Date:_____ **Individual Resident Care Plan** (Develop within 48 hours of admission) Initials_____

❑ DNR/DNI ❑ Full Code ❑ Advance Directive ❑ Proxy ❑ POLST/MOLST ❑ Other

Admission Diagnosis:

***Fall Risk ❑ Yes ❑ No
If Yes, implement safety measures)
❑ Bed Alarm ❑ Chair Alarm
❑ Sensor ❑ Grab Bar R / L
❑ Floor Mat ❑ Other _____
*****Skin Risk (Braden on admit)**
❑ High Risk-Initiate CP- tissue tolerance
❑ Special Mattress
❑ Heel Protectors/Elevate heels
❑ Barrier cream ❑ W/C cushion
❑ Repositioning Q_____hrs
❑ Incision _____
❑ Wound Location:_____
Prior to admit: ❑ Yes ❑ No
*****Behavior/Mood/ Safety**
❑ History of abusive behaviors
❑ Behaviors ↑ res. to res. altercation
❑ Mood Issues:_____
_____
_____
❑ Behaviors _____
_____
Interventions:_____
_____
❑ Environmental Risks:_____
_____
❑ Elopement Risk_____
❑ Wanderguard _____

Pain Control *(Observe for pain)*
❑ Has pain or discomfort or potential
Location:_____
❑ Use pain scale as applicable
❑ Pain management plan
Interventions:_____

❑ Isolation Precautions_____

Bathing
❑ Tub Schedule_____
❑ Shower Schedule
_____
❑ Bed bath
❑ Independent
❑ **Assist with bathing** ❑ 1 ❑ 2

Dressing
❑ Obtains own clothing
❑ Assist with dressing ❑1 ❑ 2
❑ Ind. ❑ Set-up ❑Cues ❑ Partial
❑ Total ❑
Other_____

Grooming
❑ Independent ❑ Set-up/cues
❑ Partial Assist ❑ Total Assist
Special Instructions: _____
Oral Hygiene
❑ Ind. ❑ Set-up ❑ Assist ❑ Total

Dental Status
❑ Own Teeth
❑ Dentures ❑Upper ❑ Lower
❑ Partial ❑Upper ❑ Lower

Bowel
❑ Continent ❑ Incontinent
❑ Assist ❑ 1 ❑ 2 ❑ Self
Last BM_____
❑ Bowel Program
Bladder
❑ Continent ❑ Incontinent
❑ Assist ❑ 1 ❑ 2 ❑ Self
❑ Foley ❑ Straight cath ❑ Leg bag
❑ Ostomy:_____

Toileting Plan:
❑ Toilet ❑ Urinal ❑ Bedpan
❑ Commode ❑ Check and Change
❑ Prompt ❑ Habit Training
Product:_____
Schedule:_____
_____

Ambulation
❑ Independent with ambulation
❑ Assist with ambulation ❑ 1 ❑ 2
❑ Aids for mobility_____
Transfer
❑ Independent transfer
❑ Assist transfer ❑ 1 ❑ 2
❑ Special transfer aids or mechanical lift___
Mobility
❑ Assist repositioning ❑ 1 ❑ 2
❑ Assist with bed mobility ❑ 1 ❑ 2
❑ Wheelchair mobility ❑ Self ❑ 1
❑ Side Rails Type _____
Splints
❑ Type _____

Vision
❑ Adequate ❑ Impaired
❑ Glasses ❑ Reading glasses only
❑ Contacts

Cognitive
❑ Comatose
❑ Alert and Oriented:_____
❑ Forgetfulness
❑ Confusion: _____

Communication
❑ Adequate Hearing
❑ Hearing Aid ❑ R ❑ L
❑ Deaf ❑ Other_____

Activity Pursuits
❑ Awake during day, sleeps all night
❑ Naps in a.m.
❑ Naps in p.m.
❑ Independent in activities
❑ Assist to activities ❑ In-room
Dehydration Risk
❑ Yes ❑ No Comments:

❑ **Fluid Restriction**:_____ cc
Nutritional Status
❑ Oral problem(s)
❑ Chewing ❑ Swallowing problems
❑ Mouth pain ❑Choking/aspiration
Diet Order _____
❑ **Allergies** _____
❑ Special Likes:_____
❑ Dislikes:_____
❑ Special Needs _____
❑ Thickened Liquids Type:_____
Meal Assistance
❑ Independent
❑ Set-up
❑ Partial assist with feeding
❑ Total assist with feeding
❑ Adaptive equipment – i.e. built-up spoons, plate guard, nosey cup, etc.
Dining Room
❑ Breakfast ❑Noon ❑Evening
Room Tray:_____
❑ Snacks ❑ Nourishments

❑ **Enteral Tube Feeding**: _____
❑ **IV Fluids:** Type:_____
___Nacl lock __PICC __Central line
❑ Dialysis ❑ Shunt
❑ **Oxygen**____liters/min per____

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Discharge Plans:
❑ Return to community
❑ Return to Assisted Living
❑ Remain as long term
❑ Discharge with services
❑ Referrals to be made prior to discharge
Comments:
_____
_____
_____
_____
_____
_____

PASARR Recommendations:
PASARR Level I ❑ Negative ❑ Positive
PASARR Level II
Diagnosis: ❑Mental Disorder ❑Intellectual Disability
❑ Specialized services required
❑ Services in facility
❑ Services outside of facility

Instructions:_____
_____
_____
_____
_____
_____

Therapy Services
❑ Physical therapy
Goal:_____

❑ Occupational Therapy
Goal:_____

❑ Speech Therapy
Goal:_____

❑ Respiratory Services
Goal:_____

Social Services:
❑ Advance Directive
❑ Yes ❑No
❑ Transition of care Services
❑ Specialized communication method
❑ Financial Assistance
❑ Counseling services
❑ Grieving/coping skills needed

List of Medication:

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Initial Goals:
1.
2.
3.
4.
5.

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Problem	Goals	Interim Approaches	Responsible IDT	Evaluation
❑ Potential for alteration in:				
❑ Alteration in:				
AMB:				
❑ Potential for alteration in:				
❑ Alteration in:				
AMB:				
❑ Potential for alteration in:				
❑ Alteration in:				
AMB:				

☐ Resident and resident representative, if applicable, were provided with a written summary of the baseline care plan by providing a copy of the baseline care plan

Resident Signature:_______________________________ Representative Signature:______________________________ Date:______________

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