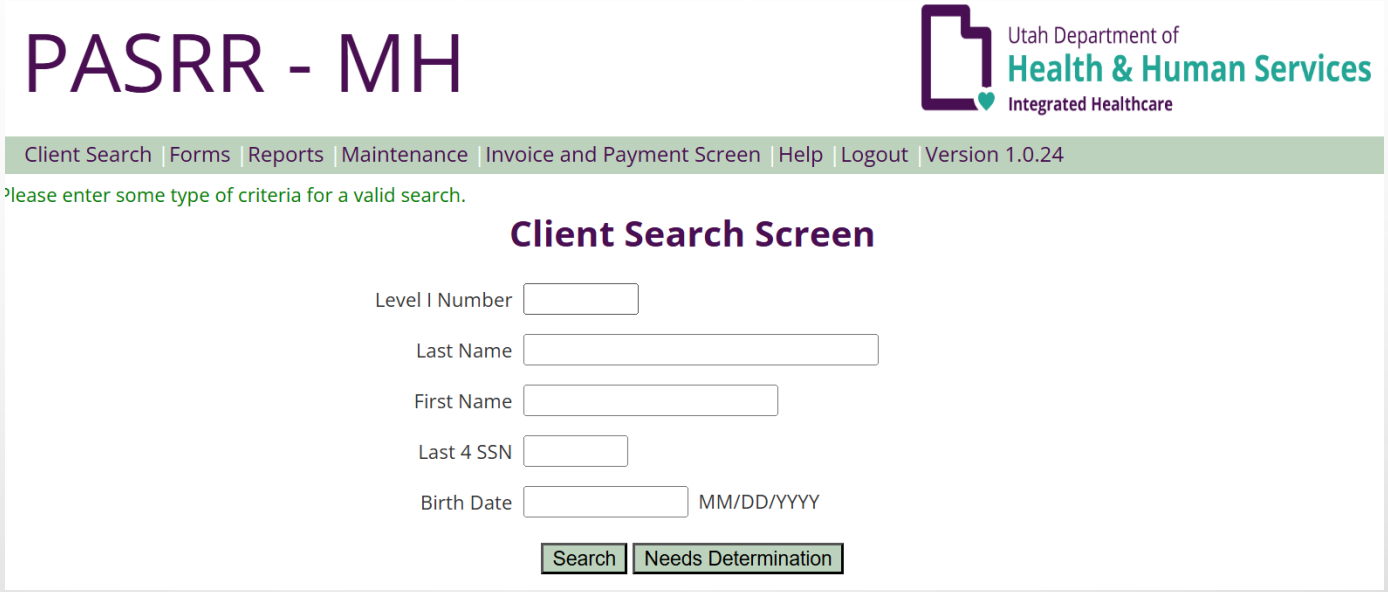
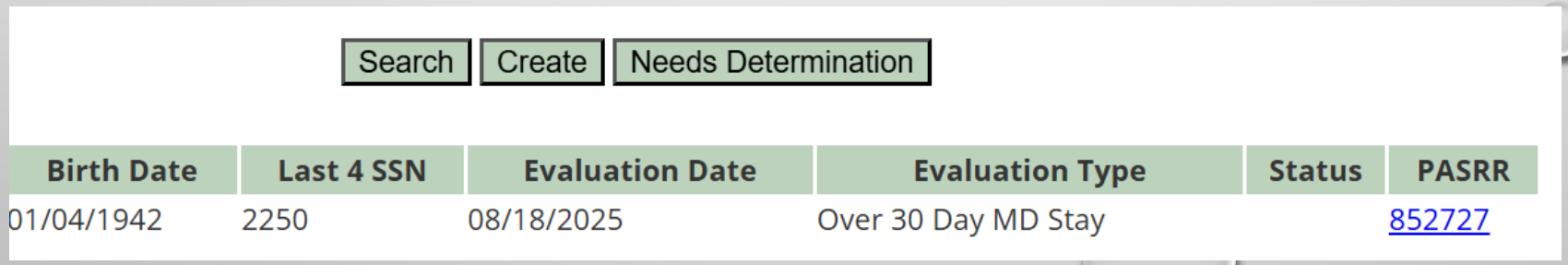
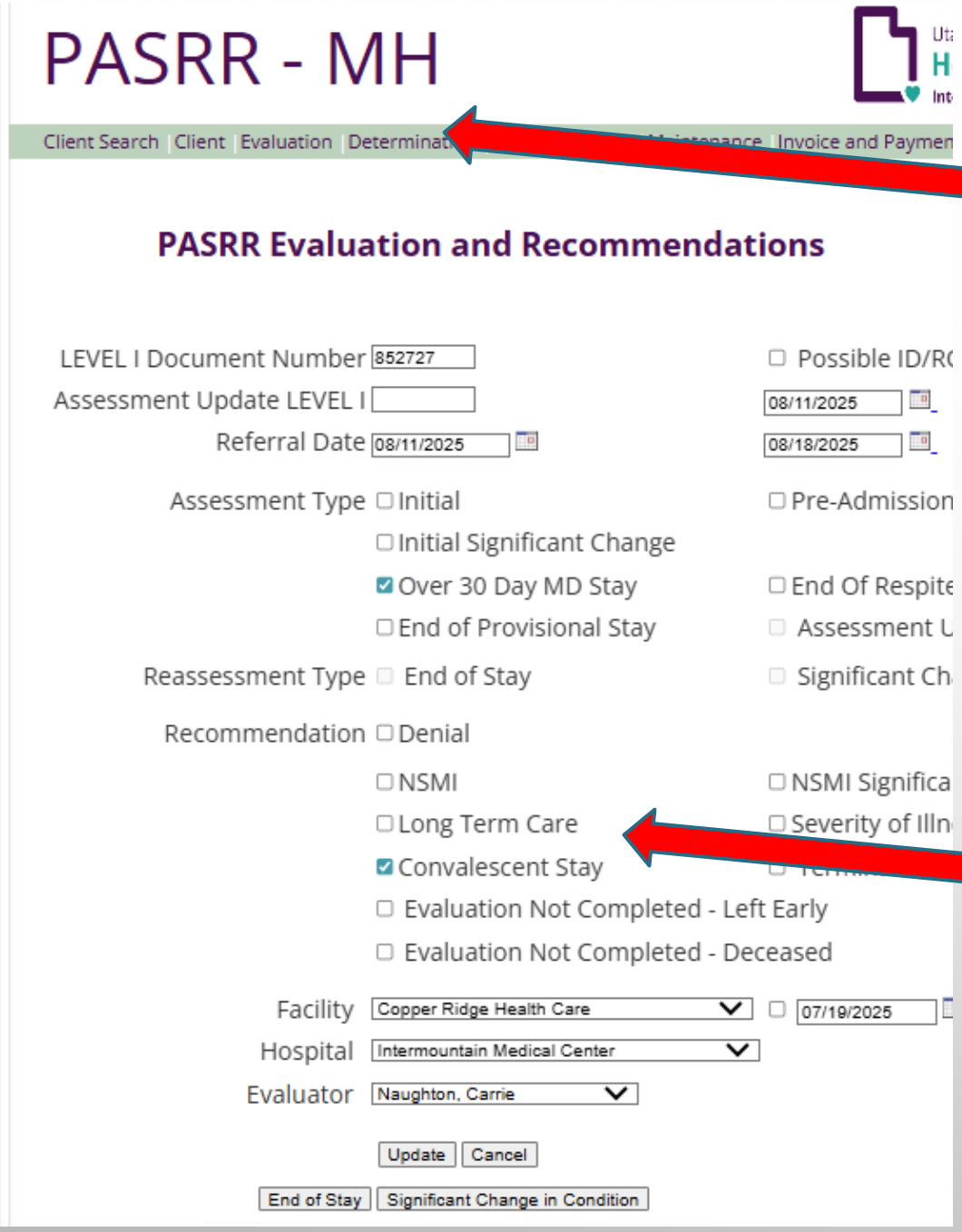
PASRR DETERMINATION/ EVALUATION REVIEW PROCESS

