PASRR/ID Level II Evaluation

For BOCK use only

RedCap _____ ☐ Pre-Admission Screening ☐ Resident Review

PASRR Outcome: ☐ IDD/RC ☐ Unable to verify IDD/RC

Specialized Services? ☐ No ☐ Yes

Re-evaluation required? ☐ No ☐ 180 days ☐ Other: _____

SECTION I: Identification

1. Name (Last, First, MI) _____ 2. Date of Birth _____ 3. Gender Male ☐ Female ☐

4. DCN _____ 5. Evaluation Date _____ 6. Type: ☐ On-Site ☐ Telehealth

7. Current Location: NF ☐ Hospital ☐ Home ☐ RCF/ALF ☐ ISL ☐ Other ☐ _____

8. Facility Name _____ Admit Date _____

City _____

Contact _____ Phone _____

9. Does the individual have a **LEGAL GUARDIAN?** No ☐ If Yes, complete the following:

Name _____ Relationship: [Select or type response]

Address _____ Phone _____

City _____ State MO Zip Code _____

SECTION II: Confirmation of ID Diagnosis

1. Has the individual been diagnosed with Intellectual Disability (ID) that results in significantly sub-average general intellectual functioning, **originating before age eighteen (18)**, that is associated with significant impairment in adaptive behavior (Note: Do not include Borderline Intellectual Functioning)? ☐ Yes ☐ No

If Yes indicated level of impairment: [Select or Type Response] _____

2. Does the individual have a related condition other than mental illness resulting in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons? ☐ Yes ☐ No If Yes, **mark all that apply:**

- ☐ Cerebral Palsy
- ☐ Down's Syndrome
- ☐ Epilepsy/Seizure Disorder
- ☐ Traumatic Brain Injury
- ☐ Spinal Cord Injury
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Autism Spectrum Disorder (Asperger's Syndrome, Pervasive Developmental Disorder)
- ☐ Severe Hearing and Visual Impairment
- ☐ Spina Bifida or other neural tube defect
- ☐ Fetal Alcohol Syndrome
- ☐ Fragile X Syndrome or other genetic disorder
- ☐ Prader-Willi Syndrome
- ☐ Para/Quadraplegia or other orthopedic impairment
- ☐ Other (specify): _____

Was the impairment **manifested before the person reached the age of 22**? ☐ No ☐ Yes

Is the impairment likely to continue indefinitely? ☐ No ☐ Yes

SECTION II: Confirmation of ID Diagnosis (continued)

3. As a result of the above diagnosis, the individual has substantial functional limitations in the following areas of major life activity prior to age 22. **Mark all that apply.**

☐ Self Care ☐ Mobility ☐ Understand and use of language

☐ Learning ☐ Self Direction ☐ Capacity for independent living

☐ No functional limitations

4. Indicate specific results of intellectual functioning measurements, or other methodology used to make determination of intellectual disability. If formal testing results are unavailable, clearly document collateral information that supports determination of intellectual/developmental disability or related condition.

5. Does the individual have a diagnosis of Major Neurocognitive impairment (Dementia)? ☐ No ☐ Yes

6. Based on the previous questions, the individual: **Select One.**

☐ Has IDD OR related condition other than mental illness as defined by PASRR.

☐ Does not have, or absence of clear evidence to substantiate/validate, IDD or related condition as defined by PASRR.

If the individual DOES NOT meet criteria for a PASRR related ID disability OR unable to confirm ID/DD/RC diagnosis, proceed to Section: Conclusions.

7. Please list all documented historical and current psychiatric **diagnoses** (include date of diagnosis if available). ☐ None

8. Describe any current/historic DMH/DD regional office services (include dates and types of services as available)

SECTION III: Psychosocial Assessment

1. Is English the individual's primary language? Yes ☐ No ☐

If No, primary language is: _____ Were interpretive services used during evaluation? Yes ☐ No ☐

2. Marital Status: [Select or Type Response]

SECTION III: Psychosocial Assessment (continued)

