Kern Regional Center

Home and Community-Based Services Developmental Disabilities Waiver

Monitoring Review Report

Conducted by: Department of Developmental Services and Department of Health Care Services

Review Dates: November 10 – 21, 2025

DDS Department of Developmental Services

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SECTION I: REGIONAL CENTER SELF-ASSESSMENT

Kern Regional Center (KRC) responded to questions that align with the California Home and Community-Based Services (HCBS) 1915(c) Developmental Disabilities Waiver requirements. The regional center self-assessment addresses the California HCBS Waiver assurances criteria and is designed to provide information about the regional center's processes and practices.

The responses indicated that the regional center has systems and procedures in place for implementing the State and HCBS Waiver laws and regulations addressed in the self-assessment criteria.

The full response to the self-assessment provided by KRC is available upon request.

SECTION II: REGIONAL CENTER RECORD REVIEW

For the review period of August 1, 2024, through July 31, 2025, a total of 26 records of individuals enrolled on the Home and Community-Based Services (HCBS) 1915(c) Developmental Disabilities Waiver and receiving services at Kern Regional Center (KRC), were reviewed for individual choice, HCBS Settings requirements, notification of proposed action and fair hearing rights, level-of-care, individual program plans (IPP) and periodic reviews and reevaluations of services. Lastly, ten additional supplemental records were reviewed for documentation that KRC determined the individual met the HCBS Waiver level-of-care requirements prior to receiving HCBS Waiver supports.

The 26 records reviewed were 94 percent in overall compliance for this review. Findings for 11 criteria are detailed below.

2.2.a Each record contains a dated and signed Medicaid Waiver Consumer Choice of Services/Living Arrangements form (DS 2200). *[42 C.F.R. § 441.302(d) (2025)]*

Findings

Twenty-three of the twenty-six (89 percent) sample records of individuals contained a signed and dated DS 2200 form. However, there were identified issues regarding the DS 2200 form for the following individuals:

1. Individual #1: The DS 2200 was not signed until October 9, 2025. Accordingly, no recommendation is required;

2. Individual #10: The DS 2200 was not signed until October 9, 2025. Accordingly, no recommendation is required; and,

3. Individual #24: The DS 2200 was not signed until October 22, 2025. Accordingly, no recommendation is required.

2.4 The individual record contains a current Client Development Evaluation Report (CDER) that has been reviewed within 12-months of the prior CDER. Reevaluations, at least annually, of each individual receiving home or community-based services to determine if the individual continues to need the level-of-care provided and would, but for the provision of Waiver services, otherwise be institutionalized. *[42 C.F.R. § 441.302(c)(2) (2025)]*

Finding

Twenty-five of the twenty-six (96 percent) sample records of individuals contained a CDER that has been reviewed annually. However, the record for individual #14 did not contain documentation that the CDER had been reviewed annually.

2.4 Recommendation	Regional Center Plan/Response
KRC should ensure that the CDER for individual #14 is reviewed annually.	Individual 14: KRC has updated the 2024 and 2025 CDERs. KRC to review/adjust monitoring procedures. SCs complete CDER reports annually. When submitting CDER for review, SC to print and present annually updated and signed CDER to Program Manager during supervision meeting; once recorded, completed CDER to be filed in client record. Training to be provided to service coordination staff on revised protocols.

2.5.b The individual's assessed needs used to meet the level-of-care requirements for care provided in intermediate care facilities that is documented in the CDER and the DS 3770 are consistent with other information contained in the individual's records. *(HCBS Waiver Requirement)*

Finding

Twenty-five of the twenty-six (96 percent) sample records of individuals documented level-of-care assessed needs that were consistent with information in the record. However, the assessed need "running/wandering" listed on the DS 3770 for individual #25 was not consistent in the record.

2.5.b Recommendation	Regional Center Plan/Response
KRC should determine if the item listed above for individual #25 is appropriately identified as an assessed need. The individual's CDER and DS 3770 form should be corrected to ensure that any items that do not represent substantial limitations in the individuals' ability to perform activities of daily living and/or participate in community activities are no longer identified as assessed needs. If KRC determines that the issues are correctly identified as assessed needs, documentation (updated IPPs, progress reports, etc.) that supports the original determinations should be submitted with the response to this report.	Individual #25: The assessed needs of toileting, elopement and emotional outbursts for individual #25 were identified as assessed needs and were included on the 1/8/2024 IPP and DS3770 dated 3/6/2025. Toileting and Elopement are still identified as substantial limitations, but the consumer chose to be addressed informally and not included on the 1/30/2025 IPP. Assessed needs not formally addressed in the IPP will now be included in the additional notes section of the IPP on future reports per the agreement with the Department. Consumer to continue on Waiver.

