Multnomah County
Aging, Disability and Veterans Services Division

ADULT CARE HOME
RESIDENTIAL CARE PLAN

Resident's Legal Name: _____ **Operator Name:** _____

Preferred/Chosen Name: _____ **Home's Address:** _____

Pronouns Used: _____ ☐ Resident declined **Plan Completed By:** _____

Gender Identity: _____ ☐ Resident declined **Date Completed:** _____

Please note: Oregon law requires care facilities to ensure that resident records include the resident's gender identity, chosen name, and pronouns, as indicated by the resident. The facility may not discriminate or permit discrimination of any kind based on an individual's actual or perceived gender identity or sexual orientation. Residents may decline to answer these questions and their care will not be affected.

Instructions: Fields will automatically expand as text is entered. Please provide accurate and thorough descriptions for each topic. If you are completing this form on paper, please expand all necessary fields by entering returns into each field until the desired space is acquired **prior** to printing.

Does this resident have the following?

Individually-Based Limitations:	☐ No	☐ Yes (if "yes," attach to care plan)
Behavioral Support Plan:	☐ No	☐ Yes (if "yes," attach to care plan)
Nursing Care Plan:	☐ No	☐ Yes (if "yes," attach to care plan)
Nursing Delegations:	☐ No	☐ Yes

Activities of Daily Living

Activities of Daily Living (ADLs) are those personal functional activities identified below that are required for continued well-being and essential for health and safety. Instrumental Activities of Daily Living (IADLs) or "self-management tasks" are defined as specific, more complex activities required for an individual to maintain independent living. Independent means that the resident does not meet criteria to require described assistance levels (i.e., assist, minimal assist, substantial assist, full assist) in any part of the ADL.

See the Classification Worksheet or MCAR Appendix I for descriptions of assistance levels associated with each ADL. Appendix I within the MCAR also contains complete definitions of each ADL.

Resident Preferred/Chosen Name: _____ Date Plan Completed: _____

Bathing - Activities of washing the body, hair, getting in/out of a bathtub/shower. Consider use of assistive devices, specific needs if confined to a bed.		
Mark one: ☐ Independent ☐ Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Frequency and usual schedule (times/week, time of day)		
Shower, bed-bath, or bathtub		
Hair washing frequency and specific needs		
Allergies to bathing products		
Transfer in and out of bathtub or shower		
Assistive devices, equipment, supplies		
Consultation, assessment		
Other preferences and considerations		

Personal Hygiene - Activities of shaving, caring for the mouth, and menstruation care.		
Mark one: ☐ Independent ☐ Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Shave area/frequency and usual schedule		
Teeth brushing or denture care, mouth/oral care, include frequency and usual schedule		
Allergies to personal hygiene products		
Assistive devices, equipment, supplies		
Other preferences and considerations including menstruation care if applicable		

Dressing - Includes the acts of dressing, undressing, and putting on/taking off shoes and socks.		
Mark one: ☐ Independent ☐ Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Daytime preferences		
Nighttime preferences		
Assistive devices, equipment, supplies		
Other preferences and considerations		

Grooming - Includes nail care and hair or scalp care based on the resident's reasonable personal preferences.		
Mark one: ☐ Independent ☐ Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Hair care, combing/ brushing, other styling needs/preferences, frequency and schedule		
Barber/hairdresser		
Makeup preferences		
Foot and toenail care		
Skin, fingernail, ear-specific care		
Allergies to grooming supplies/products		
Other preferences and considerations		

Eating - Includes the tasks of eating; feeding; nutritional IV or feeding tube set-up by another person; and may include using assistive devices.		
Mark one: ☐ Independent ☐ Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Ability to feed self, ability to swallow		
Special diet, supplemental nutrition, or allergies to food		
Assistive or adaptive devices, equipment, supplies		
Consultation, teaching, delegation, instructions, assessment		
Foods/beverage likes and preferences		
Other preferences and considerations		

Elimination - Includes bladder, bowel, and toileting: catheter and ostomy care. Dialysis care needs are not included as part of elimination.		
Bladder Elimination - Includes catheter and ostomy care.		
Mark one: ☐ Independent ☐ Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Daytime needs		
Nighttime needs		
Equipment/supplies		
Consultation, teaching, delegation, assessment		
Other preferences and considerations		

Bowel Elimination - Includes digital stimulation, suppository insertion, ostomy care, and enemas.		
Mark one: ☐ Independent ☐ Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Daytime needs		
Nighttime needs		
Equipment/supplies		
Consultation, teaching, delegation, assessment		
Other preferences and considerations		

Toileting - Includes getting on and off the toilet, cleansing after elimination, changing soiled incontinence supplies or soiled clothing, and adjusting clothing to enable elimination. Consider need for cueing to prevent incontinence and need for hands on assistance with tasks.		
Mark one: ☐ Independent ☐ Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Ability to get to and from the toilet, Ability to get on and off the toilet		
Clothing adjustment (to assist elimination or afterward)		
Ability to cleanse afterward		
Allergies to toileting supplies or products		
Assistive or adaptive equipment or supplies		
Consultation, assessment		
Other preferences and considerations		

Mobility - Includes the activities of Ambulation and Transfer (see below). Does NOT include getting on/off toilet, in/out of shower/tub, or in/out of a motor vehicle. For mobility, inside means inside the entrance to the home. Courtyards, balconies, stairs, or hallways exterior to the doorway of the home are not considered "inside."