3. Describe current **family** state. What kind of support system/resource is the family? Who are the primary contacts?

4. Describe historical/past and most recent **living situation.**

5. Prior medical and **support systems (check all that apply):**

- ☐ None
- ☐ Home health
- ☐ Personal care/ADL assistance
- ☐ Shopping assistance
- ☐ Financial management
- ☐ Family assistance
- ☐ Housekeeping
- ☐ Respite services
- ☐ Other (church, friends etc): _____
- ☐ Medication supervision/set-up/administration
- ☐ Meal preparation/home delivered meals
- ☐ Adult day care program

6. Specify reason for **NF application, admission or continued stay(check all that apply)**

- ☐ Assistance needed to complete ADLs (eating, dressing, grooming, bathing, incontinence care)
- ☐ Assistance needed for transfers, ambulation, fall prevention
- ☐ Rehabilitation services needed (physical, occupational, speech therapy)
- ☐ Medical treatment and/or monitoring for acute conditions
- ☐ Medical treatment and/or monitoring for chronic conditions
- ☐ Dementia symptoms requiring 24 hr monitoring/management
- ☐ Behavioral difficulties and/or mental illness symptoms requiring 24 hr monitoring/management
- ☐ Lack of community/family supports to maintain functioning at home
- ☐ Alternative care options are unavailable (waiting lists, etc)
- ☐ Other _____

7. Describe current and historical education/academic development/functioning learning skills.

8. Describe current and historical work experience/vocational development skills, including present vocational skills.

SECTION IV: Behavioral Assessment

1. Overt Behaviors None ☐ If yes, please indicate which of the following behaviors are problematic for the individual within the last 30 days based on the individual's medical record or staff comments.

- ☐ Unsafe smoking behavior
- ☐ Refuses medications
- ☐ Refuses activities
- ☐ Refuses to eat
- ☐ Uncooperative with diet
- ☐ Uncooperative with hygiene
- ☐ Self induced vomiting
- ☐ Frequent/continuous yelling
- ☐ Intrusive/invades others space
- ☐ Impatient/demanding
- ☐ Wandering
- ☐ Alcohol/drug use
- ☐ Destroys property
- ☐ Exposes self
- ☐ Sexually aggressive
- ☐ Verbally abusive
- ☐ Verbally threatening
- ☐ Uncooperative with medical/nursing care or treatments
- ☐ Cursing/swearing
- ☐ Disturbs other residents
- ☐ Physically threatening
- ☐ Strikes others provoked
- ☐ Strikes others unprovoked
- ☐ Elope/leave facility
- ☐ Seclusiveness
- ☐ Injures self
- ☐ Suspicious of others
- ☐ Lies purposefully
- ☐ Steals deliberately
- ☐ Talks of suicide/ideation
- ☐ Passive death wish
- ☐ Suicide threats
- ☐ Suicide attempts
- ☐ Verbalizations or crying out
- ☐ Other (specify): _____

2. Describe frequency and intensity of behaviors and staff response to behaviors noted above. ☐ NA

3. Placement in Seclusion/Restraints. In the last 30 days has the individual been placed in seclusion or restraints to control dangerous behavior? ☐ No If yes, describe:

4. Typical **Daily Activities**. Per individual and/or staff report describe how the individual spends most of her/his time (important activities, hobbies, interests).

SECTION V: Level of Functioning

Coding: I = Independent V = Verbal assist, supervision, or set up P = Physical assist

1. Personal care and independent living skills:

- ____ Toileting
- ____ Personal hygiene
- ____ Brushing teeth/oral care
- ____ Laundry/Care of clothing
- ____ Selects appropriate clothes
- ____ Dressing/undressing
- ____ Bathing
- ____ Eating
- ____ Meal preparation
- ____ Housekeeping
- ____ Shopping
- ____ Scheduling of medical treatments
- ____ Monitoring of health status
- ____ Maintaining personal safety
- ____ Budgeting and personal finance
- ____ Handling money

2. Mobility/Gait **(mark all that apply)**

- ☐ Normal/Fully independent
- ☐ Wheelchair unassisted
- ☐ Aids (cane/walker)
- ☐ Wheelchair assisted
- ☐ Unsteady
- ☐ Bedfast
- ☐ Staff assist
- ☐ Other: _____

SECTION V: Level of Functioning (continued)

3. Sensorimotor development. Does the individual have impairment in the following areas? ☐ No **If Yes, check all that apply**

- ☐ Ambulation
- ☐ Gross motor dexterity
- ☐ Eye-hand coordination
- ☐ Positioning
- ☐ Visual motor perception
- ☐ Fine motor dexterity
- ☐ Transfers

4. Could prosthetic, orthotic, corrective or **mechanical supportive devices** improve the individual's functional capacity? ☐ No If yes, describe:

5. Describe the individual's speech and language **(communication)** development, such as expressive and receptive language (verbal and nonverbal).

