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).

ABC Assisted Living
WEEKLY CARE NOTES

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.
_____
_____
_____
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: _____

EFG Assisted Living
RESIDENT WEEKLY LOG

Resident Name____

MONTH _______________YEAR_____________

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: _____

Changes in medication**?**	yes	no	n/a
Changes in food intake?	yes	no	n/a
Changes in behavior?	yes	no	n/a
Changes in mental status?	yes	no	n/a
Falls?	yes	no	n/a
Skin Issues?	yes	no	n/a
Constipation Issues?	yes	no	n/a
Insomnia problems?	yes	no	n/a
Hospitalizations/ER Visits?	yes	no	n/a
Doctor Appointments?	yes	no	n/a
Other changes to care?	yes	no	n/a

Explain any items marked yes above. **Were these reported to the ALM and/or Delegating Nurse?** Also document any other observations.

_____

_____

_____

_____

_____

_____Signature:_____

Week: _____

Changes in medication**?**	yes	no	n/a
Changes in food intake?	yes	no	n/a
Changes in behavior?	yes	no	n/a
Changes in mental status?	yes	no	n/a
Falls?	yes	no	n/a
Skin Issues?	yes	no	n/a
Constipation Issues?	yes	no	n/a
Insomnia problems?	yes	no	n/a
Hospitalizations/ER Visits?	yes	no	n/a
Doctors Appointments?	yes	no	n/a
Other changes to care?	yes	no	n/a

Explain any items marked yes above. **Were these reported to the ALM and/or Delegating Nurse?** Also document any other observations.

_____

_____

_____

_____

_____

_____Signature:_____