San Andreas Regional Center
Home and Community-Based Services Waiver
Monitoring Review Report

Conducted by:

Department of Developmental Services
and
Department of Health Care Services

October 7–25, 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 October 7–25, 2024, at San Andreas Regional Center (SARC). The monitoring team members were Ashley Guletz (Team Leader), Crystal La, Vannessa Fonseca, Janie Hironaka, Amalya Caballery, Christine Wong, Deeanna Tran, Fam Chao, Jenny Mundo, Lena Mertz, Natasha Clay, Nora Muir, and Kelly Sandoval 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 61 records for individuals served on the 1915c HCBS Waiver. In addition, the following supplemental sample records were reviewed: 1) ten individuals whose HCBS Waiver eligibility had been previously terminated, 2) ten individuals who had special incidents reported to the Department during the review period of July 1, 2023 through June 30, 2024, and 3) twenty-two individuals who were enrolled in the HCBS Waiver during the review period were reviewed for documentation that SARC determined the level of care prior to receipt of HCBS Waiver services.

The monitoring team completed visits to 13 community care facilities (CCF) and 12 day programs (DP). The team reviewed 15 day program records for individuals served, 13 CCF records and interviewed and/or observed 51 of the selected sample of individuals served.

Overall Conclusion

SARC is in overall compliance with the federal requirements for the HCBS Waiver program. Specific recommendations that require follow-up actions by SARC are included in the report findings. The Department is requesting documentation of follow-up actions taken by SARC 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 SARC 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-one 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. Two criteria were rated as not applicable for this review. Criterion 2.6.a was 84 percent in compliance because 10 of the 61 applicable records did not have the IPP reviewed annually by the planning team. Criterion 2.7.a was 82 percent in compliance because 11 of the 61 applicable records did not have the IPP signed prior to implementation by the individual and regional center. Criterion 2.9.b was 82 percent in compliance because 2 of the 11 applicable records did not address special health care conditions in the IPP. Criterion 2.10.a was 56 percent in compliance because 27 of the 61 applicable records did not have an IPP that included the type and amount of all services purchased by the regional center. Criterion 2.13.a was 67 percent in compliance because 14 of the 42 applicable records did not contain documentation of all required quarterly face-to-face visits. Criterion 2.13.b was 64 percent in compliance because 15 of the 42 applicable records did not contain documentation of all required quarterly reports of progress. The sample records were 93 percent in overall compliance for this review.

SARC's records were 96 percent and 95 percent in overall compliance for the collaborative reviews conducted in 2022 and in 2020, respectively.

Section III – Community Care Facility Record Review for Individuals Served

Thirteen records for individuals served were reviewed at 13 CCFs for 19 documentation requirements (criteria) derived from Title 17, California Code of Regulations. The sample records were 97 percent in overall compliance this review.

SARC's records were 95 percent and 99 percent in overall compliance for the collaborative reviews conducted in 2022 and in 2020, respectively.

Section IV – Day Program Record Review for Individuals Served

Fifteen records for individuals served were reviewed at 12 day programs for 17 documentation requirements (criteria) derived from Title 17, California Code of Regulations. The sample records were 96 percent in overall compliance for this review.

SARC's records were 98 percent in overall compliance for the review conducted in 2022. The closure of day programs due to COVID-19 prevented the review of Section IV Day Program records and site visits for the 2020 review.

Section V –Observations and Interviews of Individuals Served

Fifty-one 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 two of the interviewed individuals/parents indicated that they were satisfied with their services, health and choices.

Section VI A – Service Coordinator Interviews

Eleven 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 health services coordinator and health services associate coordinator were interviewed using a standard interview instrument. They 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 quality assurance manager was interviewed using a standard interview instrument. She responded to questions regarding how SARC 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

Ten CCF and seven 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

Ten CCF and seven 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 10 CCFs and seven 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 61 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. SARC reported all special incidents for the sample selected for the HCBS Waiver review. For the supplemental sample, the service providers reported 9 of the 10 applicable incidents to SARC within the required timeframes, and SARC subsequently transmitted all 10 special incidents to the Department within the required timeframes. SARC's follow-up activities for the 10 incidents of individuals served 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 SARC 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

SARC 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 SARC 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 the Department 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-one HCBS Waiver records of individuals served were selected for the review sample.

Living Arrangement	**# of Individuals Served**
Community Care Facility (CCF)	24
With Family	19
Independent (ILS) or Supported Living Services (SLS)	18

2. The review period covered activity from July 1, 2023 through June 30, 2024.

III. Results of Review

The 61 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 93 percent in overall compliance for this review. Ten supplemental records were reviewed solely for documentation that SARC 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. Twenty-two supplemental records were reviewed for documentation that SARC 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 100 percent compliance for documentation that the individual was either provided written notification before termination or voluntarily disenrolled from the HCBS Waiver.

- ✓ The sample records were in 100 percent compliance for 14 criteria. There are no recommendations for these criteria. Two criteria were not applicable for this review.

- ✓ Findings for 15 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

Fifty-seven of the sixty-one (93 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 #6: The individual was enrolled in January 1994. The DS 2200 was not signed and dated until August 26, 2024. Accordingly, no recommendation is required;

2. Individual #23: The DS220 dated December 13, 2023 in Section III – Services/living arrangement choice was not selected;

3. Individual #24: The individual's waiver status was reactivated in 2001. A new form was signed and dated July 29, 2024. Accordingly, no recommendation is required; and

4. Individual #51: The individual served did not sign the DS 2200. A new form was signed and dated on October 23, 2024. Accordingly, no recommendation is required.

2.2 Recommendation	Regional Center Plan/Response
SARC should ensure that the DS 2200 form for individual #23 indicates a choice of living arrangement.	Individual served #23 has since had an updated DS2200 Choice Form updated in the Individuals record.

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)*

Finding

Sixty of the sixty-one (98 percent) sample records of individuals served had documented qualifying conditions. However, the record for individual #32 lists the qualifying condition "constant supervision" on the DS 3770 is inconsistent with the CDER and other assessments.

2.5.a Recommendation	Regional Center Plan/Response
SARC should reevaluate the HCBS Waiver eligibility for individual #32 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.	Individual served #32 has since been reviewed and removed off of the Medicaid Waiver program for not meeting the level of care requirement. SARC QIDP's are trained to seek 2 qualifying conditions supported by a purchase of service in order to add and maintain waiver eligibility. QIDP's at SARC will endeavor to ensure all waiver participants meet the level of care requirement to remain eligible for waiver participation.