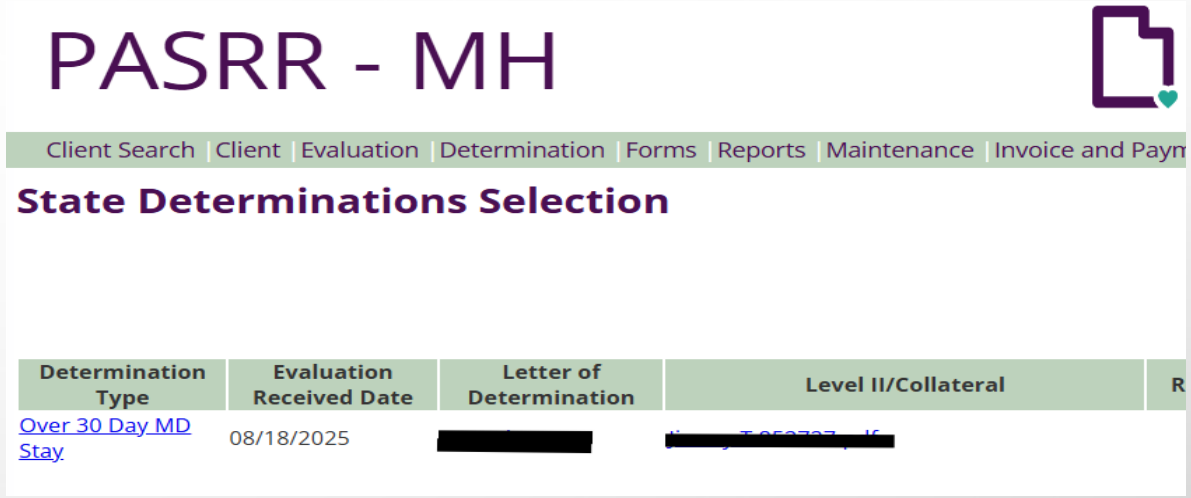
FINDING THE PASRR APPLICATIONS







Click on Determination to pull up the evaluation paperwork and then select Level II/Collateral



What the evaluator is recommending –
Glitch so that Con Stay and Short Stay are both recorded as Con Stay on this page

TYPES OF EVALUATIONS / DETERMINATIONS:

First Assessment (the patient's current situation)	**Preadmission** – Not in the SNF yet, most time sensitive
	Initial – In the SNF, preliminary evaluation
	End of Provisional Stay – In the SNF, after emergency placement of up to 7 days (APS)
	Over 30 day stay – In the SNF with an MD-signed order for 30 days but needs longer
	End of Respite – In the SNF, needs longer than the 14 day respite stay
Basic Determinations (decision that is recommended/what we decide on – may not match but usually does)	**Convalescent Stay** – Coming directly from a medical hospital and entering SNF for the same reason they were in the hospital
	Short Stay – Coming from anywhere except a medical stay (community, ER, assisted living, psych stay, LTAC like Western or Promise)
	Con stay and short stay can be max of 120 days. If it started as an over 30 day stay, then max is 90 days. Usually recommend maximum amount but don't have to.
	Long Term Care – Need longer than 120 days.

TYPES OF EVALUATIONS/DETERMINATIONS:

REASSESSMENTS

- **END OF CON STAY/END OF SHORT STAY** – REACHED 120 DAYS AND STILL REQUIRES A SNF-LEVEL OF CARE. THIS TURNS THE STAY INTO LONG TERM CARE.
- **SIGNIFICANT CHANGE** – MAY BE DONE AS INITIAL (IF THERE WAS NO LEVEL II AT START OF STAY) OR DUE TO SIGNIFICANT CHANGE IN PRESENTATION THAT IMPACTS MENTAL HEALTH (GOOD OR BAD), MUST BE PRE-APPROVED BY US
- **ASSESSMENT UPDATE** – IF SOMEONE HAS HAD AN EVALUATION IN LAST 30 DAYS, HAS A BREAK IN STAY, AND RETURNS, MUST BE PRE-APPROVED BY US

PREADMISSION SCREENING RESIDENT REVIEW
PASRR LEVEL II

UTAH DIVISION OF SUBSTANCE ABUSE
AND MENTAL HEALTH
195 N 1950 W
SALT LAKE CITY, UT 84116

SECTION 1: DEMOGRAPHIC AND ASSESSMENT INFORMATION

NAME (LAST, FIRST, MIDDLE)				LEVEL I DOCUMENT #
THAYER, JIMMY				**852727**
SOCIAL SECURITY (LAST FOUR DIGITS)	BIRTH DATE (MM/DD/YYYY)	AGE	UT MEDICAID #	GENDER ☐ F ☒ M ☐ Other
2250	**01/04/1942**	**83**	**9999**	PRONOUNS: **he, him**

RACE	ETHNICITY
☐ African-American ☐ Asian ☒ Caucasian ☐ Native American ☐ Pacific Islander	☐ Hispanic

TYPE OF EVALUATION	TYPE OF RE-EVALUATION
☐ Pre-Admission ☐ Initial ☐ End of Provisional Stay	☐ End of Convalescent Care Stay ☐ End of Short Stay
☒ Over 30 Day MD Certified Stay ☐ End of Respite	☐ Significant Change ☐ Assessment Update

