411-070-0040 CLIENT SCREENING, ASSESSMENT AND REVIEW

(1) INTRODUCTION. All individuals who are candidates for admission to a Medicaid-certified nursing facility must be assessed to evaluate their service needs and preferences and must receive information about community-based, alternative services, and resources that can meet the individual’s service needs and are safe, least restrictive, and potentially less costly than comparable nursing facility services.

(2) PRE-ADMISSION SCREENING. A pre-admission screening (PAS) as defined in OAR 411-070-0005 is required for potentially Medicaid eligible individuals who are at risk for nursing facility services.

(a) PAS includes:

(A) An assessment;

(B) The determination of an individual’s service eligibility for Medicaid-paid long term care or post-hospital extended care services in a nursing facility;

(C) The identification of individuals who can transition to community-based service settings;

(D) The provision of information about community-based services and resources to meet the individual’s needs; and

(E) Transition planning assistance as needed.

(b) PAS is conducted in conjunction with the individual and any representative designated by the individual.

(c) The PAS assessment shall be conducted by a case manager or other qualified SPD or AAA representative using SPD’s Client Assessment and Planning System (CA/PS) tool, and other standardized assessment tools and forms approved by SPD.

(d) A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a nursing facility when short-term nursing facility services are needed. A face-to-face assessment including the discussion of alternative community-based services and resources shall be completed within seven days of the initial, short term nursing facility service approval.

(e) Payment for nursing facility services may not be authorized by SPD until PAS has established that nursing facility services are required based on the individual’s service needs and Medicaid financial eligibility has been established.
(3) PRIVATE ADMISSION ASSESSMENT. A private admission assessment (PAA) is required for individuals with private funding who are referred to Medicaid-certified nursing facilities established by ORS 410.505 through 410.545 and OAR chapter 411, division 071.

(4) PRE-ADMISSION SCREENING AND RESIDENT REVIEW. A pre-admission screening and resident review (PASRR) as described in OAR 411-070-0043 is required for individuals, regardless of payment source, with either mental illness or developmental disabilities who need nursing facility services.

(5) RESIDENT REVIEW. Title XIX regulations require utilization review and quality assurance reviews of Medicaid residents in nursing facilities. The reviews carried out by the authorized utilization review organization must meet these requirements:

(a) Staff associated with SPD are required to maintain service plans on all SPD residents in nursing facilities. The frequency of their service plan update shall vary depending on such factors as the resident’s potential for transition to home or community-based care and federal or state requirements for resident review.

(b) Authorized representatives of SPD or the authorized utilization review organization must have immediate access to SPD residents and to facility records. "Access" to facility records means the right to personally read charts and records to document continuing eligibility for payment, quality of care, or alleged abuse. SPD or the authorized utilization review organization representative must be able to make and remove copies of charts and records from the facility’s property as required to carry out the above responsibilities.

(c) SPD or the authorized utilization review organization representatives must have the right to privately interview any SPD residents and any facility staff in carrying out the above responsibilities.

(d) SPD or the authorized utilization review organization representatives must have the right to participate in facility staffings on SPD residents.


411-070-0043 PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

(1) INTRODUCTION. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, subparts C through E. The purpose of PASRR is to prevent the placement of individuals with mental illness or mental retardation or developmental disabilities in a nursing facility unless their medical needs clearly indicate that they require the level of service provided by a nursing facility. Categorical determination, as described in section (2) of this rule, are groupings of individuals with
mental illness or developmental disabilities who may be admitted to a nursing facility without a PASRR Level II evaluation.

(2) CATEGORICAL DETERMINATIONS.

(a) Exempted hospital discharge:

(A) The individual is admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; or

(B) The individual is admitted to the nursing facility directly from a hospital after receiving care as an observation-status; and

(C) The individual requires nursing facility services for the condition for which he or she received care in the hospital; and

(D) The individual’s attending physician has certified before admission to the facility that the individual is likely to require nursing facility services for 30 days or less.

(b) End of life care for terminal illness. The individual is admitted to the nursing facility to receive end of life care and the individual has a life expectancy of six months or less.

(c) Emergency situations with nursing facility admission not to exceed seven days unless authorized by AAA or SPD staff.

(A) The individual requires nursing facility level of service; and

(B) The emergency is due to unscheduled absence or illness of the regular caregiver; or

(C) Nursing facility admission is the result of protective services action.

(3) PASRR includes three components.

