

Temporary Care Plan



Resident Name _____ Admit date _____

Medical Diagnoses _____

Does the resident have needs in the following areas?		How will needs be met: amount of assistance, frequency, who is responsible?
Medical and Health / Outside Services	Y N	
Behaviors	Y N	
Cognitive / Communicating	Y N	
Bathing	Y N	
Dressing	Y N	
Toileting	Y N	
Grooming	Y N	
Eating / Preparing Meals	Y N	

Temporary Care Plan



Does the resident have needs in the following areas?		How will needs be met: amount of assistance, frequency, who is responsible?
Night Needs	Y N	
Mobility & Transfers	Y N	
Emergency Evacuation	Y N	
Money Management / Access to Transportation	Y N	
Housework / Laundry	Y N	
Medication Management	Y N	

Administrator Signature _____ **Date** _____