SECTION 1.1: REFERRAL INFORMATION/SCREENING LOCATION

REFERRAL DATE	ASSESSMENT START DATE	DATE MEDICAL/PHYSICAL INFO AVAILABLE (LEVEL I, H&P AND MD ORDER)
08/11/2025	**08/18/2025**	**08/11/2025** MDS attached: ☒ YES ☐ NO

HOSPITAL ADMISSION?	NAME OF HOSPITAL	ADMIT DATE	DISCHARGE DATE	ER ONLY
☒ YES ☐ NO	**IMC**	**07/01/2025**	**07/19/2025**	☐ YES ☒ NO

REFERRING AGENCY IF NOT HOSPITAL	ADMIT DATE IF IN NF	NAME OF REFERRAL SOURCE	PHONE NUMBER
Copper Ridge	**07/19/2025**	**Kimberly**	**801-280-2273**

Medical hospital stay and went directly from the hospital to the SNF →
This MUST be a Con Stay or LTC

Over 30 MD Certified Stay
- MUST be a Convalescent Stay or LTC
- If this is a Con Stay, will be 90 days (rather than 120 days)

Look here for a break in stay

▶- This section (Section 2) should be reflective of MORE THAN just diagnostic information from a Hospital or other facility- It is always easy to "cut and paste"…

-How/Why did this individual come to be referred to/placed at the SNF

-What are the medical services that have been promoted as necessary for the BEST CARE for the individual? (PT/OT/ST, Catheter care, Medication Compliance, other supports or cares associated with facility services or care needs relative to the determination recommendation

-Are there timeframes associated with applicant care?

SECTION 2: MEDICAL JUSTIFICATION & INTENSITY OF SERVICES NEEDED IN NURSING FACILITY

Diagnosis	Onset Date	Diagnosis	Onset Date
Severe Fatigue & SIRS	2021	Weakness/Debility	Unknown
Stage III Chronic Kidney Disease	Unknown	Hepatic Steatosis	Unknown

[redacted] is a 68 year old male with a medical history significant for chronic fatigue syndrome, stage III chronic kidney disease, weakness/debility, & hepatitis C who was living at a boarding house. He went to St. Mark's Hospital on 9/13/21 secondary to severe and worsening fatigue; EMS was called as pt was unable to get out of the restroom on his own (he had been in the restroom for an hour). Pt reports that prior to this he was so weak he could not get from his room on the second floor to the dining room on the first floor d/t weakness/fatigue and he had not been eating. He was diagnosed with SIRS, metabolic acidosis, acute kidney injury, transaminitis, severe muscle deconditioning, & leukocytosis; scans indicated gallbladder sludge and hepatic steatosis. He was admitted to the hospital for treatment and once stabilized transferred to Avalon West Health & Rehab on 9/15/21 for continued medical care, assistance with ADL's, and therapies for rehabilitation. Pt reports significant gains in his strength and conditioning with his physical therapy. He reports continued poor stamina. As pt's need for SNF medical care and rehab will exceed his less than 30 day order pt was referred for a PASRR evaluation d/t a history of treatment for depression and anxiety. Interview was conducted via WebEx/telehealth d/t COVID-19 SNF visitor restrictions.

Include height and weight if obesity/eating disorder is a factor: Height: 5' 5" Weight: 165 BMI: 27.5

Quality Example

Acute kidney failure with tubular necrosis 6/3/25; Other lack of coordination 6/3/25; Weakness 6/3/25; Other abnormalities of gait and mobility 6/3/25; Morbid (severe) obesity due to excess calories 6/3/25; Unspecified Escherichia coli [e. coli] as the cause of diseases specified elsewhere 6/3/25; Anemia, unspecified 6/3/25; Hypothyroidism, unspecified 6/3/25; Hyperlipidemia, unspecified 6/3/25; Restless legs syndrome 6/3/25; Insomnia, unspecified 6/3/25; Obstructive sleep apnea (adult) (pediatric) 6/3/25; Essential (primary) hypertension 6/3/25; Atherosclerotic heart disease of native coronary artery without angina pectoris 6/3/25; Permanent atrial fibrillation 6/3/25; Gastro-esophageal reflux disease without esophagitis 6/3/25; Pain in right knee 6/3/25; Obstructive and reflux uropathy, unspecified 6/3/25; Retention of urine, unspecified 6/3/25:

This evaluation was completed in person. Resident is a 74-year-old man with multiple complex, chronic, and interacting medical conditions that clearly require 24-hour skilled nursing care and close medical oversight. Resident has a recent history of falls, including an unwitnessed event in which his legs "gave out" while ambulating with a walker. He is at high risk for further falls due to weakness, restless legs, pain, and impaired balance. He requires at least one-person assistance for transfers and bed mobility and often more support for bathing and toileting when pain and fatigue are increased. He ambulates only short distances with a walker and supervision and is otherwise dependent on a wheelchair for safe mobility. He needs staff help with grooming, dressing, and toileting because of impaired balance, limited endurance, and shortness of breath with minimal exertion.

He requires ongoing skilled nursing for IV antibiotic administration, PICC line care, oxygen titration, CPAP management, catheter care with enhanced barrier precautions, blood glucose monitoring and insulin management, anticoagulation monitoring, and frequent assessment for signs of infection, volume overload, or decompensation of heart failure and renal function. There are standing orders for alert charting for infection and falls, weekly skilled assessments, and physician certifications affirming the need for continued SNF-level care for osteomyelitis, CHF, CKD, oxygen/CPAP needs, and regular PT/OT.

Because of the combination of advanced cardiac disease, respiratory compromise, renal insufficiency, chronic infection, chronic pain, and fluctuating cognition, Resident cannot safely manage his own medications, diet, or medical regimen. He requires substantial physical assistance with ADLs and consistent clinical monitoring that goes well beyond what could be provided in a home or typical assisted living setting. Skilled nursing facility placement is medically necessary to maintain his safety, prevent further decline, and manage multiple life-threatening conditions.

