Sample Weekly Care Notes

Per COMAR 10.07.14.27D:
D. Resident Care Notes.
   (1) Appropriate staff shall write care notes for each resident:
       (a) On admission and at least weekly;
       (b) With any significant changes in the resident's condition, including
           when incidents occur and any follow-up action is taken;
       (c) When the resident is transferred from the facility to another skilled
           facility;
       (d) On return from medical appointments and when seen in home by any
           health care provider;
       (e) On return from nonroutine leaves of absence; and
       (f) When the resident is discharged permanently from the facility,
           including the location and manner of discharge.
   (2) Staff shall write care notes that are individualized, legible, chronological, and signed by the writer.

The following are three (3) samples of forms that may be used to satisfy the weekly care note requirement. Please note that these forms are not meant to be all inclusive; if warranted, additional information may be required. In addition, these samples may not be used for the admission, transfer, or discharge notes. If your program already maintains a resident record (daily or otherwise) that meets all the requirements set forth in COMAR 10.07.14.27D, you do not need to write a duplicate weekly note (provided a note is already written for each resident at least weekly).
Resident Name_______________________________________

Date ____________
Has this resident had any medical issues or cognitive changes in the past week?
Yes ____         No ____           If yes, please see nurses notes.
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Has the resident had any new orders in the past week?
Yes _____       No _____       If yes, please see physician’s orders.
Has the resident had any changes in ADL function?
Yes _____       No _____       If yes, please explain and change Service plan if needed.
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Has the resident had any tests or labs done in the past week?
Yes _____       No _____       If yes, see lab/x-ray section of the chart.
Comments: ________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Nurses signature: _________________________________________________

Date ____________
Has this resident had any medical issues or cognitive changes in the past week?
Yes ____         No ____           If yes, please see nurses notes.
__________________________________________________________________________________________
__________________________________________________________________________________________
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Has the resident had any new orders in the past week?
Yes _____       No _____       If yes, please see physician’s orders.
Has the resident had any changes in ADL function?
Yes _____       No _____       If yes, please explain and change Service plan if needed.
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Has the resident had any tests or labs done in the past week?
Yes _____       No _____       If yes, see lab/x-ray section of the chart.
Comments: ________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
Nurses signature: __________________________________________________
Resident Name_______________________________________

<table>
<thead>
<tr>
<th>MONTH</th>
<th>YEAR</th>
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Did resident go to the doctor this week? | Any change in medication? | Any physical or behavioral changes? | Any new complaints? |
YES | NO | YES | NO | YES | NO | YES | NO |

Comment on any yes responses, or state that resident is stable:

__________________________________________

Signature_________________________Date_______________________

Did resident go to the doctor this week? | Any change in medication? | Any physical or behavioral changes? | Any new complaints? |
YES | NO | YES | NO | YES | NO | YES | NO |

Comment on any yes responses, or state that resident is stable:

__________________________________________

Signature_________________________Date_______________________

Did resident go to the doctor this week? | Any change in medication? | Any physical or behavioral changes? | Any new complaints? |
YES | NO | YES | NO | YES | NO | YES | NO |

Comment on any yes responses, or state that resident is stable:

__________________________________________

Signature_________________________Date_______________________

Did resident go to the doctor this week? | Any change in medication? | Any physical or behavioral changes? | Any new complaints? |
YES | NO | YES | NO | YES | NO | YES | NO |

Comment on any yes responses, or state that resident is stable:

__________________________________________

Signature_________________________Date_______________________
XYZ Assisted Living
Weekly Care Note

Resident: ________________________________
Month: ________________________________

Week: ________________________________

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<thead>
<tr>
<th></th>
<th>yes</th>
<th>no</th>
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<tbody>
<tr>
<td>Changes in medication?</td>
<td>yes</td>
<td>no</td>
<td>n/a</td>
</tr>
<tr>
<td>Changes in food intake?</td>
<td>yes</td>
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<td>yes</td>
<td>no</td>
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<td>Changes in mental status?</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>Falls?</td>
<td>yes</td>
<td>no</td>
<td>n/a</td>
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<tr>
<td>Skin Issues?</td>
<td>yes</td>
<td>no</td>
<td>n/a</td>
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<tr>
<td>Constipation Issues?</td>
<td>yes</td>
<td>no</td>
<td>n/a</td>
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<tr>
<td>Insomnia problems?</td>
<td>yes</td>
<td>no</td>
<td>n/a</td>
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<tr>
<td>Hospitalizations/ER Visits?</td>
<td>yes</td>
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<td>n/a</td>
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<td>yes</td>
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<tr>
<td>Other changes to care?</td>
<td>yes</td>
<td>no</td>
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Explain any items marked yes above. **Were these reported to the ALM and/or Delegating Nurse?** Also document any other observations.

________________________________________________________________________________________
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_______________________________________________Signature:__________________________________

Week: ________________________________

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___________________________________________________Signature:______________________________