SERVICE PLAN

To be developed within 30 days of admission by the manager, or designee, in collaboration with the Delegating Nurse/Case Manager (DN/CM).
To be reviewed, & updated if needed, at least every 6 months, or sooner if there are significant changes to a resident's condition or preferences.

Resident:	DOB: mm-dd-yy	Service Plan Date: mm-dd-yy
Code Status:	Admission Date: mm-dd-yy	

MEDICAL/MENTAL HEALTH NEEDS	In the left column list all of the resident's medical/mental health diagnoses that are currently being treated (based on the Resident Assessment Tool). In the remaining columns document the services & care needs related to each diagnosis. Include any precautions, monitoring, or lab tests related to high-risk medications.

Risk Factors/ Precautions:			
		Services To Be Provided	
Medical/Mental Health Diagnosis	**Services To Be Provided & How They Will Be Provided**	**When & How Often** *(If "other" specify.)*	**By Whom**
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	

Resident:	DOB: mm-dd-yy	Service Plan Date: mm-dd-yy

		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	

PERSONAL CARE NEEDS * If the resident is Independent & requires no services related to the activity, check "I" & skip to the next activity.	Degree of Help Needed **I** = Independent* **A** = Some Physical Assistance **S** = With Supervision, Set-up, or Cuing & Coaching **TC** = Total Care		
(Check one box to indicate the degree of help needed.)	**Services To Be Provided & How They Will Be Provided** *(Based on the Resident Assessment Tool & nursing assessment.)*	**Services To Be Provided**	
		When & How Often	**By Whom**
Eating ☐ I ☐ S ☐ A ☐ TC	Indicate any dietary needs, such as monitoring, diet orders, supplements, restrictions, food preferences, eating patterns, etc.	☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Medication Administration ☐ I ☐ S ☐ A ☐ TC		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Continence ☐ I ☐ S ☐ A ☐ TC		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Mobility *(Includes bed mobility, using stairs, & transfers to bed, chair, or toilet)* ☐ I ☐ S ☐ A ☐ TC		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Bathing ☐ I ☐ S ☐ A ☐ TC		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Oral Care ☐ I ☐ S ☐ A ☐ TC		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Grooming ☐ I ☐ S ☐ A ☐ TC		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Dressing ☐ I ☐ S ☐ A ☐ TC		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	

BEHAVIORAL/COGNITIVE NEEDS *If an issue never occurs, check "N" & skip to the next item.	How Often The Issue Occurs **N** = Never* **R** = Regular **O** = Occasional **C** = Continuous

Resident:	DOB: mm-dd-yy	Service Plan Date: mm-dd-yy

(Check a box to indicate how often the issue occurs.)	**Services To Be Provided & How They Will Be Provided** *(Based on the Resident Assessment Tool & nursing assessment.)*	**Services To Be Provided**	
		When & How Often	**By Whom**
Vision or Hearing Impairment ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Depression or Withdrawn Behaviors *(Refuses to leave room or socialize with others)* ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Anxiety ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Impaired Recall – Recent or Distant Events *(Specify)* ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Disturbed Sleep Pattern ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Ineffective Communication *(Cannot express needs, ideas, or wishes)* ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Resists Care or Assistance ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Impaired Judgment *(Makes decisions harmful to self or others)* ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Wanders or Elopement Risk ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Agitation *(Easily upset or unsettled)* ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Disruptive Behaviors *(Yells, demands attention, takes others possessions, or inappropriate behaviors)* ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Combative/Aggressive Behaviors *(Throws objects, strikes out, or otherwise harms others)* ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	
Hallucinations or Delusions ☐ N ☐ O ☐ R ☐ C		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ( )	

Resident:	DOB: mm-dd-yy	Service Plan Date: mm-dd-yy

OTHER	**Details**
Resident's background	
Resident's likes & dislikes	
Resident's spiritual needs	
Resident's current daily routine	
Resident's participation in programs outside the facility	
Resident's finances	☐ Family, resident, or resident's representative manages all financial matters independently ☐ Resident manages financial matters with supervision ☐ Assisted living program manages finances
Transportation	☐ Travels independently, all modes of transportation ☐ Needs some assistance/escort ☐ Complete assistance/needs specialized vehicle

Signature of Person Completing the Service Plan: _____ Date Completed: _____

Signature of Delegating Nurse/Case Manager (DN/CM): _____ Date Reviewed: _____

Service Plan Review

(Every 6 months, or more frequently in the event of any significant changes.)

Date	***Reviewed By Manager/designee (signature)***	***Date***	***Reviewed By DN/CM (signature)***