SECTION 3: MENTAL ILLNESS SYMPTOMS/SUBSTANCE USE SUMMARY

Onset of Psychiatric Symptoms with a Medical Condition: N/A

History/Onset Of Psychiatric Symptoms: Depression and anxiety, severe insomina on Zoloft Hydroxyzine Trazodone William has a history of treatment for both depression and anxiety. He reports a history of symptoms of both depression and a[redacted]nd that for the past few years he has been "working with a psychiatrist (APRN at VBH) in order to manage his symptoms of depression and anxiety. He reports he is an "insomniac from way back" and he has not "found anything that really works" in regards to managing his insomnia. He reported he was also diagnosed with chronic fatigue syndrome in 1992 and that "insomnia is part of that diagnosis". He stated this was "kind of a double whammy for me". He reported that he has also experienced recurrent depressive sxs including depressed mood, anhedonia, loss of energy and motivation, sadness, isolation, along with feelings of worthlessness and hopelessness. He reports feeling of anxiety including excessive worry and trouble managing feelings of worry, restlessness and tension, trouble focusing, along with occasional panic attacks that can "come out of the blue". He reports that he has not had any panic attacks in "about 5-6 years" but when he did they were quite severe and he stated that "I wouldn't wish that on my worst enemy". He reported that it was "the worst feeling I've ever had" with intense feelings of panic, sweatiness/shakiness, shortness of breath, and chest pressure. He stated that when he was first diagnosed with chronic fatigue he "went into a full blown depression then" and that his depression has been present with him since then. He has been a client of VBH since July 2019, and he has been treated with Zoloft, Trazodone, and Seroquel (for sleep). He reports trying various medications and doses to help with his sleep but that nothing has worked for very long.

Substance Use History: Prior history of alcohol use; he quit about 6 years ago. Pt used medical marijuana while living in New Mexico for anxiety.

Current Psychiatric Functioning: In regards to past treatment other than medications pt reports that cannabis was helpful in managing his sxs of anxiety. He reports that he is not sleeping well, and that he spoke with his APRN at Valley Behavioral Health the week prior to this evaluation, and his APRN was supposed to send prescriptions for increased sleeping medications to the SNF but did not. He stated the APRN was supposed to call them in to the SNF this week. He described it as "a comedy of errors". He wants to be able to rehabilitate and return home; he would benefit from the support of home health care for continued rehab services and medical support once pt is able to discharge.

- Review of MH and formulation- Historical info "sets the stage", Current functioning is the most "pressing," current psychological information and symptomatology
- SMI/NSMI (Not Seriously Mentally Ill) for the purposes of PASRR – must meet both diagnostic and recent functional impairment, may start to justify this here. Look for outpatient engagement historical or present. Willingness to explore behavioral health services?

Current Psychiatric Functioning: At the time of this PASRR update, Resident presents as fatigued, discouraged, and emotionally strained by his ongoing medical issues and the many steps involved in his care. He acknowledges ongoing depression and describes feeling "not good" both physically and emotionally. He has periods of demoralization in which he expresses feeling like "giving up," but he denies any current suicidal plan or intent and can agree to safety within the structured environment of the nursing facility.

Anxiety remains a significant concern. Resident worries about his health, his ability to regain independence, and what the future holds. He experiences restlessness, especially related to restless legs syndrome, and has difficulty relaxing when he is in pain or unable to sleep. Insomnia is chronic and is influenced by pain, RLS symptoms, night-time care routines, and worry. Staff observe that he can become irritable or distressed when he feels that circumstances are outside of his control, but he is generally cooperative and engaged when he feels informed and supported.

Cognitively, Resident is typically oriented to person, place, and time but is a poor historian and can become confused or disorganized during medical exacerbations such as infection, renal fluctuations, or hypoxia. He has a history of delirium due to medical conditions. He shows limited insight into the complexity of his medical regimen and often cannot reliably describe his medications or recent changes. While there is some concern for mild neurocognitive changes related to chronic medical burden, vascular risk factors, and repeated episodes of delirium, his cognitive symptoms currently appear most tied to medical status and treatment demands.

Overall, Resident continues to report moderate depressive and anxiety symptoms, disrupted sleep, and low energy. There is no evidence at this time of a primary bipolar or chronic psychotic disorder. Overall, in the past several months, his depression and anxiety have been moderate-to-severe at times and have clearly affected his ability to cope with medical treatment, participate fully in therapies, and maintain motivation.

SECTION 4: LEVEL OF IMPAIRMENT (ADAPTED FROM CFR 483.102(II)(A)(B)(C))

Functional limitations in major life activities within the past 3 to 6 months. Must have at **least one** of the following characteristics on a **continuing or intermittent** basis in each area - Adaptation to Change, Concentration and Interpersonal Functioning.

Adaptation to change (serious difficulty)

- ☒ Adapting to typical changes in circumstances associated with: ☐ Family ☐ School ☒ Social Interaction ☐ Work
- ☒ Exacerbated signs and symptoms associated with the illness
- ☐ Manifests agitation
- ☒ Requires intervention of the mental health or judicial system
- ☒ Withdrawal from the situation

Concentration, Persistence and Pace (serious difficulty)

- ☒ Difficulties in concentration
- ☐ Inability to complete simple tasks within an established time period
- ☐ Makes frequent errors
- ☐ Requires assistance in completion of these tasks
- ☐ Sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work setting or work-like structured activities occurring in school or home settings

Interpersonal Functioning (serious difficulty)

☐ Maintaining interpersonal relationships	☐ Employment
☐ Communicating effectively with others	☐ Criminal Justice Involvement
☐ Housing	☒ Social Isolation
☐ Fear of strangers	☐ Violence

483.102(iii)(A)(B) Recent Treatment

- ☐ Psychiatric treatment more intensive than outpatient care **more than once** in the past 2 years: (e.g., partial hospitalization/day treatment or in-patient hospitalization; crisis intervention) **OR**

Within the last 2 years:

- ☒ Experienced an episode of significant disruption to the normal living situation which:
  - ☒ Required supportive services **due to serious mental illness**, to maintain function at home or in a residential treatment environment **OR**
  - ☐ Resulted in intervention by housing or law enforcement officials

At least one in each area

***If they don't have at least one functional limitation in each of the three areas
AND/OR one of the two types of recent treatment – the resident is likely NSMI for the purposes of PASRR

At least one of the two choices

SECTION 7: MENTAL ILLNESS/SUBSTANCE USE DISORDER DIAGNOSTIC SUMMARY IMPRESSION			
ICD 10	**Diagnosis Description**	**ICD 10**	**Diagnosis Description**
F33.1	Major Depression, recurrent, moderate		

Diagnostic Formulation: Jimmy reports a history of recurrent depression with depressed mood, anhedonia, fatigue, sleep disturbance, problems with concentration, feelings of hopelessness. He denies any history of suicidal ideation or attempts. He appears to meet criteria SMI for the purpose of PASRR>

Recommendations for services to be provided by the Nursing Facility: Medical management, assistance with ADL's, therapies for rehabilitation. Provide validation and social support during regular daily cares. Continue to monitor mood symptoms. Ongoing discharge planning. Pt is a Veteran of the US Navy but has never applied for benefits resource connection may be helpful for him to gain access to benefits.