(a) PASRR LEVEL I. PASRR Level I is a screening process that is conducted prior to nursing facility admission for all individuals applying as new admissions to a Medicaid certified nursing facility regardless of the individual’s source of payment. The purpose of the screening is to identify indicators of mental illness or mental retardation or developmental disabilities that may require further evaluation (42 CFR

(A) PASRR Level I screening is performed by AAA/SPD authorized staff, private admission assessment (PAA) programs, professional medical staff working directly under the supervision of the attending physician, or by organizations designated by DHS.

(B) Documentation of PASRR Level I screening is completed using a SPD-designated form.

(C) If there are no indicators of mental illness or mental retardation or developmental disabilities or if the individual belongs to a categorically determined group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.

(D) If PASRR Level I screening determines that an individual has indicators of mental illness and no categorical determinations are met, then the individual cannot be admitted to a
nursing facility. The Level I assessor must contact AMHD and request a PASRR Level II evaluation.

(E) If PASRR Level I screening determines that an individual has indicators of mental retardation or developmental disabilities and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact SPD and request a PASRR Level II evaluation.

(F) Except as provided in section (3)(a)(F)(ii) of this rule, nursing facilities must not admit an individual without a completed and signed PASRR Level I screening form in the individual’s resident record.

(i) Completion of the PASRR Level I form under sections (3)(a)(A) through (3)(a)(F) of this rule does not constitute prior authorization of payment. Nursing facilities must still obtain prior authorization from the local AAA or SPD office as required in OAR 411-070-0035.

(ii) A nursing facility may admit an individual without a completed and signed PASRR Level I form in the resident record provided the facility has received verbal confirmation from the Level I assessor that the screening has been completed and a copy of the PASRR Level I form will be sent to the facility as soon as is reasonably possible.

(iii) The original or a copy of the PASRR Level I form must be retained as a permanent part of the resident’s clinical record and must accompany the individual if he or she transfers to another nursing facility.

(b) PASRR LEVEL II. PASRR Level II is an evaluation and determination of whether nursing facility service and specialized services are needed for an individual who has been identified through the PASRR Level I screening process with indicators of mental illness or mental retardation or developmental disabilities who does not meet categorical determination criteria {42 CFR 483.128}.

(A) Individual’s identified with indicators or mental illness or mental retardation or developmental disabilities as a result of PASRR Level I screening are referred for PASRR Level II evaluation and determination.

(B) PASRR Level II evaluations and determinations are conducted by AMHD for individuals with mental illness or by SPD for individuals with mental retardation or developmental disabilities.

(C) PASRR Level II evaluations result in a determination of an individual’s need for nursing facility services and specialized services {42 CFR 483.128-136} consistent with federal regulations established by the Social Security Act, Section 1919(e)(7)(C).

(D) Pursuant to 42 CFR 483.130(I), the written determination must include the following findings:

(i) Whether a nursing facility level of services is needed;

(ii) Whether specialized services are needed;
The placement options that are available to the individual consistent with these determinations; and

The rights of the individual to appeal the determination.

The PASRR Level II evaluation report must be sent to the individual or their legal representative, the individuals attending physician, and the admitting or retaining nursing facility. In the case of an individual being discharged from the hospital, the discharging hospital must receive a copy of the PASRR evaluation report as well {42 CFR 483.128 (l)(1)-(3)}.

Denials of nursing facility service are subject to appeal {OAR 137-003, 461-025 & 42 CFR Subpart E}.

(c) RESIDENT REVIEW. Resident reviews are conducted by AMHD for individuals with indicators of mental illness or SPD for individuals with mental retardation or developmental disabilities who are residents of nursing facilities. Based on the findings of the resident review, a PASRR Level II may be requested. {42 CFR 483.114}.

(A) All residents of a Medicaid certified nursing facility may be referred for resident review when symptoms of mental illness develop.

(i) Resident review for individuals with indicators of mental illness that require further evaluation must be referred to the local Community Mental Health Program who shall determine eligibility for PASRR Level II evaluations.

(ii) The resident review form, part A, must be completed by the nursing facility. The resident review must be performed in conjunction with the comprehensive assessment specified by the AMHD, in accordance with OAR 411-086-0060.

(B) All individuals identified as having mental retardation or developmental disabilities through the PASRR Level I screening process that are admitted to a nursing facility must receive a resident review. A resident review must be conducted within seven days if the nursing facility admission is due to an emergency situation {OAR 411-070-0043(2)(c)(A)-(C)}, within 20 days if the nursing facility admission is due to other categorical determinations {OAR 411-070-0043(2)(a)-(b)}, and annually, or as dictated by changes in resident's needs or desires.

(i) The resident review must be completed by SPD or designee.

(ii) The resident review must be completed using forms designated by SPD.

(4) SPECIALIZED SERVICES.