6. Could **non-oral communication systems,** amplification devices or a program of amplification improve the individual's functional capacity? ☐ No If yes, describe:

7. Describe the individual's **social development** such as interpersonal skills, recreation-leisure skills, and relationships with others.

8. Describe the individual's **affective development** such as interest and skills involved with expressing emotions, making judgments, and making independent decisions.

SECTION VI: Medical History and Physical Assessment

1. Does the individual have any medication allergies? ☐ No

   If Yes, specify: _____

2. Has the client been compliant with medication instructions in the past? Unknown ☐ No ☐ Yes ☐

3. Current Medications. Record current meds, excluding convenience meds or attach current MAR/Physician Orders/POS

   ☐ Current MAR /Physician Orders/POS attached Date: _____

Drug Name	Dosage	Frequency	Start Date

4. Describe individual's response to hypnotics, anti-psychotics, mood stabilizers and anti-depressants, anti-anxiety/sedative agents, and anti-Parkinson agents. ☐ NA

5. Describe the individual's ability to self-administer physician-prescribed medications: _____

6. Has the individual had any significant medication changes in the last 30 days? ☐ No If yes, describe:

SECTION VI: Medical History and Physical Assessment (continued)

7. Has the individual received an emergency (STAT) or PRN administration of medications to control behavior in the last 30 days?

☐ No If Yes, describe:

8. List all current and historical medical diagnoses as documented in the individual's record

☐ Current Diagnosis List/History & Physical Attached Date: _____

Diagnoses	Status

9. Level of Impact medical/physical health conditions and treatments have on individual's independent functioning

☐ None ☐ Mild ☐ Moderate ☐ Severe

10. Height _____ 11. Weight: _____ 12. Weight trend past six months: _____

13. Appetite: _____

14. Sleep Pattern **(mark all that apply)**

☐ Normal ☐ Problems falling asleep ☐ Problems staying asleep

☐ Receives medication ☐ Severely disturbed pattern ☐ Hypersomnia/daytime sedation

☐ Other: _____

15. **Review of Systems**. Complete Review of Systems or attach current History & Physical with Review of Systems from medical record.

☐ Completed by PASRR Assessor (Addendum B Attached) **OR** ☐ Review of Systems addressed in existing medical records

Provider: _____ Date: _____

16. Summarize Review of Systems/H&P and describe any abnormal results/provide additional comments as necessary:

SECTION VI: Medical History and Physical Assessment (continued)

17. Does the individual currently receive any special **medical treatments**/supports?

☐ No If Yes, please indicate which of the following treatments the individual receives **(mark all that apply)**

☐ Blood transfusions	☐ Foot care	☐ Monitoring of Vital Signs
☐ Bowel and bladder/Incontinence care	☐ Fracture care	☐ Oral suction
☐ Catheterization care	☐ Hemodialysis	☐ Oxygen
☐ Choking/Aspiration precautions	☐ Hospice Services	☐ Prosthesis care
☐ Colostomy/Ileostomy/Ureterostomy	☐ Inhalation therapy/Respiratory care	☐ Seizure precautions
☐ CPAP/BIPAP	☐ Injections	☐ Special skin care/monitoring
☐ Diabetic monitoring	☐ Intake and output	☐ Tracheostomy care
☐ Dietary supplements	☐ IV fluids	☐ Tube feedings/TPN
☐ Decubitus care	☐ IV meds/antibiotics	☐ Weight monitoring
☐ Dialysis	☐ Medication monitoring	☐ Wound/incision care
☐ Fall precautions	☐ Therapeutic diet (specify): _____	

☐ Ordered labs (specify): _____

☐ Other (specify): _____

18. Rehabilitation services. Does the individual receive any type of rehabilitative services?

☐ None ☐ Physical therapy ☐ Occupational therapy ☐ Speech therapy ☐ Restorative nursing services

