# CARE SENIORS, LLC • PLAN OF HOME HEALTH CARE

| PERSONAL CARE | CARE TO BE PROVIDED | COMMENTS |
|---|---|---|
| Complete Bed Bath | | ☐ Every Visit ☐ OTHER: |
| Assist With Bed Bath-Partial/Complete | | ☐ Every Visit ☐ OTHER: |
| Shower/Peri Care | | ☐ Every Visit ☐ OTHER: |
| Shampoo/Hair Care/Comb Hair | | ☐ Every Visit ☐ OTHER: |
| Shave | | ☐ Every Visit ☐ OTHER: |
| Skin Care/Moisture | | ☐ Every Visit ☐ OTHER: |
| Oral Hygiene | | ☐ Every Visit ☐ OTHER: |
| Assist With Dressing | | ☐ Every Visit ☐ OTHER: |

| DIETARY | | | CARE TO BE PROVIDED | |
|---|---|---|---|---|
| Meal Prep: B ☐ L ☐ D ☐ | | Vacuum | ☐ Every Visit | ☐ OTHER: |
| | | Dust | ☐ Every Visit | ☐ OTHER: |
| | | Sweep | ☐ Every Visit | ☐ OTHER: |
| | | Wet mop | ☐ Every Visit | ☐ OTHER: |
| | | Dishes | ☐ Every Visit | ☐ OTHER: |
| Meal Serving/Set-Up ☐ | | Refrigerator | ☐ Every Visit | ☐ OTHER: |
| HDM ☐ | | Clean toilet/tub/sink | ☐ Every Visit | ☐ OTHER: |
| Assist With Feeding ☐ | | Laundry | ☐ Every Visit | ☐ OTHER: |
| Encourage Fluids ☐ | | | | |

| ACTIVITIES | | | |
|---|---|---|---|
| Turn and Position | | ☐ Every Visit | ☐ Other: |
| Transfer to: chair | | ☐ Every Visit | ☐ Other: |
| commode | | ☐ Every Visit | ☐ Other: |
| wheel chair | | ☐ Every Visit | ☐ other: |
| Ambulation with: cane | | ☐ Every Visit | ☐ Other: |
| walker | | ☐ Every Visit | ☐ Other: |
| crutches | | ☐ Every Visit | ☐ Other: |
| assistance | | ☐ Every Visit | ☐ Other: |
| Assist with R.O.M. | | ☐ Every Visit | ☐ Other: |

| ELIMINATION | |
|---|---|
| Bedpan/urinal - Measure | ☐ |
| Commode | ☐ |
| Bathroom | ☐ |
| External Catheter Care | ☐ |
| Empty cath.dmg.bag-measure | ☐ |
| Empty ostomy drng.bag-measure | ☐ |

**Specific Instructions Given By Assessment Nurse
**Do Not Cut Toenails or Fingernails. **Notify Supervisor of Need.**

| Foot Care** | Nail Care** | Cath Care* | Side Rails* |
|---|---|---|---|
| | | | |

| CARE OF PATIENT AREA | | OTHER |
|---|---|---|
| Linen Change/Make Bed | ☐ EveryVisit | ☐ |
| Patient Laundry | ☐ EveryVisit | ☐ |
| Light Housekeeping | ☐ EveryVisit | ☐ |
| Kitchen Cleaning | ☐ EveryVisit | ☐ |
| Bathroom Cleaning/Care | ☐ EveryVisit | ☐ |
| Living Room Cleaning | ☐ EveryVisit | ☐ |
| Bedroom Cleaning | ☐ EveryVisit | ☐ |
| Garbage Removal | ☐ EveryVisit | ☐ |
| Pharmacy Errands | ☐ EveryVisit | ☐ |
| Errands | ☐ EveryVisit | ☐ |

| | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
|---|---|---|---|---|---|---|---|
| PCS | | | | | | | |
| HMK | | | | | | | |
| RESPITE | | | | | | | |

I, _____ have reviewed the Plan of Care with
CLIENT

_____, and completely understand the duties/tasks of my care that will be performed.
Assessment Nurse Name

Client Signature: _____ Date : _____

Assessment Nurse Signature : _____ Date: _____