



Delaware Health and Social Services  
Division of Long Term Care Residents Protection

**Uniform Assessment Instrument  
for  
Assisted Living Facilities**

Revised January 23, 2008

## INTRODUCTION

The purpose of the Uniform Assessment Instrument (UAI) is to collect information regarding an assisted living applicant/resident's physical condition, medical status and psychosocial needs. The information is to be used to: (1) determine if an applicant meets eligibility for entrance or retention in an assisted living facility; (2) if admitted, determine the appropriate level of care for the resident and develop a service agreement; and (3) update service needs and the service agreement.

A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission and no later than day of admission. In all cases the assessment will be completed prior to admission. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.

Regulation 5.9 states that the Assisted Living facilities shall not admit, provide services to, or permit the provision of services to any individual with any of the following conditions: Check whether these conditions are present:

- Requires care by a nurse that is more than intermittent or for more than a limited period of time.
- Requires skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or reasonable potential of, an acute episode unless there is a RN to provide appropriate care.
- Requires monitoring of a chronic medical condition that is not essentially stabilized through available medications and treatments.
- Is bedridden for more than 14 days.
- Has developed stage three or four skin ulcers.
- Requires a ventilator.
- Requires treatment for a disease or condition that requires more than contact isolation.
- Has an unstable tracheostomy or has a stable tracheostomy of less than six months' duration.
- Has an unstable peg tube.
- Requires an IV or central line with an exception for a completely covered subcutaneously implanted venous port, provided the assisted living facility meets the following standards: 1) Facility records shall include the type, purpose and site of the port, the insertion date, and the last date medication was administered or the port flushed; 2) The facility shall document the presence of the port on the Uniform Assessment Instrument, the service plan, interagency referrals and any facility reports; and 3) The facility shall not permit the provision of care to the port or surrounding area, the administration of medication or the flushing of the port or the surgical removal of the port within the facility by facility staff, physicians or third party providers.
- Wanders such that the assisted living facility would be unable to provide adequate supervision and/or security arrangements.
- Exhibits behaviors that present a threat to the health or safety of themselves or others, such that the assisted living facility would be unable to eliminate the threat either through

immediate discharge or use of immediate appropriate treatment modalities with measurable documented progress within 45 days.

- Is socially inappropriate as determined by the assisted living facility such that the facility would be unable to manage the behavior after documented, reasonable efforts such as clinical assessments and counseling for a period of no more than 60 days.

If any of these conditions are present **and the resident/applicant is not receiving Hospice care**, assisted living is not appropriate for the resident/applicant. **If the resident is receiving Hospice care**, the above restrictions do not apply, provided that the Hospice program: 1) is licensed by the Department of Health and Social Services and 2) provides written assurance that, in conjunction with care provided by the assisted living facility, all of the resident's needs will be met without placing other residents at risk.

## SECTION ONE - General Information

Resident Name (Last, First, MI) \_\_\_\_\_  
SS # \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  male  female

Date of Admission: \_\_\_\_\_

Assessment (✓ one):

- Initial date \_\_\_\_\_  
 30-day date \_\_\_\_\_  
 Significant Change date \_\_\_\_\_  
 Annual date \_\_\_\_\_

Source of Information (✓ all that apply)

- Self  
 Family  
 Healthcare Provider  
 Other

## SECTION TWO - Functional Abilities, Supports, and Related Information

### Activities of Daily Living (ADLs)

1. \_\_\_ Eating Meals
  - A Independent
  - B Supervision, set up, cuing, coaching, reminders of meal times
  - C Fluid and food Intake recorded for each meal/supplements/snacks; and/or observation due to chewing, swallowing, eating difficulties
  - D Must be fed; needs tube feeding; 1:1 observation/assistance
2. \_\_\_ Toileting
  - A Toilets self; completes own hygiene including incontinence care; colostomy/catheter self-care
  - B Assist with empty, flush, hygiene after use; toilets self during day; assisted at night
  - C Needs observation/standby/transfer assist during toileting; output monitored/recorded by staff
  - D Unable to toilet self or self manage incontinence; needs colostomy/catheter assist; requires formal bowel/bladder incontinence program
3. \_\_\_ Mobility
  - A Independent (or with assistive device)
  - B Supervision, cuing and coaching
  - C Occasional physical assistance required
  - D Walks/wheels only with physical assistance
4. \_\_\_ Bed Mobility
  - A Independent (or with assistive device)
  - B With supervision, cuing and coaching
  - C One person physical assistance
  - D Two person physical assistance, needs complete assistance
5. \_\_\_ Use of Stairs
  - A Independent (or with assistive device)
  - B With supervision, or standby, or cuing and coaching
  - C One person physical assistance
  - D Two person physical assistance, or unable to use stairs
6. \_\_\_ Transferring
  - A Transfers self
  - B Needs standby assistance during transfers
  - C One person physical assistance
  - D Two person physical assistance; needs complete assistance or mechanical assistance (e.g. Hoyer lift)