Ambulation - Activity of moving around inside and outside the home/care setting, consider level of independence while using assistive devices (walkers, canes, crutches, wheelchairs, motorized scooters, etc). Does not include exercise/physical therapy.

Mark one: ☐ Independent ☐ Minimal Assist ☐ Substantial Assist ☐ Full Assist

Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Moving around inside the home		
Moving around outside the home		
Fall risk or history		
Assistive devices, equipment, supplies		
Consultation, assessment		
Other preferences and considerations		

Transfer -	Includes the tasks of moving to/from a chair, bed, or wheelchair using assistive devices, if needed; assessing ability to transfer from areas used on a daily/regular basis (e.g., sofas, chairs, recliners, beds, other areas inside the home based on their reasonable preferences); repositioning when confined to bed or wheelchair. Assistance must be required because of physical limitations, not physical location.

Mark one: ☐ Independent ☐ Assist ☐ Full Assist

Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Moving to/from a chair or wheelchair		
Moving to/from a bed		
Caregiver assistance for transfers		
Assistive devices, equipment, supplies		
Consultation, assessment		
Other preferences and considerations		

Number of caregivers needed for transfers: ☐ 0 ☐ 1 ☐ 2

Resident Preferred/Chosen Name: _____ Date Plan Completed: _____

Cognition/Behavior -	Cognition/Behavior addresses how the resident is able to use information, make decisions, and ensure their daily needs are met. There are four components to cognition: self-preservation, decision-making, ability to make one's self understood, and unsafe behaviors.
Self-Preservation -	Ability to recognize and take action in a changing environment or a potentially harmful situation (e.g., find way home, safe appliance use, take medication, protect self from abuse, meet basic health and safety needs). Does not include engaging in risky behavior when potential consequences are understood.

Mark one: ☐ Independent ☐ Minimal Assist ☐ Substantial Assist ☐ Full Assist

Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Ability to be in the community and/or find way home		
Using appliances		
Taking medications		
Protect self from abuse, neglect, or exploitation		
Meet basic health and safety needs		
Other preferences and considerations		

Resident Preferred/Chosen Name: _____ Date Plan Completed: _____

Decision-Making - Ability to make everyday decisions about ADLs, IADLs, and related tasks. Consider if a resident demonstrates they are unable to make decisions, needs help understanding how to accomplish the tasks necessary to complete a decision, or does not understand the risks or consequences of their decisions.		
Mark one: ☐ Independent ☐ Minimal Assist ☐ Substantial Assist ☐ Full Assist		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Making decisions		
Understanding how to accomplish the tasks necessary to complete a decision		
Understanding risk and consequences of their decisions		
Other preferences and considerations		

Ability to Make Self Understood -	Cognitive ability to communicate or express needs, opinions, or urgent problems, whether in speech, writing, sign language, body language, symbols, pictures, or a combination of these including use of assistive technology. Impairment means inability to express self clearly to the point needs cannot be met independently and does not include the need for assistance due to language barriers or physical limitations to communicate.

Mark one: ☐ Independent ☐ Minimal Assist ☐ Substantial Assist ☐ Full Assist

Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Ability to communicate/ express needs, urgent problems, preferences and/or opinions.		
Language and/or speech barriers		
Visual and/or hearing barriers		
Assistive or adaptive devices		
Equipment/supplies (including glasses and/or hearing aids)		
Interpreter or translation needs		
Consultation, assessment		
Other preferences and considerations		

Resident Preferred/Chosen Name: _____ Date Plan Completed: _____

Challenging Behaviors -	Exhibits behaviors that negatively impact self or others' health or safety (verbal/physical aggressive, socially inappropriate, disruptive, etc.). A resident who requires assistance with challenging behaviors does not understand the impact or outcome of their decisions or actions. Does not include exhibiting behaviors when the potential risks and consequences are understood. Please describe each behavior individually and what the caregiver must do to assist the resident (e.g., play soothing music, use calming statements or phrases, remove resident from stimuli) consistent with any Behavior Support Plan.