(a) Specialized services for individuals with mental illness are not provided in nursing facilities. Individuals with mental illness who are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(b) Specialized services for individuals with mental retardation or developmental disabilities under age 21 are equal to school services and must be based on the Individualized Education Plan.
(c) Specialized services for individuals with mental retardation or developmental disabilities over age 21 are not provided in nursing facilities. Individuals with mental retardation or developmental disabilities over age 21 that are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

[ED. NOTE: Forms referenced are available from the agency.] [Publications: Publications referenced are available from the agency.]


411-071-0000 PURPOSE

(1) The purpose of Private Admission Assessment is to ensure that non-Medicaid eligible individuals applying for or considering admission to a Medicaid certified nursing facility receive information regarding appropriate service and placement alternatives.

(2) These rules establish procedures and requirements for admission assessment of non-Medicaid eligible individuals applying for or considering admission to a Medicaid certified nursing facility as required in ORS 410.505 to 410.545. The admission assessment includes mandatory services necessary to comply with the federal pre-admission screening requirements established by the Health Care Financing Administration. It also provides optional information regarding appropriate care settings and services, including nursing facilities and community-based options such as adult foster care, assisted living, residential care, in-home services, and other community-based services.

(3) These rules establish a certification process for programs henceforth called "certified programs," to perform admission assessments to individuals seeking admission to nursing facilities with a Medicaid contract. These rules establish standards for assessments performed by certified programs, local Area Agencies on Aging and Department personnel. Recommendations made during the admission assessment are not binding. Each individual has the right to choose from any of the long-term care options available.


411-071-0010 ASSESSMENT REQUIREMENTS

(1) An admission assessment must be provided prior to admission for all non-Medicaid eligible individuals applying as new admissions to a Medicaid certified nursing facility
except as provided in OAR 411-071-0015. The admission assessment must occur no more than 90 days prior to the date of admission.

(2) Admission assessments are to be performed by certified programs.

(3) If the assessment is performed by personnel from a certified program, such personnel must make a good faith effort to determine whether the individual receiving the assessment is or appears to be Medicaid eligible based on a review of optional income and asset information provided by the individual. If the individual appears to be Medicaid eligible or may become Medicaid eligible within 60 days, the certified program must contact and coordinate with the local Area Agency on Aging/Seniors and People with Disabilities unit to provide further assessment services.

Exemptions

(1) The criteria under which an individual is exempted must be clearly indicated on the form designated by the Department.

(2) An exemption from the full assessment process may be granted for an individual who meets one of the following criteria:

(a) An individual seeking temporary admission to a nursing facility from a hospital and meets all of the following criteria as certified by the attending physician:

(A) Seeks admission directly from a hospital, or within 30 days of discharge from the hospital, after receiving acute inpatient care at the hospital; and

(B) Requires nursing facility services for the condition for which he or she received care in the hospital; and

(C) Requires nursing facility services for 30 days or less.

(b) An individual has a medical prognosis with life expectancy of 30 days or less;

(c) An individual seeking temporary admission for respite services with expected length of stay of 30 days or less;

(d) A resident of a continuing care retirement community who is seeking admission to a Medicaid certified nursing facility that is part of the same continuing care retirement community; or

(e) An individual certified by the attending physician that he/she must be admitted from the community or hospital emergency room without delay due to a serious and immediate threat to the individual’s health and safety.
(3) The assessment must be completed and signed by a certified program, the attending physician, or a professional medical staff person working directly under the supervision of the attending physician for individuals admitted under an exemption criteria.

(4) An individual admitted to a nursing facility under an exemption under subsections (2)(a), (b), or (c) of this rule must receive an assessment within 7 days after the 30th day of admission.

(5) An individual temporarily admitted to a nursing facility under subsection (2)(e) of this rule must receive an assessment within seven days from the date of admission.

(6) No assessment or exemption is required for:

(a) An individual returning to a nursing facility after having entered a hospital from the same nursing facility; or

(b) An individual transferring from one Oregon nursing facility to another Oregon nursing facility with or without an intervening hospital stay.


411-071-0020 ASSESSMENT PROCESS

(1) The Department must develop and provide to certified programs an assessment instrument to be used for all admission assessments.

(2) The admission assessment must consist of:

(a) Information necessary to comply with federal pre-admission screening requirements as established by the Centers for Medicare Services;

(b) Recommendations regarding appropriate care settings and services based on the individual's personal, family, and community support system, discussion of the individual's lifestyle preferences and goals, and other information. An individual or the individual's representative must indicate on the assessment form provided by the Department whether the individual has received information about care options or does not want the information. An individual may not be required to receive this information. Documentation by non-hospital based programs must be on the form designated by the Department. Hospital based programs must document information regarding appropriate care settings and services in their own discharge planning documents for all individuals assessed.

