Resident Service Plan

Initiation Date: __________ Resident Name: ____

Physician Name and Phone Number: ____

Date of Move in: __________ Date of Last TB Test/Chest XRay: ___________

Resident Representative and Phone Number: _____________________________________

Level of Care: ☐Supervisory Care (Must renew every 1 year) ☐Personal Care (Must renew every 6 months) ☐Directed care (Must renew every 3 months) ☐Behavioral Health Services (Must renew every 6 months)

Resident Service Plan: ☐Initial Service Plan ☐Routine update ☐Change in condition

Next Service Plan Due: ____________

Date of Birth: _____________ Code Status: ☐Full Code ☐DNR

Advanced Directives: ☐Yes ☐No Evacuation Plan: ☐Yes ☐No

Emergency Contact: ____

Hospice: ____

Home Health Agency: ____

Height: ____ft ____ in Weight: _____ Temp: ______ Pulse: ______ RR:___

BP: _______ Pulse Ox: __________

*Medical Diagnosis and History:

____

____

____

*Allergies:

____

____

Commented [D1]: Must be within 14 calendar days of resident move-in date.

Commented [D2]: Must be before or within seven calendar days after the resident's move-in date. TB skin tests/Chest Xrays must be updated annually.

Commented [D3]: Refers to the party responsible for the resident. The resident may also be their own representative.

Commented [D4]: Selection for level of care. Refer to Chart 1 for definitions.

Commented [D5]: Type of service plan and the date when it will be due next. Refer to **"When are service plans to be updated?"** question in this packet.

Commented [D6]: Does the resident have advanced directives on file at the facility?

Commented [D7]: Does the patient participate in evacuation drills?

Commented [D8]: Is the resident enrolled in Hospice?

Commented [D9]: Is the resident enrolled in Home Health?

Commented [D10]: If unable to obtain weight for resident, you must have a signed and dated doctors order indicating "It is clinically not recommended to obtain weight"

Commented [D11]: Vital signs are not a requirement on service plans, however they are recommended to obtain.

Commented [D12]: List of medical diagnosis and medical history.

R|D Health Services

Activities of Daily Living Assessment

Commented [D13]: List of activities of daily living, frequencies, and the level of assistance the resident needs.

Functional Ability ADL's	Independent	Supervision	Assist Level of 1 or 2	Total Care	Frequency
Eating					QD + PRN
Oral Care					QD + PRN
Nail Care					PRN
Hair Care/Shaving					QD + PRN
Dressing					QD + PRN
Bathing					QD + PRN
Toileting					QD + PRN
Transferring					QD + PRN
Walking/Mobility					QD + PRN
Transportation To Appointments					QD + PRN
Finances					QD + PRN
Supplies					QD + PRN

- Self bathe ____x/ week, caregiver help bed bath ____x's/week, self-shower ____x's/week, caregiver/CNA helps with shower ________x's/week, teeth, hair, QD

Commented [D14]: Specification of what type of hygiene requirement resident has or can tolerate and who is administering the care.

- **Hospice services:**
  - CNA Visits: _____length of appt____time(s) per ____________ & PRN
  - Nursing Visits: _____length of appt____time(s) per __________ & PRN
  - Chaplain Visits: _____length of appt____time(s) per _________ & PRN
  - Social Worker Visits: ____length of appt____time(s) per ______ & PRN
  - Wound Care Visits: _____length of appt____time(s) per _______ & PRN

Commented [D15]: Amount, type, and frequency of hospice services the resident is receiving.

- **Home Health Services:**
  - Nursing Visits: _____length of appt____time(s) per ____________ & PRN
  - Physical Therapy: Nursing Visits: _____length of appt____time(s) per ________& PRN
  - Occupational Therapy: Nursing Visits: _____length of appt____time(s) per _____
  - Speech Therapy: Nursing Visits: _____length of appt____time(s) per __________

Commented [D16]: Amount, type, and frequency of Home Health services the resident is receiving.

Body Assessment

Commented [D17]: This "Select all that apply" section covers medical or health problems, including physical, behavioral, cognitive, or functional conditions or impairments.

Additional notes or comments may be written under the "comments" section of each item as needed.

Neurological

No problems identified	History of Headaches	History of orthostatic hypotension
History of Dizziness		

Comments: ____

Vision

Normal for Age	Glasses	Impaired	Blind

Comments: ____

Speech

Normal for age	Slurred/garbled	Difficulty/Mute	Aphasic

Comments:____

Hearing

Normal for age	Impaired	Uses hearing aides	Deaf

Comments: ____

Mobility

Independent	Stands with assistance	Wanders	Unsteady gait
Fall Risk	Walks with assistance	Wheel Chair	Cane/walker
Bed Bound	Chair bound	Hoyer Lift	
Motorized scooter	Supervision		

Requires positioning: ☐Yes ☐No ☐Q __ Hours Transfer Assistance: ☐ None ☐ X ___ Person(s)

Commented [D18]: Repositioning requirements and transfer assistance must match all other corresponding documents the resident has on file at the facility.