2.6.a The IPP for every individual is reviewed, and revised as appropriate, based upon the reassessment of functional need at least every 12-months by the planning team and modified, as necessary, in response to the individual's changing needs, wants or health status. *[42 C.F.R. § 441.301 (C)(3) (2025)]; [W.I.C. § 4646.5(b) (2023)]*

Findings

Twenty-four of the twenty-six (92 percent) sample records of individuals contained documentation that the individual's IPP had been reviewed annually by the planning team. However, there was no documentation that the IPPs for the following individuals were reviewed annually as indicated below:

1. Individual # 14: The IPP was dated June 20, 2024. There was no documentation that the IPP was reviewed annually; and,

2. Individual # 17: The IPP was dated April 22, 2024. There was no documentation that the IPP was reviewed annually. A new IPP was completed on June 3, 2025.

2.6.a Recommendation	Regional Center Plan/Response
KRC should ensure that the IPPs for individuals #14 and #17 are reviewed at least annually by the planning team.	Individual #14: KRC has completed an IPP on 06/20/2024 and 11/13/2025; 2025 IPP was not completed within time limit. Individual #17: KRC has completed an IPP on 04/22/2024 and 06/03/2025; 2025 IPP was not completed not within time limits. KRC to review/adjust monitoring protocols to ensure IPP meetings are reviewed annually. SC to submit completed and signed IPP to PM during supervision meetings. Once recorded, completed IPP to be filed in client records. Training to be provided to service coordination staff on revised protocols.

2.7.a The IPP is prepared jointly with the planning team and a list of agreed upon services is signed, prior to its implementation, by an authorized representative of the regional center and the individual or, where appropriate, the individual's parents, legal guardian, conservator or the authorized representative. [*W.I.C. § 4646(d) (2023)]; [W.I.C. § 4646(i) (2023)]; [42 C.F.R. § 441.301(c)(1)(i) (2025)]; [42 C.F.R. § 441.301(c)(2)(ix) (2025)]*

Findings

Twenty-two of the twenty-six (85 percent) sample records of individuals contained IPPs that were signed by KRC and the individuals or, where appropriate, their parents, legal guardian, conservator or the authorized representative. However, there were issues with the following IPPs as indicated below:

1. Individual #3: The IPP dated November 14, 2024, was not signed by the individual and the regional center until November 20, 2025. Accordingly, no recommendation is required;

2. Individual #4: The IPP dated September 25, 2024, was not signed by the regional center until November 14, 2025. Accordingly, no recommendation is required;

3. Individual #10: The IPP dated February 20, 2025, was not signed by the individual and the regional center until October 10, 2025. Accordingly, no recommendation is required; and,

4. Individual #14: The IPP dated June 20, 2024, was not signed by the individual and the regional center.

2.7.a Recommendation	Regional Center Plan/Response
KRC should ensure that the IPP for individual #14 is signed. If the individual does not sign, KRC should ensure that the IPP addresses the reason why the individual did not or could not sign.	Individual #14: KRC completed an IPP on 06/20/2024, however, the IPP signature page was not obtained. KRC attempted to obtain the client's signature as a response to this audit, however, were not successful in doing so; as of the date of this response, the 2024 IPP is still missing the signature page. However, for the 2025 IPP, KRC obtained the client's signature, on the 11/13/25 IPP. Individual #14 is able to provide a signature. Going forward, KRC will ensure that individual signs all signature pages at the time of the IPP meeting. KRC will ensure meetings are conducted and reviewed on an annual basis in accordance with established requirements. Service Coordinators (SCs) will be required to submit completed and fully signed IPPs to the Program Manager (PM) during scheduled supervision meetings for verification and oversight. Upon review and

	confirmation of completeness, the finalized IPP and signature page will be uploaded to the client's electronic record.