Mark one: ☐ Independent ☐ Minimal Assist ☐ Substantial Assist ☐ Full Assist

Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Behavior that is unsafe for self and others		
Verbally and/or physically inappropriate behavior		
Socially inappropriate behavior		
Behavior that disrupts home processes or schedule		
Other preferences and considerations		

Emotional and Mental Health Support	
Emotional or Mental Health support services or resources used by the resident	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Resident goals for maintaining and (if possible) improving levels of functioning	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Other preferences and considerations	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided

Night Needs		
Issues/concerns	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Preferred bedtime routines		
Ability to alert caregiver to nighttime needs		
Medication		
Equipment (medical, assistive)		
Nighttime toileting or incontinence care		
RN consultation		
Other preferences and routines		

Resident Preferred/Chosen Name: _____ Date Plan Completed: _____

Medical Issues and Concerns		
Issues/concerns	**Describe interventions and symptoms/issues being addressed**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Health issues to monitor, include diagnoses		
Pain management		
Treatment, therapies or procedures		
Weight/goal		
Physical restraints (IBL required)		
Psychoactive medications		
Physical disabilities		
RN consultation, PT/OT/Speech Therapy		
RN delegations		
Medication allergies		
Other allergies		
Other considerations		
RN or Physician Monitoring Resident in Home: _____	**Phone Number**: _____	**Frequency of Visits**: _____

Community Engagement and Emotional and Spiritual Well-Being

Consider activities that will enhance engagement in the larger community and support emotional and spiritual well-being.

Involvement	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Daily schedule or routine		
Support or supervision needs		
Clubs/organizations		
Spiritual (religious affiliation)		
Cultural preferences		
Family/friends		
Current hobbies, activities, and interests		
Special arrangements		
Interests or activities enjoyed in the past		

Resident Preferred/Chosen Name: _____ Date Plan Completed: _____

Transportation		
Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Resources including arranging transportation		
Ability to get in/out of a vehicle		
Assistance during ride		
Assistive or adaptive devices		
Other preferences and considerations		

Resident Preferred/Chosen Name: _____ Date Plan Completed: _____

Emergency/Fire Drill Evacuation

Mark one: ☐ Independent ☐ Assist ☐ Full Assist

Considerations	**Resident's needs, preferences, and capabilities**	**Caregiver responsibilities**: Describe what is required; who, when, & how often it will be provided
Plan for daytime hours based on assistance needed		
Plan for nighttime hours based on assistance needed		
Resident cannot participate in evacuation drills	☐ Resident cannot participate per prescriber's order	In lieu of resident participation, a substitute will be used during evacuation drills. (Substitute must be of similar size to and must be able to simulate the evacuation needs of the resident.)
Equipment, supplies or assistive devices needed		
Other preferences and considerations		

Care Plan Signature Page & Signature Log

Resident legal name: _____ Resident preferred/chosen name: _____

Date plan implemented: _____

	Resident Signature (if applicable)	Date	Resident Initials
Operator name	Signature	Date	Operator Initials
Name ☐ Resident Manager / ☐ Shift Manager	Signature	Date	RM/SM Initials
Legal Representative name (if applicable)	Signature	Date	Rep Initials
Caregiver name	Signature	Date	Caregiver initials
Caregiver name	Signature	Date	Caregiver initials
Caregiver name	Signature	Date	Caregiver initials
Caregiver name	Signature	Date	Caregiver initials
Caregiver name	Signature	Date	Caregiver initials

Plan Updates

Care plans must be reviewed at minimum every 6 months, and more frequently if a resident's care needs change. At the time of review, care plans must be updated if needed to address care needs. Care plans must be rewritten annually. When updated, changes to the plan should be dated and initialed. Initials can be used in place of a signature below if they have been recorded on the signature page above.

Date of update:				
	Initial / date	Initial / date	Initial / date	Initial / date
Operator				
Resident				
Representative:				
Resident Manager/ Shift Manager				
Caregiver				
Caregiver				
Caregiver				
Caregiver				
Caregiver				
Caregiver				
Caregiver				

Plan Reviews

Care plans must be reviewed at minimum every six months and earlier if a resident's care needs change; and must be reviewed and rewritten annually. Reviews must be documented within the resident record. You may use the following optional log to document care plan reviews in compliance with requirements.

Review date: Plan updated? ☐ Yes ☐ No	Decisions made during the review and/or other significant topics discussed:	List the names of those present during the review:
Review date: Plan updated? ☐ Yes ☐ No	Decisions made during the review and/or other significant topics discussed:	List the names of those present during the review:
Review date: Plan updated? ☐ Yes ☐ No	Decisions made during the review and/or other significant topics discussed:	List the names of those present during the review:
Review date: Plan updated? ☐ Yes ☐ No	Decisions made during the review and/or other significant topics discussed:	List the names of those present during the review: