

NAME OF YOUR FACILITY: _____

PLAN FOR ALL RESIDENTS OF THE GROUP HOME UNIMPEDED BY THE CARE PROVIDED FOR:

RESIDENT'S NAME

- Our home will continue to provide 24 hour quality care to all residents.
- Our current census is: _____
- Our current staffing pattern is: (Example: 2 caregivers and 1 med-tech at all times)

- All residents will continue to be under constant watch during the day and throughout the night in order to monitor all safety precautions, fall prevention, general precautions and repositioning needs.
- All medication management processes will continue to be followed at the direction of the physician's prescription and logged appropriately on the Medication Administration Record.
- All medication management will continue to be followed as directed by the facility Medication Management Plan and as prescribed by the physician.
- Current assistance given to all residents will continue according to their agreement with the group home and their assessed needs which may include assistance with bathroom visits, incontinence care, bathing, dressing, grooming, feeding, activities and all other general care services as needed.

Attestation:

By signing this notice I accept the responsibility to ensure the care of this resident will not detract from the care of any other resident. I accept responsibility to ensure the care provided follows the plan of care for all residents in my facility.

Signature of Administrator: _____

Print Name of Administrator: _____

Date _____