2.9.a The IPP addresses the assessed needs identified in the CDER and DS 3770. *[42 C.F.R. § 441.301(c)(2)(iii)(iv) (2025)] (HCBS Wavier Requirement)*

Findings

Eighteen of the twenty-six (69 percent) sample records of individuals contained IPPs that addressed the individual's assessed needs. However, the following IPPs did not address the supports for assessed needs identified in the CDER and DS 3770:

1. Individual #1: The IPP dated April 26, 2024, does not address the assessed needs of "resistiveness in one or more settings" and "emotional outburst less than weekly requiring intervention";

2. Individual #4: The IPP dated September 25, 2024, does not address the assessed need of "aggressive social behavior occurs monthly but has not caused injury within the past 12 months";

3. Individual #11: The IPP dated June 20, 2025, does not address the assessed needs of "requires assistance to take medication" and "self-injurious behaviors occur monthly requiring first aid or medical care";

4. Individual #18: The IPP dated March 19, 2025, does not address the assessed needs of "emotional outbursts occur weekly requiring intervention", "disruptive behaviors occur weekly", "toileting with assistance", and "wetting/soiling occurs weekly during waking hours";

5. Individual #20: The IPP dated July 29, 2025, does not address the assessed needs of "supervision in unfamiliar environments", "emotional outbursts occur weekly not requiring intervention, and "disruptive behavior interferes with social behavior weekly";

6. Individual #22: The IPP dated February 28, 2025, does not address the assessed needs of "emotional outbursts less than weekly requiring intervention" and "major property destruction once within the past 12 months";

7. Individual #23: The IPP dated December 30, 2024, does not address the assessed need of "performs personal care independently when reminded"; and,

8. Individual #24: The IPP dated March 10, 2025, does not address the assessed needs of "dressing with assistance", "constant supervision in all settings during waking hours", "running/wandering away occurs or is attempted almost every day", "no control of either

bladder or bowel" and "aggressive social behavior occurs monthly but has not caused injury within the past 12 months".

2.9.a Recommendations	Regional Center Plan/Response
KRC should ensure that the IPP for individuals #1, #4, #11, #18, #20, #22, #23 and #24 address the services and supports in place for the assessed needs identified above.	Individual #1: KRC has completed an IPP addendum on 03/18/2026 to address the assessed needs of "resistiveness in one or more settings" and "emotional outburst less than weekly requiring intervention." Individual #4: KRC has completed an IPP addendum on 03/25/2026 to address the assessed needs of "aggressive social behavior occurs monthly but has not caused injury within the past 12 months." Individual #11: KRC has completed an IPP Addendum on 03/20/2026 to address the assessed needs of "requires assistance to take medication" and "self-injurious behaviors occur monthly requiring first aid or medical care. Individual #18: KRC completed an IPP meeting on 03/26/2026 to include the assessed needs of "emotional outbursts occur weekly requiring intervention", "disruptive behaviors occur weekly", "toileting with assistance", and "wetting/soiling occurs weekly during waking hours," however, individual #18 has declined to formally discuss assessed need in the IPP. KRC will include all assessed needs not formally discussed in the IPP in the additional notes section of the IPP as agreed with the Department. Client will continue as part of the Waiver. Individual #20: KRC completed an IPP Addendum on 03/19/2026 to address the addressed needs of:

	"supervision in unfamiliar environments", "emotional outbursts occur weekly not requiring intervention, and "disruptive behavior interferes with social behavior weekly." Individual #22: KRC completed an IPP Addendum on 03/04/2026 to address the assessed needs of "emotional outbursts less than weekly requiring intervention" and "major property destruction once within the past 12 months," however, client continues to decline to have assessed needs listed in the individual's IPP, KRC has removed individual from the HCBS Waiver as of 03/27/2026. Individual #23: KRC completed an IPP on 12/30/2025 to address the assessed needs of "performs personal care independently when reminded." Individual #24: KRC completed an IPP Addendum on 03/23/2026 to address the assessed needs of "dressing with assistance", "constant supervision in all settings during waking hours", "running/wandering away occurs or is attempted almost every day", "no control of either bladder or bowel" and "aggressive social behavior occurs monthly but has not caused injury within the past 12 months."
In addition, KRC should evaluate what actions may be necessary to ensure that IPPs address the assessed needs identified in the CDER and the DS3770 for all individuals.	KRC to adjust review/adjust documentation standards on how to ensure IPPs address the assessed special health care requirements and/or safety risks for applicable individuals. Training to be provided to service coordination staff on revised protocols.