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-six of the sixty-one (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 five 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 #17: "Performs personal care activities, but needs assistance," however, IPP dated January 17, 2024 indicates individual can complete personal care tasks independently with reminders;

2. Individual #22: "Constant supervision in unfamiliar settings" but IPP dated January 4, 2024 indicates individual requires daily supervision at home;

3. Individual #27: "Constant supervision in unfamiliar settings" but IPPs dated April 24, 2023 and March 25, 2024 state he is mobility trained and walks in the community and he has appropriate safety awareness;

4. Individual #32: "Constant supervision in unfamiliar settings" but IPP dated October 17, 2023 indicates the individual is safe at home and in the community and is allowed to access the community on their own; and,

5. Individual #44: "Constant supervision in unfamiliar settings" but IPP dated August 8, 2022 indicated individual requires supervision at all times.

2.5.b Recommendation	Regional Center Plan/Response
SARC should determine if the qualifying conditions listed above for individuals #17, #22, #27, #32 and #44 are appropriately identified as qualifying conditions. The individual's DS 3770 form should be corrected to ensure that any qualifying conditions 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 SARC 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.	Individuals Served #17, #22, #27, #32, and #44 have had qualifying conditions that are not substantiated in the IPP removed and updated for all findings listed above. SARC QIDP endeavor to work in collaboration with assigned SARC case managers to assure IPP's are clearly written and clearly identify needs of support and qualifying conditions in order to include them in the 3770 record. QIDP's will continue to stride towards full compliance in assuring the 3770 accurately supports the individuals' served needs.

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

Fifty-one of the sixty-one (84 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 10 individuals were reviewed annually as indicated below:

1. Individual #6: The IPP was dated March 27, 2023. There was no documentation that the IPP was reviewed within a year. An annual review was completed on June 27, 2024;

2. Individual #9: The IPP was dated September 14, 2023. There was no documentation that the IPP was reviewed during the monitoring review period;

3. Individual #10: The IPP was dated September 20, 2023. There was no documentation that the IPP was reviewed during the monitoring review period;

4. Individual #25: The IPP was dated April 17, 2024. There was no documentation that the IPP was reviewed during the monitoring review period;

5. Individual #30: The IPP was dated October 5, 2023. There was no documentation that the IPP was reviewed during the monitoring review period;

6. Individual #32: The IPP was dated April 13, 2022. There was no documentation that the IPP was reviewed within a year. A new IPP was completed on October 17, 2023;

7. Individual #38: The IPP was dated May 21, 2024. There was no documentation that the IPP was reviewed during the monitoring review period;

8. Individual #40: The IPP was dated January 10, 2023. There was no documentation that the IPP was reviewed during the monitoring review period;

9. Individual #44: The IPP was dated August 8, 2022. There was no documentation that the IPP was reviewed during the monitoring review period;

10. Individual #46: The IPP was dated March 28, 2024. There was no documentation that the IPP was reviewed during the monitoring review period;

2.6.a Recommendations	Regional Center Plan/Response
SARC should ensure that the IPP for individuals #6, #9, #10, #25, #30, #32, #38, #40, #44, and #46 are reviewed at least annually by the planning team.	Service Coordinator's, District Manager's, and Associate Directors of Individuals #6, #9, #10, #25, #30, #32, #38, #40, and #46 were made aware of these findings and were reminded on the importance of reviewing the IPP on annual basis on every off year of the IPP. SC's and DM's confirmed the next date of the annual IPP review in order to meet this expectation.
In addition, SARC should evaluate what actions may be necessary to ensure that IPPs are reviewed annually for all individuals.	Since the Cycle 14 audit all district managers were trained and notified of the responsibility and the obligation of the regional center to meet this requirement when the IPP is not an annual IPP. SARC works with our Individuals Served to offer annual IPP visits and documentation in lieu of a bi-annual or tri-annual IPP format. It is the expectation of SARC case management to assure our individuals served have annual review of all non-annual IPP's.

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)*

Finding

Fifteen of the seventeen (88 percent) applicable sample records of individuals served contained a completed SARF. However, two records did not contain a SARF as indicated below:

1. Individual #39: No SARF completed in review period; IPP was dated August 15, 2022; and,

2. Individual #44: No SARF completed in review period; IPP was dated August 8, 2022.

2.6.b Recommendation	Regional Center Plan/Response
SARC should ensure that the SARF for individuals #39 and #44 are completed during the annual IPP review process.	Service Coordinator's, District Manager's, and Associate Director's for Individuals Served #39 and #44 were made aware of these findings. SC's and DM's were trained and reminded of the importance to include a Standardized Annual Review Form whenever there is an Individual Served that has a non-annual IPP and participates in the Medicaid Waiver program.

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 of the sixty-one (82 percent) sample records of individuals served contained IPPs that were signed by SARC and the individuals served, or their legal representatives. However, the following individuals' IPPs were not signed by the appropriate individual:

1. Individual #8: The IPP dated June 16, 2022 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 #9: The IPP dated September 14, 2023 was not signed by the individual served. The IPP was signed on August 28, 2024 by the individual served. Accordingly, no recommendation is required;

3. Individual #10: The IPP dated September 20, 2023 was not signed by the individual served. The IPP was signed on January 2, 2024 by the individual served. Accordingly, no recommendation is required;

4. Individual #17: The IPP dated January 17, 2024 was not signed by the individual's legal representative. The IPP was signed on September 1, 2024 by the legal representative. Accordingly, no recommendation is required;

5. Individual #22: The IPP dated January 24, 2024 was not signed by the individual served;

6. Individual #23: The IPP dated December 13, 2023 was not signed by the individual served or the regional center;

7. Individual #43: The IPP dated January 18, 2022 was not signed by the individual served;

8. Individual #45: The IPP dated August 10, 2023 was not signed by the individual served. The IPP was signed on October 3, 2024 by the individual served. Accordingly, no recommendation is required;

9. Individual #46: The IPP dated March 28, 2024 was not signed by the individual served. The IPP was signed on August 27, 2024 by the individual served. Accordingly, no recommendation is required;

10. Individual #47: The IPP dated September 28, 2023 was not signed by the individual served. The IPP was signed on March 21, 2024 by the individual served. Accordingly, no recommendation is required; and,

11. Individual #59: The IPP dated June 15, 2022 was not signed by the legal representative.

2.7.a Recommendations	Regional Center Plan/Response
SARC should ensure that the IPP for individuals #22, #23, #43 and #59 are signed by the individual served and/or the legal representative/guardian and the regional center. If the individual served does not sign, SARC should ensure that the record addresses the reason why the individual did not or could not sign.	Service Coordinator's, District Manager's, and Associate Director's for Individuals Served #22, #23, #43, and #59 were notified of these findings. SC's and DM's obtained required signatures and will continue to assure that all SARC individuals served documentation is signed in accordance with signature requirements and signee's.
In addition, SARC should evaluate what actions may be necessary to ensure that IPPs are signed by the appropriate individuals.	SARC implements signature protocol in new hire orientations as well as ongoing unit SC trainings. SARC trains staff on the importance of signatures as it is used to also acknowledge the Individual is in agreement with the IPP contract for SARC services. SARC will endeavor to ensure that all required signatures are in place in order for the Individual Served to meet this compliance expectation.

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.