7. \_\_\_ Grooming: oral hygiene, make-up, shaving, hair, nail care  
 A Independent  
 B Needs set up  
 C With supervision, cuing and coaching  
 D Needs complete assistance
8. \_\_\_ Dressing  
 A Independent  
 B With supervision, or set-up, or cuing and coaching.  
 C With physical assistance  
 D Needs complete assistance
9. \_\_\_ Bathing  
 A Bathes self  
 B Bathes with reminders/prompts  
 C Needs to be set up with water and supplies; needs occasional assistance with back, feet, peri-care  
 D Needs complete assistance or constant supervision
10. \_\_\_ Medication Management  
 A Independent  
 B Reminders  
 C Set-up or assistance  
 D Administration of medication
11. \_\_\_ Emergency Response  
 A Independent (or with assistive device)  
 B With supervision, cuing and coaching  
 C One person physical assistance  
 D Two person physical assistance, needs complete assistance

**Assistive Devices and Medical Equipment (Please check all that apply)**

	Currently Uses	Requires Assessment to Determine Need		Currently Uses	Requires Assessment to Determine Need
<b><u>MOBILITY</u></b>			<b><u>TOILETING</u></b>	<input type="checkbox"/>	<input type="checkbox"/>
Cane	<input type="checkbox"/>	<input type="checkbox"/>	Bed pan/Urinal	<input type="checkbox"/>	<input type="checkbox"/>
Crutches	<input type="checkbox"/>	<input type="checkbox"/>	Commode	<input type="checkbox"/>	<input type="checkbox"/>
Hoyer Lift	<input type="checkbox"/>	<input type="checkbox"/>	Grab Bars	<input type="checkbox"/>	<input type="checkbox"/>
Walker	<input type="checkbox"/>	<input type="checkbox"/>	Raised Toilet Seat	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair (electric)	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Wheelchair (manual)	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>COMMUNICATION</u></b>		
Other _____			Electronic Communication Device	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>RESPIRATION</u></b>			Eye Glasses/Corrective Lenses	<input type="checkbox"/>	<input type="checkbox"/>
Nebulizer	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen	<input type="checkbox"/>	<input type="checkbox"/>	Interpreter (Language)	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Interpreter (Sign)	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>EATING</u></b>			Lifeline	<input type="checkbox"/>	<input type="checkbox"/>
Hand Splint/Braces	<input type="checkbox"/>	<input type="checkbox"/>	TTY (Teletypewriter)	<input type="checkbox"/>	<input type="checkbox"/>
Feeding Pump	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Special Utensil/Plate	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>BATHING</u></b>		
Other _____			Bath Bench	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>SKIN CARE</u></b>			Grab Bar/Tub Rail	<input type="checkbox"/>	<input type="checkbox"/>
Special Mattress	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Pressure Relief Device	<input type="checkbox"/>	<input type="checkbox"/>			
Positioning Device	<input type="checkbox"/>	<input type="checkbox"/>			
Other _____					

### SECTION THREE - Health Information

Primary Physician's Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Most Recent Hospitalization - date and reason: \_\_\_\_\_

Vital Signs: BP \_\_\_\_\_ T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

**Physical and Mental Health (check all that apply)**

Onset (if known)

**Neurological Disorders/Developmental Disabilities**

- \_\_\_\_\_ Brain Injury
- \_\_\_\_\_ Seizure disorder/Epilepsy
- \_\_\_\_\_ Spinal Cord Injury, \_\_\_\_\_Level
- \_\_\_\_\_ Stroke
- \_\_\_\_\_ Paralysis
- \_\_\_\_\_ Dementia/Alzheimer's
- \_\_\_\_\_ ALS
- \_\_\_\_\_ Multiple Sclerosis
- \_\_\_\_\_ Mental Retardation
- \_\_\_\_\_ Autism
- \_\_\_\_\_ Cerebral Palsy
- \_\_\_\_\_ Parkinson's
- \_\_\_\_\_ Other \_\_\_\_\_

