North Los Angeles County Regional Center
Home and Community-Based Services Waiver
Monitoring Review Report

Conducted by:

Department of Developmental Services
and
Department of Health Care Services

July 29–August 16, 2024

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EXECUTIVE SUMMARY

The Department of Developmental Services (Department) and the Department of Health Care Services (DHCS) conducted the federal compliance monitoring review of the Home and Community-Based Services (HCBS) Waiver from July 29, 2024 through August 16, 2024, at North Los Angeles County Regional Center (NLACRC). The monitoring team members were Natasha Clay (Team Leader), Kelly Sandoval, Nora Muir, Fam Chao, Deeanna Tran, Amalya Caballery, Crystal La, Janie Hironaka, Dominique Johnson and Vannessa Fonseca from the Department.

Purpose of the Review

The Department contracts with 21 private, non-profit corporations to operate regional centers, which are responsible under state law for coordinating, providing, arranging or purchasing all services needed for eligible individuals with developmental disabilities in California. All HCBS Waiver services are provided through this system. It is the responsibility of the Department to ensure, with the oversight of DHCS, that the HCBS Waiver is implemented by regional centers in accordance with Medicaid statute and regulations.

Overview of the HCBS Waiver Programmatic Compliance Monitoring Protocol

The compliance monitoring review protocol is comprised of sections/components designed to determine if the individuals' served needs and program requirements are being met and that services are being provided in accordance with the individual program plans (IPP). Specific criteria have been developed for the review sections listed below that are derived from federal/state statutes and regulations and from Centers for Medicare & Medicaid Services directives and guidelines relating to the provision of HCBS Waiver services.

Scope of Review

The monitoring team reviewed a sample of 62 records for individuals served on the 1915c HCBS Waiver. In addition, the following supplemental sample records were reviewed: 1) eleven individuals whose HCBS Waiver eligibility had been previously terminated, 2) one individual who moved from a developmental center, and 3) ten individuals who had special incidents reported to the Department during the review period of April 1, 2023, through March 31, 2024, and 4) fifteen individuals who were enrolled in the HCBS Waiver during the review period were reviewed for documentation that determined the level of care prior to receipt of HCBS Waiver services.

The monitoring team completed visits to 10 community care facilities (CCF) and four day programs. The team reviewed six day program records for individuals served, 10 CCF records and interviewed and/or observed 40 of the selected sample of individuals served.

Overall Conclusion

NLACRC is in overall compliance with the federal requirements for the HCBS Waiver program. Specific recommendations that require follow-up actions by NLACRC are included in the report findings. The Department is requesting documentation of follow-up actions taken by NLACRC in response to each of the specific recommendations within 30 days following receipt of this report.

Major Findings

Section I – Regional Center Self-Assessment

The self-assessment responses indicated that NLACRC has systems and procedures in place for implementing the state and HCBS Waiver requirements addressed in the self-assessment criteria.

Section II – Regional Center Record Review of Individuals Served

Sixty-two sample records for individuals served on the HCBS Waiver were reviewed for 31 documentation requirements (criteria) derived from federal and state statutes and regulations and HCBS Waiver requirements. One criterion was rated as not applicable for this review. Criterion 2.2 was 65 percent in compliance because 22 of the 62 applicable sample records did not contain a signed and/or dated DS 2200 form. Criterion 2.3 was 55 percent in compliance because 5 of the 11 applicable sample records did not contain documentation indicating that the individual served had voluntarily disenrolled or that a Notice of a Proposed Action (NOA) had been sent prior to the termination of their eligibility from the HCBS Waiver. Criterion 2.6.a was 71 percent in compliance because 18 of the 62 did not contain documentation that the individual's IPP had been reviewed annually by the planning team. Criterion 2.6.b was 85 percent in compliance because 6 of the 41 applicable sample records did not contain a completed Standardized Annual Review Form (SARF). Criterion 2.10.a was 87 percent in compliance because 8 of the 62 applicable sample records did not contain IPPs that include a schedule of the type and amount of all services and supports purchased by the regional center. Criterion 2.13.a was 50 percent in compliance because 16 of the 32 applicable sample records did not contain documentation of all required quarterly face-to-face visits. Criterion 2.13.b was 50 percent in compliance because 16 of the 32 applicable sample records did not contain documentation of all required quarterly reports of progress. The sample records were 91 percent in overall compliance for this review.

NLACRC's records were 91 percent and 95 percent in overall compliance for the collaborative reviews conducted in 2022 and in 2020, respectively.

Terminations: Eleven supplemental records were reviewed solely for documentation that NLACRC had either provided the individual served with written notification prior to termination of the individual's HCBS Waiver eligibility, or the individual served had

voluntarily disenrolled from the HCBS Waiver. NLACRC's records were 55 percent in overall compliance for this review.

Section III – Community Care Facility Record Review for Individuals Served

Ten records for individuals served were reviewed at 10 CCFs for 19 documentation requirements (criteria) derived from Title 17, California Code of Regulations. The sample records were 100 percent in overall compliance for 19 criteria on this review.

NLACRC's records were 100 percent in overall compliance for the collaborative reviews conducted in 2022 and in 2020, respectively.

Section IV – Day Program Record Review for Individuals Served

Six records for individuals served were reviewed at four day programs for 17 documentation requirements (criteria) derived from Title 17, California Code of Regulations. The sample records were 100 percent in overall compliance for this review.

NLACRC's records were 100 percent in overall compliance for the collaborative review conducted in 2022. The closure of day programs due to the COVID-19 pandemic prevented the review of Section IV Day Program records and site visits for the 2020 review.

Section V –Observations and Interviews of Individuals Served

Forty individuals served, or in the case of minors, their parents, were interviewed and/or observed at their CCFs, day programs, or in independent living settings. The monitoring team observed that all of the individuals were in good health and were treated with dignity and respect. All but one of the interviewed individuals/parents indicated that they were satisfied with their services, health and choices.

Section VI A – Service Coordinator Interviews

Twelve service coordinators were interviewed using a standard interview instrument. The service coordinators responded to questions regarding their knowledge of the individual served, the IPP/annual review process, the monitoring of services, health issues, and safety. The service coordinators were very familiar with the individuals served and knowledgeable about their roles and responsibilities.

Section VI B – Clinical Services Interview

The Nursing Services Manager was interviewed using a standard interview instrument. She responded to questions regarding the monitoring of individuals with medical issues, medications, behavior plans, the coordination of medical and mental health care for individuals, clinical supports to assist service coordinators, and the clinical team's role on the Risk Management and Mitigation Committee and special incident reporting.

Section VI C – Quality Assurance Interview

A community services specialist was interviewed using a standard interview instrument. He responded to questions regarding how NLACRC is organized to conduct Title 17 monitoring reviews, verification of provider qualifications, resource development activities, special incident reporting, and QA activities where there is no regulatory requirement.

Section VII A – Service Provider Interviews

Six CCF and four day program service providers were interviewed using a standard interview instrument. The service providers responded to questions regarding their knowledge of the individual served, the annual review process, and the monitoring of health issues, medication administration, progress, safety, and emergency preparedness. The staff was familiar with the individuals served and knowledgeable about their roles and responsibilities.

Section VII B – Direct Service Staff Interviews

Six CCF and four day program direct service staff were interviewed using a standard interview instrument. The direct service staff responded to questions regarding their knowledge of individuals served, the IPP, communication, service delivery, procedures for safety, emergency preparedness, and medications. The staff were familiar with the individuals served and knowledgeable about their roles and responsibilities.

Section VIII – Vendor Standards Review

The monitoring team reviewed six CCFs and four day programs utilizing a standard checklist with 23 criteria that are consistent with HCBS Waiver requirements. The reviewed CCFs and day programs were in good repair with no immediate health or safety concerns observed.

Section IX – Special Incident Reporting

The monitoring team reviewed the records of the 62 records for individuals served who are on the HCBS Waiver and 10 supplemental sample records of individuals served for special incidents during the review period. NLACRC reported all special incidents for the sample selected for the HCBS Waiver review. For the supplemental sample, the service providers reported 8 of the 10 incidents to NLACRC within the required timeframes, and NLACRC subsequently transmitted 7 of the 10 special incidents to DDS within the required timeframes. NLACRC's follow-up activities for the 10 incidents were timely and appropriate for the severity of the situation.

SECTION I

REGIONAL CENTER SELF-ASSESSMENT

I. Purpose

The regional center self-assessment addresses the California Home and Community-Based Services (HCBS) Waiver assurances criteria and is designed to provide information about the regional center's processes and practices. The responses are used to verify that the regional center has processes in place to ensure compliance with federal and state laws and regulations.

The self-assessment obtains information about NLACRC's procedures and practices to verify that there are processes in place to ensure compliance with state and federal laws and regulations as well as the assurances contained in the HCBS Waiver application approved by the Centers for Medicare & Medicaid Services.

II. Scope of Assessment

NLACRC is asked to respond to questions in four categories that correspond to the HCBS Waiver assurances with which the regional center is responsible for complying. The questions are shown at the end of this section.

III. Results of Assessment

The self-assessment responses indicate that NLACRC has systems and procedures in place for implementing the state and HCBS Waiver requirements addressed in the self-assessment criteria.

- ✓ The full response to the self-assessment is available upon request.

Regional Center Self-Assessment HCBS Waiver Assurances	
HCBS Waiver Assurances	Regional Center Assurances
State conducts level of care need determinations consistent with the need for institutionalization.	The regional center ensures that individuals served meet ICF/DD, ICF/DD-H, or ICF/DD-N facility level of care requirements as a condition of initial and annual eligibility for the HCBS Waiver Program. Regional center ensures that the regional center staff responsible for certifying and recertifying individual's HCBS Waiver eligibility meet the federal definition of a Qualified Intellectual Disabilities Professional (QIDP). The regional center ensures that individuals served are eligible for full scope Medi-Cal benefits before enrolling them in the HCBS Waiver.
Necessary safeguards have been taken to protect the health and welfare of persons receiving HCBS Waiver Services.	The regional center takes action(s) to ensure individuals' rights are protected. The regional center takes action(s) to ensure that the individuals' health needs are addressed. The regional center ensures that behavior plans preserve the right of the individual served to be free from harm. The regional center maintains a Risk Management, Risk Assessment and Planning Committee. The regional center has developed and implemented a Risk Management/Mitigation Plan. Regional centers and local Community Care Licensing offices coordinate and collaborate in addressing issues involving licensing requirements and monitoring of CCFs pursuant to the MOU between DDS and Department of Social Services. The regional center has developed and implemented a quality assurance plan for Service Level 2, 3 and 4 community care facilities. The regional center reviews each community care facility annually to assure services are consistent with the program design and applicable laws and development and implementation of corrective action plans as needed. The regional center conducts not less than two unannounced monitoring visits to each CCF annually. Service coordinators perform and document periodic reviews (at least annually) to ascertain progress toward achieving IPP objectives and the individual served and the family's satisfaction with the IPP and its implementation. Service coordinators have quarterly face-to-face meetings with individuals served in CCFs, family home agencies, supported living services, and independent living services to review services and progress toward achieving the IPP objectives for which the service provider is responsible. The regional center ensures that needed services and supports are in place when an individual moves from a developmental center (DC) to a community living arrangement.