Finding

Eight of the nine (89 percent) applicable sample records for individuals served contained IPP addenda signed by SARC 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 addendum for individual #48 completed on October 18, 2023, was not signed by the individual served.

2.7.b Recommendation	Regional Center Plan/Response
SARC should ensure that the IPP addendum for individual #48 is signed by the individual served.	The Service Coordinator, District Manager, and Associate Director for Individual Served #48 were made aware of this finding and has obtained required signature for the IPP addendum. SARC will continue to train staff as to the importance of obtaining signatures for IPP addendums as they are modifications to the original IPP contract agreed upon by the Individual Served and the IPP planning team. It confirms the Individual Served is in agreement and wishes to continue with the addendums to the original IPP documentation.

2.7.c The IPP is prepared jointly with the planning team, the planning team is, at minimum the individual served and a representative of the reginal center. *(WIC § 4646.5(d)*)

Finding

Sixty of the sixty-one (98 percent) sample records of individuals served contained IPPs that were prepared jointly by the planning team. However, the record for individual #45 did not indicate that the IPP was prepared jointly by the planning team.

2.7c Recommendation	Regional Center Plan/Response
SARC should ensure that the IPP for individual #45 is prepared with the individual served.	Service Coordinator, District Manager, and Associate Director for Individual Served #45 was made aware of this finding. SC and DM were reminded of this requirement. Since the Cycle 14 audit this case has now been closed with SARC an Individual is no longer served by SARC.

2.9.a The IPP addresses the qualifying conditions identified in the CDER and Medicaid Waiver Eligibility Record (DS 3770). *[W&I Code §4646.5(a)(2)]*

Findings

Fifty-nine of the sixty-one (97 percent) sample records of individuals served contained IPPs that addressed the individual's qualifying conditions. However, the IPPs for two individuals did not address supports for qualifying conditions identified in the record as indicated below:

1. Individual #8: The IPP dated June 16, 2022, does not address the qualifying condition, "requires constant supervision to prevent injury/harm in unfamiliar setting only"; and,

2. Individual #27: The IPP dated March 25, 2024, does not address the qualifying condition, "requires constant supervision to prevent injury/harm in unfamiliar setting only".

2.9.a Recommendation	Regional Center Plan/Response
SARC should ensure that the IPPs for individuals #8 and #27 address the services and supports in place for the qualifying conditions identified above.	Service Coordinator's, District Manager's, and Associate Director's for Individuals Served #8, and #27 were made aware of these findings. Since the Cycle audit those qualifying conditions were removed from the 3770's.

2.9.b The IPP addresses the special health care requirements. *[WIC §4646.5(a)(2)]*

Findings

Nine of the eleven (82 percent) applicable sample IPPs for individuals served addresses the individuals' special health care requirements. However, the IPPs for the following individuals do not address the special health care requirements for the conditions noted:

1. Individual #16: Braces/splints/cast/orthopedic shoes; and,

2. Individual #52: Braces/splints/cast/orthopedic shoes. A new CDER was updated October 22, 2024 to remove the special health care requirement. Accordingly, no recommendation is required.

2.9.b Recommendation	Regional Center Plan/Response
SARC should ensure that the IPP for individual #16 addresses the special health care requirements as noted.	Associate Director of Healthcare Services, District manager, Service Coordinator, and Associate Director was made aware of this finding and was corrected on the Individual Served #16's record. SARC staff is reminded and trained as to this requirement through new hire orientation and ongoing service coordinator training.

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

Thirty-four of the sixty-one (56 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 27 individuals did not include SARC funded services as indicated below:

1. Individual #6: Community Integration Training Program, Transportation Company, Transportation – Additional Component, and Residential Facility were not included in the IPPs covering all months of the review period in the IPP dated March 27, 2023;

2. Individual #8: Dental Services was not included for the month of January 2024 in IPP dated June 16, 2022;

3. Individual #10: Behavior Management Program, Transportation Company, and Residential Facility were not included for the months of July 2023 through August 2023 in the IPP dated September 20, 2023;

4. Individual #11: Behavior Management Program, Psychiatrist, Transportation – Additional Component, and Residential Facility were not included for the months of July 2023 through August 2023 in the IPP dated August 29, 2023;

5. Individual #13: Supplemental Residential Program Support was not included for the months of July 2023 through June 2024 and Residential Facility was not included for the month of July 2023 in the IPPs dated April 27, 2023 and April 10, 2024;

6. Individual #15: Specialized Therapeutic Services – Dental Services was not included for the month of March 2024 and Behavior Management Program was not included for the months of October 2023 through June 2024 in the IPPs dated August 31, 2022 and August 24, 2023;

7. Individual #16: Supplemental Day Program Support was not included for the months of July 2023 through June 2024 in the IPPs dated May 26, 2023 and March 6, 2024;

8. Individual #20: Transportation – Public/Rental/Taxi was not included for the months of July 2023 through October 2023 in the IPP dated March 18, 2022;

9. Individual #21: Licensed Vocational Nurse and Registered Nurse were not included for the months of October 2023 through June 2024 and Specialized Therapeutic Services – Respiratory Therapy was not included for the months of October 2023 through May 2024 in the IPP dated June 13, 2023;

10. Individual #22: Specialized Therapeutic Services – Dental Services was not included for the months of August 2023, December 2023, February 2024, and April 2024 and Psychiatrist was not included for the months of July 2023 through June 2024 in the IPPs dated January 4, 2023 and January 4, 2024;

11. Individual #25: Housing Access Service was not included for the months of May 2024 and June 2024 in the IPP dated April 17, 2024;

12. Individual #29: Housing Access Service, SLS Admin, and SLS were not included for the months of July through September 2023. However, the new IPP dated October 13, 2023 retroactively covered the missing dates. Accordingly, no recommendation is required;

13. Individual #30: Housing Access Service was not included for the months of July 2023 through September 2023 in the IPP dated October 5, 2023. However, an addendum was completed to retroactively add the purchased

service to the IPP dated October 5, 2023. Accordingly, no recommendation is required;

14. Individual #32: Crisis Team was not included for the months of January 2024 through May 2024 in the IPP dated October 17, 2023;

15. Individual #34: Housing Access Services and SLS Admin were not included for the months of January 2024 through June 2024 in the IPP dated January 18, 2024;

16. Individual #35: Behavior Management Technician, Behavior Management Consultant, SLS, and SLS Admin were not included for the months of February 2024 through June 2024 in the IPP dated January 10, 2024;

17. Individual #38: Psychiatrist was not included for the months of November 2023 through February 2024, Specialized Therapeutic Services – Dental Services was not included for the month of December 2023, SLS Admin, and SLS were not included for the months of November 2023 through April 2024 in the IPP dated October 14, 2020. However, the May 21, 2024 IPP retroactively covered the review dates. Accordingly, no recommendation is required;