(3) Appropriate information about care settings and services may be made available to individuals choosing to receive such information, including information on community-based care services, nursing facility options, and additional information as may be appropriate to a particular geographic area.
(4) The recommendations of the admission assessment are not binding; an individual has the right to choose any or none of the available options. An individual may designate someone to participate in the assessment process.

(5) As part of the admission assessment process, the individual or the individual's representative, as specified in section (6) of this rule,

(6) The following descending hierarchy is to be observed when certifying the information required in sections (5) and (6) of this rule and signing the assessment form:

(a) The individual, if the individual is capable at the time the assessment is performed;

(b) The individual's legally designated representative (as defined in OAR 411-071-0005) if the individual is not capable at the time the admission assessment is performed;

(c) The individual's next of kin or, if appropriate, a knowledgeable friend if the individual has no legally designated representative and is not capable at the time the admission assessment is performed;

(d) The person performing the assessment if a good faith effort fails to locate the individual's next of kin or appropriate friend, the individual has no legally designated representative, and is not capable at the time the admission assessment is performed;

(e) The person performing the assessment if the individual is capable at the time the assessment is performed but refuses to sign.


411-071-0043 QUALIFICATIONS FOR PERSONNEL PERFORMING ADMISSION ASSESSMENTS

(1) Except as provided in section (2) of this rule, all persons performing admission assessments shall meet one of the following criteria:

(a) Be a registered nurse licensed by the State of Oregon;

(b) Have a master of social work degree from an accredited institution of higher education; or

(c) Have a bachelor's degree from an accredited institution of higher education and have experience in gerontology, health care, long-term care, or other relevant human services.

(2) Any applicant or Certified Program may request that the Division allow an employee who meets the following conditions to perform admission assessments:
(a) The employee for whom the exception is being requested works directly under the supervision of someone qualifying under section (1) of this rule; and

(b) One or more of the following apply:

(A) The employee has at least one year of experience performing functions substantially similar to admission assessments;

(B) The employee has other work or educational experiences that provide clear and convincing evidence of the person’s ability to perform admission assessments.


RESPONSIBILITIES OF NURSING FACILITIES

(1) A Medicaid eligible individual must have an AAA/Seniors and People with Disabilities Pre-Admission Screening and prior authorization of payment prior to admission to a nursing facility. A nursing facility must not admit a Medicaid eligible individual based on a Private Admission Assessment.

(2) A nursing facility receiving an application for admission from an individual who is subject to the admission assessment requirement but has not had an assessment performed within the preceding 90 days must provide the individual with information on the admission assessment process and a list of certified programs provided by the Department or the area agency on aging/Seniors and People with Disabilities office.

(3) Except as provided in section (4) of this rule, nursing facilities must not admit an individual without a completed and signed assessment form in the client record. Such forms are to be maintained as a permanent part of the client record.

(4) A nursing facility may admit an individual without a completed and signed assessment form in the client record provided the facility has received verbal confirmation from a certified program that an assessment has been completed for the individual within the preceding 90 days and a copy of the assessment form will be sent to the facility as soon as is reasonably possible. The facility must note in the client record the name of the certified program, the name and title of the person providing the verbal confirmation, and the date and time confirmation was provided.

(5) If a nursing facility admits an individual under an exempted hospital discharge set forth in OAR 411-071-0015(3)(a) for the purpose of rehabilitative and/or nursing services for 30 days or less, the nursing facility must contact a certified program to ensure a Private Admission Assessment is completed within seven days after the 30th day of admission.

(6) If a nursing facility admits an individual under an emergency exemption set forth in OAR 411-071-0015(3)(e), the nursing facility must contact a certified program and must ensure a Private Admission Assessment is completed within seven days of admission.
(7) A nursing facility receiving an application from an individual who is not an Oregon resident, or from an individual who is being discharged from a hospital that is not a certified program, or from an individual currently residing in a nursing facility outside the state of Oregon must immediately notify the local Area Agency on Aging/Seniors and People with Disabilities unit of the need for the individual to receive an admission assessment. The nursing facility must contact a certified program to ensure a Private Admission Assessment is completed within seven days of admission.

(8) The nursing facility is responsible for assuring that an individual subject to the Level II pre-admission screening evaluation required by the federal pre-admission screening requirements has been referred to the Seniors and People with Disabilities of the Department of Human Services.

(9) The Department may disallow payment for nursing services provided to an individual who has not been screened in compliance with the federal pre-admission screening requirements or an individual who is subject to the Level II evaluation and determination but who has not received such a determination within the time limits established in the federal pre-admission requirements.