2.9.b The IPP addresses special health care requirements and safety risks. *[42 C.F.R. § 441.301(c)(2)(vi) (2025)]; (HCBS Waiver Requirement)*

Findings

Eleven of the sixteen (69 percent) applicable sample IPPs for individuals addresses the individuals' special health care requirements and safety risks. However, IPPs for the following individuals do not address the special health care requirements and safety risks identified below:

1. Individual #4: Diabetic test;

2. Individual #7: Other health care requirement not listed;

3. Individual #16: Other health care requirement not listed;

4. Individual #17: Inhalation therapy and other health care requirement not listed; and,

5. Individual #20: Other health care requirement not listed.

2.9.b Recommendations	Regional Center Plan/Response
KRC should ensure that the IPPs for individuals #4, #7, #16, #17 and #20 address special health care requirements and/or safety risks as noted.	Individual #4: KRC has completed an IPP Addendum on 03/25/2025 to address Diabetic testing. Individual #7: KRC has completed an IPP Amendment on 03/18/2026 to address, "Other health care requirement not listed identified as prescription glasses." Individual #16: KRC has completed an IPP Addendum on 08/25/25 to address, "Other health care requirement not listed;" identified as prescription glasses. Individual #17: KRC has completed an IPP Addendum on 03/27/2026 to include and address Inhalation therapy and other health care requirements not listed and has updated the CDER to remove other health care requirements not listed. Individual #20: KRC has completed an IPP Addendum on 03/19/2026 to include other

	health care requirement not listed identified as prescription glasses. KRC Program Managers will conduct monthly case reviews to monitor that Individual Program Plans (IPPs) address identified special health care requirements and safety risks, including verification that these needs are appropriately reflected. Client Services leadership will provide oversight of this process through existing supervisory structures, with Program Managers following up with Service Coordinators, as needed, to ensure IPPs consistently reflect assessed health care needs and safety risks prior to finalization.
In addition, KRC should evaluate what actions may be necessary to ensure that IPPs address special health care requirements and/or safety risks for all applicable individuals.	KRC to adjust review/adjust documentation standards on how to ensure IPPs address the assessed special health care requirements and/or safety risks for applicable individuals. Training to be provided to service coordination staff on revised protocols.

2.9.h Regional centers shall implement the standardized individual program plan template and procedures no later than January 1, 2025. *[W.I.C. § 4435.1(d)]*

Findings

Sixteen of the eighteen (89 percent) applicable sample IPPs utilized the standardized individual program plan (IPP) template and signature page beginning January 1, 2025, as required. However, the following IPPs did not use the IPP template and/or signature page:

1. Individual #6: IPP dated January 15, 2025 did not use the standardized IPP signature page; and,

2. Individual #12: IPP dated January 17, 2025 did not use the standardized IPP template and signature page.

2.9.h Recommendation	Regional Center Plan/Response

KRC should ensure that the IPPs for individual #6 and #12 are completed using all standardized IPP templates.	Individual #6: KRC did not use/complete the standardized IPP signature page due to initial issues with implementation of the new format. KRC will use the standardized IPP signature page for all future IPP's. Individual #12: KRC did not use/complete the standardized IPP template and signature page. KRC will use the standardized IPP template and signature page moving forward. KRC will ensure consistent use of standardized IPP templates and required components across all IPPs moving forward. Program Managers will review IPPs prior to finalization to verify that the correct template and signature page are utilized. Client Services leadership will provide oversight through existing supervisory structures to support consistent compliance with standardized IPP requirements.

2.10.a The IPP includes a schedule of the type and amount of all services and supports purchased by the regional center. *[W.I.C. § 4646.5(a)(5)(2023)]; [42 C.F.R. § 441.301(c)(2)(v)(2025)]*

Findings

Twenty-five of the twenty-six (96 percent) sample IPPs of individuals included a schedule of the type and amount of all services and supports purchased by the regional center. However, the following IPP did not include KRC funded services as indicated below:

1. Individual #19: Supported Living Services Supports was not included for the months of August 2024 and December 2024 through February 2025 in the IPP dated May 16, 2024.

