Resident Review of Change in Condition

**Nursing Facility Notification to Missouri Department of Mental Health**

PASRR is achieving its federal purpose when all NF residents with PASRR disabilities are identified, their disability related needs are evaluated, services and supports needed are identified, and the PASRR recommended services and supports are delivered to them. Resident care plans must include the Specialized Services or Specialized Rehabilitative Services that the NF will provide as a result of the Level II recommendations made by PASRR. If the NF disagrees, it must indicate its rationale for disagreeing in the resident's medical record [CFR 483.21(a)].

PASRR Resident assessment is an ongoing process that begins before the individual moves into a Nursing Facility and continues throughout the stay. The Final Rule [CRF 483.20(k)(4)] was published in November 2016 (80 FR 42168). Under this rule, nursing facilities (NFs) must notify the state mental health authority (SMHA) or state intellectual disability authority (SIDA) promptly after a resident experiences a significant change in condition of any kind. Please keep a copy of this Resident Review notification form for your records.

**Section I: Resident Information**

Name (Last, First, MI):

Date of Birth:       SSN:       DCN (Medicaid #):

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

Name:

Phone:

**Section II: Nursing Facility Information**

Facility Name:

Admit Date:       Name of Facility Representative:

Email address:

Phone:       Fax:

Is the individual currently hospitalized?  No  Yes If Yes, complete the following:

Hospital name:

Contact person:

Phone:

Current hospitalization is primarily for:

Medical/physical care & treatment  Mental Health/Behavioral care & treatment

**Section III: Change in Condition**

Indicate reason for DMH Notification of Change in Condition **(mark all that apply).**

**For Residents previously identified by PASRR** (Note: this is not an exhaustive list):

Resident with increased behavioral, psychiatric, or mood-related symptoms.

Resident with behavioral, psychiatric, or mood related symptoms that have not responded to ongoing treatment.

Resident with an improved medical condition - such that the residents plan of care or placement recommendations may require modifications.

Resident with significant physical change, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities that may influence adjustment to an altered pattern of daily living.

Resident has indicated a preference (may be communicated verbally or through other forms of communication, including behavior) to leave the facility.

Resident's condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination.

Change in location, such as hospitalization (medical or psych), or transfer from one nursing facility (NF) to another NF (with or without an intervening hospital stay).

**For residents NOT previously identified by PASRR** (Note: this is not an exhaustive list):

Resident with behavioral, psychiatric, or mood-related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 4893.100 (where dementia is not the primary diagnosis).

Resident whose intellectual disability as defined under 42 CFR 483.100, or related condition as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.

Resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

# Please contact DMH at [DMHNotifications@dmh.mo.gov](mailto:DMHNotifications@dmh.mo.gov)

# for concerns or changes not described above.

Summarize the change in condition indicated above:

Describe current mental health and/or developmental disability treatment and/or services:

**Section IV: Conclusions**

Individual completing form

Name:

Position:

Date:

# Please attach/provide copy of:

* Current medication list
* Most recent Medical History and Physical and/or Medical Consult reports
* Most recent Psychiatric History and Physical, Assessment or Consult report, Psychiatric Inpatient Admission Report and/or Discharge Summary

# Procedure for Notification and Resident Review

* Via email: [DMHNotifications@dmh.mo.gov](mailto:DMHNotifications@dmh.mo.gov)
* Via mail: Missouri Department of Mental Health, Division of Developmental Disabilities, 1706 Elm Street, P.O. Box 687, Jefferson City, MO 65102

**For Office Use Only**

Previous PASRR?  No  Yes If yes, Date:

PASRR Resident Review

PASRR Required (Indicate  MI,  ID,  DU

PASRR Not Required

Notes/Others: