State of California—Health and Human Services Agency
Department of Health Care Services

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

HO CAO
The Pavilion at Sunny Hills
2222 NORTH HARBOR BOULEVARD
FULLERTON, CA 92835

DATE: 07/17/2023
PASRR CID: 203-081-916

Dear HO CAO,

Re: **Negative Level I Screening Indicates a Level II Mental Health Evaluation is Not Required.**

Federal law requires[1] all individuals seeking admission to a Medicaid Certified Nursing Facility (NF) receive a Level I Screening. The Level I Screening identifies if an individual has a suspected Mental Illness (MI) or an Intellectual/Developmental Disability or Related Condition (ID/DD/RC). If MI is suspected, then a Level II Mental Health Evaluation may be conducted to determine if the individual can benefit from specialized mental health services. This process is known as the Preadmission Screening and Resident Review (PASRR).

Below is a summary of your Level I Screening:

Level I Screening for: HO CAO
Submitted on: 07/17/2023
Submitted by: Sarah Cormier
Result: Negative
Reason: No MI
Level II Mental Health Evaluation Referral: Not Required

Please note that your eligibility for PASRR specialized services does not affect your eligibility for nursing facility services. If you have questions regarding this matter, please call the Department of Health Care Services IT Service Desk at (916) 440-7000 or email ITServiceDesk@dhcs.ca.gov. If you have general questions or concerns, please call the DHCS Ombudsman at 1-888-452-8609 or email MMCDOmbudsmanOffice@dhcs.ca.gov.

Sincerely,

Shelly Taunk, Chief
Special Programs Branch

Cc: As appropriate the Facility Administrator or designee will distribute copies of this letter:

- Resident and Resident's Conservator or Guardian (if applicable)
- Discharge Hospital and Resident's Attending Physician
- Admitting NF

[1]Federal law [42 U.S.C. 1396r(e)(7)] PASRR

Preadmission Screening and Resident Review (PASRR) Level I Screening

The federal Omnibus Reconciliation Act (Public Law 100-203) and 42 CFR 483.100-38 requires that each resident, regardless of payment source, applying for admission to, or residing in, a Medicaid-certified Nursing Facility be screened for mental illness and intellectual disability. Federal law prohibits payment for Nursing Facility services until the PASRR screening has been completed.

Questions? MI-DHCS Tel: (916) 440-7000 ID/DD/RC-DDS Tel: (916) 654-1954 Fax: (916) 654-3256

Facility Information

PASRR CID : **203-081-916**
Result of Level I Screening :Level I - **Negative**
ID/DD/RC: **No**
Reason Code : **No Serious Mental Illness**
Date Started: **07/17/2023**
Facility Name: **The Pavilion at Sunny Hills**
Name of Person Completing Level I Screening : **Sarah Cormier**
Facility Address: **2222 NORTH HARBOR BOULEVARD, FULLERTON, CA 92835**
Phone : **(714) 992-5701**

Section I - Individual Information

1. Last Name: **CAO** First Name : **HO** Middle Name : **V**
2. Date Of Birth : **02/01/1943**
3. Screening Type (●) Initial Preadmission Screening(PAS) ( ) Resident Review (RR) (Status Change) Admission Date: **07/14/2023**

Section II - Intellectual or Developmental Disability(ID) / (DD) or Related Condition(RC)

4. The Individual has or is suspected of having a primary diagnosis of ID/DD/RC. ID/DD/RC include disabilities that originated before the age of 18, are expected to continue indefinitely, and constitute a substantial disability for an individual. This includes intellectual disability, cerebral palsy, epilepsy, autism, and closely related disabling conditions, but shall not include handicapping conditions that are solely physical in nature. ( ) Yes (●) No ( ) Unknown

Specify type/Diagnosis

5. The Individual has a history of a substantial disability prior to the age of 22. ( ) Yes ( ) No (●) Unknown

Age of onset

6. The Individual has received services through a Regional Center. ( ) Yes ( ) No (●) Unknown

Describe the services

7. The Individual has received ID/DD services, from another agency or facility. ( ) Yes ( ) No (●) Unknown

Describe the services

8. Has the Individual ever been referred to Regional Center Services? ( ) Yes ( ) No (●) Unknown

Describe the services

9. Because of ID/DD, the Individual experiences functional limitations. Examples of functional limitations include mobility, self-care, self-direction, learning/understanding/using language, capacity for living independently. ( ) Yes ( ) No (●) Unknown

Describe the limitations

Section III - Serious Mental Illness - Definition

10. Does the Individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? ( ) Yes (●) No

Explain

11. After observing the Individual or reviewing their records, do you believe the Individual may be experiencing serious depression or anxiety, unusual or abnormal thoughts, extreme difficulty coping, or significantly unusual behaviors or does the individual actively engage in community mental health services? ( ) Yes (●) No

Explain

12. The Individual has been prescribed psychotropic medications for mental illness. ( ) Yes (●) No

Section IV – Categorical Determination

Section IV is not required to be filled by the user.

13. The Individual requires less than 15 days stay. ( ) Yes ( ) No

13a. Please select the reason for brief stay

- Protective services (Stay is not expected to exceed 6 days)
- Providing temporary respite for the in-home caregiver (respite case less than 15 days)

14. The individual has a diagnosis of delirium. Further diagnosis cannot be made until delirium clears. Yes No

15. The individual could not benefit from specialized (mental health) services because there is a severe physical condition such as coma, ventilator dependence, or neurocognitive disorder (dementia) that prevents the individual from engaging with others, communicating effectively, and/or participating in mental health care; Or the Individual has a terminal illness that is currently being treated under palliative, comfort, or hospice care. Yes No

15a. Provide the physical diagnoses that causes the individual to require Nursing Facility care, followed by the specific conditions or reasons that prevent the individual from participating in specialized services.

16. Please select the data source that is the basis for the above categorical application

- Hospital/Facility records
- Physician's evaluation
- Election of hospice status
- Records of community mental health centers
- Records of community intellectual disability or developmental disability providers

Section V - Current Physical Diagnoses, Bed Type, and Exempted Hospital Discharge

Section V is not required to be filled by the user.

17. Please indicate the physical diagnosis/diagnoses that requires NF level of care.

18. What type of bed is the resident currently residing in?

- General Acute Care Hospital
- Skilled Nursing Facility
- Group Home/Assisted
- Acute Psychiatric Hospital/Unit
- Special Treatment Program/Institution for Mental Disease
- Intermediate Care Facility
- Other – specify

If Other - Specify

Location Description :

Address :

City:

State:

Zip Code:

Phone:

Fax:

19. Exempted Hospital Discharge Yes No Unknown

State Use Only Comments:	
ID/DD/RC:**No**	Level I - **Negative**
Case State : **Closed**	Resolution : **LII- Not Required**
Reason Code : **No Serious Mental Illness**	
Categorical: **N/A**	