Recommendation for Specialized Services for mental illness treatment: Continued follow-up with pt's provider. Pt may also benefit from mental health therapy while at SNF.

Gradual dose reduction concerns: Dose reductions should be approached with caution and by provider familiar with pt's history and diagnosis

These sections include BOTH recommendations on what/how nursing facility services would best benefit this individual, AND "Recommended" Behavioral health services necessary for resident care

This person is SMI, if not, NSMI would be marked

Determination ☐ Pending

☐ Revised Date:

☑ Verifiable Serious Mental Illness

☐ Documented Cognitive Disorder

☑ Needs Nursing Facility Services

☑ Needs Outpatient Behavioral Health Services

☐ Optional Community Placement-ADRC

☐ * Admit / Long Term Care LTC ☐ LTC I ☐

☐ * NSMI ☐ * Primary Diagnosis Dementia

☐ * Denial DA ☐ DB ☐ DC ☐

Diagnostic Formulation

Diagnostic Formulation: Resident has a long-standing history of depression and anxiety that has intensified with progressive medical decline, loss of independence, chronic pain, and repeated hospitalizations. Over an extended period he has experienced persistently depressed mood, reduced interest in activities, sleep disturbance, low energy, feelings of hopelessness, and passive thoughts of death or "giving up," in the absence of substance misuse and not solely during delirium. These symptoms meet DSM-5 criteria for Major Depressive Disorder, recurrent, moderate in severity.

He also experiences chronic generalized worry about his health, living situation, and future functioning, with associated restlessness, irritability, muscle tension, and sleep disturbance. These symptoms are consistent with Generalized Anxiety Disorder. His anxiety and depression interact with his medical conditions, reducing his tolerance for pain and procedures, undermining motivation for rehabilitation, and limiting his ability to independently navigate a complex treatment regimen.

He has episodic cognitive changes—confusion, disorientation, and visual hallucinations—that are best explained by delirium related to infections, renal insufficiency, hypoxia, and medication effects rather than a primary psychotic disorder. There is possible emerging mild neurocognitive disorder due to multiple etiologies (vascular risk, chronic medical burden, and prior delirium episodes), but further neurocognitive assessment would be most accurate when his medical status is stable.

Functionally, Resident's mental health symptoms have contributed to difficulties with coping, concentration, and adaptation to change. He has required repeated hospital and SNF stays and benefits from a structured environment to maintain stability. His mood and anxiety symptoms are chronic, recurrent, and significantly impairing, and they substantially affect his ability to live in a less restrictive setting.

Based on the severity and persistence of his mental health symptoms, their impact on major life activities, and the ongoing need for structured support, resident meets criteria for Serious Mental Illness (SMI) for the purposes of PASRR.

Recommendations for services to be provided by the Nursing Facility: Resident would continue to benefit from skilled nursing services and rehabilitation that will help her strengthen to the point where she may be able to return to her home. She would benefit from out of room, activities, socialization, and cognitive stimulation. Please provide opportunities for resident to get outside in the sunshine and fresh air.

Recommendations for services to be provided by the Nursing Facility: Resident would benefit from rehabilitation and skilled nursing services that will help to strengthen and rehabilitate him to the point where he could return to a less restrictive environment. He would benefit from encouragement to participate in out-of-room activities and socialization. He may try to refuse this but please provide consistent and positive encouragement to do so. He would also benefit from cognitive stimulation as well as activities that he can do in his room. Should it be possible, when the weather permits, he would enjoy going fishing. Please try to build a ***relationship of trust*** with resident in a positive and genuine manner as this appears to allow him to open up more.

Quality examples/ expect this quality

Recommendations for services to be provided by the Nursing Facility: Encouraging his participation in structured, lowkey social or recreational activities that align with his interests (music, art, conversation, supervised walks with a cane as tolerated) can help reduce isolation and support mood. Documentation and communication of any significant changes in mood, sleep, appetite, or statements about "giving up" will help the wider team respond promptly.

Recommendation for Specialized Services for mental illness treatment: A psychiatric consultation is recommended to review his current regimen, consider adjustments or augmentation strategies, and assess for any emerging neurocognitive disorder once he is medically stable. Supportive counseling or psychotherapy within the facility would be beneficial, focusing on coping with chronic illness, grief over loss of independence, and building on his creative and relational strengths to improve quality of life.

Recommendation for Specialized Services for mental illness treatment: Please continue to monitor and assess mental health symptoms throughout his stay. Please also refer for mental health treatment if symptoms persist to ensure mental health needs are met.

Quality examples/ expect this quality

Recommendation for Specialized Services for mental illness treatment: Please see that resident is referred for counseling services. Resident would benefit from regular visitation from mental health professional/therapeutic services to learn strategies and coping to manage daily functioning and to best understand the nature of her relationships/ relationship patterns. Please see that she can maintain long-term medication management to help with her paranoia and possible delusions.

Everything in this section matches a box on the State Determinations page

SECTION 8: REVIEW OF RECOMMENDATIONS–ONLY CHECK ONE RECOMMENDATION

SECTION 8.1: RECOMMENDATIONS FOR CATEGORICAL DETERMINATIONS

☒ **Convalescent Care Stay** ☐ **Short Stay** - Complete Section 14 and sign the evaluation
☐ **Severe Physical Illness** ☐ **Terminal Illness** - Complete Sections 9 through 14 and sign the evaluation

SECTION 8.2: RECOMMENDATIONS FOR NSMI/DENIAL DETERMINATIONS

☐ **Not Seriously Mentally Ill (NSMI) for purposes of PASRR** – Stop here and sign the evaluation

☐ **Denial A due to the need for acute psychiatric treatment with a medical need that requires NF services**
☐ **Denial B due to the need for acute psychiatric treatment with no medical need**
Denials A and B – Complete Section 14 and sign the evaluation

☐ **Denial C due to a lack of medical need and no need for acute psychiatric treatment** – Complete Sections 9 through 14 and sign the evaluation

For all Denial recommendations: Inform the Nursing Facility and the State PASRR office (pasrradmin@utah.gov) no later than the day the evaluation is submitted to the online PASRR system.

SECTION 8.3: RECOMMENDATIONS FOR LONG TERM CARE

☐ **Long Term Care** - Complete Sections 9 through 14 and sign the evaluation.