Regional Center Self-Assessment HCBS Waiver Assurances	
HCBS Waiver Assurances	Regional Center Assurances
Necessary safeguards have been taken to protect the health and welfare of persons receiving HCBS Waiver Services (cont.)	Service coordinators provide enhanced case management to individuals who move from a DC by meeting with them face-to-face every 30 days for the first 90 days they reside in the community.
Only qualified providers serve HCBS Waiver participants.	The regional center ensures that all HCBS Waiver service providers have signed the "HCBS Provider Agreement Form" and meet the required qualifications at the time services are provided.
Plans of care are responsive to HCBS Waiver participant needs.	The regional center ensures that all individuals on HCBS Waiver are offered a choice between receiving services and living arrangements in an institutional or community setting. Regional centers ensure that planning for IPPs includes a comprehensive assessment and information gathering process which addresses the total needs of individuals on HCBS Waiver and is completed at least every three years at the time of his/her triennial IPP. The IPPs of individuals on HCBS Waiver are reviewed at least annually by the planning team and modified, as necessary, in response to the individuals' changing needs, wants and health status. The regional center uses feedback from individuals served, families and legal representatives to improve system performance. The regional center documents the manner by which individuals indicate choice and consent.

SECTION II

REGIONAL CENTER
RECORD REVIEW OF INDIVIDUALS SERVED

I. Purpose

The review is based upon documentation criteria derived from federal/state statutes and regulations and from the Centers for Medicare & Medicaid Services directives and guidelines relating to the provision of Home and Community-Based Services (HCBS) Waiver services. The criteria address requirements for eligibility, choice of individual served, notification of proposed action and fair hearing rights, level of care, individual program plans (IPP) and periodic reviews and reevaluations of services. The information obtained about the individual's needs and services is tracked as a part of the onsite program reviews.

II. Scope of Review

1. Sixty-two HCBS Waiver records of individuals served were selected for the review sample.

Living Arrangement	# of Individuals Served
Community Care Facility (CCF)	14
With Family	29
Independent or Supported Living Services	19

2. The review period covered activity from April 1, 2023 through March 31, 2024.

III. Results of Review

The 62 sample records of individuals served were reviewed for 31 documentation requirements derived from federal and state statutes and regulations and HCBS Waiver requirements. The sample records were 91 percent in overall compliance for this review. Eleven supplemental records were reviewed solely for documentation that NLACRC had either provided the individual served with written notification prior to termination of the individual's HCBS Waiver eligibility, or the individual had voluntarily disenrolled from the HCBS Waiver. Additionally, one supplemental record was reviewed solely for documentation indicating that the individual served received face-to-face reviews every 30 days after moving from a developmental center for the first 90 days. Fifteen supplemental records were reviewed for documentation that NLACRC determined the level of care prior to receipt of HCBS Waiver services.

- ✓ The supplemental records were in 100 percent compliance for determining the level of care prior to receiving HCBS Waiver services.

- ✓ The supplemental records were in 55 percent compliance for documentation that the individual was either provided written notification before termination or voluntarily disenrolled from the HCBS Waiver.

- ✓ The supplemental record was in 100 percent compliance for documentation that the individual received face-to-face reviews every 30 days for 90 days after moving from a developmental center.

- ✓ The sample records were in 100 percent compliance for 16 criteria. There are no recommendations for these criteria. One criterion was not applicable for this review.

- ✓ Findings for 14 criteria are detailed below.

- ✓ A summary of the results of the review is shown in the table at the end of this section.

IV. Findings and Recommendations

2.2 Each record contains a dated and signed Medicaid Waiver Consumer Choice of Services/Living Arrangements form (DS 2200). *[SMM 4442.7; 42 CFR 441.302(d)]*

Findings

Forty of the sixty-two (65 percent) sample records of individuals served contained a signed and dated DS 2200 form. However, there were identified issues regarding the DS 2200 form for the following individuals:

1. Individual #9: The individual served was determined eligible on March 1, 2009. The DS 2200 form was signed and dated May 16, 2024. Accordingly, no recommendation is required;

2. Individual #10: The individual served was determined eligible on February 1, 1995. The DS 2200 form was signed and dated May 13, 2024. Accordingly, no recommendation is required;

3. Individual #11: The individual served was determined eligible on March 1, 2007. The DS 2200 form was signed and dated May 15, 2024. Accordingly, no recommendation is required;

4. Individual #12: The individual served was determined eligible on February 1, 2019. The DS 2200 form was signed and dated May 9, 2024. Accordingly, no recommendation is required;

5. Individual #13: The individual served was determined eligible on July 1, 1996. The DS 2200 form was signed and dated May 8, 2024. Accordingly, no recommendation is required;

6. Individual #16: The individual served was determined eligible on February 1, 2008. The DS 2200 form was signed and dated May 7, 2024. Accordingly, no recommendation is required;

7. Individual #17: The individual served was determined eligible on March 1, 2009. The DS 2200 form was signed and dated May 10, 2024. Accordingly, no recommendation is required;

8. Individual #21: The individual served was determined eligible on March 1, 2016. There was not a DS 2200 form on file;

9. Individual #30: The individual served was determined eligible on April 1, 2003. The DS 2200 form was signed and dated May 13, 2024. Accordingly, no recommendation is required;

10. Individual #34: The individual served was determined eligible on June 1, 2009. The DS 2200 form was signed and dated May 6, 2024. Accordingly, no recommendation is required;

11. Individual #35: The individual served was determined eligible on June 1, 2019. The DS 2200 form was signed and dated June 25, 2024. Accordingly, no recommendation is required;

12. Individual #41: The individual served was determined eligible on October 1, 2009. The DS 2200 form was signed and dated January 1, 2019. The individual's choice for living arrangement was not specified on the form;

13. Individual #42: The individual served was determined eligible on August 1, 2013. The DS 2200 form was signed and dated May 7, 2024. Accordingly, no recommendation is required;

14. Individual #43: The individual served was determined eligible on June 1, 2011. The DS 2200 form was signed and dated May 7, 2024. Accordingly, no recommendation is required;

15. Individual #47: The individual served was determined eligible on December 1, 2017. The DS 2200 form was signed and dated June 18, 2024. Accordingly, no recommendation is required;

16. Individual #50: The individual served was determined eligible on March 1, 2013. The DS 2200 form was signed and dated June 30, 2024. Accordingly, no recommendation is required;

17. Individual #51: The individual served was determined eligible on December 1, 2016. The DS 2200 form was signed and dated May 15, 2024. Accordingly, no recommendation is required;

18. Individual #56: The individual served was determined eligible on April 1, 2014. The DS 2200 form was signed and dated May 13, 2024. Accordingly, no recommendation is required;

19. Individual #57: The individual served was determined eligible on February 1, 2019. The DS 2200 form was signed and dated May 17, 2024. Accordingly, no recommendation is required;

20. Individual #60: The individual served was determined eligible on May 1, 2018. The DS 2200 form was signed and dated May 14, 2024. Accordingly, no recommendation is required;

21. Individual #61: The individual served was determined eligible on February 1, 2016. The DS 2200 form was signed and dated May 6, 2024. Accordingly, no recommendation is required; and

22. Individual #62: The individual served was determined eligible on August 1, 2020. The DS 2200 form was signed and dated May 15, 2024. Accordingly, no recommendation is required.

2.2 Recommendations	Regional Center Plan/Response
NLACRC should ensure that the DS 2200 form for individual #21 and #41 is properly signed and dated with the choice of living arrangement specified.	#21 Individual passed away in the home on 6/4/24. Individual was terminated from the HCBS Waiver effective 6/4/24. #41 Updated DS2200 Choice Form includes individual's specified choice of living arrangement (e.g. with Family).
In addition, NLACRC should evaluate what actions may be necessary to ensure that DS 2200s are completed and documented for all individuals enrolled on the HCBS Waiver.	Preliminary findings on DS2200 Choice Forms discussed at Case Management Leadership Meetings on 8/12/24 and 9/3/24. Continued training regarding the importance of DS2200 completion being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings. Additionally, a mandatory eLearning training in LMS (Learning Management

	System) titled "DS2200 Choice Form and HCBS Waiver Standardized Annual Review Form (SARF) Overview" was created and implemented June 2024. The mandatory training was completed by Case Management (all Lanterman Teams- School Age, Transition, Adult, Specialized Caseloads, Officer of the Day Specialists, Lead Trainers, and Floaters) in July 2024. Last, a designated email address (e.g. HCBSwaiver@nlacrc.org) was created specifically for our Medicaid Waiver Department to send encrypted emails with DS2200 Choice Forms to individuals/families for signature and return in addition to mailing through the United States Postal Service. Detailed letters sent to individuals/families to include a request to return document within a 30-day timeline. Administrative Assistants to assist with tracking. Service Coordinators to ensure receipt of completed DS2200 Choice Form.

2.3 There is a written Notice of Action (NOA) and documentation that the individual served has been sent written notice of their fair hearing rights whenever choice of living arrangements is not offered, services or choice of services are denied, the individual served/parent/legal guardian or legal representative does not agree with all, or part, of the components in the IPP, or the individual's HCBS Waiver eligibility has been terminated. *[SMM 4442.7*; *42 CFR Part 431, Subpart E*; *WIC 4710(a)(1)]*

Findings

Six of the eleven (55 percent) sample records of individuals served contained documentation indicating that the individual served had voluntarily disenrolled or that a NOA had been sent prior to the termination of their eligibility from the HCBS Waiver. However, the record of the following individuals did not contain documentation as indicated above:

1. Individual #T-2: The individual served was disenrolled on October 17, 2023. The DS 2200 form was signed in the voluntary disenrollment section and dated May 17, 2024. Accordingly, no recommendation is required;

2. Individual #T-4: The individual served was disenrolled on December 31, 2023. The DS 2200 form was signed in the voluntary disenrollment section and dated May 15, 2024. Accordingly, no recommendation is required;

3. Individual #T-8: The individual served was disenrolled on November 30, 2023. The DS 2200 form was signed in the voluntary disenrollment section and dated June 14, 2024. Accordingly, no recommendation is required;

4. Individual #T-9: The individual served was disenrolled on February 29, 2024. The DS 2200 form was signed in the voluntary disenrollment section and dated June 14, 2024. Accordingly, no recommendation is required; and,

5. Individual #T-10: The individual served was disenrolled on June 30, 2023. The DS 2200 form was signed in the voluntary disenrollment section and dated June 18, 2024. Accordingly, no recommendation is required.

2.3 Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that applicable individuals have signed a voluntary disenrollment on the DS 2200 or have been provided an NOA prior to terminating eligibility from the HCBS Waiver.	Preliminary findings on DS2200 Choice Forms discussed at Case Management Leadership Meetings on 8/12/24 and 9/3/24. Continued trainings regarding the importance of DS2200 completion being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings. Additionally, a mandatory eLearning training in LMS (Learning Management System) titled “DS2200 Choice Form and HCBS Waiver Standardized Annual Review Form (SARF) Overview” was created and implemented in June 2024. The training was completed by Case Management (all Lanterman Teams- School Age, Transition, Adult, Specialized Caseloads, Officer of the Day Specialists, Lead Trainers, and Floaters) in July 2024. Last, a designated email address was created specifically for our Medicaid Waiver Department to send encrypted emails with DS2200 Choice Forms to individuals/families for signature and return in addition to mailing through the United States Postal Service. Detailed

	letters sent to individuals/families to include request to return document within a 30-day timeline. Administrative Assistants to assist with tracking. Service Coordinators to ensure receipt of completed DS2200 Choice Form.

2.4 Each record contains a current Client Development Evaluation Report (CDER) that has been reviewed annually. *(SMM 4442.5; 42 CFR 441.302(c)]*

Findings

Fifty-eight of the sixty-two (94 percent) sample records of individuals served contained a CDER that had been reviewed annually. However, the records for individuals #30, #35, #36, and #42 did not contain documentation that the CDER had been reviewed annually.

2.4 Recommendation	Regional Center Plan/Response
NLACRC should ensure that the CDER for individuals #30, #35, #36, and #42 is reviewed annually.	CDERs for all identified individuals were reviewed and updated annually. However, the 2023 CDERs were not uploaded into the electronic chart, Therefore and subsequently replaced with the 2024 CDER update. Unfortunately, once the CDER is updated in SANDIS Regional Center cannot retrieve the previous CDER. All CDER updates must be uploaded in to Therefore. Preliminary findings on missing CDERs due to lack of saving previous CDER in Therefore discussed at Case Management Leadership Meetings on 8/12/24 and 9/3/24. Continued trainings regarding the importance of reviewing/updating/uploading CDER annually being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings.

2.5.a The qualifying conditions and any special health care requirements used to meet the level-of-care requirements for care provided in an ICF-DD, ICF/DD-H, or ICF/DD-N facility are documented in the individual's Client Development

Evaluation Report (CDER) and other assessments. *(SMM 4442.5*; *42 CFR 441.302(c)*; *Title 22, CCR, §51343)*

Findings

Sixty of the sixty-two (97 percent) sample records of individuals served had documented qualifying conditions. However, there were identified issues regarding the CDER for the following individuals:

1. Individual #19: The qualifying condition "self-injurious behavior" on the DS 3770 dated December 2023 is inconsistent with the CDER and other assessments; and

2. Individual #42: The qualifying conditions "not toilet or habit trained", "no control of either bladder or bowel", "personal care", "dressing", safety awareness", "bathing", "aggressive behavior", "hyperactive", "resistive behavior", and "self-injurious behavior" on the DS 3770 dated August 2023 are inconsistent with the CDER and other assessments. During the monitoring review the CDER dated 2023 was not available.

2.5.a Recommendation	Regional Center Plan/Response
NLACRC should reevaluate the HCBS Waiver eligibility for individual #19 and #42 to ensure that the individual served meets the level-of-care requirements. If the individual does not have at least two distinct qualifying conditions that meet the level-of-care requirements, the individual's HCBS Waiver eligibility should be terminated.	#19 CDER updated 12/19/23, DS3770 printed 12/13/23 therefore, did not reflect "self-injurious behavior" update from CDER updated after recertification. Unable to provide 2022 CDER as not uploaded to electronic chart. "Self-Injurious behavior" discussed in 1/8/24 IPP provided to auditors during initial audit review. Individual #19 meets the level of care requirements of the HCBS Waiver. #42 Unable to provide 2023 CDER as not uploaded to electronic chart prior to 2024 update. Current IPP dated 5/7/24 (provided to auditors during initial audit review) discussed the noted qualifying conditions. Aggressive behavior has been removed from CDER. Individual #49 meets the level of care requirements of the HCBS Waiver.

2.5.b The qualifying conditions documented in the Client Development Evaluation Report (CDER) are consistent with information contained in the individual's record. *[SMM 4442.5*; *42 CFR 441.302(c)*; *Title 22, CCR, §51343]*

Findings

Fifty-seven of the sixty-two (92 percent) sample records of individuals served documented level-of-care qualifying conditions that were consistent with information found elsewhere in the record. However, information contained in four records (detailed below) did not support the determination that all the issues identified in the CDER and the Medicaid Waiver Eligibility Record (DS 3770) could be considered qualifying conditions. The following were identified as qualifying conditions on the DS 3770, but there was no supporting information in the records of individuals served (IPP, progress reports, vendor reports, etc.) that described the impact of the identified conditions or need for services and supports:

1. Individual #19: "self-injurious behavior";

2. Individual #28: "past/present assault causing injury or death";

3. Individual #31: "property damage", Subsequent to the monitoring review, an IPP dated May 7, 2024 was completed to add information supporting this qualifying condition. Accordingly, no recommendation is required;

4. Individual #38: "personal care activities independently with reminders" and "emotional outburst"; and,

5. Individual #42: "becomes aggressive or hostile".

2.5.b Recommendation	Regional Center Plan/Response
NLACRC should determine if the items listed above for individuals #19, #28, #31, #38, and #42 are appropriately identified as qualifying conditions. The individual's DS 3770 form should be corrected to ensure that any items that do not represent substantial limitations in the individuals' ability to perform activities of daily living and/or participate in community activities are no longer identified as qualifying conditions. If NLACRC determines that the issues are correctly identified as qualifying conditions, documentation (updated IPPs, progress reports, etc.) that supports the original determinations should be submitted with the response to this report.	#19 A review of 1/8/24 IPP discussed the progress on "self-injurious behavior" since, the qualifying condition has been removed from CDER and DS3770. CDER updated 12/19/23, DS3770 printed 12/13/23 therefore, did not reflect "self-injurious behavior" update from CDER updated after recertification. Unable to provide 2022 CDER as not uploaded to electronic chart. 1/8/24 IPP provided to auditors during initial audit review. #28 A review of 3/9/22 IPP, 3/22/23 Annual Review, and 2/21/24 Annual Review reports did not support the qualifying condition indicated on CDER and DS3770. An Addendum to 3/9/22

	IPP will be completed to accurately reflect qualifying condition. (attached) #38 A review of 8/24/22 presents an inconsistency and did not support the qualifying condition (personal care activities independently when reminded) noted on the CDER and DS3770. An Addendum to the 8/24/22 IPP was completed to accurately reflect the qualifying condition (personal care activities). (attached). An addendum to the 8/24/22 IPP will be completed to accurately reflect the qualifying condition (outbursts). (attached) #42 A review of 5/7/24 IPP provided to auditors during initial audit review provides an update to qualifying condition. Hence, aggressive behavior has been removed from current CDER.

2.6.a The IPP is reviewed (at least annually) by the planning team and modified, as necessary, in response to the individual's changing needs, wants or health status. *[42 CFR 441.301(c)(3)]*

Findings

Forty-four of the sixty-two (71 percent) sample records of individuals served contained documentation that the individual's IPP had been reviewed annually by the planning team. However, there was no documentation that the IPPs for eighteen individuals were reviewed annually as indicated below:

1. Individual #7: The IPP was dated August 24, 2022. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on June 24, 2024. Accordingly, no recommendation is required;

2. Individual #8: The IPP was dated October 26, 2022. There was no documentation that the IPP was reviewed within the year. An annual review was completed on December 14, 2023. Accordingly, no recommendation is required;

3. Individual #16: The IPP was dated January 29, 2021. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on January 17, 2024. Accordingly, no recommendation is required;

4. Individual #17: The IPP was dated April 13, 2022. There was no documentation that the IPP was reviewed within the year. An annual review was completed on August 24, 2023. Accordingly, no recommendation is required;

5. Individual #18: The IPP was dated January 19, 2021. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on May 7, 2024. Accordingly, no recommendation is required;

6. Individual #22: The IPP was dated November 19, 2020. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on May 10, 2024. Accordingly, no recommendation is required;

7. Individual #30: The IPP was dated November 29, 2022. There was no documentation that the IPP was reviewed during the monitoring review period;

8. Individual #31: The IPP was dated April 23, 2020. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on May 7, 2024. Accordingly, no recommendation is required;

9. Individual #33: The IPP was dated April 6, 2020. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on April 18, 2024. Accordingly, no recommendation is required;

10. Individual #34: The IPP was dated May 25, 2022. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on February 13, 2024. Accordingly, no recommendation is required;

11. Individual #35: The IPP was dated July 13, 2020. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on May 14, 2024. Accordingly, no recommendation is required;

12. Individual #36: The IPP was dated October 7, 2021. There was no documentation that the IPP was reviewed within the year. An annual review was completed on June 11, 2024. Accordingly, no recommendation is required

13. Individual #39: The IPP was dated August 22, 2022. There was no documentation that the IPP was reviewed within the year. An annual review was completed on February 5, 2024. Accordingly, no recommendation is required;

14. Individual #44: The IPP was dated August 5, 2020. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on November 13, 2023. Accordingly, no recommendation is required;

15. Individual #46: The IPP was dated April 11, 2022. There was no documentation that the IPP was reviewed within the year. An annual review was completed on June 14, 2023. Accordingly, no recommendation is required;

16. Individual #47: The IPP was dated October 14, 2020. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on May 8, 2024. Accordingly, no recommendation is required;

17. Individual #54: The IPP was dated February 7, 2022. There was no documentation that the IPP was reviewed within the year. An addendum was completed on June 12, 2024. Accordingly, no recommendation is required; and

18. Individual #59: The IPP was dated December 29, 2021. There was no documentation that the IPP was reviewed within the year. An annual review was completed on March 6, 2024. Accordingly, no recommendation is required.

2.6.a Recommendations	Regional Center Plan/Response
NLACRC should ensure that the IPP for individual #30 is reviewed at least annually by the planning team.	The importance of timely/annual IPP renewal documentation (from the date of IPP, not the birth month) was discussed at Case Management Leadership Meetings on 8/12/24 and 9/3/24. To ensure future compliance, continuous training will be provided to Service Coordinators and Supervisors regarding HCBS Waiver requirement. In addition, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with waiver compliance. NLACRC will discuss with SANDIS the ability to track reports from month and year of completion and not the birth month.
In addition, NLACRC should evaluate what actions may be necessary to ensure that IPPs are reviewed annually for all individuals.	The importance of timely/annual IPP renewal documentation (from the date of IPP, not the birth month) was discussed at Case Management

	Leadership Meetings on 8/12/24 and 9/3/24. To ensure future compliance, continuous training will be provided to Service Coordinators and Supervisors regarding HCBS Waiver requirement. In addition, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with waiver compliance. NLACRC will discuss with SANDIS the ability to track reports from month and year of completion and not the birth month.

2.6.b The HCBS Waiver Standardized Annual Review Form (SARF) is completed and signed annually by the planning team to document whether or not a change to the existing IPP is necessary and that the individual's health status and CDER have been reviewed. *(HCBS Waiver Requirement)*

Findings

Thirty-five of the forty-one (85 percent) applicable sample records of individuals served contained a completed SARF. However, two records did not contain a SARF and records for four individuals did not contain a completed SARF as indicated below:

1. Individual #7: No SARF completed; IPP was dated August 24, 2022;

2. Individual #11: SARF dated September 12, 2023 was not signed. The SARF was signed and dated May 15, 2024. Accordingly, no recommendation is required;

3. Individual #24: SARF dated April 7, 2023 was not signed. The SARF was signed and dated May 22, 2024. Accordingly, no recommendation is required;

4. Individual #32: SARF dated April 17, 2023 was not signed. The SARF was signed and dated May 15, 2024. Accordingly, no recommendation is required;

5. Individual #36: No SARF completed; IPP was dated October 7, 2021;

6. Individual #45: SARF dated April 19, 2023 was not signed. The SARF was signed and dated June 12, 2024. Accordingly, no recommendation is required.

2.6.b Recommendations	Regional Center Plan/Response
NLACRC should ensure that the SARF for individuals #7, and #36 are completed during the annual IPP review process.	#7 IPP completed 8/24/22. A SARF was not required at such time. Meeting and SARF missing for 8/2023. A new IPP was completed on 6/24/24. A SARF was not required at such time. #36 SARF for 10/24/22 missing individual #36 signature. A new IPP was completed on 10/2/24. A SARF was not required.
In addition, NLACRC should evaluate what actions may be necessary to ensure that SARFs are completed and documented for all applicable individuals.	Preliminary findings on missing and/or incomplete SARF's discussed at Case Management Leadership Meetings on 8/12/24 and 9/3/24. Continuous training regarding the importance of SARF completion for Annual Reviews not including the completion of a new IPP being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management meetings. Additionally, a mandatory eLearning training in LMS (Learning Management System) titled "DS2200 Choice Form and HCBS Waiver Standardized Annual Review Form (SARF) Overview" was created and implemented in June 2024. The training was completed by Case Management (all Lanterman Teams- School Age, Transition, Adult, Specialized Caseloads, Officer of the Day Specialists, Lead Trainers, and Floaters) in July 2024. Last, NLACRC has implemented a technical system called SCRIVE that allows for electronic signatures from individuals/families. Service Coordinators to ensure receipt of completed SARF.

2.7.a The IPP is signed, prior to its implementation, by an authorized representative of the regional center and the individual served or, where appropriate, his/her parents, legal guardian, or conservator. *[W&I Code §4646(g)]*

Findings

Fifty-five of the sixty-two (89 percent) sample records of individuals served contained IPPs that were signed by NLACRC and the individuals served, or their legal representatives. However, the following individuals' IPPs were not signed by the appropriate individual:

1. Individual #11: The IPP dated September 30, 2021 was not signed by the individual served. The IPP was signed on June 18, 2024 by the individual served. Accordingly, no recommendation is required;

2. Individual #13: The IPP dated December 21, 2021 was not signed by the individual legal representative. The IPP was signed on July 1, 2024 by the legal representative. Accordingly, no recommendation is required;

3. Individual #32: The IPP dated April 25, 2022 was not signed by the individual served. The IPP was signed on June 14, 2024 by the individual served. Accordingly, no recommendation is required;

4. Individual #38: The IPP dated August 4, 2022 was not signed by the individual served. The IPP was signed on May 21, 2024 by the individual served. Accordingly, no recommendation is required;

5. Individual #39: The IPP dated August 22, 2024 was not signed by the individual served. The IPP was signed on June 21, 2024 by the individual served. Accordingly, no recommendation is required;

6. Individual #45: The IPP dated April 13, 2021 was not signed by the individual served. The IPP was signed on June 12, 2024 by the individual served. Accordingly, no recommendation is required; and,

7. Individual #47: The IPP dated October 14, 2020 was not signed by the individual served. The IPP was signed on June 18, 2024 by the individual served. Accordingly, no recommendation is required.

2.7.b IPP addenda are signed by an authorized representative of the regional center and the individual served or, where appropriate, his/her parents, legal guardian, or conservator and/or there is documentation of planning team agreement.

Findings

Thirty-nine out of forty-four (89 percent) applicable sample records for individuals served contained IPP addenda signed by NLACRC and the individual served or, where appropriate, his/her parents, legal guardian, or conservator and there was no documentation of planning team agreement. However, the following individuals' IPP addendums were not signed by the appropriate individual:

1. Individual #13: The IPP addendum dated December 21, 2023 was not signed by the individual's legal representative. The IPP addendum was signed on June 12, 2024 by the legal representative. Accordingly, no recommendation is required;

2. Individual #38: The IPP addendum dated May 17, 2023 was not signed by the individual served. The IPP addendum was signed on May 23, 2024 by the legal representative. Accordingly, no recommendation is required;

3. Individual #42: The IPP addendum dated October 25, 2023 was not signed by the individual served. The IPP addendum was signed on June 7, 2024 by the individual served. Accordingly, no recommendation is required;

4. Individual #51: The IPP addendum dated September 11, 2023 was not signed by the individual served. The IPP addendum was signed on May 8, 2024 by the individual served. Accordingly, no recommendation is required; and,

5. Individual #57: The IPP addendum dated April 13, 2023 was not signed by the individual served. The IPP addendum was signed on May 22, 2024 by the individual served. Accordingly, no recommendation is required.

2.10.a The IPP includes a schedule of the type and amount of all services and supports purchased by the regional center. *[WIC §4646.5(a)(5)]*

Findings

Fifty-four of the sixty-two (87 percent) sample IPPs of individuals served included a schedule of the type and amount of all services and supports purchased by the regional center. However, IPPs for eight individuals did not include NLACRC funded services as indicated below:

1. Individual #5: Supplemental Residential Program Support was not included for the months covering September 2023 through March 2024, in the IPP dated March 4, 2020 and March 13, 2024;

2. Individual #6: Dentistry was not included for the month covering September 2023, in the IPP dated September 9, 2021;

3. Individual #18: Community Integration Training Program and Transportation. An addendum was completed March 26, 2024, addressing the purchased services. Accordingly, no recommendation is required;

4. Individual #29: Counseling and Supportive Living Services. An addendum was completed June 7, 2024, addressing the purchased service. Accordingly, no recommendation is required;

5. Individual #35: Community Integration Training Program and Transportation was not included for the months covering August 2023 through March 2024, in the IPP dated July 13, 2020. A new IPP was completed May 14, 2024, addressing the purchased services. Accordingly, no recommendation is required.

6. Individual #44: Activity Center and Transportation. An addendum was completed June 3, 2024, addressing the purchased services. Accordingly, no recommendation is required;

7. Individual #47: Personal Assistance and In Home Respite was not included for the months covering November 2023 through March 2024, in the IPP dated October 14, 2020. An IPP was completed May 8, 2024, addressing the purchased service. Accordingly, no recommendation is required; and,

8. Individual #51: In Home Respite. An addendum was completed May 9, 2024, addressing the purchased services. Accordingly, no recommendation is required.

2.10.a Recommendations	Regional Center Plan/Response
NLACRC should ensure that the IPPs for individuals #5, #6, and #35 include a schedule of the type and amount of all services and supports purchased by NLACRC.	#5 IPPs dated 9/14/23 and 3/13/24 indicates NLACRC will serve as payee on individual's Social Security benefits and will supplement funding his residential placement. The services for Residential Supplemental Program Support were not provided services and was terminated 7/1/23-9/30/23. (attached) #6 IPP dated 9/9/21 indicates NLACRC to fund disability related dental care per dental consultant approval once all generic resources have been exhausted.
In addition, NLACRC should evaluate what actions may be necessary to ensure that IPPs include a schedule of the type and amount of services and supports purchased by NLACRC.	NLACRC has implemented a new "Person Centered IPP Writing Refresher Course" to reinforce Case Management knowledge and understanding of writing person centered IPPs in order to achieve waiver compliance.

2.11 The IPP identifies the provider or providers of service responsible for implementing services, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports. *[W&I Code §4646.5(a)(5)]*

Finding

Sixty-one of the sixty-two (98 percent) sample records of individuals served contained IPPs that identified the provider or providers responsible for implementing services. However, the IPP for individual #9 did not indicate the provider for Transportation NLACRC funded services.

2.11 Recommendation	Regional Center Plan/Response
NLACRC should ensure the IPP for individual #9 identifies the provider for the service listed above.	#9 IPP dated 4/8/22 indicates Group Home Administrator will provide transportation to and from day program NLACRC funds for the community care facility (Staff operated level 3 adult home) (includes transportation). An Addendum to the 4/8/22 IPP report completed to accurately reflect vendor name for the community care facility and duration (2 hours/day Monday-Friday).

2.12 Periodic reviews and reevaluations of progress for individuals served are completed (at least annually) to ascertain that planned services have been provided, that progress has been achieved within the time specified, and the individual served, and his/her family are satisfied with the IPP and its implementation. *[W&I Code §4646.5(a)(8)]*

Findings

Fifty-three of the sixty-two (86 percent) sample records of individuals served contained documentation of periodic review and reevaluation of progress at least annually. However, the records for individuals #18, #22, #29, #31, #35, #36, #39, #47, and #54 did not contain documentation that the individual's progress had been reviewed within the year.