2.10.a Recommendation	Regional Center Plan/Response
KRC should ensure that the IPPs for #19 include a schedule of the type and amount of all services and supports purchased by KRC.	Individual #19: The time period in question was processed in error as SLS and thus SLS was not captured in the IPP; the intent was for ILS services to be provided as stated in the 01/03/25 IPP. Subsequently,

	for the period of 01/08/25 through 01/31/25, ILS services were covered via an IPP addendum dated 03/11/25. SLS was not formally agreed to by KRC and the client until 02/19/25 via an IPP addendum for SLS services to start effective 03/01/25.

2.12.a Quarterly face-to-face meetings are completed with individuals living in community out-of-home settings, i.e., service level 2-7 community care facilities, family home agencies, or supported living and independent living services. *[Cal. Code. Regs tit. 17, § 56047 (2023)]; [Cal. Code. Regs tit. 17, §56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 (2023)]; (Contract Requirement)*

Findings

Thirteen of the seventeen (77 percent) applicable sample records of individuals contained completed quarterly face-to-face meetings. However, the following records did not meet the requirement as indicated below:

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

2. The records for individuals #14 and #17 contained documentation of one of the four required meetings that were consistent with the quarterly timeline.

2.12.a Recommendations	Regional Center Plan/Response
KRC should ensure that all future face-to-face meetings are completed and documented each quarter for individuals #13, #14, #17, and #18.	Individual #13: KRC did not complete the missing documentation for the face-to-face quarterly meetings for this individual. Individual #14: KRC did not complete the missing documentation for the face-to-face quarterly meeting for this individual. Individual #17: KRC did not complete the missing documentation for the face-to-face quarterly meeting for this individual. Individual #18: KRC did not complete the missing documentation for the face-to-face quarterly meetings for this individual.
Further action is required by KRC to ensure that quarterly face-to-face meetings are completed and documented for all applicable individuals.	KRC submitted a plan of correction to the Department for the issue of non-compliance with the completion of quarterly meetings and reports in the month of January 2025.

	KRC will continue to follow this plan, however, will provide a training to update service coordination staff on the particulars of the plan of correction. It is anticipated that this training will be conducted on or before July 31, 2026.

2.12.b Quarterly reports of progress toward achieving IPP objectives are completed for individuals living in community out-of-home settings, i.e., service level 2-7 community care facilities, family home agencies, or supported living and independent living settings. [*Cal. Code. Regs tit. 17, CCR, § 56047 (2023)]; [Cal. Code. Regs tit. 17, § 56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 (2023)]; (Contract Requirement)*

Findings

Thirteen of the seventeen (77 percent) applicable sample records of individuals contained quarterly reports of progress completed for individuals living in community out-of-home settings. However, the following records did not meet the requirements as indicated below:

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

2. The record for individuals #14 and #17 contained documentation of one of the four required quarterly reports of progress that were consistent with the quarterly timeline.

2.12.b Recommendations	Regional Center Plan/Response
KRC should ensure that future quarterly reports of progress are completed for individuals #13, #14, #17, and #18.	Individual #13: KRC did not complete the missing quarterly reports of progress. Individual #14: KRC did not complete the missing quarterly reports of progress. Individual #17: KRC did not complete the missing quarterly reports of progress. Individual #18: KRC did not complete the missing quarterly reports of progress.
Further action is required by KRC to ensure that quarterly progress reports are completed and documented for all applicable individuals.	KRC submitted a plan of correction to the Department for the issue of non-compliance with the completion of quarterly meetings and reports in the month of January 2025. KRC will continue to follow this plan, however, will provide a training to update service coordination staff on the particulars

	of the plan of correction. It is anticipated that this training will be conducted on or before July 31, 2026.

SECTION III: COMMUNITY CARE FACILITY RECORD REVIEW

The monitoring team visited four community care facilities (CCF) and reviewed four individual records for individuals supported by Kern Regional Center (KRC) who are living in those facilities. The monitoring team reviewed the records to determine if the record addressed all the elements CCFs are required to maintain in their individual records. The monitoring team also reviewed that the CCFs prepared written reports of progress in relation to the services and supports identified in the individual program plan (IPP) for which the facility is responsible. The review criteria in this section are derived from Title 17, California Code of Regulations and Title 42, Code of Federal Regulations.

