.) ☐
Bathing/Personal Hygiene Bathing includes washing hair, and getting in and out of tub or shower. Personal hygiene includes shaving, and caring for the mouth.	Needs no assistance ☐	Requires assist in bathing, **or** full assist in hygiene. (needs hands-on assist through all phases of hygiene, every time, even with assistive devices.) ☐	Requires full assistance in bathing. (needs hands-on assist through all phases of bathing, every time, even with assistive devices.) ☐

Mobility Includes ambulation and transfer. Does NOT include getting to/from toilet or in/out of shower/tub or motor vehicle.	Needs no assistance ☐	Must require assistance of another person with ambulation, **or** with transfers, **or** with both. ☐	Must need full assist with ambulation **or** with transfers **or** both. Unable to ambulate or transfer without the assistance of another person throughout the activity, every time, even with assistive devices. ☐
Elimination Toileting, bowel & bladder management includes getting on/off toilet, cleansing after elimination, and clothing adjustment; catheter and ostomy care, toileting schedule, changing incontinence supplies, digital stimulation.	Needs no assistance. Continent, or manages own incontinence ☐	Requires assist with bladder care **or** bowel care **or** toileting. Even with assistive devices, the individual is unable to accomplish some tasks of bladder care, bowel care, or toileting without the assistance of another person. ☐	Requires full assist with bladder care **or** bowel care **or** toileting. Full assist means that the individual is unable to accomplish any part of the task and assistance of another person is required throughout the activity, every time. ☐
Cognition/Behavior **8 components**: Functions of the brain (5) : **adaptation, awareness, judgment/ decision-making, memory, orientation.** Behavioral symptoms (3): **demands on others, danger to self, wandering**	Needs no assistance ☐	Needs assist in at least 3 of the 8 components of cognition and behavior. Assist implies that the need is less than daily, or if daily, impairment is not severe. ☐	Needs full assist in at least 3 of the 8 components of cognition and behavior. Full assist implies that the need is ongoing and daily. The level of impairment is severe. ☐

	Independent	**Assist**	**Full Assist**
Total:	_____	_____	_____

Class Level: _____

Class I = Assist with 4 or fewer ADL and not full assist in any ADL
Class II = Assist with all ADL, full assist in no more than 3.
Class III = Full assist (dependent) with 4 or more ADL.

Name of RN or Physician responsible for monitoring client care in the home: _____

Phone: _____ **Frequency of visits:** _____

APD Adult Care Home Care Plan

Resident Name:_____ Date of annual plan: _____ Update: _____

Operator Name:_____ License No:_____

Eating	**What resident does:**	**What caregiver does/when:**
Special diet:		
General appetite:		
Allergies:		
Special equipment:		
Preferences:		

Dressing **Equipment:** **Day preferences:** **Night preferences:** **Other:**	**What resident does:**	**What caregiver does/when:**
Grooming **Nail care** • **Fingernails:** • **Toenails:** **Brushing/combing hair** **Preferences:** **Other:**		

Residential Initials:_____

Bathing	**What resident does:**	**What caregiver does/when:**
Frequency: **Schedule:** **Time Required:** **Equipment:** **Transfer:** **Preferences:**		
Personal Hygiene **Shaving** **Frequency:** **Schedule:** **Caring for the mouth** **Frequency:** **Dentures:** **Schedule:** **Preferences:**		

Residents Initials:_____

Mobility	**What resident does:**	**What caregiver does/when:**
Ambulation Equipment : **Transfer Equipment:** **Preferences:** **Special Transportation Needs:**		
Elimination		
Toileting: **Transfer:** **Other assist:** **Bladder management:** **Bowel management:** **Equipment/supplies:** **Schedule:**		

Residents Initials:_____

Cognition **Adaptation:** **Awareness:** **Judgment/decision making:** **Memory:** **Orientation:**	**What resident does:**	**Interventions:** **What caregiver does/when:**
Behavior (describe) **Demands on others:** **Danger to self:**		

Residents initials:_____

Night Needs	**What resident does:**	**What caregiver does/when:**
Toileting/Incontinence care: **RN consultation:** **Medication:** **Equipment:** **Other needs:** **Resident's preferred bedtime:** **Other preferences:**		
Communication Needs **Glasses:** **Hearing Aids:** **Interpreter:** **Other:**		

Residents Initials:_____

Medical Concerns

Health Issues to Monitor:

Treatment/Therapies/Procedures:

RN Consultation:

RN Delegation:

Physical Restraints:

Allergies:

Other:

Residents initials:_____

Social/Spiritual/Emotional	**What resident does:**	**What caregiver and/or significant others do:**
Activity Needs: **Church affiliation:** **Clubs:** **Social Contacts:** **Activities Preferred:**		
Exiting in an Emergency **Equipment needed:**		

Residents Initials:_____

APD Care Plan Signature Page

Name of Resident: _____ Date of annual Plan: _____

Signatures: **Dates:**

_____	_____	_____	_____
Operator	Annual Plan	6 month review	change of condition
_____	_____	_____	_____
Resident	Annual Plan	6 month review	change of condition
_____	_____	_____	_____
Resident's Representative	Annual Plan	6 month review	change of condition

421 SW Oak St, Suite 650 □ Portland, Oregon 97204 □ Phone: 503-988-3000

Signature: **Dates:**

Caregiver	Annual Plan	6 month review	change of condition
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