Pain

None	Occasional	Constant	Frequent

Location: ____

Method of relief: ____

Respiratory

No problems Identified	Lung sounds clear	Lung sounds diminished	Crackles
Dyspnea on exertion	Dyspnea at rest	Inspiratory Wheezing	Expiratory Wheezing
Sputum (Color)	SOB	Pursed lip breathing	

Comments: ____

Cardiovascular

No problems Identified	Chest pain HTN	Ankle/Leg Swelling Cardiac Hx	Pacemaker

Comments: ____

Gastrointestinal

No problems identified	Indigestion	Nausea	Vomiting
Laxative use Incontinent at times Incontinent	Chronic diarrhea	Chronic Constipation	BM Daily
BM every 2-3 days	BM every 4-5 days	Multiple BM daily	Ostomy

Comments: ____

Urinary

No problems identified	Stress incontinence	Painful urination
Frequent urination	Blood in urine	Chronic infection
Ileostomy	Underwear liners	Belted undergarments
briefs (Day) (Night)	Indwelling catheter	Straight catheter
Pull up (Day) (Night)	Incontinent at times	UTI risk (encourage fluids).
Prostate issues	Incontinent	

R|D Health Services

Urinary System

Comments: ____

Musculoskeletal

No problems identified	Joint Pain	Low back pain
Unsteady Gait	History of falls	Amputation
Stiff/Limited ROM	Bed/chair bound	
Fall risk		

Comments (Include last fall):____

Integumentary: *comment on how to prevent & treat bruises, injuries, pressure sores & infections*

No problems identified	Dry skin	Oily skin
Bruises (Locations)	Scars (Locations)	Abrasions (Locations)
Lacerations (Locations)	Sensitive skin	Rash (Locations)
Check pressure areas q2h	Pressure ulcers *	Wounds
	Precaution-thin skin	Surgical Incision

* (If pressure sore, stage, location, wound care nurse name and agency; person/agency notified) The following are performed to prevent & treat bruises, injuries, pressure sores & infections: Keep resident's skin clean and dry Apply hydrating lotion Check resident's skin at every shower, bath, and PRN Ensure good hygiene and nutrition Communicate weekly with wound care nurse Other: ________________

____

Commented [D19]: AZDHS proactively checks for strategies used to prevent & treat bruises, injuries, pressure sores & infections. Selecting these 4 boxes meets their requirements.

Mental Status: *Include behavioral, physical, functional or cognitive conditions or impairments.*

Awake/Alert	Confused at times	Uncooperative	Hallucinates
Oriented	Forgetful at times	Paranoid	Flat Affect
Mild dementia	Anxious at times	Combative	Bipolar
Moderate dementia	Agitated at times	Schizophrenic	Schizophrenic
Advanced dementia	Depressed at times	Mental retardation	Impaired Cognition

Comments:____

Diet:

☐ Regular, ☐ Low salt, ☐ Low fat, ☐ No caffeine, ☐ No dairy, ☐ BS controlled diet, ☐ Puree food, ☐ mechanical soft diet, ☐ help to eat, ☐ choking risk, ☐ Ensure/Boost drinks

Eats: ____% of food. Drinks: ______ cups of water.

☐ Resident is encouraged to drink 6-8 cups of water per day.

☐ Resident is encouraged to eat meals and snacks as tolerated

Commented [D20]: Type of diet resident adheres to. For special diets resident must have signed and dated doctor's order on file.

Commented [D21]: AZDHS proactively checks to ensure residents are encouraged to drink and eat as tolerated. Selecting these 2 boxes meets their requirements.

If Diabetic (Please circle): ☐Insulin self-inject **or** ☐Insulin inject (staff)
☐BS check (staff) X__ Per day **or** ☐BS self-check X __/Day

Medications

(Please current MAR)

Medication Administration

______ Resident receives staff assistance with medication self-administration
______ Resident receives medication administration
______ Resident self- administers
______ Medications administered per Doctor's Orders
______ MD delegation to caregivers to administer meds
______ Medications are stored in the residential facility
______ Medications are stored in the resident's room

- How meds are stored:____

Commented [D22]: Select all options that apply for resident. Refer to Chart 2 for selecting the appropriate level of medication administration.

Strategies to ensure Resident's Personal Safety (Directed Care):

☐Resident has bell at bedside to call for assistance/ safety. ☐Doors are alarmed.

☐Resident is checked on every 1-2 hours and as needed to ensure safety

☐Other: ____

Commented [D23]: AZDHS proactively checks to ensure there are strategies in place to promote resident's personal safety.

Select all that apply for resident and/or include additional strategies in the "Other" Section.

Activities (Cognitive stimulation and activities to maximize function):

☐Watch TV ☐Read ☐Socialize with other residents ☐Board games ☐Encouraged to participate in group activities ☐ Exercises as tolerated

☐Other:____

Coordination of communication with resident's Representative by phone, text, email or in person (Directed Care):

Coordination of communication with resident's representatives is present ☐Daily ☐Weekly ☐Monthly ☐PRN through phone calls, visits, text messages and or email.

Assistive Devices (Circle):
☐Hearing aids ☐dentures ☐hospital bed ☐wheelchair (self-propel) ☐glasses ☐prosthesis ☐air bed ☐wheelchair (unable to self-propel) ☐glucose meter ☐Hoyer lift ☐shower chair ☐walker ☐cane ☐fall pad ☐02 concentrator ☐bed-side commode
☐Other:____

- Notes:____
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Manager Signature (Or Delegated Personnel):_________________Date: _______________

RN Signature (Directed Care): _____________________________Date: _______________

Resident Representative: _________________________________ Date: _______________

Medical Practitioner/Behavioral Health Professional (Only required for residents receiving behavioral Health Services): _________________________________ Date: ____________

Commented [D24]: AZDHS proactively checks to ensure there are strategies in place to promote cognitive stimulation and activities to maximize function.

Select all that apply for resident and/or include additional strategies in the "Other" Section.

Commented [D25]: Coordination of communications with resident's representative is a requirement. Please select all that apply for the resident.

Commented [D26]: This section has been designated for managers to add any additional information they would like to include in the service plan (which has not already been covered).

Commented [D27]: Refer to **"Who must sign the service plan?"** Question in this packet.