Service Plans 101

Compliance, Clarity & Care

A plain-English guide to Arizona assisted living service plan requirements, the most common reasons plans get cited, and what changed under the 2025 rule updates.

R|D Health Services

Approved by Dr. David Lup, DNP, FNP-C · RDhealthservices.com

BEFORE YOU START

A Note From Dr. Lup

I founded RD Health Services in 2016 to help Arizona assisted living homes stay compliant and organized, and I've personally completed thousands of service plans for assisted living facilities in Arizona ever since — today that means over 12,000 service plans completed, across 300+ assisted living homes and 2,000+ residents statewide. I'm a Doctor of Nursing Practice and a high-honors graduate of the University of Arizona's DNP program, and I remain personally involved in every plan that comes through our system, because the person reviewing your resident's care should actually understand it.

The vast majority of citations I see aren't caused by bad intentions or careless staff — they're caused by small, easy-to-miss gaps that repeat across facility after facility. This guide walks through what a service plan actually requires, the update schedule by level of care, the most common ways plans get cited, and what genuinely changed under the 2025 rule updates — in plain English, with the actual regulatory citations so you can verify everything yourself.

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SECTION 1

What Is a Service Plan?

The regulatory definition

Under Arizona Administrative Code R9-10-801, a service plan is defined as "a written description of a resident's need for supervisory care services, personal care services, directed care services, ancillary services, or behavioral health services and the specific assisted living services to be provided to the resident."

The plain-English version

A service plan is a personalized care roadmap. It's required for every resident, at every level of care, and it exists to give caregivers clarity, ensure consistency across shifts, and hold the facility accountable for the specific care a resident actually needs.

> **Why it matters beyond compliance:** A well-built service plan isn't just a document you produce for a surveyor. It's the reference every caregiver on every shift uses to understand exactly what a resident needs — which is exactly why an inaccurate or outdated one causes real problems long before a survey ever happens.

SECTION 2

Core Requirements & Timing

Every service plan, regardless of level of care, must meet the following baseline requirements under R9-10-808.

Timing

A service plan must be completed no later than **14 calendar days** after a resident's date of acceptance.

Who must be involved

- The resident or the resident's representative
- The facility manager
- Any individual requested by the resident or the resident's representative

What every service plan must include

- A description of the resident's medical or health problems, including physical, behavioral, cognitive, or functional conditions or impairments
- The level of care the resident is expected to receive
- The type, amount, and frequency of assisted living services provided
- Whether the resident receives medication administration or assistance with self-administration
- If medications are stored in the resident's room or unit, how they will be safely stored and controlled

Additional clinical review requirements

Some services trigger an additional review requirement beyond the standard service plan process:

- **Intermittent nursing services or medication administration** require review by a nurse or medical practitioner (R9-10-808(A)(3)(d)).
- **Behavioral care services** require review by a medical practitioner or behavioral health professional at least every 6 months, and must include target behaviors, any psychotropic medications prescribed, planned interventions, and goals for improvement.

SECTION 3

Medication Administration vs. Self-Administration

Another common point of confusion: what a caregiver is allowed to do with a resident's medication depends entirely on which of these two categories applies.

Medication Administration (R9-10-101.84)	Assistance in Self-Administration (R9-10-101.13)
Caregiver prepares the medication (e.g., crushing, mixing)	Resident takes their own medication
Caregiver measures the dosage	Staff may open bottles or blister packs
Caregiver places medication in the resident's mouth or injects it	Staff may read labels and provide reminders
Caregiver applies topical medications	Staff may hand medication to the resident, but cannot place medication in the resident's mouth
Performed by a licensed nurse or trained caregiver	Resident must know the correct dose and route
Requires a physician's order	Requires a physician's order

Why the distinction matters: Which category applies determines who can legally do what for a resident's medication — and your service plan needs to reflect which one is actually happening for each resident, not just that "medication is handled." A resident who self-administers with reminders is documented very differently than one who requires full administration.

SECTION 4

Update Requirements by Level of Care

Every level of care has two update triggers: a routine schedule, and a significant change — whichever comes first.