18. Individual #40: Specialized Therapeutic Services – Dental Services was not included for the months of November 2023, January 2024, May 2024, and June 2024, Crisis Intervention was not included for all months of the review period in the IPP dated January 10, 2023. However, an addendum was completed October 22, 2024 addressing the purchased services. Accordingly, no recommendation is required;

19. Individual #41: Behavior Management Program, Transportation Company, and SLS were not included for the months of August 2023 through June 2024 in the IPP dated August 9, 2022. However, an addendum was completed October 24, 2024 addressing the purchased services. Accordingly, no recommendation is required;

20. Individual #42: Crisis Team, SLS, and SLS Admin were not included for the months of December 2023 and January 2024 in the IPPs dated December 16, 2020 and January 25, 2024;

21. Individual #44: Activity Center was not included for the months of July 2023 through May 2024, Transportation – Additional Component was not included for the months of July 2023 through June 2024, and In-Home Respite was not included for the months of November 2023 through May 2024 in the IPP dated August 8, 2022;

22. Individual #45: Financial Management Services Co-Employer was not included for all months of the review period in the IPP dated August 10, 2023;

23. Individual #46: In-Home Respite was not included for all months of the review period in the IPPs dated October 7, 2022 and March 28, 2024;

24. Individual #48: Community Integration Training Program was not included for the months of November 2023 through June 2024 in the IPP dated June 8, 2023;

25. Individual #51: Transportation Assistant was not included for the months of July 2023 through December 2023 in the IPP dated December 28, 2022;

26. Individual #53: Other Medical Equipment or Supplies was not included for the months of March 2024 through June 2024 in the IPP dated November 29, 2023; and,

27. Individual #59: In-Home Respite was not included for all months covering the review period in IPP dated June 15, 2022.

2.10.a Recommendations	Regional Center Plan/Response
SARC should ensure that the IPPs for individuals #6, #8, #10, #11, #13, #15, #16, #20, #21, #22, #25, #32, #34, #35, #42, #44, #45, #46, #48, #51, #53, and #59 include a schedule of the type and amount of all services and supports purchased by SARC.	Service Coordinator's, District Manager's, and Associate Director's for Individuals Served #6, #8, #10, #11, #13, #15, #16, #20, #21, #22, #25, #32, #34, #35, #42, #44, #45, #46, #48, #51, #53, and #59 have been made aware of these findings. Since the Cycle audit, all type and amount of services findings identified have been addressed and updated through the use of an updated Schedule of Services page of the SARC IPP. SARC SC's and DM's will endeavor to assure the type and amount is captured accurately and the dates of the service coincide with the IPP and service delivery.
In addition, SARC 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 SARC.	SARC Staff will improve on this requirement through new hire orientation and ongoing service coordinator training. Staff are also trained on the new S-IPP form as well that includes a section in which to capture type and amount of

	services in the IPP developed utilizing a principles of Person-Centered Training.

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)]*

Findings

Fifty-nine of the sixty-one (97 percent) sample records of individuals served contained IPPs that identified the provider or providers responsible for implementing services. However, two IPPs did not indicate the provider for the SARC funded services indicated below:

1. Individual #22: Transportation-Additional Component was not included in the IPP dated January 4, 2024; and,

2. Individual #32: Crisis Team was not included in the IPP dated October 17, 2023.

2.11 Recommendation	Regional Center Plan/Response
SARC should ensure the IPPs for individuals #22 and #32 identify the provider for the services listed above.	IPP's for Individuals Served #22 and #32 have been updated to reflect the type and amount and provider of services and supports identified in the findings from the Cycle audit. This was accomplished through IPP addendums and updates Schedule of Services and Supports page. SARC will endeavor for all Individuals Served to have accurate identification of services and supports authorized to the Individual Served.

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)]*

Finding

Sixty of the sixty-one (98 percent) sample records of individuals served contained documentation of periodic review and reevaluation of progress at least annually. However, the record for individual #44 did not contain documentation that the individual's progress had been reviewed within the year.

2.12 Recommendation	Regional Center Plan/Response
SARC should ensure that a review and reevaluation of progress regarding planned services, timeframes, and satisfaction for individual #44 is completed and documented at least annually.	SARC Service Coordinator, District Manger, and Associate Director assigned to Individual Served #44 were made aware of this finding and has since completed a review of the IPP and has updated the Schedule of Services and Supports page. SARC will endeavor to assure all Individuals Served will have all IPP and progress to be monitored and reviewed at least annually. This will be accomplished by continued new hire orientation and by ongoing unit trainings to our Service Coordinators.

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

Twenty-eight of the forty-two (67 percent) applicable sample records of individuals served contained quarterly face-to-face meetings completed and documented. However, the records for 14 individuals did not meet the requirement as indicated below:

1. The records for individuals #5, #9, #11, #18, #24, #25, #31 and #42 contained documentation of three of the four required meetings that were consistent with the quarterly timeline.

2. The records for individuals #30, #37, #38 and #39 contained documentation of two of the four required meetings that were consistent with the quarterly timeline.

3. The records for individuals #4 and #27 contained documentation of one of the four required meetings that were consistent with the quarterly timeline.

2.13.a Recommendations	Regional Center Plan/Response
SARC should ensure that all future face-to-face meetings are completed and documented each quarter for individuals #4, #5, #9, #11, #18, #24, #25, #27, #30, #31, #37, #38, #39, and #42.	SARC Service Coordinator's, District Manager's, and Associate Director's were all made aware of these quarterly F-F findings for Individuals Served #4, #5, #9, #11, #18, #24, #25, #27, #30, #31, #37, #38, #39, and #42. Since the audit review the individuals served identified in this Cycle review have been seen F-F and have been scheduled for ongoing F-F meetings moving forward.
In addition, SARC should evaluate what actions may be necessary to ensure that quarterly face-to face meetings are completed and documented for all applicable individuals.	Quarterly F-F visits have unfortunately been an ongoing finding for SARC. SARC recognizes the importance and the health and safety need for our Individuals Served to have the highest of quality of services, including assuring through a F-F the Individual Served is maintaining a high quality of life when not living in the family home. SARC continues to implement our plan to improve in this area and is evaluating progress on a monthly basis for quarterly F-F meetings and reports using spreadsheets to identify all SARC individuals served who require quarterly reports and require SARC case management to report if the F-F meeting occurred. SARC Standards Compliance Manager is meeting with DDS monthly to share progress on meeting the 86% minimum compliance for F-F. DDS will assess the success of SARC's efforts in meeting this requirement at the time of the Cycle 14 Follow Up review come October 2025.

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

Twenty-seven of the forty-two (64 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 15 individuals did not meet the requirement as indicated below:

1. The records for individuals #5, #9, #11, #18, #24, #25, #31, #40 and #42 contained documentation of three of the four required meetings that were consistent with the quarterly timeline.
2. The records for individuals #30, #37, and #38 contained documentation of two for the four required meetings that were consistent with the quarterly timeline.
3. The records for individuals #4, #27, and #39 contained documentation of one of the four required meetings that were consistent with the quarterly timeline.

2.13.b Recommendations	Regional Center Plan/Response
SARC should ensure that future quarterly reports of progress are completed for individuals #4, #5, #9, #11, #18, #24, #25, #27, #30, #31, #37, #38, #39, #40 and #42.	SARC Service Coordinator's, District Manager's, and Associate Director's were all made aware of these quarterly F-F findings for Individuals Served #4, #5, #9, #11, #18, #24, #25, #27, #30, #31, #37, #38, #39, #40, and #42. Since the audit review the individuals served identified in this Cycle have had ongoing F-F and quarterly reports completed in order to assure improved compliance in this measure.
In addition, SARC should evaluate what actions may be necessary to ensure that quarterly reports of progress are completed for all applicable individuals.	Quarterly report completions have unfortunately been an ongoing finding for SARC. SARC recognizes the importance and the health and safety need for our Individuals Served to have the highest of quality of services, including assuring through a written quarterly report, the Individual Served is maintaining a high quality of life when not living in the family home. SARC Standards Compliance Manager is meeting with DDS monthly to share progress on meeting the 86% minimum compliance for quarterly report completion. This is accomplished with the use of monthly spreadsheets where SARC will identify all SARC Individuals Served who require quarterly reports and require SARC case management to

	report if the F-F meeting occurred and when the subsequent report will be completed. DDS will assess the success of SARC's efforts in meeting this requirement at the time of the Cycle 14 Follow Up review come October 2025.

Summary for Regional Center Record Review of Individuals Served Sample Size = 61 + 10 Supplemental Records *(see Section II, Part III)*						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.0	The individual is Medi-Cal eligible. *(SMM 4442.1)*	61		10	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.	61		10	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.	61		10	100	None
2.1.c	The DS 3770 form documents annual re-certifications.	61		10	100	None
2.1.d	The DS 3770 documents short-term absences of 120 days or less, if applicable.			71	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)]*	57	4	10	93	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)]*	10		61	100	None

Summary for Regional Center Record Review of Individuals Served Sample Size = 61 + 10 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)*	61		10	100	None
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	1	10	98	See Narrative
2.5.b	The individual's qualifying conditions documented in the CDER are consistent with information contained in the individual's record.	56	5	10	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)]*	51	10	10	84	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*)	15	2	54	88	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)]*	50	11	10	82	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.	8	1	62	89	See Narrative
2.7.c	The IPP is prepared jointly with the planning team. *[WIC §4646(d)]*	60	1	10	98	See Narrative
2.8	The IPP includes a statement of goals based on the needs, preferences and life choices of the individual. *[WIC §4646.5(a)]*	61		10	100	None

Summary for Regional Center Record Review of Individuals Served Sample Size = 61 + 10 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).	59	2	10	97	See Narrative
2.9.b	The IPP addresses special health care requirements.	9	2	60	82	See Narrative
2.9.c	The IPP addresses the services which the CCF provider is responsible for implementing.	24		47	100	None
2.9.d	The IPP addresses the services which the day program provider is responsible for implementing.	30		41	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.	18		53	100	None
2.9.f	The IPP addresses the individual's goals, preferences and life choices.	61		10	100	None
2.9.g	The IPP includes a family plan component if the individual served is a minor. *[WIC §4685(c)(2)]*	9		62	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)]*	34	27	10	56	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)]*	61		10	100	None
2.10.c	The IPP specifies the approximate scheduled start date for the new services. *[WIC §4646.5(a)(5)]*	10		61	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)]*	59	2	10	97	See Narrative

Summary for Regional Center Record Review of Individuals Served Sample Size = 61 + 10 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)]*	60	1	10	98	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)*	28	14	29	67	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)*	27	15	29	64	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)*			71	NA	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

Thirteen records for individuals served were reviewed at 13 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 16 criteria.
- ✓ A summary of the results of the review is shown in the table at the end of this section.
- ✓ Findings for three criteria are detailed below.

IV. Findings and Recommendations

3.5.a Service Level 4 facilities prepare and maintain written quarterly reports of consumer progress. (Title 17, CCR, §56026(c))

Finding

Nine of the eleven (82 percent) applicable sample records for individuals served contained written quarterly reports for individual progress. However, the record for individual #5 at CCF #9 contained only one report of individual progress during the review period and individual #9 at CCF #11 contained only three reports of individual progress during the review period.

3.5.a Recommendation	Regional Center Plan/Response
SARC should ensure that CCF #9 and CCF #11 prepare and maintain written quarterly reports of progress for individuals #5 and #9.	Service Coordinator's, District Manager's, Quality Assurance Manager, and Associate Director's for Individuals Served #5 at CCF #9 and

	individual #9 at CCF#11 were made aware of this finding of the facility not preparing quarterly reports. SC and the Quality Assurance Manager followed up with CCF#11 and shared the importance of fulfilling this quarterly requirement. Since the Cycle Audit SARC continues to monitor and assure CCF#11 submits required quarterly reporting. SARC will ensure all CCF's continue to receive appropriate trainings and ongoing follow ups at the time of site visits to assure all SARC Individuals Served residing in a CCF setting receive the highest quality of services that's expected out of our vendored CCF's.

3.5.b Quarterly reports address and confirm the consumer's progress toward achieving each of the IPP objectives for which the facility is responsible.

Finding

Nine of the eleven (82 percent) applicable sample records for individuals served contained quarterly reports address and confirm the individual's progress toward achieving each of the IPP objectives for which the facility is responsible. However, the records for individual #5 at CCF #9 contained only one report of individual progress during the review period and individual #9 at CCF #11 contained only three reports of individual progress during the review period.

3.5.b Recommendation	Regional Center Plan/Response
SARC should ensure that CCF #9 and CCF #11 prepare and maintain written quarterly reports that address and confirm the individual's progress toward achieving each of the IPP objectives for which the facility is responsible for individuals #5 and #9, respectively.	Service Coordinator's, District Manager's, Quality Assurance Manager, and Associate Director's for Individuals Served #5 and #9 for CCF#9 and CCF#11 were made aware of this finding and have followed up with CCF#11 accordingly. CCF#9 and CCF#11 were trained towards assuring all quarterly reports properly and completely address progress towards IPP objectives. Since the Cycle review this requirement has been met.

	SARC will continue to endeavor to assure all CCF's vendored by the regional center adequately and accurately document all progress towards IPP goals through quarterly reporting requirements. This will be achieved by ongoing new vendor trainings and at the time of site visit reviews.

3.5.c Quarterly reports include a summary of data collected. (Title 17, CCR, §56013(d)(4)), (Title 17, CCR, §56026)

Finding

Nine of the ten (90 percent) applicable sample records for individuals served contained quarterly reports include a summary of data collected. However, the record for individual #9 at CCF #11 contained only three reports of individual progress during the review period.