Evaluator Recommendation

Determination ☐ Pending
☐ Revised Date:
☑ Verifiable Serious Mental Illness
☐ Documented Cognitive Disorder
☑ Needs Nursing Facility Services
☑ Needs Outpatient Behavioral Health Services
☐ Optional Community Placement-ADRC
☐ * Admit / Long Term Care LTC ☐ LTC I ☐
☐ * NSMI ☐ * Primary Diagnosis Dementia
☐ * Denial DA ☐ DB ☐ DC ☐

Categorical ☑ * Convalescent Stay 90 Date 10/06/2021 To 01/04/2022
☐ * End of Provisional Stay Date To
☐ * Short Stay Date To
☐ Terminal Illness
☐ Severity of Illness
☐ * Requires Active Discharge Once Medically Stabilized

Determination Worksheet

Con stay as came from medical hospital stay – given 90 days as they have already had 30 days - Make sure to add in first date, second date will auto-generate

SECTION 7: MENTAL ILLNESS/SUBSTANCE USE DISORDER DIAGNOSTIC SUMMARY IMPRESSION

ICD 10	Diagnosis Description	ICD 10	Diagnosis Description
F33.1	Major Depression, recurrent, moderate		

Diagnostic Formulation: Jimmy reports a history of recurrent depression with depressed mood, anhedonia, fatigue, sleep disturbance, problems with concentration, feelings of hopelessness. He denies any history of suicidal ideation or attempts. He appears to meet criteria SMI for the purpose of PASRR>

Recommendations for services to be provided by the Nursing Facility: Medical management, assistance with ADL's, therapies for rehabilitation. Provide validation and social support during regular daily cares. Continue to monitor mood symptoms. Ongoing discharge planning. Pt is a Veteran of the US Navy but has never applied for benefits resource connection may be helpful for him to gain access to benefits.

Recommendation for Specialized Services for mental illness treatment: Continued follow-up with pt's provider. Pt may also benefit from mental health therapy while at SNF.

Gradual dose reduction concerns: Dose reductions should be approached with caution and by provider familiar with pt's history and diagnosis

- Some diagnostic presentations may have increased/high risk for psychiatric hospitalization
  - LTCI vs. LTC
- Gradual dose reduction concerns can/should be noted on the Letter of Determination

SECTION 8: REVIEW OF RECOMMENDATIONS– ONLY CHECK ONE RECOMMENDATION

SECTION 8.1: RECOMMENDATIONS FOR CATEGORICAL DETERMINATIONS

☒ **Convalescent Care Stay** ☐ **Short Stay** - Complete Section 14 and sign the evaluation

☐ **Severe Physical Illness** ☐ **Terminal Illness** - Complete Sections 9 through 14 and sign the evaluation

SECTION 8.2: RECOMMENDATIONS FOR NSMI/DENIAL DETERMINATIONS

☐ **Not Seriously Mentally Ill (NSMI) for purposes of PASRR** – Stop here and sign the evaluation

☐ **Denial A due to the need for acute psychiatric treatment with a medical need that requires NF services**

☐ **Denial B due to the need for acute psychiatric treatment with no medical need**

Denials A and B – Complete Section 14 and sign the evaluation

☐ **Denial C due to a lack of medical need and no need for acute psychiatric treatment** – Complete Sections 9 through 14 and sign the evaluation

For all Denial recommendations: Inform the Nursing Facility and the State PASRR office (pasrradmin@utah.gov) no later than the day the evaluation is submitted to the online PASRR system.

SECTION 8.3: RECOMMENDATIONS FOR LONG TERM CARE

☐ **Long Term Care** - Complete Sections 9 through 14 and sign the evaluation.

Severe Physical Illness and/or **Terminal Illness** are viewed similarly to LTC. - Please make sure that appropriate recommendation is checked on the State Determination Worksheet along with LTC.

PASRR LETTER OF DETERMINATION

Determination Date: 08/19/2025 - 9:24 AM

Convalescent

Admit Date: 07/19/2025

[redacted]
Copper Ridge Health Care
3706 W 9000 S
West Jordan UT 84088

Dear [redacted]

The purpose of this letter is to inform you of the results of your Preadmission Screening Resident Review (PASRR) evaluation. You have been approved for Nursing Facility Services. The State PASRR Office has determined that as long as your medical condition requires services you are approved for a Convalescent Care Stay from 08/19/2025 to 11/17/2025. Recommendations for specialized services are available on the PASRR evaluation which may be obtained through the Nursing Facility. It is recommended that you have continued follow up with your provider and that any medication dose changes be consulted with somebody who is familiar with your history and diagnosis. It may be beneficial for you to engage in mental health therapy while at the facility. Referrals can be provided for you.

Please speak with the discharge planner if you prefer to leave the Nursing Facility.

If you continue to need Nursing Facility Services, the Nursing Facility must contact your local PASRR Office prior to 11/17/2025 to request a reassessment.

All questions regarding insurance or financial responsibility should be discussed with the Nursing Facility.

Determination ☐ Pending

☐ Revised Date: ☐

☐ Verifiable Serious Mental Illness

☐ Documented Cognitive Disorder

☐ Needs Nursing Facility Services

☐ Needs Outpatient Behavioral Health Services

☐ Optional Community Placement-ADRC

☐ * Admit / Long Term Care LTC ☐ LTC I ☐

☐ * NSMI ☐ * Primary Diagnosis Dementia

☐ * Denial DA ☐ DB ☐ DC ☐

NSMI- Not Seriously Mentally Ill

SECTION 7: MENTAL ILLNESS/SUBSTANCE USE DISORDER DIAGNOSTIC SUMMARY IMPRESSION

ICD 10	Diagnosis Description	ICD 10	Diagnosis Description
F06.32	Mood disorder due to known physiological condition with major depressive-like episode		

Diagnostic Formulation: Douglas presents with depressed mood, times of sadness, and anhedonia since dealing with his Parkinson's diagnosis, and his current inability to care for himself and be mobile. He struggles with restlessness as well. He is on several medications to help with his symptoms. Though partly due to his present situation, his depression is likely, mostly attributable to his Parkinson's disease as he is not seriously mentally ill for the purposes of PASRR.

Recommendations for services to be provided by the Nursing Facility: Continued assistance with mobility services.

Recommendation for Specialized Services for mental illness treatment: Continued access to medications as needed.

Gradual dose reduction concerns: None.

