

Health Care / Service Plan for Category B / C and A / C Assisted Living Residents **Copy given to resident / legal representative: YES (date):** _____

Resident Name: _____ Emergency Contact Name and Number: _____

Physician (name, telephone, and address): _____

Advanced Directive / Living Will / POLST / DNR (etc): NO YES Type? _____ Date included in resident file: _____

Date of Initial Health Care / Service Plan (within 21 days of admission to Category B / C status): _____ 60 Day Review: _____

Quarterly Reviews: _____ Change of Condition Reviews: _____

For a category B / C resident, the below Health Care / Service Plan must, in addition to regular Service Plan items, specifically address the following conditions, and must be prepared in conjunction with the facility RN:

1. Physician ordered treatments and diets (staff responsible for preparing or supervising diets must have documentation training in the area);
2. Resident Needs and preferences regarding their health care;
3. Incontinence issues / care (see rule 37.106.2879 for specifics);
4. Pressure sores / Skin integrity (see rule 37.106.2880 for specifics);
5. Routine nursing tasks that have been delegated to facility staff per the Montana Nurse Practice Act;
6. Resident cares that require the care of a licensed health care professional (RN or higher), with clear documentation of their responsibilities.

What is the service to be provided?	Who will provide the service?	When will the service be provided?	Where and how often is the service provided?	Changes to the service (with dates), and reasons for those changes.	Desired outcomes, and means to measure them (if appropriate).	Additional information.

In addition to the above Health Care / Service Plan, the following issues specific to Category C residents must be addressed:

	Detailed Assessment of:	Therapeutic Management of:	Intervention Techniques for:
MEMORY			
JUDGEMENT			
ABILITY TO CARE FOR SELF			
ABILITY TO SOLVE PROBLEMS			
MOOD AND CHARACTER CHANGES			
BEHAVIORAL PATTERNS			
WANDERING NEEDS			
DIETARY NEEDS			

Caregiver / Staff signatures

Additional Care Notes

(Caregiver orientation to Service Plans may be documented here, or in the Employee File)

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____
5. _____ Date _____
6. _____ Date _____
7. _____ Date _____
8. _____ Date _____
9. _____ Date _____
10. _____ Date _____
11. _____ Date _____
12. _____ Date _____
13. _____ Date _____
14. _____ Date _____
15. _____ Date _____
16. _____ Date _____
17. _____ Date _____
18. _____ Date _____
19. _____ Date _____
20. _____ Date _____
21. _____ Date _____
22. _____ Date _____
23. _____ Date _____
24. _____ Date _____
25. _____ Date _____
26. _____ Date _____
27. _____ Date _____