2.12 Recommendation	Regional Center Plan/Response
NLACRC should ensure that a review and reevaluation of progress regarding planned services, timeframes and	#18 Annual Review of progress regarding planned services, timeframes, and satisfaction for

satisfaction for individuals #18, #22, #29, #31, #35, #36, #39, #47, and #54 is completed and documented at least annually.	individual #18 completed in 2022 and 2023 for 2020 IPP. 2021 Annual Review missed. A new IPP completed May 2024 #22 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #22 completed in 2022 for 2021 IPP. 2023 Annual Review missed. A new IPP completed May 2024. #29 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #29 completed in 2021 for 2020 IPP. Attempts made in 2022 to no avail. Service Coordinator separated from agency. Consequently, 2022 and 2023 Annual Review missed. A new IPP completed May 2024. #31 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #31 completed in 2021 and 2022 for 2020 IPP. 2023 IPP missed due to Service Coordinator moving to branch office in Antelope Valley. A new IPP completed May 2024. #35 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #35 completed in 2021 and 2022 for 2020 IPP. 2023 IPP missed due to Service Coordinator separated from agency. A new IPP completed May 2024. #36 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #36 completed in 2022 for

	2021 IPP. 2023 Annual Review missed due to Service Coordinator separated from agency. A new IPP completed October 2024. #39 Annual Review of progress regarding planned services, timeframe, and satisfaction for individual #39 completed in 2024 for 2022 IPP. 2023 Annual Review missed due to Service Coordinator separated from agency. Next IPP scheduled for 2025. #47 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #47 completed in 2021 and 2022 for 2020 IPP. 2023 IPP missed. A new IPP completed May 2024. #54 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #54 completed in 2023 and April 2024 (after the monitoring review period of 4/1/23 through 3/31/24). 2024 report not submitted to auditors during initial review as outside of monitoring review period. Next IPP scheduled for 2025. Preliminary findings and the importance of timely/annual review of progress regarding planned services, timeframes, and satisfaction was discussed at Case Management Leadership Meetings on 8/12/24 and 9/3/24. To ensure future compliance, continuous training being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings regarding HCBS Waiver requirements. Additionally, NLACRC has implemented a tracking date

	base, Power BI Caseload Reports, to assist Case Management with waiver compliance.

2.13.a Quarterly face-to-face meetings are completed for individuals living in community out-of-home settings, i.e., Service Level 2, 3 or 4 community care facilities or family home agencies or receiving supported living and independent living services *(Title 17, CCR, §56047), (Title 17, CCR, §56095), (Title 17, CCR, §58680), (Contract requirement)*

Findings

Sixteen of the thirty-two (50 percent) applicable sample records of individuals served contained quarterly face-to-face meetings completed and documented. However, the records for sixteen individuals did not meet the requirement as indicated below:

1. The records for individuals #5, #6, #10, #13, and #18 contained documentation of three of the four required meetings that were consistent with the quarterly timeline.

2. The records for individuals #8, #17, #20, and #33 contained documentation of two for the four required meetings that were consistent with the quarterly timeline.

3. The records for individuals #7, #12, #15, #30, and #31 contained documentation of one of the four required meetings that were consistent with the quarterly timeline.

4. The record for individual #22 and #29 did not contain documentation of any of the four required meetings that were consistent with the quarterly timeline.

2.13.a Recommendations	Regional Center Plan/Response
NLACRC should ensure that all future face-to-face meetings are completed and documented each quarter for individuals #5, #6, #7, #8, #10, #12, #13, #15, #17, #18, #20, #22, #29, #30, #31, and #33.	Continuous training regarding the importance of timely quarterlies being provided to Service Coordinator, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings.
In addition, NLACRC should evaluate what actions may be necessary to ensure that quarterly face-to face meetings are completed and documented for all applicable individuals.	The importance of timely quarterly face-to-face meetings and progress reports discussed at Case Management Leadership Meetings on 8/12/24 and 9/3/24. Supervisors to ensure implementation of monitoring timely

	completion of reports during scheduled supervision with each Service Coordinator. Continuous training provided to Service Coordinators and Supervisors regarding this Title 17 requirement from date of IPP. Floater Service Coordinator position implemented to provide support for uncovered caseloads to ensure compliance. Last, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with waiver compliance.

2.13.b Quarterly reports of progress are completed for individuals living in community out-of-home settings, i.e., Service Level 2, 3 or 4 community care facilities or family home agencies or receiving supported living and independent living services *(Title 17, CCR, §56047), (Title 17, CCR, §56095), (Title 17, CCR, §58680), (Contract requirement)*

Findings

Sixteen of the thirty-two (50 percent) applicable sample records of individuals served contained quarterly reports of progress completed for individuals living in community out-of-home settings. However, the records for seven individuals did not meet the requirement as indicated below:

1. The records for individuals #5, #6, #10, #13, and #18 contained documentation of three of the four required quarterly reports of progress that were consistent with the quarterly timeline.

2. The record for individuals #8, #17, #20, and #33 contained documentation of two of the four required quarterly reports of progress that were consistent with the quarterly timeline.

3. The record for individual #7, #12, #15, #30, and #31 contained documentation of two of the four required quarterly reports of progress that were consistent with the quarterly timeline.

4. The record for individual #22 and #29 did not contain documentation of any of the four required quarterly reports of progress that were consistent with the quarterly timeline.

2.13.b Recommendations	Regional Center Plan/Response

NLACRC should ensure that all future face-to-face meetings are completed and documented each quarter for individuals #5, #6, #7, #8, #10, #12, #13, #15, #17, #18, #20, #22, #29, #30, #31, and #33.	Continuous training regarding the importance of timely quarterlies being provided to Service Coordinator, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings.
In addition, NLACRC should evaluate what actions may be necessary to ensure that quarterly reports of progress are completed for all applicable individuals.	The importance of timely quarterly face-to-face meetings and progress reports discussed at Case Management Leadership Meetings on 8/12/24 and 9/3/24. Supervisors to ensure implementation of monitoring timely completion of reports during scheduled supervision with each Service Coordinator. Continuous training provided to Service Coordinators and Supervisors regarding this HCBS Waiver requirement from date of IPP. Floater Service Coordinator position implemented to provide support for uncovered caseloads in an attempt to ensure compliance. Last, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with waiver compliance.

Summary for Regional Center Record Review of Individuals Served Sample Size = 62 +12 Supplemental Records *(see Section II, Part III)*						
	Criteria	+	-	N/A	% Met	Follow-up
2.0	The individual is Medi-Cal eligible. *(SMM 4442.1)*	62		12	100	None
2.1	Each record contains a Medicaid Waiver Eligibility Record (DS 3770), signed by a Qualified Intellectual Disabilities Professional (QIDP), which documents the date of the individual's initial HCBS Waiver eligibility certification, annual recertifications, the individual's qualifying conditions and short-term absences. *(SMM 4442.1), [42 CFR 483.430(a)]*	Criterion 2.1 consists of four sub-criteria (2.1.a-d) that are reviewed and rated independently.				
2.1.a	The DS 3770 is signed by a Qualified Intellectual Disabilities Professional and the title "QIDP" appears after the person's signature.	62		12	100	None
2.1.b	The DS 3770 form identifies the individual's qualifying conditions and any applicable special health care requirements for meeting the Title 22 level of care requirements.	62		12	100	None
2.1.c	The DS 3770 form documents annual re-certifications.	62		12	100	None
2.1.d	The DS 3770 documents short-term absences of 120 days or less, if applicable.			74	NA	None
2.2	Each record contains a dated and signed Medicaid Waiver Consumer Choice of Services/Living Arrangements form, (DS 2200). *(SMM 4442.7), [42 CFR 441.302(d)]*	40	22	12	65	See Narrative
2.3	There is a written notification of a proposed action and documentation that the individual served has been sent written notice of their fair hearing rights whenever choice of living arrangements is not offered, services or choice of services are denied, the individual served/parent/legal guardian or legal representative does not agree with all or part of the components in the individual's IPP, or the individual's HCBS Waiver eligibility has been terminated. *(SMM 4442.7), (42 CFR Part 431, Subpart E), [WIC §4710(a)(1)]*	6	5	63	55	See Narrative

Summary for Regional Center Record Review of Individuals Served Sample Size = 62 +12 Supplemental Records *(see Section II, Part III)*						
	Criteria	+	-	N/A	% Met	Follow-up
2.4	Each record contains a current Client Development Evaluation Report (CDER) that has been reviewed within the last 12 months. *(SMM 4442.5), (42 CFR 441.302)*	58	4	12	94	See Narrative
2.5.a	The individual's qualifying conditions and any special health care requirements used to meet the level of care requirements for care provided in an ICF/DD, ICF/DD-H, and ICF/DD-N facility are documented in the individual's CDER and other assessments. *(SMM 4442.5), [42 CFR 441.302(c)], (Title 22, CCR, §51343)*	60	2	12	97	See Narrative
2.5.b	The individual's qualifying conditions documented in the CDER are consistent with information contained in the individual's record.	57	5	12	92	See Narrative
2.6.a	IPP is reviewed (*at least annually*) by the planning team and modified as necessary in response to the individual's changing needs, wants or health status. *[42 CFR 441.301(b)(1)(l)]*	44	18	12	71	See Narrative
2.6.b	The HCBS Waiver Standardized Annual Review Form is completed and signed annually by the planning team to document whether or not a change to the existing IPP is necessary, and health status and CDER have been reviewed. (*HCBS Waiver requirement*)	35	6	33	85	See Narrative
2.7.a	The IPP is signed, prior to its implementation, by an authorized representative of the regional center and the individual served, or where appropriate, his/her parents or legal guardian or conservator. *[WIC §4646(g)]*	55	7	12	89	See Narrative
2.7.b	IPP addenda are signed by an authorized representative of the regional center and the individual served, or where appropriate, his/her parents, legal guardian, or conservator.	39	5	30	89	See Narrative
2.7.c	The IPP is prepared jointly with the planning team. *[WIC §4646(d)]*	62		12	100	None
2.8	The IPP includes a statement of goals based on the needs, preferences and life choices of the individual. *[WIC §4646.5(a)]*	62		12	100	None

Summary for Regional Center Record Review of Individuals Served Sample Size = 62 +12 Supplemental Records *(see Section II, Part III)*						
	Criteria	+	-	N/A	% Met	Follow-up
2.9	The IPP addresses the individual's goals and needs. *[WIC §4646.5(a)(2)]*	Criterion 2.9 consists of seven sub-criteria (2.9.a-g) that are reviewed independently.				
2.9.a	The IPP addresses the qualifying conditions identified in the CDER and Medicaid Waiver Eligibility Record (DS 3770).	62		12	100	None
2.9.b	The IPP addresses special health care requirements.	7		67	100	None
2.9.c	The IPP addresses the services which the CCF provider is responsible for implementing.	14		60	100	None
2.9.d	The IPP addresses the services which the day program provider is responsible for implementing.	24		50	100	None
2.9.e	The IPP addresses the services which the supported living services agency or independent living services provider is responsible for implementing.	19		55	100	None
2.9.f	The IPP addresses the individual's goals, preferences and life choices.	62		12	100	None
2.9.g	The IPP includes a family plan component if the individual served is a minor. *[WIC §4685(c)(2)]*	17		57	100	None
2.10.a	The IPP includes a schedule of the type and amount of all services and supports purchased by the regional center. *[WIC §4646.5(a)(5)]*	54	8	12	87	See Narrative
2.10.b	The IPP includes a schedule of the type and amount of all services and supports obtained from generic agencies or other resources. *[WIC §4646.5(a)(5)]*	62		12	100	None
2.10.c	The IPP specifies the approximate scheduled start date for the new services. *[WIC §4646.5(a)(5)]*	46		28	100	None
2.11	The IPP identifies the provider or providers of service responsible for implementing services, including but not limited to vendors, contract providers, generic service agencies and natural supports. *[WIC §4646.5(a)(5)]*	61	1	12	98	See Narrative

