Assisted living facility type I & II resident assessment

Resident name: _____ Admission date: _____

Date of birth: _____ Age: _____

Assessment date: _____ Assessment type: ____ Initial ____ 6 month ____ Significant change

Medication assessment

Medication	Dosage	Route	Frequency by time

OR

- ☐ **Reviewed all current medications.**
- ☐ **See Medication Administration Record (MAR) for a list of current medication, dosage and frequency.**

Assessed level of medication assistance needed:

- ☐ **Self-administer:** Requires no assistance or supervision, may keep under own control in own room. Locked container may be needed for safety.
- ☐ **Self-direct medication administration:** Resident can recognize medications offered by color or shape; and questions differences in the usual routine of medications. Assistance Needed:
  - ☐ Reminder to take
  - ☐ Opening Container
  - ☐ Remind Resident/Responsible person when prescriptions need to be filled
- ☐ **Family/designated person administer:** If a family member or designated responsible person assists with medication administration, they shall sign a waiver indicating that they agree to assume the responsibility to fill prescriptions, administer medication, and document that the medication has been administered. Facility staff may not serve as the designated responsible person.
- ☐ **Significant total assist:** Facility Staff administer medications as delegated by a licensed health care professional according to service plan.
- ☐ **Home health or hospice agency to administer:** Agency staff may provide medication administration to resident exclusively, or in conjunction with the above methods.

Comment: _____

_____

Independent Personal Insulin Injections Assessment: (if applicable)

- ☐ **Self-administer:** Requires no assistance or supervision, may keep under own control in own room. Locked container may be needed for safety.

Known medication allergies: _____

_____

Person who will provide medications for resident: Name, address, and telephone number: _____

_____

_____

Applicable diagnoses: _____

_____

_____

Physical assessment

Vital signs: Temperature: _____ Pulse: _____ Respiration: _____ B/P: _____

Weight: _____ Height: _____ SpO2: _____

Medical/surgical history: _____

_____

_____

- ☐ Pneumococcal vaccine date:_____
- ☐ Influenza vaccine date:_____

Integumentary System	☐ Abrasions, skin tears, rashes, open lesions ☐ Skin color good within normal limits ☐ Pressure ulcer- any lesion caused by pressure resulting in damage of underlying tissue ☐ Stasis ulcer- open lesion caused by poor circulation in the lower extremities ☐ Bruises, abrasions ☐ Burns ☐ Open lesions other than ulcers, rashes, cuts ☐ Rashes- eczema, drug rash, heat rash, herpes, blisters ☐ Skin tears or cuts (other than surgery) ☐ Surgical wounds Narrative/describe: _____ _____ _____ _____ _____

Respiratory System	☐ Lungs clear to auscultation in all fields ☐ Respirations quiet/easy/regular, no cough ☐ Cough (productive, non-productive and chronic) ☐ Nail beds and mucous membranes pink ☐ Shortness of breath Inability to lie flat due to shortness of breath ☐ Oxygen therapy ☐ Other respiratory problems Narrative/describe:
Genitourinary System	☐ Able to empty bladder without difficulty or pain ☐ Frequent urinary tract infections ☐ Incontinence of urine ☐ Uses urinal/pads/brief ☐ Urine clear, yellow ☐ Prostate problems Narrative/describe:

Musculoskeletal System	☐ Joint swelling\tenderness ☐ ROM limitations ☐ Muscle weakness ☐ ADL problems ☐ Activity/function limitations ☐ Inflammation ☐ Nodules Narrative/describe:
Cardiovascular System	☐ Regular heart rate ☐ Peripheral pulses palpable ☐ Chest pain ☐ Edema in lower extremities ☐ Calf tenderness ☐ Dizziness ☐ Weight gain ☐ Headaches, especially in the morning ☐ Heart murmur Narrative/describe:

Gastrointestinal System	☐ Bowel sounds present ☐ Good to fair appetite ☐ Nausea or vomiting with meals ☐ Regular bowel movements, normal consistency ☐ Adequate fluid intake ☐ Weight loss or gain ☐ Constipation ☐ Diarrhea ☐ Ulcers ☐ Ostomy present ☐ Uses dentures or removable bridge ☐ Mechanically altered diet ☐ Dietary supplement between meals ☐ Chewing problems ☐ Swallowing problems ☐ Aspiration risk Narrative/describe: _____ _____ _____ _____ _____ _____
Accidents	☐ Fell in the past 30 days ☐ Fell in the past 31-180 days ☐ Hip fracture in the last 180 days ☐ Other fracture in the last 180 days Narrative/describe: _____ _____ _____ _____ _____

Memory	☐ Can you tell me how old you are?_____ ☐ When is your birthday?_____ ☐ Can you tell me what day is today?_____ ☐ Can you tell me the address where you live?_____ ☐ Can you tell me the city in which you live?_____ ☐ The state?_____ ☐ Can you tell me who the president of the United States is?_____ ☐ Who was the president before him?_____ ☐ Can you spell world?_____ ☐ Can you spell world backwards for me?_____ Narrative/describe: _____ _____ _____ _____ _____ _____
Pain Assessment	☐ Chronic pain ☐ Back pain ☐ Bone pain ☐ Chest pain while doing usual activities ☐ Headaches ☐ Hip pain ☐ Joint pain (other than hip) ☐ Stomach pain ☐ Muscle pain Narrative/describe: _____ _____ _____ _____ _____ _____

Endocrine System	☐ Absence of thyroid or endocrine problems or dysfunctions ☐ Diabetes ☐ Prostate gland problems ☐ Mastectomy ☐ Hysterectomy ☐ Normal menopause ☐ Breast mass or pain Narrative/describe: _____ _____ _____ _____ _____ _____
Neurological System	☐ PERL ☐ Alert and oriented to person, place and time ☐ Memory intact ☐ Verbalization clear and understandable ☐ Slurred speech ☐ Normal gait ☐ Normal swallowing/gag reflex ☐ Regular sleep pattern ☐ Hearing impairment ☐ Using hearing aid ☐ Visual impairment ☐ Visual limitations ☐ Glasses ☐ Seizures ☐ Active ROM of all extremities with symmetry and strength Narrative/describe: _____ _____ _____ _____ _____ _____

Activities of daily living assessment

Assessment of resident's ability or present condition in the following:

"Independent" the resident can perform without help.