Level of Care	Initial Completion	Update Frequency
Supervisory Care	≤ 14 days	Annually, and/or within 14 days after a significant change
Personal Care	≤ 14 days	Every 6 months, and/or within 14 days after a significant change
Directed Care	≤ 14 days	Every 3 months, and/or within 14 days after a significant change
Behavioral Care	≤ 14 days	Every 6 months, and/or within 14 days after a significant change
Respite Care	≤ 3 working days	Within 3 working days of a change

Note: if a respite resident isn't expected to stay more than seven calendar days, they are exempt from these service plan requirements entirely.

What counts as a "significant change"?

Trigger	Update Required?	Note
Severe fall, behavior change, hospital, home health, or hospice admission	Yes	Affects condition or care needs
Significant weight change	Yes	May impact mobility, nutrition, or support needed
Medication change with care impact	Yes	e.g., new injections, insulin, PRNs
Medication change without care impact	No	No update if tasks or supervision stay the same
New diagnosis, no care change	No	Log elsewhere unless it affects services
Routine time-based review	Yes	Based on level of care, per table above

SECTION 5

Directed Care vs. Behavioral Health Services

This is one of the most misunderstood distinctions in Arizona assisted living licensing — getting it wrong in either direction causes real problems.

What directed care means

Directed care, as defined in A.A.C. R9-10-101, means programs and services — including personal care services — provided to residents who are incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions. In plain terms, that's residents who can't recognize danger, can't effectively ask for help, can't express basic needs, or can't make simple daily care decisions.

Two things that do NOT, by themselves, require behavioral health licensing

- A resident being prescribed a psychotropic medication (antidepressants, antipsychotics, mood stabilizers)
- A resident receiving directed care who has a primary diagnosis of dementia, Alzheimer's-related dementia, or traumatic brain injury

> **Key point (A.A.C. R9-10-701(F)):** No behavioral health license is needed unless your facility is delivering mental health treatment directed by a behavioral health clinician — assistance with psychosocial interactions or therapies under the direction of an LCSW, LPC, or psychiatrist. Standard directed care practices like redirection, routine, and a calm environment do not cross that line.

SECTION 6

The 2025 Memory Care Endorsement Rules

New rules took effect July 1, 2025. Here's what actually changed — and what didn't.

What's new

The Memory Care Endorsement rules (R9-10-726 and related sections) introduced new requirements for homes serving directed care residents:

- Additional staff training requirements for caregivers working with directed care residents
- Environmental safeguards for residents who may wander or become disoriented
- Additional documentation requirements tied specifically to directed care services

What did NOT change

> These new rules do **not** override or blur the existing distinction between Directed Care and Behavioral Health Services under R9-10-701(F). A dementia or Alzheimer's diagnosis still does not, by itself, require behavioral health licensing — see Section 4.

If your home serves directed care residents, audit your staff training records and environmental setup against these requirements specifically. But don't let that audit bleed into second-guessing whether you need behavioral health licensing — that answer hasn't changed.

SECTION 7

The 8 Most Common Surveyor Citations

These eight causes account for the large majority of service plan citations we see. None of them require anything dramatic to go wrong — just a small gap that repeats.

1. **Service plan not individualized**
   Generic or copy-paste plans that don't reflect the resident's unique needs or preferences.

2. **Failure to update after a significant change**
   No revision following a hospitalization, behavioral change, fall, or hospice admission.

3. **Missing documentation of participation**
   No evidence the resident or representative was involved in the planning process.

4. **Plans don't align with assessed needs (ADLs)**
   The service plan doesn't match the facility's ADL chart — see Section 7.

5. **Incorrect level of care identified**
   Resident receiving services above or below the stated care level.

6. **No review by required clinical personnel**
   Required nurse, medical practitioner, or behavioral health review wasn't performed.

7. **Failure to document decline or refusal**
   Services a resident declines, like showers or medication assistance, aren't addressed in the record.