Summary for Regional Center Record Review of Individuals Served Sample Size = ## + # Supplemental Records *(see Section II, Part III)*						
	Criteria	+	-	N/A	% Met	Follow-up
2.12	Periodic review and reevaluations of progress are completed *(at least annually)* to ascertain that planned services have been provided, that progress has been achieved within the time specified, and the individual and his/her family are satisfied with the IPP and its implementation. *[WIC §4646.5(a)(8)]*	53	9	12	86	See Narrative
2.13.a	Quarterly face-to-face meetings are completed with individuals living in community out-of-home settings, i.e., Service Level 2, 3 or 4 community care facilities or family home agencies or receiving supported living and independent living services. *(Title 17, CCR, §56047), (Title 17, CCR, §56095), (Title 17, CCR, §58680), (Contract requirement)*	16	16	42	50	See Narrative
2.13.b	Quarterly reports of progress are completed for individuals living in community out-of-home settings, i.e., Service Level 2, 3 or 4 community care facilities or family home agencies or receiving supported living and independent living services. *(Title 17, CCR, §56047), (Title 17, CCR, §56095), (Title 17, CCR, §58680), (Contract requirement)*	16	16	42	50	See Narrative
2.14	Face-to-face reviews are completed no less than once every 30 days for the first 90 days following the individual's move from a developmental center to a community living arrangement. *(WIC §4418.3)*	1		73	100	None

SECTION III

COMMUNITY CARE FACILITY
RECORD REVIEW OF INDIVIDUALS SERVED

I. Purpose

The review addresses the requirements for community care facilities (CCF) to maintain records for the individuals served and prepare written reports of progress in relation to the services addressed in the individual program plan (IPP) for which the facility is responsible. The criteria are derived from Title 17, California Code of Regulations.

II. Scope of Review

Ten records for individuals served were reviewed at ten CCFs visited by the monitoring team. The facilities' records were reviewed to determine compliance with 19 criteria.

III. Results of Review

- ✓ The records were 100 percent in compliance for 19 criteria. There are no recommendations for these criteria.

IV. Findings and Recommendations

None

Community Care Facility Record Review Summary Sample Size = 10						
	Criteria	+	-	N/A	% Met	Follow-up
3.1	An individual file for individuals served is maintained by the CCF that includes the documents and information specified in Title 17 and Title 22. *[Title 17, CCR, §56017(b)], [Title 17, CCR §56059(b)], (Title 22, CCR, §80069)*	10			100	None
3.1.a	The individuals record contains a statement of ambulatory or non-ambulatory status.	10			100	None
3.1.b	The individuals record contains known information related to any history of aggressive or dangerous behavior toward self or others.	6		4	100	None
3.1.c	The individuals record contains current health information that includes medical, dental and other health needs of the individual including annual visit dates, physicians' orders, medications, allergies, and other relevant information.	10			100	None
3.1.d	The individuals record contains current emergency information: family, physician, pharmacy, etc.	10			100	None
3.1.e	The individuals record contains a recent photograph and a physical description of the individual.	10			100	None
3.1.i	Special safety and behavior needs are addressed.	6		4	100	None
3.2	The individuals record contains a written admission agreement completed for the individual served that includes the certifying statements specified in Title 17 and is signed by the individual served or his/her authorized representative, the regional center and the facility administrator. *[Title 17, CCR, §56019(c)(1)]*	10			100	None
3.3	The facility has a copy of the individual's current IPP. *[Title 17,CCR, §56022(c)]*	10			100	None

Community Care Facility Record Review Summary Sample Size = 10						
	Criteria	+	-	N/A	% Met	Follow-up
3.4.a	Service Level 2 and 3 facilities prepare and maintain written semiannual reports of progress for individuals served. *[Title 17, CCR, §56026(b)]*	8		2	100	None
3.4.b	Semiannual reports address and confirm the individual's progress toward achieving each of the IPP objectives for which the facility is responsible.	8		2	100	None
3.5.a	Service Level 4 facilities prepare and maintain written quarterly reports of progress. *[Title 17, CCR, §56026(c)]*	2		8	100	None
3.5.b	Quarterly reports address and confirm the individual's progress toward achieving each of the IPP objectives for which the facility is responsible.	2		8	100	None
3.5.c	Quarterly reports include a summary of data collected. *[Title 17, CCR, §56013(d)(4)], (Title 17, CCR, §56026)*	2		8	100	None
3.6.a	The facility prepares and maintains ongoing, written notes for the individual served, as required by Title 17. *[Title 17, CCR §56026(a)]*	10			100	None
3.6.b	The ongoing notes/information verify that behavior needs are being addressed.	10			100	None
3.7.a	Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. *(Title 17, CCR, §54327)*	5		5	100	None
3.7.b	A written report of the special incident is submitted to the regional center within 48 hours after the occurrence of the special incident. *(Title 17, CCR, §54327)*	5		5	100	None
3.7.c	Follow-up activities were undertaken to prevent, reduce or mitigate future danger to the individual served. *(Title 17, CCR, §54327)*	5		5	100	None

SECTION IV

DAY PROGRAM
RECORD REVIEW OF INDIVIDUALS SERVED

I. Purpose

The review criteria address the requirements for day programs to maintain records for individuals served and prepare written reports of progress in relation to the services addressed in the individual program plan (IPP) that the day program provider is responsible for implementing. The criteria are derived from Title 17, California Code of Regulations.

II. Scope of Review

Six records for individuals served were reviewed at four day programs visited by the monitoring team. The records were reviewed to determine compliance with 17 criteria.

III. Results of Review

- ✓ The records were 100 percent in compliance for 17 criteria.
- ✓ A summary of the results of the review is shown in the table at the end of this section.

IV. Findings and Recommendations

None

Day Program Record Review Summary Sample Size = 6						
	Criteria	+	-	N/A	% Met	Follow-up
4.1	An individual file is maintained for the individual served by the day program that includes the documents and information specified in Title 17. *(Title 17, CCR, §56730)*	6			100	None
4.1.a	The individuals record contains current emergency and personal identification information including the individual's address, telephone number; names and telephone numbers of residential care provider, relatives, and/or guardian or conservator; physician name(s) and telephone number(s); pharmacy name, address and telephone number; and health plan, if appropriate.	6			100	None
4.1.b	The individuals record contains current health information that includes current medications, known allergies; medical disabilities; infectious, contagious, or communicable conditions; special nutritional needs; and immunization records.	6			100	None
4.1.c	The individuals record contains any medical, psychological, and social evaluations identifying the individual's abilities and functioning level, provided by the regional center.	6			100	None
4.1.d	The individuals record contains an authorization for emergency medical treatment signed by the individual served and/or the authorized representative.	6			100	None
4.1.e	The individuals record contains documentation that the individual served and/or the authorized representative has been informed of his/her personal rights.	6			100	None
4.1.f	Data is collected that measures progress in relation to the services addressed in the IPP which the day program provider is responsible for implementing.	6			100	None
4.1.g	The individuals record contains up-to-date case notes reflecting important events or information not documented elsewhere.	6			100	None

Day Program Record Review Summary Sample Size = 6						
	Criteria	+	-	N/A	% Met	Follow-up
4.1.h	The individuals record contains documentation that special safety and behavior needs are being addressed.	5		1	100	None
4.2	The day program has a copy of the individual's current IPP. *[Title 17, CCR §56720(b)]*	6			100	None
4.3.a	The day program provider develops, maintains, and modifies as necessary, documentation regarding the manner in which it implements the services addressed in the IPP. *[Title 17, CCR, §56720(a)]*	6			100	None
4.3.b	The day program's individual service plan or other program documentation is consistent with the services addressed in the individual's IPP.	6			100	None
4.4.a	The day program prepares and maintains written semiannual reports. *[Title 17, CCR, §56720(c)]*	6			100	None
4.4.b	Semiannual reports address the individual's performance and progress relating to the services for which the day program is responsible for implementing.	6			100	None
4.5.a	Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. *(Title 17, CCR, §54327)*	1		5	100	None
4.5.b	A written report of the special incident is submitted to the regional center within 48 hours after the occurrence of the special incident. *(Title 17, CCR, §54327)*	1		5	100	None
4.5.c	There is appropriate follow-up to special incidents to resolve issue and eliminate or mitigate future risk. *(Title 17, CCR, §54327)*	1		5	100	None

SECTION V

OBSERVATIONS AND INTERVIEWS OF INDIVIDUALS SERVED

I. Purpose

The observations are conducted to verify that the individuals served appear to be healthy and have good hygiene. Interview questions focus on the individuals' satisfaction with their living situation, day program, and work activities, health, choice, and regional center services.

II. Scope of Observations and Interviews

Forty of the Sixty-two individuals served or in the case of minors, their parents, were interviewed and/or observed at their day programs, employment sites, community care facilities (CCF), or in independent living settings.

- ✓ Twenty-two individuals agreed to be interviewed by the monitoring teams.
- ✓ Seven individuals did not communicate verbally or declined an interview but were observed.
- ✓ Eleven interviews were conducted with parents of minors.
- ✓ Twenty-two individuals were unavailable for or declined interviews.

III. Results of Observations and Interviews

Thirty-nine of the forty individuals/parents of minors interviewed, indicated satisfaction with their living situation, day program, work activities, health, choice, and regional center services. The appearance for all of the individuals that were interviewed and observed reflected personal choice and individual style.

IV. Finding and Recommendation

Individual #49 parent of minor stated that she was not satisfied with regional center services. Based on the interview, parent reported that individual #49 was denied a generic resource and the regional center did not provide a contact to resolve the disagreement.

Recommendation	Regional Center Plan/Response
NLACRC should follow up with individual #49 parent of minor regarding the concerns.	#49 IPP held 4/26/23 at which time Service Coordinator provided information for generic resources regarding Social Security benefits. Individual #49 was denied benefits and

	informed of appeal process through Social Security Administration. Service Coordinator has also provided a resource, Family Focus Resource Center, for parent's follow up. On 7/17/23 Service Coordinator provided parent with another option (transitional program for women from homelessness to independence) when parents were fighting. On 7/25/23 Service Coordinator offered to assist parent with contacting supervisor at vendor and IHSS. Assistance provided. On 10/17/23 parent requested a Regional Center paid vendor to assist with IHSS/SSI benefits. Parent encouraged to use generic resources for support. Older sibling assisted with same request reported by parent. Service Coordinator provided information on the agency that assisted older sibling. There has been constant contact with parent in 2024 regarding resources to assist with SSI appeals. Annual Review meeting held on 5/13/24. Parent provided additional resources of CRA (Client's Rights Advocate) for further assistance.

