

**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:**

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

**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 \_\_\_\_\_