SECTION 8: REVIEW OF RECOMMENDATIONS– ONLY CHECK ONE RECOMMENDATION

SECTION 8.1: RECOMMENDATIONS FOR CATEGORICAL DETERMINATIONS

☐ **Convalescent Care Stay** ☐ **Short Stay** - Complete Section 14 and sign the evaluation

☐ **Severe Physical Illness** ☐ **Terminal Illness** - Complete Sections 9 through 14 and sign the evaluation

SECTION 8.2: RECOMMENDATIONS FOR NSMI/DENIAL DETERMINATIONS

☒ **Not Seriously Mentally Ill (NSMI) for purposes of PASRR** – Stop here and sign the evaluation

SECTION 7: MENTAL ILLNESS/SUBSTANCE USE DISORDER DIAGNOSTIC SUMMARY IMPRESSION

ICD 10	Diagnosis Description	ICD 10	Diagnosis Description
F33.1	Major Depression, recurrent, moderate	F03.9	Dementia NOS
S06	TBI		

Diagnostic Formulation: Patient has been noted to have depressive symptoms for many years. Patient has required medications to reduce and manage his symptoms including hypersomnia, anhedonia, fatigue and diffiulty concentrating. Patient has shown signs of memory loss for approximately 6 months and it is uncertain if his cognitive impairments have been exacerbated by the multiple health concerns he has including UTI, sepsis, multiple falls, or brain bleed causing a TBI. Patient appears to meet criteria for above diagnoses.

Recommendations for services to be provided by the Nursing Facility: Encouragement, reorientation as needed. Reassurance. Encourage family involvement. Medications as prescribed

Recommendation for Specialized Services for mental illness treatment: N/A

Gradual dose reduction concerns: Dose reductions are likely not warranted for this patient as he has required anti-depressant medications for many years and continues to experience significant symptoms of depression.

- Formulation and other support in the evaluation should include statement(s)/evidence regarding the diagnosis of dementia2.
- Clinical determination as to whether Dementia is or is not primary.
  - Additional information/testing results aid in promoting cognitive decline and service needs

Determination ☐ Pending
☐ Revised Date:
☐ Verifiable Serious Mental Illness
☐ Documented Cognitive Disorder
☐ Needs Nursing Facility Services
☐ Needs Outpatient Behavioral Health Services
☐ Optional Community Placement-ADRC
☐ * Admit / Long Term Care LTC ☐ LTC I ☐
☐ * NSMI ☐ * Primary Diagnosis Dementia
☐ * Denial DA ☐ DB ☐ DC ☐

NSMI, Primary Dementia

FINAL CHECKLIST

- IS THE DETERMINATION A PRE-ADMISSION/INITIAL (TOP HALF OF FORM) OR A REASSESSMENT? IS THE CORRECT SECTION OF THE DETERMINATION FORM FILLED OUT?
- DO DATES AND STAY TIMEFRAMES MEET PRESENTED INFORMATION (IS THERE A <30 DAY ORDER IN PLACE? 90 OR 120 DAYS? – IF <30 IN PLACE DETERMINATION CANNOT BE SHORT STAY)
- IS LTCI MARKED IF THE RESIDENT MAY NEED ONGOING PSYCHIATRIC CARE/INPATIENT STAY (PER HISTORY)
- IS THIS A DENIAL? HAVE YOU LET GERI (PASRRADMIN@UTAH.GOV) KNOW IT'S A DENIAL SO SHE CAN INFORM RESIDENT ASSESSMENT? HAS THE EVALUATOR INFORMED THE REFERRAL SOURCE (FACILITY/HOSPITAL)?
- HAS THE EVALUATOR CHECKED THE APPROPRIATE RECOMMENDATION OF CARE FOR RESIDENT (CON STAY, SHORT STAY, TERMINAL ILLNESS, LTC, LTCI?)
- IS THERE INFORMATION PROMOTING GRADUAL DOSE REDUCTIONS (CONCERNS) OR RECOMMENDATIONS FOR ACTIVE DISCHARGE TO THE LOD AT THE BOTTOM?
- HAVE YOU INCLUDED NOTES TO RESIDENT/APPLICANT REGARDING RECOMMENDATIONS? REMEMBER THIS LETTER IS ADDRESSED TO THE INDIVIDUAL – USE DETERMINATORS GUIDE?
- DID YOU CHECK TO MAKE SURE THAT THE WHOLE LEVEL II IS INCLUDED AND SIGNED/DATED?
- DID YOU CHECK TO MAKE SURE THAT THE LEVEL I IS COMPLETED/SIGNED BY APPROPRIATE INDIVIDUALS?
- IS THE MEDICAL COLLATERAL RECENT AND WITH AN H&P FOR FIRST EVALS.

IF ANY OF THE INFORMATION PRESENTED IN THE LEVEL II DOCUMENT IS INSUFFICIENT IN CONTENT OR QUALITY…

- Please make certain documentation is clear and professional- This is the PRODUCT of the Utah State PASRR Program and should be reflective of that "weight"
- Incomplete documents, Unchecked or unsigned documents, insufficient content or quality of content MUST BE SENT BACK to the Evaluator to be remedied and resubmitted:
  - ***The Process of sending evaluation back to the Evaluator***
    - Mark PENDING on the determination (Top Box on form)
    - Write needs and insufficiencies / Needs for completion or clarity for the evaluator in the Notes section (bottom of the page). Be detailed and clear as to what you need to see changed
    - Click "SAVE W/O Emailing" button on the bottom of the page following Notes
    - Click on the Evaluator Name link (top right of the document (in blue))
    - Evaluator Email Screen will open in a separate window-
      - Your Comments/Notes/Needs for successful completion will be in the Comments field
    - Click Send Email
    - Close Send Email Screen (Full tab at the very top of screen- Close Tab)

DETERMINATORS GUIDE (IF YOU WANT)

Determinators Guide to LOD's
In an effort to increase the effectiveness and clarity of PASRR Letters of Determination (LOD's), please consider using the following to effectively send clear messages to those who we serve:

General Mental health/behavioral health services:

Please consider behavioral health services, including medications/medication evaluations and psychotherapy to address mental health concerns. Ongoing assistance/directed care to make sure you are taking the right medicine(s) at the right dose(s), and exploration of strategies and techniques to manage li events is important for your overall mental health. Therapy and medications offer the best opportunity to manage mental health.

Medication/ GDR:

Medications, paired with therapy, are important to maintain positive mental health. Please continue to take medications as directed. Consider adding thera to best address mental health issues/concerns. Therapy and medications offer the best opportunity to manage mental health.

Continue Behavioral Health:

Please continue existing behavioral health services, including medications/medication evaluations and psychotherapy to address mental health concerns. Ongoing assistance/directed care to make sure you are taking the right medicine(s) at the right dose(s), and exploration of strategies and techniques to manage life events is important for your overall mental health. Therapy and medications offer the best opportunity to manage mental health.