SECTION VI A

SERVICE COORDINATOR INTERVIEWS

I. Purpose

The interviews determine how well the service coordinators know the individuals they serve, the extent of their participation in the individual program plan (IPP)/ annual review process, and how they monitor services, health and safety issues.

II. Scope of Interviews

1. The monitoring team interviewed 12 NLACRC service coordinators.

2. The interview questions are divided into two categories.

   ✓ The questions in the first category are related to the individuals selected by the monitoring team.

   ✓ The questions in the second category are related to general areas.

III. Results of Interviews

1. The service coordinators were very familiar with the individuals selected for the monitoring review. They were able to relate specific details regarding the individuals' desires, preferences, life circumstances and service needs.

2. The service coordinators were knowledgeable about the IPP/annual review process and monitoring requirements. Service providers and family members provided input on the individuals' needs, preferences and satisfaction with services outlined in the IPP. For individuals in out-of-home placement settings, service coordinators conduct quarterly face-to-face visits and develop written assessments of progress and satisfaction. In preparation for the quarterly visits, service coordinators review their previous progress reports, pertinent case notes, special incident reports, and vendor reports of progress.

3. To better understand issues related to individuals' use of medication and issues related to side effects, the service coordinators utilize NLACRC medical director and online resources for medication.

4. The service coordinators monitor the individuals' services, health and safety during periodic visits. They are aware of the individuals' health issues. The service coordinators were knowledgeable about the special incident reporting process and work with the vendors to ensure all special incidents are reported and appropriate follow-up activities are completed.

SECTION VI B

CLINICAL SERVICES INTERVIEW

I. Purpose

The clinical services interview is used to obtain supplemental information on how the regional center is organized to provide clinical support to individuals served and service coordinators. This interview aids in determining what measures the regional center is utilizing to ensure the ongoing health and safety of all individuals who are on the Home and Community-Based Services Waiver.

II. Scope of Interview

1. The monitoring team interviewed Nursing Services Manager at NLACRC.

2. The questions in the interview cover the following topics: routine monitoring of individuals with medical issues, medications and behavior plans; coordination of medical and mental health care for individuals; circumstances under which actions are initiated for medical or behavior issues; clinical supports to assist service coordinators; improved access to preventive health care resources; role on the Risk Management Assessment and Planning Committee and Special Incident Reports (SIR).

III. Results of Interview

1. The clinical team at NLACRC consists of the Clinical Services Director, Director of Medical Services, physicians, registered nurses, behaviorists, psychologists, a psychiatrist, a dentist, and a dental hygienist. This team will also include Clinical Director, MD, Medical Services Manager, MD, Nursing Services Supervisor, Behavior Services Manager, PHD, Behavior Services Supervisor and outside vendors.

2. Members of the clinical team will participate in the planning team meeting for the individual served when needed. Individuals who have significant health problems are referred for a nursing evaluation by the service coordinators. The clinical team and service coordinators work closely with providers and/or families to provide consultation, training, local resources, and follow-up, as needed. Nurses also provide staff training on topics such as restricted health care conditions, medications, and falls. The registered nurses are available to visit hospitalized consumers and assist in the discharge planning process. They are also available to collaborate with the consumers' primary physician to assist with coordination of care. Clinical staff is involved in reviewing and making recommendations for Special Incident Reports (SIRs). Interdisciplinary meetings are also held regularly to discuss clinical issues.
3. The clinical team provides support for individuals with behavior challenges. The clinical staff assists service coordinators with consumers' behavior and mental health needs. The psychiatrist is available for emergency consultation and follow-up until the consumer is transitioned to community resources. The

psychiatrist is also available to review psychotropic medication concerns. The behavioral team reviews behavior plans and makes recommendations to regional center staff, families and providers, as necessary. Onsite behavioral training is also available to providers. A behaviorist is available to participate in parenting groups and provides in-home evaluations and observations, as needed. If generic resources are unavailable, the regional center may provide funds for outpatient and inpatient mental health services. Monthly meetings with Department of Mental Health Liaison for particularly challenging cases. The clinical team will become involved in discussions in multidisciplinary meetings. Working as a team the clinical team will take a holistic approach while find the best placement will identifying while taking account for their behavior or medical needs.

4. NLACRC's clinical team supports service coordinators on an ongoing basis, assisting with any referrals. Service coordinators can access team members to assist with coordinating generic resources, nursing, managed care, and autism services. The clinical team participates in new employee orientation and offers ongoing trainings to all staff. The regional center nurses are available to review all medication SIRS and provide onsite medication training for providers, as needed. Clinical team is also available to provide informed consent for psychotropic medications when needed.

5. NLACRC has taken a proactive role in advocating for prevention, education, resource development, and medical treatment for its individuals. These efforts include:

   - ✓ Maintaining a list of Medi-Cal providers;
   - ✓ Conducting multi-disciplinary evaluations;
   - ✓ Funding for physical therapy, adaptive equipment, and other needs if no other resources are available;
   - ✓ Resource library available for families and providers;
   - ✓ Dental consultant provides services for vendors and families;
   - ✓ Partnering with local home health agencies;
   - ✓ Providing funding for dental services, as needed; and,
   - ✓ RC work with individuals to ensure they are aware of the health care resources they are entitled to.

6. The Clinical Services Director participates as part of the Risk Management Committee. Members of the clinical team review health, medication, and behavior-related special incidents. The Clinical Staff will review the quality of care being provided to consumers and based on the findings a plan of care, placement or disciplinary actions will be taken. All deaths are reviewed by a physicians and nurses from the clinical team. The regional center utilizes Mission Analytics Group, Inc., the State's risk management contractor, to analyze special incidents for trends and makes recommendations for appropriate follow-up and training, as needed. Recent trainings have

included fall prevention, medication administration, and SIR reporting requirements.

SECTION VI C

QUALITY ASSURANCE INTERVIEW

I. Purpose

The interview with quality assurance (QA) staff ascertains how the regional center has organized itself to conduct Title 17 monitoring of community care facilities (CCF), two unannounced visits to CCFs, and service provider training. The interview also inquires about verification of provider qualifications, resource development activities, and quality assurance (QA) among programs and providers where there is no regulatory requirement to conduct QA monitoring.

II. Scope of Interview

The monitoring team interviewed a community services specialist who is part of the team responsible for conducting NLACRC QA activities.

III. Results of Interview

Community Services Specialists conduct the annual Title 17 visits and the two required unannounced visits. Consumer Service Coordinators are assigned as liaisons to residential facilities and are responsible for conducting unannounced visits at the community care facilities. Each review utilizes standardized report forms and checklists based on Title 17 regulations. The dates of the reviews are tracked in a database for monitoring and additional unannounced visits are completed as needed. When substantial inadequacies are identified, corrective action plans (CAP) are developed by the CSS. The CSS also takes the lead in conducting the follow-up review for investigations, determines findings, issues CAPs with assistance from the consumer service coordinator liaisons as needed.

The community services specialist reviews and approves vendor applications, ensures compliance with regulatory standards, approves the program design, interviews staff, conducts orientation and required trainings. The Risk Assessment team monitors programs and providers where there is no regulatory authority to ensure the programs are operating per approved program design.

The Risk Assessment Unit maintains statistics on compliance with reporting special incidents and makes the information available to regional center staff. The special incident (SIR) data is used to identify specific trends and opportunities for training to mitigate risk.

The community services specialist conducts trainings for vendors and staff, such as medication training, consultant training, SIR training, behavior modification, sanitation, environmental standards, residential service orientation, health precautions, personal rights, and disaster training.

SECTION VII A

SERVICE PROVIDER INTERVIEWS

I. Purpose

The interviews determine how well the service provider knows the individuals served; the extent of their assessment process for the individual program plan (IPP) development and/or review; the extent of their plan participation; how the plan was developed; how service providers ensure accurate documentation, communicate, address and monitor health issues; their preparedness for emergencies; and how they monitor safety and safeguard medications.

II. Scope of Interviews

1. The monitoring team interviewed 14 service providers at 10 community care facilities and four day programs where services are provided to the individuals that were visited by the monitoring team.

2. The interview questions are divided into two categories.

   - ✓ The questions in the first category are related to sample individuals selected by the monitoring team.

   - ✓ The questions in the second category are related to general areas.

III. Results of Interviews

1. The service providers were familiar with the strengths, needs and preferences of the individuals served.

2. The service providers indicated that they conducted assessments of the individual, participated in their IPP development, provided the program-specific services addressed in the IPPs and attempted to foster the progress of the individual served.

3. The service providers monitored the individual's health issues and safeguarded medications.

4. The service providers communicated with people involved in the individual's life and monitored progress.

5. The service providers were prepared for emergencies, monitored the safety of the individual served, and understood special incident reporting and follow-up processes.

SECTION VII B

DIRECT SERVICE STAFF INTERVIEWS

I. Purpose

The interviews determine how well the direct service staff know the individuals served and their understanding of the individual program plan (IPP) and service delivery requirements, how they communicate, their level of preparedness to address safety issues, their understanding of emergency preparedness, and their knowledge about safeguarding medications.

II. Scope of Interviews

1. The monitoring team interviewed 14 direct service staff at 10 community care facilities and four day programs where services are provided to the individual that was visited by the monitoring team.

2. The interview questions are divided into two categories:

   - ✓ The questions in the first category are related to sample individuals selected by the monitoring team.

   - ✓ The questions in the second category are related to general areas.

III. Results of Interviews

1. The direct service staff were familiar with the strengths, needs and preferences of the individuals served.

2. The direct service staff were knowledgeable about their roles and responsibilities for providing the services addressed in the individual's IPP.

3. The direct service staff demonstrated that they understood the importance of communication with all individuals concerned with the individual served.

4. The direct service staff were prepared to address safety issues and emergencies and were familiar with special incident reporting requirements.

5. The direct service staff demonstrated an understanding about emergency preparedness.

6. The direct service staff were knowledgeable regarding safeguarding and assisting with self-administration of medications where applicable.

SECTION VIII

VENDOR STANDARDS REVIEW

I. Purpose

The review ensures that the selected community care facilities (CCF) and day programs are serving individuals in a safe, healthy and positive environment where their rights are respected. The review also ensures that CCFs are meeting the HCBS Waiver definition of a homelike setting.

II. Scope of Review

1. The monitoring teams reviewed a total of ten CCFs and four day programs.

2. The teams used a monitoring review checklist consisting of 24 criteria. The review criteria are used to assess the physical environment, health and safety, medications, services and staff, individuals' rights, and the handling of individuals' money.

