Chimes Virginia Residential Daily Notes: Shift 9 AM – 11 PM

Date: _____ Individual: _____ Medicaid Number: _____
Any Medical/Safety Concerns □ No □ Yes What? _____

_____

Any Medication Concerns or Refusals? □ No □ Yes What? _____

_____

Incident Report completed During the Shift? □ No □ Yes _____

*If you checked yes to any Medical, Safety, Medication or Incidents you must verbally report to Manager. Staff Initials: _____ Date/Time Reported: _____

Did Individual Go to Day Program/Work □ No □ Yes Arrival Time: _____ Provider Name: _____

Ate how much of Lunch: □ Away During Lunch □ None □ Less than 25% □ 26%-50% □ 51%-75% □76%-100%

Comments about Lunch: _____

*If less than 25% eaten, employee must verbally notify manager. Staff Initials: _____ Date/Time Reported: _____

Ate how much of Dinner: □ Away During Dinner □ None □ Less than 25% □ 26%-50% □ 51%-75% □76%-100%

Comments about Dinner: _____

*If less than 25% eaten, employee must verbally notify manager. Staff Initials: _____ Date/Time Reported: _____

Aggressive/Inappropriate Behaviors Observed □ No □ Yes What? _____

_____

□ Community Participation: Where? _____ What activity? _____
What did the individual enjoy or not enjoy? _____

_____

PM Supports
□ Lunch Preparation □ Dinner Prepared □ Dressing □ Medication Administration □ Money Management
□ Chores/Other (List) _____

_____

Personal Hygiene Activities: □ Bath/Shower □ Teeth Brushing □ Hair Care □ Shaving □ Face Washing
□ Hand Washing □ Toileting
Anything different than Normal? _____

_____

PM Individual Service Plan Outcomes
Outcome/s Addressed # _____
How did you support them to complete the outcome/s? _____

_____

_____

_____

_____

_____

What did individual do and how did they respond? _____

_____

_____

_____

_____

_____

Progress made or challenges with outcomes? _____

_____

_____

Staff Name: _____ Staff Signature: _____
Staff Name: _____ Staff Signature: _____
Manager's Signature: _____ Date Manager Reviewed: _____

Chimes Virginia Residential Daily Notes: Shift 11 PM - 9 AM

Date: _____ Individual: _____ Medicaid Number: _____

Any Medical/Safety Concerns □ No □ Yes What? _____

_____

Any Medication Concerns or Refusals? □ No □ Yes What? _____

_____

Incident Report completed During the Shift? □ No □ Yes _____

*If you checked yes to any Medical, Safety, Medication or Incidents you must verbally report to Manager. Staff Initials: _____ Date/Time Reported: _____

Did Individual Go to Day Program/Work □ No □ Yes Time Left: _____ Provider Name: _____

Ate how much of Breakfast: □ Away During Breakfast □ None □ Less than 25% □ 26%-50% □ 51%-75% □76%-100%

Comments about Breakfast: _____

*If less than 25% eaten, employee must verbally notify manager. Staff Signature: _____ Date/Time Reported: _____

Aggressive/Inappropriate Behaviors Observed □ No □ Yes What? _____

_____

Overnight Supervision Provided: □ 15 minute checks □ One-on-One □Other _____

Individual assisted during Overnight with: □ Using Restroom □ Checking/Changing Incontinence Product

□ Seizure □ Behavior □ Safety Concerns □ Medical Concern □ Other (List):

_____

AM Supports

□ Breakfast Preparation □ Dressing □ Medication Administration □ Money Management □ Chores (List) _____

_____

Personal Hygiene Activities: □ Bath/Shower □ Teeth Brushing □ Hair Care □ Shaving □ Face Washing □ Hand Washing □ Toileting

Anything different than Normal? _____

_____

AM Individual Service Plan Outcomes

Outcome/s Addressed # _____

How did you support them to complete the outcome/s? _____

_____

_____

_____

_____

_____

What did individual do and how did they respond? _____

_____

_____

_____

_____

_____

Progress made or challenges with outcomes? _____

_____

_____

Overnight Staff Name: _____ Overnight Staff Signature: _____

Manager's Signature: _____ Date Manager Reviewed: _____