**ALLERGIES**

- Food: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Latex \_\_\_\_\_
- IV Contrast \_\_\_\_\_
- \_\_\_\_\_
- Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Eye Disorders**

- \_\_\_\_\_ Cataracts
- \_\_\_\_\_ Glaucoma
- \_\_\_\_\_ Macular Degeneration
- \_\_\_\_\_ Blindness
- \_\_\_\_\_ Other \_\_\_\_\_

**Metabolic Disorders**

- \_\_\_\_\_ Diabetes: \_\_\_\_\_Type I \_\_\_\_\_Type II
- \_\_\_\_\_ Renal: \_\_\_\_\_Dialysis \_\_\_\_\_Chronic Renal Failure
- \_\_\_\_\_ Thyroid: \_\_\_\_\_Hyper \_\_\_\_\_Hypo
- \_\_\_\_\_ Other \_\_\_\_\_

**Musculoskeletal**

- \_\_\_\_\_ Amputation
- \_\_\_\_\_ Arthritis: \_\_\_\_\_Osteo \_\_\_\_\_Rheumatoid
- \_\_\_\_\_ Osteoporosis
- \_\_\_\_\_ Fractures
- \_\_\_\_\_ Weakness
- \_\_\_\_\_ Other \_\_\_\_\_

**Cardio/Vascular/Pulmonary Disorders**

- \_\_\_\_\_ Congestive Heart Failure
- \_\_\_\_\_ Hypertension
- \_\_\_\_\_ Myocardial Infarct
- \_\_\_\_\_ CABG \_\_\_\_\_Valve Surgery
- \_\_\_\_\_ Afib \_\_\_\_\_V-tach \_\_\_\_\_AICD \_\_\_\_\_PACER \_\_\_\_\_Angina
- \_\_\_\_\_ Peripheral Vascular Disease
- \_\_\_\_\_ COPD: \_\_\_\_\_Asthma \_\_\_\_\_Asbestosis \_\_\_\_\_Emphysema
- \_\_\_\_\_ Chronic Bronchitis
- \_\_\_\_\_ Pneumonia

- \_\_\_\_\_ Sleep Apnea
- \_\_\_\_\_ Shortness of Breath
- \_\_\_\_\_ Other \_\_\_\_\_

**Gastrointestinal Disorders**

- \_\_\_\_\_ Stomach: \_\_\_\_\_GERD \_\_\_\_\_Ulcers
- \_\_\_\_\_ Liver: \_\_\_\_\_Hepatitis \_\_\_\_\_Cirrhosis
- \_\_\_\_\_ Intestinal: \_\_\_\_\_Colitis \_\_\_\_\_Diverticulosis \_\_\_\_\_Hemorrhoids \_\_\_\_\_Constipation \_\_\_\_\_Loose Stools
- \_\_\_\_\_ Bowel Incontinence
- \_\_\_\_\_ Other \_\_\_\_\_

**Hematologic/Oncological Disorders**

- \_\_\_\_\_ Anemia
- \_\_\_\_\_ Cancer \_\_\_\_\_
- \_\_\_\_\_ Immune System Disorder \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

**Psychiatric**

- \_\_\_\_\_ Anxiety Disorders
- \_\_\_\_\_ Bipolar
- \_\_\_\_\_ Major Depression
- \_\_\_\_\_ Schizophrenia
- \_\_\_\_\_ Other \_\_\_\_\_

**Infectious Disease Disorders**

- \_\_\_\_\_ Hepatitis \_\_\_\_\_A \_\_\_\_\_B \_\_\_\_\_C
- \_\_\_\_\_ HIV/AIDS
- \_\_\_\_\_ TB
- \_\_\_\_\_ MRSA
- \_\_\_\_\_ VRE
- \_\_\_\_\_ Other \_\_\_\_\_

**GenitoUrinary Disorders**

- \_\_\_\_\_ Incontinence
- \_\_\_\_\_ Urinary Tract Infection
- \_\_\_\_\_ Nocturia

**Past Surgeries (date, if known)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**All Other Problems**

\_\_\_\_\_

\_\_\_\_\_

**HOSPICE**

Is the resident currently receiving or arranging for hospice care?