"Assistance" the resident can perform some part, but cannot do it entirely alone.

"Dependent" the resident cannot perform any part; it must be done entirely by someone else.

1. **Memory** (Narrative) _____

_____

_____

2. **Capacity in making daily decisions**

☐ Independent ☐ Assistance ☐ Dependent

Describe: _____

_____

_____

3. **Ability to communicate effectively with others** (Narrative)

☐ Independent ☐ Assistance ☐ Dependent

Describe: _____

_____

_____

4. **Physical functioning and ability to perform activities of daily living (ADL)**

a. **Personal grooming**

☐ Independent ☐ Assistance ☐ Dependent

Describe: _____

_____

b. **Oral hygiene/denture care**

☐ Independent ☐ Assistance ☐ Dependent

Describe: _____

_____

c. **Dressing**

☐ Independent ☐ Assistance ☐ Dependent

Describe:

d. **Toileting, toilet hygiene**

☐ Independent ☐ Assistance ☐ Dependent

Describe:

e. **bathing**

☐ Independent ☐ Assistance ☐ Dependent

Describe:

f. **Eating at mealtime**

☐ Independent ☐ Assistance ☐ Dependent

Describe:

Type of diet:

Food allergies:

g. **Ambulation or mobility**

☐ Independent ☐ Assistance ☐ Dependent

Describe:

h. **Transfers**

☐ Independent ☐ Assistance ☐ Dependent

Describe:

i. **Hearing aides/assistive devices**

☐ Independent ☐ Assistance ☐ Dependent

Describe:

5. **Continence**

Continent of ☐ Bowel & bladder ☐ Bowel only ☐ Bladder only

Describe:

6. **Mood and behavior patterns** (Narrative)

7. **Special treatments and procedures** (Narrative)

8. **Assistive devices and assistance needed to promote independence - walker, cane, wheelchair, crutches, etc.** (Narrative)

9. **Prosthetic devices used and assistance needed - glasses, dentures, hearing aids etc.** (Narrative)

10. **Specific assistance needs (include frequency and time):**

Housekeeping

Maintain independence and sense of direction

Ambulation

Transferring

Communication

Managing personal resources

Scheduling appointments

Activities and leisure needs assessment

Resident will be encouraged to maintain and develop their fullest potential for independent living through participation in activity and recreational programs.

Current interests

Past interests

Residents needs

Assess needed physician and or other appointments (lab work, therapy etc.) and person responsible to schedule and transport.

If resident is receiving home health or hospice agencies services, identify services provided and provider's name and phone numbers.

Physician: _____

Phone: _____

Address: _____

Dentist: _____

Phone: _____

Address: _____

Family contact person(s)

Physician: _____ Relationship _____

Phone: _____

Address: _____

Physician: _____ Relationship _____

Phone: _____

Address: _____

Physician: _____ Relationship _____

Phone: _____

Address: _____

Assisted Living Facilities are intended to enable persons experiencing functional impairment to receive 24-hour personal care and health-related services in a place of residence with sufficient structure to meet their care needs in a safe manner. Type I and Type II assisted living facilities **shall not admit or retain a person who**: (1) manifests behavior that is suicidal, sexually or socially inappropriate, assaultive, or poses a danger to self or others; (2) has active tuberculosis or other chronic communicable diseases that cannot be treated in the facility or on an outpatient basis; or may be transmitted to other residents or guests through the normal course of activities; or (3) requires inpatient hospital, long-term nursing care or 24-hour continual nursing care that will last longer than 15 calendar days after the day on which the nursing care begins.

AL Type I Residents are provided limited assistance with Activities of Daily Living, and social care in a residential setting. A Type I facility **shall accept and retain** residents who meet the following criteria: (1) are ambulatory or mobile and are **capable of taking life-saving action in an emergency without the assistance of another person**; (2) have stable health; (3) require no assistance or only limited assistance in the activities of daily living (ADL); and (4) do not require total assistance from staff or others with more than three ADLs. A Type I facility may accept and retain residents who meet the following criteria: (1) are cognitively impaired or physically disabled but able to evacuate from the facility without the assistance of another person; and (2) require and receive intermittent care or treatment in the facility from a licensed health care professional either through contract or by the facility, if permitted by facility policy.

AL Type II Residents are provided care in a home-like setting that provides an array of coordinated supportive personal and health care services available 24 hours per day to residents who need any of these services as required by Utah Department of Health rule. A Type II facility may accept and retain residents who meet the following criteria: (1) require total assistance from staff or others in more than three ADLs, provided that the staffing level and coordinated supportive health and social services meet the needs of the resident and the **resident is capable of evacuating the facility with the limited assistance of one person**; (2) are physically disabled but able to direct their own care; or (3) are cognitively impaired or physically disabled but able to evacuate from the facility with the limited assistance of one person.

- ☐ To the best of my knowledge this resident meets the above admission criteria for an Assisted Living **Type I facility**.
- ☐ To the best of my knowledge this resident meets the admission criteria for an Assisted Living **Type II facility**.

Assisted Living facility assessments must be completed by a licensed health care professional (physician, advanced practice registered nurse, physician assistant, or a registered nurse)

Signature: _____ Title: _____

Date: _____ Printed name: _____