3.5.c Recommendation	Regional Center Plan/Response
SARC should ensure that quarterly reports include a summary of data collected at CCF #11 for individual #9.	Service Coordinator, District Manager, Quality Assurance Manager, and Associate Director for Individual Served #9 residing in CCF#11 have been made aware of this finding and have trained CCF#11 moving forward to assure all summary of data is entered and completed on a quarterly basis. SARC will ensure and endeavor towards all SARC vendored CCF's meet this requirement by attending ongoing vendor trainings and additionally ongoing facility monitoring.

Community Care Facility Record Review Summary Sample Size = 13						
	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)*	13			100	None
3.1.a	The individuals record contains a statement of ambulatory or non-ambulatory status.	13			100	None
3.1.b	The individuals record contains known information related to any history of aggressive or dangerous behavior toward self or others.	11		2	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.	13			100	None
3.1.d	The individuals record contains current emergency information: family, physician, pharmacy, etc.	13			100	None
3.1.e	The individuals record contains a recent photograph and a physical description of the individual.	13			100	None
3.1.i	Special safety and behavior needs are addressed.	11		2	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)]*	13			100	None
3.3	The facility has a copy of the individual's current IPP. *[Title 17,CCR, §56022(c)]*	13			100	None

Community Care Facility Record Review Summary Sample Size = 13						
	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)]*	2		11	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.	2		11	100	None
3.5.a	Service Level 4 facilities prepare and maintain written quarterly reports of progress. *[Title 17, CCR, §56026(c)]*	9	2	2	82	See Narrative
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.	9	2	2	82	See Narrative
3.5.c	Quarterly reports include a summary of data collected. *[Title 17, CCR, §56013(d)(4)], (Title 17, CCR, §56026)*	9	1	3	90	See Narrative
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)]*	13			100	None
3.6.b	The ongoing notes/information verify that behavior needs are being addressed.	13			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		8	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		8	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		8	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

Fifteen records for individuals served were reviewed at twelve 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 13 criteria.
- ✓ A summary of the results of the review is shown in the table at the end of this section.
- ✓ Findings for four criteria are detailed below.

IV. Findings and Recommendations

4.1.d The individual's record contains an authorization for emergency medical treatment signed by the individual served and/or the authorized representative. *(Title 17, CCR, §56730)*

Findings

Fourteen of the fifteen (93 percent) sample records for individuals served contained signed authorizations for emergency medical treatment. However, the record for individual #12 at DP #11 did not contain an authorization for emergency medical treatment that was signed by the individual served or conservator. During the review, an emergency medical treatment authorization for individual #12 at DP #11 was signed by the individual served. Therefore, no recommendation is required.

4.2 The day program has a copy of the current IPP for the individual served. *[Title 17, CCR, §56720)(b)]*

Findings

Thirteen of the fifteen (87 percent) sample records of individuals served contained a copy of the individual's current IPP. However, the records for individual #44 at DP #2 and individual #20 at DP #12 did not contain a copy of their current IPP.

4.2 Recommendation	Regional Center Plan/Response
SARC should ensure that the records for individual #44 at DP #2 and individual #20 at DP #12 contain a current copy of the individual's IPP.	Service Coordinator's, District Manager's, Quality Assurance Manager, and Associate Director's for Individuals Served #44 and #20 at Day Program's #2 and #12 were made aware of this finding. SC's of the Individuals Served provided the Day Programs with copies of the current signed IPP's. SARC will ensure all Day Programs have current copies of IPP's for all participants utilizing Day Program. This is accomplished through vendor trainings as well as SARC SC trainings.

4.4.a The day program prepares and maintains written semiannual reports of performance and progress. *[Title 17, CCR, §56720(c)]*

Finding

Twelve of the fifteen (80 percent) sample records of individuals served contained written semiannual reports of progress. However, the record for the following individuals contained only one of the required progress reports:

1. Individual #15 at DP #5;

2. Individual #41 at DP #4; and,

3. Individual #44 at DP #2.

4.4.a Recommendation	Regional Center Plan/Response
SARC should ensure that day program providers #2, #4, and #5 prepare written semiannual reports of individual progress for individuals #15, #41 and #44.	Service Coordinator's, District Manager's, Quality Assurance Manager, and Associate Director's for Individuals Served #15, #41, and #44; attending Day Programs #2, #4, and #5 were made aware of this finding. Day Program's #2

	#4, and #5 were trained and reminded of the importance of executing and producing semiannual reports and to share them with the case management team when produced.

4.4.b The semiannual reports address performance and progress toward achieving each of the IPP objectives for which the day program is responsible. *[Title 17, CCR, §56720(c)]*

Finding

Thirteen of the fifteen (87 percent) sample records of individuals served contained semiannual reports that addressed progress. However, the record for individual #44 at DP #2 and individual #41 at DP #4 contained none of the required progress reports.

4.4.b Recommendation	Regional Center Plan/Response
SARC should ensure that day program providers #2 and #4 maintain semiannual reports that address progress toward achieving IPP objectives for individuals #44 and #41.	Service Coordinator's, District Manager's, Quality Assurance Manager, and Associate Director's for Individuals Served #44 and #41 attending Day Programs #2 and #4 were made aware of this finding. Day Program's #2 and #4 were trained and reminded of the importance of executing and producing semiannual reports and to share them with the case management team when produced.

Day Program Record Review Summary Sample Size = 15						
	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)*	15			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.	15			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.	15			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.	15			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.	14	1		93	See Narrative
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.	15			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.	15			100	None
4.1.g	The individuals record contains up-to-date case notes reflecting important events or information not documented elsewhere.	15			100	None

Day Program Record Review Summary Sample Size = 15						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
4.1.h	The individuals record contains documentation that special safety and behavior needs are being addressed.	11		4	100	None
4.2	The day program has a copy of the individual's current IPP. *[Title 17, CCR §56720(b)]*	13	2		87	See Narrative
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)]*	15			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.	15			100	None
4.4.a	The day program prepares and maintains written semiannual reports. *[Title 17, CCR, §56720(c)]*	12	3		80	See Narrative
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.	13	2		87	See Narrative
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)*	3		12	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)*	3		12	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)*	3		12	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

Fifty-one of the sixty-one 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-three individuals agreed to be interviewed by the monitoring teams.
- ✓ Nineteen individuals were observed
- ✓ Nine interviews were conducted with parents of minors.
- ✓ Ten individuals were unavailable for or declined interviews.

III. Results of Observations and Interviews

Forty-nine of the fifty-one 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

1. Individual #30 would like to look into placement in a care home.
2. Individual #49 would like to explore or re-evaluate services and supports surrounding dental, housing, and SLS, and feels service coordinator is dismissive of services and supports.

Recommendation	Regional Center Plan/Response
SARC should follow up with individuals #30 and #49 regarding their concerns.	Service Coordinator's, District Manager's, and Associate Director's for Individuals Served were made aware of these findings and SARC staff have followed up accordingly.