(10) A nursing facility failing to comply with these rules may be subject to administrative sanctions as provided in ORS 410.540 and/or civil penalties as provided in OAR 411-071-0105.


411-086-0040 ADMISSION OF RESIDENTS

(1) Admission Conditions:

...(e) No facility shall admit an individual who is mentally ill or mentally retarded unless the Division or local representative thereof has determined that such placement is appropriate.

(2) Admission Status, Preliminary Care Plan, Preliminary Nursing Assessment:

(a) A licensed nurse shall document the admission status of the resident within eight hours, including but not limited to skin condition, nutritional status, hydration status, mental status, vital signs, mobility, and ability to perform ADLs. This review of resident status shall be sufficient to ensure that the immediate needs of the resident are met;

(b) A licensed nurse shall develop a preliminary resident care plan within 24 hours of admission. Staff providing care for the resident shall have access to, be familiar with, and follow this plan;

(c) Social services shall be provided to the resident in accordance with the preliminary resident care plan not later than three days after admission;
(d) A registered nurse shall complete and document a comprehensive nursing assessment within 14 days of admission;

(e) A resident care plan shall be completed pursuant to OAR 411-086-0060.

411-086-0060 COMPREHENSIVE ASSESSMENT AND CARE PLAN
(Effective 10/01/1993)

(1) COMPREHENSIVE ASSESSMENT.

(a) An RN shall ensure completion and documentation of a comprehensive assessment of the resident's capabilities and needs for nursing services within fourteen days of admission. Comprehensive assessments shall be updated promptly after any significant change of condition and reviewed no less often than quarterly. This assessment shall be on a form specified by the Division. The assessment shall include the following:

(A) Medically defined conditions and medical history;
(B) Medical status measurement;
(C) Functional status;
(D) Sensory and physical impairments;
(E) Nutritional status and requirements;
(F) Treatments and procedures;
(G) Psychosocial status (see OAR 411-086-0240);
(H) Discharge potential (see OAR 411-086-0160);
(I) Dental condition;
(J) Activities potential (see OAR 411-086-0230);
(K) Rehabilitation and restorative potential (see OAR 411-086-0150 and 411-086-0220);
(L) Cognitive status; and
(M) Drug therapy.

(b) Social services, activities and dietary personnel shall complete an assessment within fourteen days of admission.

(2) CARE PLAN PREPARATION and IMPLEMENTATION. The facility, through the nursing services department and the interdisciplinary staff, shall provide services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written, dated, care plan.
(a) The plan shall be completed within seven days after completion of the comprehensive assessment. The care plan shall be reviewed and updated whenever the resident's needs change, but no less often than quarterly.

(b) The care plan shall describe the medical, nursing, and psychosocial needs of the resident and how the facility will actively meet those needs. This description of needs shall include measurable objectives and time frames in which the objectives will be met.

(c) The plan shall provide for and promote personal choice and independence of the resident.

(d) The plan shall be reviewed and completed at an interdisciplinary care planning conference with participation from the resident's RN care manager and personnel from dietary, activities and social services. The resident's attending physician will participate in the development and any revision of the care plan. Physician participation may be in person, through communication with the DNS or RN Care Manager, or via telephone conference.

(e) The resident, the resident's legal representative, and anyone designated by the resident shall be requested to participate. The request shall be documented in the resident's clinical record.

(f) The plan shall be prepared and implemented with participation of the resident and in accordance with the resident's wishes.

(g) The plan shall include an assessment of the resident's potential for discharge and the facility's efforts to work toward discharge.

(h) The plan shall be available to and followed by all staff involved with care of the resident.

3) DOCUMENTATION.

(a) The care plan shall be written in ink and made a part of the resident's clinical record;

(b) Participation in development of the care plan by interdisciplinary staff will be clearly documented.


Stats. Implemented: ORS 441.055 & 441.615

**411-086-0160 NURSING SERVICES: DISCHARGE SUMMARY**

1) Discharge Summary Required. A discharge summary shall be completed for each resident before discharge.

2) Contents. The discharge summary shall include:

(a) A recapitulation of the resident's stay;
(b) A final summary of the resident’s status, including the most recent nursing assessment as defined in OAR 411-086-0060; and

(c) A post-discharge plan of care developed in accordance with OAR 411-086-0060 which will assist the resident to adjust to his/her new living environment. A post-discharge plan is not required when the resident is discharged to acute care or to the morgue.

Hist.: SSD 19-1990, f. 8-29-90, cert. ef. 10-1-90; SSD 8-1993, f. & cert. ef. 10-1-93