SECTION VII: Affective Behavioral Observations

1. Orientation ☐ Person ☐ Place ☐ Circumstance ☐ Time ☐ Unable to assess

2. Memory

Immediate _____

Short term _____

Long term _____

3. Affect. **Mark all that apply.**

☐ Appropriate in quality and intensity to stated themes	☐ Angry	☐ Mood congruent
☐ Flat or blunted	☐ Constricted	☐ Mood incongruent
☐ Labile	☐ Other (specify): _____	

SECTION VIII: NF/Community Interest

1. **Nursing Facility Interest.** What are your thoughts or feelings about going to or remaining in a Nursing Facility? What are your preferences regarding your current and future living situation?

2. **Community Interest.** Are you interested in the possibility of returning to live and receiving services in the community instead of a Nursing Facility? ☐ No ☐ Yes

3. **Community Services.** Were you previously receiving any services/supports or participating in any activities in the community that you considered helpful, valuable, or important? If Yes specify: ☐ No

SECTION IX: PASRR Level II Evaluation Report

Client Name: _____

1. Provide a **summary** of the client's medical and social history

2. Individual's **limitations** (developmental needs, physical, communication, memory, needs, etc.)

3. Individual's **strengths** (positive traits and developmental strengths, abilities, accomplishments, personal traits, etc.)

4. Has a prospective Nursing Facility been identified? No ☐ N/A (Currently in NF) ☐

If Yes, please indicate facility name: _____

5. Is the level of support for ADLs and other identified needs such that the individual's total care needs could be met in a nursing facility?

- ☐ Yes, the individual's needs could be met in a nursing facility at this time.
- ☐ No, the individual's needs cannot be met in a nursing facility at this time (**check all that apply**):
  - ☐ Requires 1:1 supervision to maintain safety due to behavioral/mental health symptms
  - ☐ Recent/current aggressive/violent behavior requiring seclusion, restraints, PRN medications etc.
  - ☐ Current/active homicidal ideation
  - ☐ Current/active suicidal ideation/self harm
  - ☐ Medication refusal leading to acute exacerbation/continuation/instability of psychiatric symptoms
  - ☐ Other (specify): _____

If the individual requires services beyond the capabilities of a nursing facility contact Bock before proceeding and skip to Section: Conclusions.

6. Could alternatives to NF services be considered at this time? ☐ Yes ☐ No

SECTION IX: PASRR Level II Evaluation Report (continued)

7. Provide discussion/supporting documentation for Nursing Facility recommendation including community alternatives to NF and services and supports provided to the individual prior to considering NF placement.

8. The individual needs or continues to need the following supports and services.

☐ A. Provision of specific services to address the individual's **mental health and behavioral needs**.

- ☐ Obtain Individual Support Plan (ISP), Individualized Treatment Plan (ITP), Behavioral Support Plan (BSP) from DMH Community Mental Health Center and/or Developmental Disability Regional Office.
- ☐ Monitoring of behavioral symptoms
- ☐ Trauma informed services
- ☐ Tools of choice or other Positive Behavioral Support services

Identify and describe behaviors to be addressed in the NF plan of care:

☐ B. **Medication** therapy and monitoring services

- ☐ Psychiatric follow up to prescribe and manage medications
- ☐ Medication set up/administration by staff and monitoring for compliance with prescribed medication
- ☐ Monitoring of interaction or adverse effects (AIMS, etc)
- ☐ Monitoring of therapeutic effect in managing mental health symptoms including labs as indicated
- ☐ Address, report, and implement plan to manage patient refusals/noncompliance (including cheeking, hoarding, etc.)
- ☐ Provide education/training in drug therapy management
- ☐ Pharmaceutical services/medication review
- ☐ Other: _____

SECTION IX: PASRR Level II Evaluation Report (continued)

☐ C. Provision of a **structured environment**.

- ☐ Maintain environment with low stimulation
- ☐ Maintain environment with a minimum of visual/auditory distractions
- ☐ Provide instructions at the individual's level of understanding
- ☐ Environmental supports to prevent elopement
- ☐ Provide for individual personal space
- ☐ Provide for sensory supports
- ☐ Establish consistent routines
- ☐ Provide schedule of daily tasks/activities
- ☐ Assess and plan for the level of supervision required to prevent harm to self or others

List needs and rationale as well as level of supervision needed:

☐ D. Implementation of **ADL program** to increase independence and self determination.