Dementia Process-

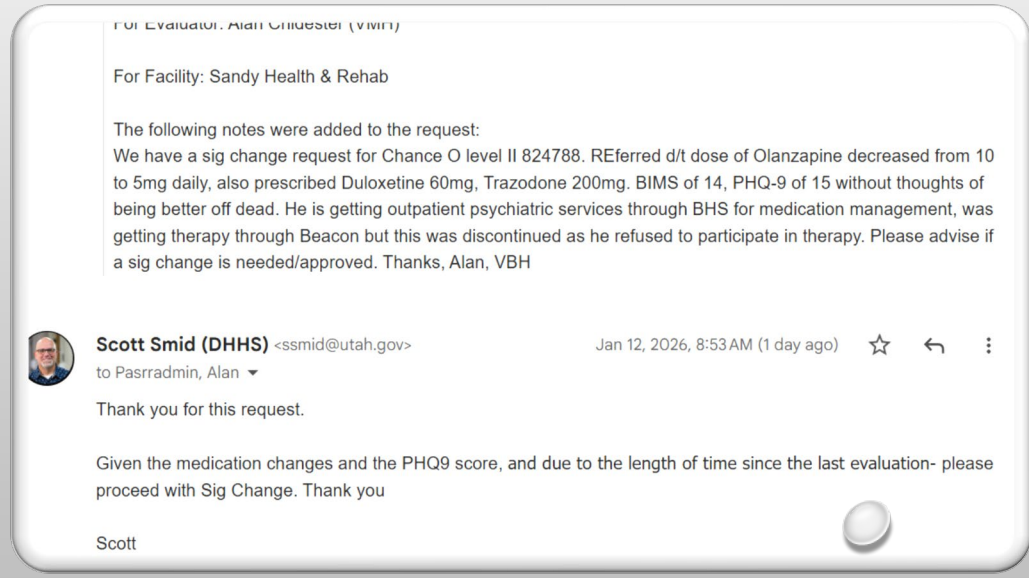
Please encourage Neuro-cognitive testing so that accurate and directed care might be delivered. If there is identification of significant decline now or i the future, an NSMI determination can be delivered and directed care may be provided.

Sig Change request with valid >30 day:
Let's please monitor and observe this individual and see if, at the 30 day timeframe, if there is need for the Evaluation for PASRR Identified Services. There is NOT need for a Significant Change at this point as this individual may not be present to receive identified services. Thank you.

Telehealth Request

ADDITIONAL NEEDS/QUESTIONS IF COVERING…

- SIGNIFICANT CHANGE REQUESTS-
  - THROUGHOUT THE COURSE OF THE DAY, SIGNIFICANT CHANGE REQUESTS COME INTO THE OFFICE
    - GENERALLY COVERED BY SCOTT, BUT, IF HE IS NOT IN/AVAILABLE
  - EVALUATORS, ON BEHALF OF THE FACILITIES, REQUEST A SIGNIFICANT CHANGE (FULL EVALUATION PROCESS) FOR AN INDIVIDUAL/RESIDENT
  - INFORMATION TO SUBSTANTIATE THE NEED FOR THE CHANGE PROCESS (FULL EVALUATION) IS OFFERED
    - **SIG CHANGE** CAN BE OFFERED IF:
      - THE CIRCUMSTANCES PRESENTED REPRESENT A NEED TO MAKE A CHANGE IN THE EXISTING CARE PLANNING FOR THE RESIDENT- A SHIFT IN THE **DIRECTION** OF THE CARE PLAN, OR A SIGNIFICANT ADDITION TO THAT WHICH IS ALREADY BEING ADDRESSED VIA THIS CARE PLAN.
    - **NO SIG CHANGE** CAN BE OFFERED WHEN:
      - THE CHANGES OR CIRCUMSTANCES DO NOT BRING ABOUT NEED FOR A SHIFT IN THE EXISTING CARE PLAN



For Facility: Sandy Health & Rehab

The following notes were added to the request:
We have a sig change request for Chance O level II 824788. REferred d/t dose of Olanzapine decreased from 10 to 5mg daily, also prescribed Duloxetine 60mg, Trazodone 200mg. BIMS of 14, PHQ-9 of 15 without thoughts of being better off dead. He is getting outpatient psychiatric services through BHS for medication management, was getting therapy through Beacon but this was discontinued as he refused to participate in therapy. Please advise if a sig change is needed/approved. Thanks, Alan, VBH

Scott Smid (DHHS) <ssmid@utah.gov> Jan 12, 2026, 8:53 AM (1 day ago)
to Pasrradmin, Alan

Thank you for this request.

Given the medication changes and the PHQ9 score, and due to the length of time since the last evaluation- please proceed with Sig Change. Thank you

Scott

ADDITIONAL NEEDS/QUESTIONS IF COVERING…

No Sig Change

For Evaluator: Alan Chidester (VMH)

For Facility: Holladay Healthcare

The following notes were added to the request:
We have a sig change for Jay K level one 864826. Admitted to SNF 12/9/25 w/no hx of SMI noted and no psych meds prescribed. Referred d/t scoring 10 on the PHQ-9 without thoughts of being better off dead. BIMS of 10. Does not appear to be referred for psych services. Please advise if a sig change is needed/approved. Thanks, Alan, VBH

Scott Smid (DHHS) <ssmid@utah.gov> Thu, Jan 8, 9:31 AM (5 days ago)

to Pasrradmin, Alan

Thank you for this request. As there is no history of any psych issues and there is the possibility that the higher PHQ9 score could be reflective of admission to a SNF, Holiday malaise, or other factors- Please continue to observe and support this resident. If there continues to be challenges with mood and/or presentation, please resubmit for consideration. Thank you- No Sig Change at this time.

Scott

ADDITIONAL NEEDS/QUESTIONS IF COVERING…

- OTHER CLINICAL QUESTIONS/CLINICAL CONSULT NEEDED FROM EVALUATOR/FACILITY
  - OCCASIONALLY, AN EVALUATOR OR FACILITY MAY CALL WITH A NEED FOR A CLINICAL CONSULT,
    - A VARIETY OF CLINICAL AND OTHER QUESTIONS COME TO THE OFFICE AND MAY NEED SOME CLINICAL EXPERTISE. WHILE GERI IS A WIZARD AND CAN ANSWER NEARLY EVERY QUESTION- SHE IS TECHNICALLY NOT SUPPOSED TO ANSWER CLINICAL QUESTIONS. SHE MAY ASK FOR ASSISTANCE IN THIS INSTANCE
  - AN EVALUATOR MAY CALL IN NEED OF SOME DIRECTION OR GUIDANCE REGARDING A CLINICAL MATTER.
    - REGARDING PASRR HISTORY/DETERMINATION HISTORY
- OTHER RANDOM CLINICAL QUESTION