- Yes  No

If Yes, name of provider

\_\_\_\_\_



**FALL RISK ASSESSMENT**

Identify any conditions and/or factors currently present that may increase the resident’s risk of falling and/or suffering injury from a fall (check all that apply):

- Paralysis
- Orthostatic Hypotension
- Osteoporosis
- Gait Problem
- Impaired balance
- Confusion
- Parkinsonism
- Amputation
- Pain
- TIA
- Dizziness/Vertigo
- Unstable transition from seated to standing position
- Balance problems when standing
- Limits activities due to fear of falling
- Fell in last 30 days
- Fell in last 31-180 days
- Other (describe)\_\_\_\_\_

**SMOKING HABITS**

- Does resident smoke?  yes  no  
If yes, does resident smoke -  indoors  outdoors  
Is resident receiving oxygen therapy?  yes  no  
Describe any safety concerns pertaining to the resident’s smoking habits:
- 

**ALCOHOL HABITS**

- Does resident drink alcoholic beverages?  yes  no  
How many drinks per week? \_\_\_\_\_  
Has the resident ever had any health and/or personal problems due to his/her intake of alcohol?  yes  no

**SKIN CARE/TREATMENTS**

- Skin ulcers  yes  no  
Type  pressure  Stasis  
Stage (1,2) \_\_\_\_\_  
 Reddened areas/frequent assessments  
 Decubitus care required (stages 1, 2)

Current Skin Condition: (check all that apply)

- Normal skin care required, including diabetic skin assessment
- Dry skin requires frequent lotioning
- Wound care required for Stage 3, 4 (Hospice only)
- Bruises, abrasions
- Cancerous lesions
- Rash (eczema, herpes zoster, etc.)
- Skin tears
- Other (describe)\_\_\_\_\_

Skin Treatment: (describe)

---

---



**TREATMENTS/THERAPIES:** Identify physician ordered/referred, or authorized services resident currently receives

	Self-Arranged or Self-Administered	Arranged by Facility	Administered by Facility
Behavior Management Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Control Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Control Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Catheter Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemo/Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding Tube (established)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ostomy Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rehab (pt,ot,st)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy or Counseling Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Therapy Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wound or Skin Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**TESTING/MONITORING:**

Describe any assistance required to facilitate treatments/therapies, including and specifying any assistance provided by family member/support person:

---



---



---



---



---

Does a recommendation need to be made that the resident see a physician for a medical problem not being addressed?

Yes  No

If Yes, describe medical problem:

---



---



---



---



---

**SECTION FOUR - Psychological/Social/Cognitive Information**

<u>Background Information</u>	
Orientation: Indicate Yes or No	<input type="checkbox"/> ___ Person <input type="checkbox"/> ___ Place <input type="checkbox"/> ___ Time
Short-term Memory OK - seems to recall after five (5) minutes:	<input type="checkbox"/> Memory OK <input type="checkbox"/> Memory Problem
Long-Term Memory OK - seems/appears to recall long past:	<input type="checkbox"/> Memory OK <input type="checkbox"/> Memory Problem
Appears Anxious:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Expresses sadness, anger, empty feelings over lost roles or status:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Absence of personal contact with family/friends:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Compared to other people resident gets down in the dumps more often:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems making self understood:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems understanding others:	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of danger to self and/or others:	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of wandering:	<input type="checkbox"/> Yes: <input type="checkbox"/> Inside <input type="checkbox"/> Outside <input type="checkbox"/> No
History of:	___ Disruptive ___ Socially inappropriate ___ Assaultive ___ Destructive ___ Demanding behaviors. Please describe:
Resists care: Refuses to bathe, eat, medicate, care for self, allow others to assist, etc.	
___ Yes ___ No	
If yes, please describe:	

**THIS INSTRUMENT IS A BASELINE DETERMINATION. IT IS THE RESPONSIBILITY OF THE FACILITY TO ANALYZE THE DATA COLLECTED HEREIN AND REFER FOR, AND/OR CONDUCT, FURTHER EVALUATION AS NEEDED.**

The applicant/resident represents that all oral and/or written information made or furnished by, or on behalf of, the applicant for completion of the Uniform Assessment Instrument are true and accurate to the best of his/her knowledge and belief. The applicant understands and acknowledges that providing this information does not represent a commitment for, or guarantee of, service or admission to an Assisted Living Facility and is provided solely for the purpose of evaluation.

<b>Signature</b>	<b>Print Name</b>	<b>Date</b>
_____	_____	_____
Applicant/Resident		
_____	_____	_____
Legal Representative, if applicable		

**UAI completed by:**

_____	_____	_____
Registered Nurse		
License #: _____		
State of Licensure: _____		

<input type="checkbox"/> <b>30 Day Assessment (date)</b> _____	<input type="checkbox"/> <b>No Change</b>	<input type="checkbox"/> <b>Change</b>
_____		_____
<b>Signature (RN)</b>		<b>Date</b>