III. Results of Review

All of the CCFs and the day programs were found to be in good condition with no immediate health and safety concerns. Specific findings and recommendations are detailed below.

IV. Findings and Recommendations

8.3.c Staff responsible for providing direct care and supervision will receive training in first aid from qualified agencies. A copy of the current first aid card shall be maintained in the personnel record. Adults who supervise individuals using a pool or other body of water that require rescuer's ability to swim, will have a valid water safety certificate. Water safety certificates are required *IF* the pool/spa is used. *[Title 22, CCR, §80065(e); Title 22, CCR, §80075(f)); Title 22, CCR, §87923(a)(1)]*

Findings

Twelve of the 14 facilities had first aid certificates on record for staff providing direct care and supervision. However, there were issues at two facilities as indicated below:

1. CCF #5: One staff with an expired first aid certificate. However, it was completed on August 12, 2024. Accordingly, no recommendation is required.

2. DP #1: Three direct care staff that did not have first aid certificate available for review.

8.3.c Recommendation	Regional Center Plan/Response
NLACRC should ensure that the providers at CCF #5 and DP #1 have current first aid certificates available for all direct care staff.	CCF #5 NLACRC Quality Assurance Specialist conducted the home's annual review on 7/30/24 at which time identified several staff did not have current First Aid Certification completed and/or available for review. Due to the homes failure to ensure staff had the required certifications, NLACRC issued a Corrective Action Plan on 8/13/24 to address the expired First Aid Certification. The staff completed the First Aid Certification on 8/12/24, which was provided to DDS on 8/15/24. NLACRC will continue to monitor and ensure all residential providers have current First Aid Certifications on file and available for review upon request. (MET) DP#1 NLACRC followed up with the provider and confirmed staff had completed the required training however did not have the record available upon request. Vendor provided DDS with certifications on 8/7/24 and 8/9/24. NLACRC requested vendor to provide a plan to ensure records are available. Vendor reported they will be creating e-files for all staff; upload all documents upon receiving; and monitor regularly for compliance. NLACRC will continue to monitor and ensure all day program providers maintain records, current, accessible, and available upon request. (MET)

8.5.c A statement of rights will be prominently posted in each community care facility and day program. The statement will be in English, Spanish or other appropriate language. *[(Title 17, CCR §50520(1)), (W&I §4503), (W&I §4648(a)(10)(E))]*

Findings

Thirteen of the 14 facilities had a statement of consumer rights prominently posted. However, there were issues with one facility at CCF #7. The facility did not have a statement of rights posted.

8.5.c Recommendation	Regional Center Plan/Response
NLACRC should ensure that CCF #7 posts a statement of rights.	CCF#7: NLACRC would like to highlight at the time of the visit on 8/5/2024, the home had the Community Care Licensing, "Personal Rights Adult Community Care Facilities" posted in the common area and accessible to all residents. NLACRC also requested the home post the "Rights of Individual with Developmental Disabilities/Derechos de Personas Incapacitadas" which was completed at the time of the visit. NLACRC Quality Assurance Specialist confirmed during the Annual Review (5/14/2024) the Administrator reviewed "Client's Rights" with all residents. NLACRC will continue to monitor all homes for Client's Rights posters and ensure educational material are posted and available for residents and staff. Last, NLACRC also has the link for the, Rights of Individuals with Developmental Disabilities Handout - English and Spanish poster posted on our website, Publications -North Los Angeles County for our community to print and share. (MET AT TIME OF VISIT)

SECTION IX

SPECIAL INCIDENT REPORTING

I. Purpose

The review verifies that special incidents have been reported within the required timeframes, that documentation meets the requirements of Title 17, California Code of Regulations, and that the follow-up was complete.

II. Scope of Review

1. Special incident reporting of deaths by NLACRC was reviewed by comparing deaths entered into the Client Master File for the review period with special incident reports (SIR) of deaths received by the Department of Developmental Services (DDS).

2. The records of the 62 individuals selected for the Home and Community-Based Services (HCBS) Waiver sample were reviewed to determine that all required special incidents were reported to the Department during the review period.

3. A supplemental sample of 10 individuals who had special incidents reported to the Department within the review period was assessed for timeliness of reporting and documentation of follow-up activities. The follow-up activities were assessed for being timely, appropriate to the situation, resulting in an outcome that ensures the individual served is protected from adverse consequences, and that risks are either minimized or eliminated.

III. Results of Review

1. NLACRC reported all deaths during the review period to the Department.

2. NLACRC reported all special incidents in the sample of 62 records selected for the HCBS Waiver review to the Department.

3. NLACRC's vendors reported 8 of the 10 (80 percent) incidents in the supplemental sample within the required timeframes.

4. NLACRC reported 7 of the 10 (70 percent) incidents in the supplemental sample to the Department within the required timeframes.

5. NLACRC's follow-up activities on incidents in the supplemental sample were appropriate for the severity of the situations for the 10 incidents.

IV. Findings and Recommendations

SIR #6: The incident occurred on November 20, 2023. However, the vendor did not submit a written report to NLACRC until December 7, 2023.

SIR #9: The incident occurred on October 26, 2023. However, the vendor did not submit a written report to NLACRC until October 29, 2023.

SIR #3: The incident was reported to NLACRC on January 4, 2024. However, NLACRC did not report the incident to the Department until January 11, 2024.

SIR #6: The incident was reported to NLACRC on November 20, 2023. However, NLACRC did not report the incident to the Department until December 12, 2023.

SIR #10: The incident was reported to NLACRC on April 17, 2023. However, NLACRC did not report the incident to the Department until April 24, 2023.

Recommendations	Regional Center Plan/Response
NLACRC should ensure that the vendor for SIR #6 and SIR #9 report special incidents within the required timeframes.	The Risk Assessment team will reach out to the vendors to provide guidance on T-17 reporting guidelines and recommend staff training to ensure compliance.
NLACRC should ensure that all special incidents are reported to the Department within the required timeframe.	The Risk Assessment (RA) team will review, process, and transmit Special Incident Reports (SIRs) within the T-17 reporting window. SIR submission timelines will be reviewed with the RA team, and Case Management will be reminded of the critical importance of promptly informing RA of Special Incidents to ensure compliance with reporting requirements. Email to Vendor: We are reaching out regarding the incident report you submitted for [UCI and/or Consumer Name] on [DATE], which was received outside of the T-17 reporting window. As a reminder, NLACRC must be notified within 24 hours of an incident occurring and a written report must be submitted within 48 hours to ensure compliance with reporting standards and to facilitate a timely response. We understand that circumstances may sometimes arise that could lead to delays. However, timely reporting is

	required and is essential to mitigate risks and ensure that all necessary actions can be taken properly. To help avoid delays in the future, we recommend that your team review and familiarize themselves with the reporting requirements. We suggest providing additional training on the reporting guidelines to ensure that all staff are fully aware of the timelines and procedures. Our Risk Assessment department will be forwarding you T-17 guidelines and we recommend that you review these with your staff. Thank you for your attention to this matter, and for your continued partnership. We appreciate your cooperation in adhering to these reporting guidelines in the future.

SAMPLE OF INDIVIDUALS SERVED AND SERVICE PROVIDERS/VENDORS

HCBS Waiver Review of Individuals Served

#	UCI	CCF	DP
1	XXXXXX		
2	XXXXXX	9	
3	XXXXXX	3	
4	XXXXXX	4	
5	XXXXXX	2	
6	XXXXXX	11	
7	XXXXXX	10	
8	XXXXXX	5	
9	XXXXXX		
10	XXXXXX		4
11	XXXXXX	6	
12	XXXXXX		1
13	XXXXXX	8	
14	XXXXXX	7	
15	XXXXXX		
16	XXXXXX		
17	XXXXXX		
18	XXXXXX		
19	XXXXXX		
20	XXXXXX		
21	XXXXXX		
22	XXXXXX		
23	XXXXXX		
24	XXXXXX		
25	XXXXXX		
26	XXXXXX		
27	XXXXXX		
28	XXXXXX		
29	XXXXXX		
30	XXXXXX		
31	XXXXXX		
32	XXXXXX		
33	XXXXXX		
34	XXXXXX		
35	XXXXXX		3
36	XXXXXX		
37	XXXXXX		

#	UCI	CCF	DP
38	XXXXXX		
39	XXXXXX		2
40	XXXXXX		
41	XXXXXX		
42	XXXXXX		
43	XXXXXX		
44	XXXXXX		4
45	XXXXXX		3
46	XXXXXX		
47	XXXXXX		
48	XXXXXX		
49	XXXXXX		
50	XXXXXX		
51	XXXXXX		
52	XXXXXX		
53	XXXXXX		
54	XXXXXX		
55	XXXXXX		
56	XXXXXX		
57	XXXXXX		
58	XXXXXX		
59	XXXXXX		
60	XXXXXX		
61	XXXXXX		
62	XXXXXX		

Supplemental Sample of Waiver Terminations

#	UCI
T-1	XXXXXX
T-2	XXXXXX
T-3	XXXXXX
T-4	XXXXXX
T-5	XXXXXX
T-6	XXXXXX
T-7	XXXXXX
T-8	XXXXXX
T-9	XXXXXX
T-10	XXXXXX
T-11	XXXXXX

Supplemental Sample Individuals moving out of Developmental Center

#	UCI
DC-1	XXXXXX

Supplemental New Enrollees Sample

#	UCI
NE-1	XXXXXX
NE-2	XXXXXX
NE-3	XXXXXX
NE-4	XXXXXX
NE-5	XXXXXX
NE-6	XXXXXX
NE-7	XXXXXX
NE-8	XXXXXX
NE-9	XXXXXX
NE-10	XXXXXX
NE-11	XXXXXX
NE-12	XXXXXX
NE-13	XXXXXX
NE-14	XXXXXX
NE-15	XXXXXX

HCBS Waiver Review Service Providers

CCF #	Vendor
2	XXXXXX
3	XXXXXX
4	XXXXXX
5	XXXXXX
6	XXXXXX
7	XXXXXX
8	XXXXXX
9	XXXXXX
10	XXXXXX

Day Program #	Vendor
1	XXXXXX
2	XXXXXX
3	XXXXXX
4	XXXXXX

SIR Review

#	UCI	Vendor
SIR 1	XXXXXX	XXXXXX
SIR 2	XXXXXX	XXXXXX
SIR 3	XXXXXX	XXXXXX
SIR 4	XXXXXX	XXXXXX
SIR 5	XXXXXX	XXXXXX
SIR 6	XXXXXX	XXXXXX
SIR 7	XXXXXX	XXXXXX
SIR 8	XXXXXX	XXXXXX
SIR 9	XXXXXX	XXXXXX
SIR 10	XXXXXX	XXXXXX