**Section 225.3010 Resident Comprehensive Care Plan**

a) *An Alzheimer's Disease Management Center shall develop and implement an ongoing treatment plan for each resident. The treatment plan shall have defined goals.* (Section 35(5) of the Act)

b) The comprehensive care plan shall be implemented within 24 hours after the resident's admission to the facility based on the pre-admission assessment.

c) The comprehensive care plan shall be revised as needed based on assessments conducted in accordance with Section 225.3000 of this Part.

d) The comprehensive care plan shall include, at a minimum:

1) Staging of the resident based on cognitive study;

2) Assignment to a care manager;

3) Dietary prescription; and

4) Activities provided throughout the day and evening.

e) The facility shall define the members of the care team who will develop and review the plan. The members of the team shall include, at a minimum:

1) The resident;

2) Resident representative, if he/she chooses to participate, and any other persons chosen by the resident;

3) A person assigned to coordinate services for the person (care manager);

4) A nurse; and

5) Persons providing services for the resident, based on the assessment.

f) The care team shall meet at least every 30 days to implement and modify the care plan as needed. The care manager shall ensure that the comprehensive care plan is implemented and that the appropriate services are coordinated to ensure that the comprehensive care plan is followed.