Assess and plan a program for the development and maintenance of necessary living skills including **(mark all that apply)**:

- ☐ Grooming/dressing
- ☐ Nutrition needs
- ☐ Bathing
- ☐ Personal Hygiene
- ☐ Money Management
- ☐ Maintenance of own living environment
- ☐ Toileting/bowel/bladder
- ☐ Other: _____

By providing the following services **(mark all that apply)**

- ☐ Physical therapy evaluation and/or treatment
- ☐ Occupational therapy evaluation and/or treatment
- ☐ Speech-language pathology evaluation and/or treatment
- ☐ Restorative services (for turning/positioning, transferring, ambulation, ADLs, range of motion, bowel/bladder program
- ☐ Provision of, training or assistance in use of adaptive equipment or assistive devices
- ☐ Dietary or nutritional services
- ☐ Provide cueing, reminders, education and/or modeling of daily living skills

☐ E. **Crisis Intervention** Services. Assess and plan for Crisis Intervention that provides emotional support, education, safety planning and case management to handle an immediate crisis. A crisis plan should developed to create clear steps that are to be taken to support client during a behavioral health crisis including who to contact for assistance, how to work together with client during the crisis, and how to determine when the crisis is over. The plan should also identify a physician and emergency medical services that should be contacted. Facility may also wish to utilize DMH Behavioral Health Crisis Hotline: https://dmh.mo.gov/behavioral-health/treatment-services/specialized-programs/behavioral-health-crisis-hotline

- ☐ Suicidal precautions
- ☐ Assault precautions
- ☐ Elopement precautions

SECTION IX: PASRR Level II Evaluation Report (continued)

☐ F. Development of **Personal Supports**

☐ Assess and plan for meaningful socialization and recreational activities to diminish tendencies toward isolation, withdrawal, etc.

☐ Assess, plan, and develop appropriate personal support network through community and social connections.

☐ G. Assess and plan for **discharge**, transition to less restrictive environment by application/referral to appropriate community resources. Facility/staff to make referral and assist with application for resources and/or services. Describe and specify:

Identify what supports/services may be needed for the individual to live successfully in a **less restrictive/community setting**.

☐ Community based substance abuse treatment
☐ Community based psychiatric treatment and supports
☐ 12 step/substance abuse program
☐ Behavioral supports/supervision
☐ Day programming/Adult day care
☐ Family support/education
☐ Financial assistance/eligibility evaluation
☐ Group counseling/psychotherapy/support group
☐ Hospice services
☐ Housekeeping/homemaker services
☐ Individual counseling/psychotherapy
☐ Medication education/counseling/set-up/admin
☐ Occupational therapy evaluation
☐ Physical therapy evaluation
☐ Referral to DMH/DD Regional Office for intake/eligibility evaluation, community services
☐ Residential services/supported housing
☐ Skills training/vocation rehabilitation/supported employment
☐ Social Work services/Case management
☐ Speech/language therapy evaluation

☐ Adaptive equipment evaluation (specify): _____

☐ Home health nursing services (specify): _____

☐ Medical follow up/Physician services (specify): _____

☐ Nutritional/dietary evaluation/meal or shopping assistance (describe needs):

_____

☐ Personal care/ADL assistance (specify):

_____

☐ Other (describe): _____

SECTION IX: PASRR Level II Evaluation Report (continued)

9. Describe any additional information to be utilized by the nursing facility for care planning purposes.

SECTION: Conclusions

Source of information used in completing evaluation:

- ☐ Client interview
- ☐ Previous PASRR (date): _____
- ☐ Record review - previous facility (specify): _____
- ☐ Record review - Regional Office (specify): _____
- ☐ Staff interview (specify): _____
- ☐ Family/guardian (specify): _____
- ☐ Case Manager (specify): _____
- ☐ Other (specify): _____
- ☐ Record review - current facility
- ☐ CIMOR

Assessor Name: _____ Date: _____

Signature: *** Signature on File *** Title

For BOCK USE ONLY:

Reviewed/Edited by: _____ Date: _____