	Individual Served #30 was met for a f-f meeting to discuss placement into a care home by the SC. Individual Served #49 was met with by the Service Coordinator F-F to address and resolve concerns regarding feelings of feeling dismissed and not heard. SARC endeavors to support all of our individuals Served through a Person-Centered approach assuring all needs and concerns are addressed and resolved on an individual basis.

SECTION VI A

SERVICE COORDINATOR INTERVIEWS

I. Purpose

The interviews determine how well the service coordinators (SC) 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 11 SARC SCs.

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 SCs 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 SCs 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, SCs 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 SCs utilize SARC medical director and online resources for medication.

4. The SCs monitor the individuals' services, health and safety during periodic visits. They are aware of the individuals' health issues. The SCs 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 participants and service coordinators. This interview aids in determining what measures the regional center is utilizing to ensure the ongoing health and safety of all Home and Community-Based Services Waiver participants.

II. Scope of Interview

1. The questions in the interview cover the following topics: routine monitoring of participants with medical issues, medications and behavior plans; coordination of medical and mental health care for participants; 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 in Risk Management Committee and Special Incident Reports (SIR).

2. The monitoring team interviewed the Health Services Coordinator (HSC) and Health Services Associate Coordinator (HSAC) at SARC.

III. Results of Interview

1. The clinical team at SARC consists of a contracted Physician, Psychologists, a Board-Certified Behavior Analyst (BCBA), Registered Nurses (RN), Nurse Consultants (contractor), Occupational Therapist (OT), a Dental Hygienist Coordinator and D/HOH (Deaf/Hard of Hearing).

2. The clinical team is available to respond to the service coordinator's requests when there are concerns regarding participants' health or safety issues. The clinical team can assist staff with medication reviews, as needed. The nurses review and approve care plans with restricted or special health condition living in community care facilities or attending day programs, including participants that tested positive with covid. Nurses are available to evaluate participants with medical issues to ensure appropriate placement and respite services. A bioethics team is in place for participants that needs decision to be made on their behalf. The bioethics team can also assist family and conservator in taking those hard difficult decisions. Nurses are also involved in the surgical consent process for participants who are unable to give informed consent. They monitor hospitalized participants, assist with discharge planning and end-of-life issues. Nurses also conduct training for Personal Protective Equipment (PPE) doffing for staff and participants to ensure that care homes

are following the licensing, Centers for Disease Control and Prevention and public health guidelines. They participate in monthly zoom meetings with the service providers to give updates on PPE training, the importance of care plans, and information on antigen test kits distribution.

Primary responsibility for monitoring medical or health conditions rests with the family or care provider. If the care provider is vendored with SARC, they are expected to become knowledgeable about the condition and needed care and follow-up. Updates to the SIR are submitted, along with the After Visit Summary from the doctor's appointment, emergency room Visit, or hospitalization. The individual's SARC Service Coordinator obtains information during meetings, home visits, and/or phone calls and can discuss with their unit RN. A lot of communication between entities occurs, depending on the issue.

3. Nurses investigate those who have special incidents reports with medication errors or adverse reactions and review discharge summary for medications for participants that were hospitalized. SARC nurses educate providers by conducting a 6-hour monthly training on safety with medications, including providing them information regarding policies and procedures, and the importance of training their staff. Nurses participate in the quality evaluation of care homes, and in the event of any discrepancies nurses will evaluate on-site how providers are monitoring medications, and where and how unused medications are disposed. A corrective action plan is then required by training/attending class at SARC to make sure medications are monitored correctly. Providers will be monitored by SARC until they are stabilized. Nurses also go to Adult Residential Facility monthly to review for medication errors, usage of ‘as needed” or PRN medications and outcomes. These are the main ways SARC clinical staff monitor participants’ medications.

4. A psychologist and BCBA are available for consultation regarding behavior issues and may review behavior plans to assess for appropriateness. Also, the psychologist and BCBA will provide behavior training to regional center staff and vendors. The clinical staff has minimal involvement in the coordination of mental health services for clients; while they may be involved in suggesting a referral for mental health supports or working with the team to ensure coordination of comprehensive clinical supports for the clients in our Enhanced Behavioral Supports and Crisis homes, the Service Coordinator is typically the team member who coordinates supports across agencies. The clinical team does provide consultative support to the interdisciplinary team when needed.

5. The clinical team provides ongoing training and support to service coordinators, as well as training nurses for community care homes and new employee orientation. The nurses offer provider training on topics such as medications, SIRs, signs and symptoms, dementia, pressure sores, nutrition,

obesity, dysphagia, and restricted healthcare plans. The clinical team assists with bioethics meetings and completes placement assessments for participants with medical needs or possible needs. Each service coordinator unit has a nurse assigned, who is available to service coordinators anytime via phone call, email or visit. The external Registered Nurse Consultants work with the Residential Facilities and Adult Day Programs in formulating care plans for restricted health conditions, based on Medical Doctor orders and train staff accordingly.

6. SARC has improved health care access for its participants through the following resources and/or programs:

   - ✓ The SARC dental coordinator reviews dental plans of care for participants. Dentists vendored by SARC are available to provide anesthesia care, as needed. For complex cases, the dental coordinator will assess and help coordinate dental care based on participant needs;

   - ✓ Six Registered Dental Hygienists-Alternative Practice see a select number of participants three times per year;

   - ✓ The HSC and HSAC work with the local Medi-Cal managed care plans to coordinate care and eligibility for participants;

   - ✓ A full time Emergency Specialist with training services is responsible for the whole emergency plan, training, and community integration;

   - ✓ The OT is available to evaluate participants for durable medical equipment needs. The OT will also attend Fair Hearings and write Medi-Cal appeals for denied services;

   - ✓ HSC and HSAC review incident reports to provide recommendation and to gather data on how to better assist individual and educate service providers; and,

   - ✓ D/HOH evaluates client needs and advocate for appropriate services for clients.

7. The Risk Management Committee consists of the following: Standards compliance coordinator, Quality assurance manager, Quality Assurance (QA) staff, RN, and Executive Director for community resources. Members of the clinical team participate on the Risk Management and Quality Assurance Committees by reviewing all death and hospital-related SIRs. Other medically related SIRs are reviewed, as needed. Trainings may be provided based on SIR findings. The regional center also utilizes Mission Analytics Group, Inc., the State's risk management contractor, which meets twice a

year to analyze special incidents for trends. The clinical team uses this information to make recommendations for appropriate follow-up.

8. Registered Nurses work as training specialists for SIRs and conduct monthly training for providers and SARC staff. Each RN receive SIR reports and work closely with compliance standards coordinator to ensure that all SIRs are processed correctly. A monthly meeting with the Quality Assurance Advisory committee is conducted when planning for agency wide activity may occur.

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 QA among programs and providers where there is no regulatory requirement to conduct QA monitoring.