8. **Outdated or expired plans in active use**
   Caregivers referencing an old version instead of the most current plan on file.

SECTION 8

Why Your ADL Flowsheet Has to Match

Citation #4 deserves its own section — it's one of the most common, and one of the least intuitive.

A resident's service plan says they require assistance with bathing. Their ADL flowsheet, filled out separately by caregiving staff, says they require total care. Neither document is "wrong" on its own — they were probably both accurate when someone wrote them. But a surveyor sees two official records of the same resident's needs that contradict each other.

This happens because, in most facilities, the service plan and the ADL flowsheet are built by different people, at different times, through different processes — and over weeks and months, they quietly drift apart. Unlike a missing document, nothing about this looks broken from the inside. Every required document is present and filed. The mismatch only becomes visible when someone puts both side by side.

QUICK CHECK

Pick three residents at random and compare their service plan to their ADL flowsheet — specifically bathing, toileting, transferring, and mobility. These are the ADLs most likely to have shifted since either document was last updated.

THE REAL FIX

The only fix that holds up over time is structural, not procedural: generate the ADL flowsheet directly from the same information entered for the service plan, so there's never a separate step where the two can diverge. If a resident's bathing needs change on the service plan, the flowsheet should reflect it automatically.

QUICK REFERENCE

Glossary of Terms

Service Plan
A written description of a resident's needs and the specific assisted living services to be provided, required for every resident under A.A.C. R9-10-808.

ADL (Activities of Daily Living)
Basic self-care tasks such as bathing, dressing, toileting, and eating, used to assess a resident's level of independence.

ADL Flowsheet
The document caregivers use to track a resident's actual day-to-day support needs. Must match the service plan.

Supervisory Care
The lowest level of assisted living care, for residents who need general oversight but can largely direct their own care.

Personal Care
Care for residents needing hands-on assistance with ADLs, including hydration, skin maintenance, and incontinence care.

Directed Care
Care for residents incapable of recognizing danger, summoning assistance, expressing need, or making basic care decisions (A.A.C. R9-10-101).

Behavioral Care Services
Services addressing target behaviors and psychosocial challenges, requiring review by a medical practitioner or behavioral health professional at least every 6 months.

Behavioral Health Services
A higher regulatory tier requiring licensure, triggered only when a behavioral health professional directs psychosocial interventions or therapy (A.A.C. R9-10-701(F)).

Medication Administration
A caregiver directly preparing and giving medication to a resident (R9-10-101.84). Requires a physician's order.

Assistance in Self-Administration of Medication
Supporting a resident who takes their own medication, without preparing or placing it for them (R9-10-101.13).

PHI (Protected Health Information)
Health information protected under HIPAA.

Significant Change
A major, lasting shift in a resident's physical, cognitive, or functional status that requires a service plan update within 14 days.

AZDHS
The Arizona Department of Health Services, the state agency responsible for licensing and inspecting assisted living facilities.

ABOUT THIS GUIDE

RD Health Services

Dr. David Lup, DNP, FNP-C founded RD Health Services in 2016. He's a high-honors graduate of the University of Arizona's Doctor of Nursing Practice program, and today RD Health Services supports 300+ assisted living homes and 2,000+ residents statewide, with more than 12,000 service plans completed. Dr. Lup personally reviews and signs every plan submitted through RD Health Services within one business day or less — he hasn't missed a day in over ten years.

What RD Health Services provides

- A digital service plan built around actual AZDHS requirements — completed in about 15 minutes
- Review and signature by a DNP, FNP-C, within one business day or less
- An ADL flowsheet generated from the same data as the service plan, so the two never drift apart
- Automatic expiration tracking and reminders for every resident's service plan and TB test
- Electronic signatures for resident representatives — no printing, no chasing paperwork

Ready to see it for yourself?

Start a free trial or request a completed sample service plan at RDhealthservices.com.

This guide is provided for general educational purposes and reflects Arizona Administrative Code as of 2026. It is not a substitute for reviewing the full text of applicable regulations or consulting with qualified legal or clinical counsel for your specific facility.