II. Scope of Interview

The monitoring team interviewed a quality assurance manager who is part of the team responsible for conducting SARC QA activities.

III. Results of Interview

Service coordinators (SC) are responsible for conducting the Title 17 monitoring reviews for the Level 2, 3, and 4A-4H CCF homes. The QA manager monitors all level 4I CCF homes. Clinical staff and the behaviorist are invited to attend, as needed. In addition, two unannounced visits are conducted by SC or other regional center staff, as appropriate. Reviews are generally conducted in the afternoon so that consumers may be interviewed and observed.

Results of the Title 17 reviews and unannounced visits are forwarded to the QA manager, who oversees corrective action plans (CAP) using a tracking system. The QA manager oversees activities related to CAPs, special incident reports (SIR) and trends. When issues of substantial inadequacies are identified, service coordinators, with assistance from the QA manager or the district manager, are responsible for developing CAPs and ensuring providers complete the requirements. SARC offers various regularly scheduled trainings for service providers and SCs.

SARC maintains a Resource Department that interviews potential providers, reviews applications and program designs and conducts new provider orientation. The QA manager monitors ongoing compliance issues, certifications, and updates of continuing education hours. The Resource Department investigates CAPs or significant issues for non-licensed vendors and providers where there is no regulatory requirement to monitor. An SC is assigned to each vendor and is responsible for issues relating to day programs, supported living services and independent living services. When necessary, the SC will involve the QA department for technical support or follow-up.

SARC's QA manager, district managers and the SIR coordinator participate on the QA Advisory Committee, which meets monthly. The committee reviews information regarding SIRs, CAPs and trends and makes recommendations and/or conducts trainings for both providers and service coordinators. In addition, the QA manager has developed a committee called, "Let's Talk Committee." This committee meets twice a month with service coordinators, district managers and other regional center staff to discuss and remedy relevant issues. The QA manager also attends the Mortality and Morbidity Committee meetings once a month. Managers, SCs and QA staff have the ability to staff a case as needed and are able to invite members of the health services department to present or discuss cases that may require that type of review. QA managers also attend QA around the Bay quarterly with all bay area regional centers to discuss trends. QA Managers also attend a "Wrap Session" with the Executive Director, District Managers, and Community Care Licensing to discuss client and vendor services.

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 17 service providers at 10 community care facilities and seven 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 17 direct service staff at 10 community care facilities and seven 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 10 CCFs and seven 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

8.2.c Medication Records are maintained for all prescribed, Non-Pro Re Nada (N-PRN), medications taken by the individual.

Finding

Sixteen of the seventeen facilities maintained medication records for all prescribed, Non-PRN medications taken by the individual. However, at CCF #6, it was noted that individual #8 had missed a medication for one day.

8.2.c Recommendation	Regional Center Plan/Response
SARC should ensure that CCF #6 administers all Non-PRN medications as ordered.	Service Coordinator's, District Manager's, Quality Assurance Manager, and Associate Director's for Individuals Served residing in CCF #6 were made aware of this finding. Follow up was conducted with CCF #6 to assure compliance with administering all non-PRN

	medications. Quality Assurance Manager and her team conducted additional follow at the CCF #6 site to assure this compliance.

8.3.c Staff responsible for providing direct care and supervision will receive training in first aid from qualified agencies. 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)]*

Findings

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

1. CCF #4: One staff with an expired first aid certificate. However, it was completed on October 15, 2024. Accordingly, no recommendation is required;

2. CCF #7: One staff with an expired first aid certificate;

3. CCF #8: One staff with an expired first aid certificate. However, it was completed on October 15, 2024. Accordingly, no recommendation is required;

4. CCF #10: One staff with an expired first aid certificate;

5. DP #2: Four staff with expired first aid certificates; and,

6. DP #4: Three staff with expired first aid certificates. However, two were completed on October 17, 2024 and one was completed on October 23, 2024. Accordingly, no recommendation is required;

8.3.c Recommendation	Regional Center Plan/Response
SARC should ensure that the providers at CCF #7, CCF #10 and DP #2 have current first aid certificates available for all direct care staff.	Service Coordinator's, District Manager's, Quality Assurance Manager, Director of Healthcare Services, and Associate Director's for Individuals Served residing in CCF #7, CCF #10, and DP #2 have been made aware of this finding regarding first aid certificates. Since the Cycle audit First Aid Certificates were obtained

	and updated. SARC staff and vendors are notified and trained as to this requirement during established vendor trainings and new hire orientations. This requirement is maintained during a facility review by the SC and by the Quality Assurance team. SARC will endeavor to assure all vendorized staff that requires first-aid certificates are accounted for.

8.4.a Individuals served or an authorized representative will sign for cash given directly to them, either with a signature or mark. If the individual served is unable to sign or make a mark, the provider should document why. Cash kept on the facility premises will be locked in a secure location. *[Title 22, CCR, §80026(h)(A)(B)(j)]*

Findings

Sixteen of the seventeen facilities' records had individuals served or authorized representatives' signatures or marks for cash disbursements. However, at CCF #3 the individual or an authorized representative did not sign for personal and incidental disbursements. During the monitoring review the individual signed for all disbursements. Accordingly, no recommendation required.

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 SARC 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.

2. The records of the 61 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. SARC reported all deaths during the review period to the Department.

2. SARC reported all special incidents in the sample of 61 records selected for the HCBS Waiver review to the Department.

3. SARC's vendors reported 9 of the 10 (90 percent) incidents in the supplemental sample within the required timeframes.

4. SARC reported all (100 percent) incidents in the supplemental sample to the Department within the required timeframes.

5. SARC'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 #7: The incident occurred on February 9, 2024. However, the vendor did not submit a written report to SARC until February 16, 2024.

Recommendation	Regional Center Plan/Response
SARC should ensure that the vendor for SIR #7 report special incidents within the required timeframes.	SARC Quality Assurance manager followed up with this vendor regarding special incident report identified in this finding. QA Manager reminded vendor or the importance of accurate and timely SIR reporting to assure the health and safety of the individual served.

SAMPLE OF INDIVIDUALS SERVED AND SERVICE PROVIDERS/VENDORS

HCBS Waiver Review of Individuals Served

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

#	UCI	CCF	DP
38			
39			
40			
41			4
42			
43			
44			2
45			
46			
47			
48			7
49			
50			
51			
52			3
53			
54			
55			
56			
57			
58			
59			
60			
61			

Supplemental Sample of Waiver Terminations

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

Supplemental New Enrollees Sample

#	UCI
NE-1	
NE-2	
NE-3	
NE-4	
NE-5	
NE-6	
NE-7	
NE-8	
NE-9	
NE-10	
NE-11	
NE-12	
NE-13	
NE-14	
NE-15	
NE-16	
NE-17	
NE-18	
NE-19	
NE-20	
NE-21	
NE-22	

HCBS Waiver Review Service Providers

CCF #	Vendor
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	

Day Program #	Vendor
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

SIR Review

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