The four records reviewed were 93 percent in overall compliance for 16 criteria. Findings for one criterion are detailed below.

3.2.b In a provider-owned or controlled residential setting, the unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. *[42, CFR, § 441.301(c)(4)(vi)(A) (2025)]*

Findings

None of the four (0 percent) sample records contained documentation of agreement for eviction procedures and appeals process. The records of the following individuals did not include documentation of the appeals and eviction process:

1. Individual #1 at CCF #1;

2. Individual #2 at CCF #2;

3. Individual #3 at CCF #3; and,

4. Individual #4 at CCF #4.

3.2.b Recommendations	Regional Center Plan/Response
KRC should ensure that individual records maintained by CCF #1 for individual #1,	Individual #1 at CCF #1: did not have documentation containing agreement

CCF #2 for individual #2, CCF #3 for individual #3, and CCF #4 for individual #4 contain documentation of agreement for eviction procedures and appeals process.	for eviction procedures and appeals process. Individual #2 for CCF #2: did not have documentation containing agreement for eviction procedures and appeals process. Individual #3 at CCF #3: did not have documentation containing agreement for eviction procedures and appeals process. Individual #4 at CCF #4: did not have documentation containing agreement for eviction procedures and appeals process. KRC to develop an addendum to the KRC admission agreement to document evictions procedures and appeals process.
In addition, KRC should ensure that individual records maintained by all CCFs contain documentation of agreement for eviction procedures and appeals process.	KRC currently has an Admissions Agreement that is signed by the facility and the resident. KRC will create an addendum to this agreement that includes the eviction and appeal process that both parties will sign. This task will be completed by December 31, 2026. The addendum will be executed with applicable individuals and maintained in the client record at both the facility and KRC. Providers will be required to utilize agreements that clearly outline services and applicable policies, including eviction and appeal procedures, in alignment with HCBS requirements. Training will be provided to Service Coordination staff on updated requirements related to Admissions Agreements and documentation standards.

SECTION IV: DAY PROGRAM RECORD REVIEW

The monitoring team visited four day programs and reviewed five records for individuals supported by Kern Regional Center (KRC) who are receiving services from those day programs (DP). The monitoring team reviewed the records to ensure that the day program addressed the requirements to maintain records and prepare written reports of progress in relation to the services and supports identified in the individual program plan (IPP) for which the day program is responsible. The review criteria in this section are derived from Title 17, California Code of Regulations and Title 42, Code of Federal Regulations.

The five records reviewed were 97 percent in overall compliance for 13 criteria. Findings for two criteria are detailed below.

4.5.a Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. *[Cal. Code. Regs tit. 17, § 54327(f) (2023)]*

Finding

One of the two (50 percent) of applicable sample records for individuals served contained documentation that special incidents were reported to the regional center within 24 hours of occurrence. However, the special incident for individual #5 at DP #1 occurred on August 2, 2024, but was not reported to KRC until October 8, 2024.

4.5.a Recommendation	Regional Center Plan/Response
KRC should ensure that the vendor for DP #1 reports special incidents within the required timeframes.	DP #1: A CAP was issued to the Day Program on 10/16/2024 for delayed response to KRC. KRC staff held training on 10/30/2024 including DP#1 with vendors to ensure that they understand rules and regulations required for SIR and timeliness of reporting to KRC. DP #1 held their own personnel training on 11/15/2024.
In addition, KRC should evaluate what actions may be necessary to ensure that the vendor reports special incidents within the required timeframes.	KRC held a training for vendors on the SIR regulations and timelines on 10/16/2024. KRC will continue to provide technical assistance to vendors as needed by interpreting SIR regulations. Additionally, KRC will continue its practice of issuing corrective action plans to vendors who fail to meet requirements.

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. *[Cal. Code. Regs tit. 17, § 54327(g) (2023)]*

Finding

One of the two (50 percent) applicable sample records of individuals served contained documentation that a written report of the special incident was submitted to the regional center within 48 hours after the occurrence of the special incident. However, the special incident for individual #5 at DP #1 occurred on August 2, 2024, but the written report was not submitted to KRC until October 8, 2024.

4.5.b Recommendations	Regional Center Plan/Response
KRC should ensure that the vendor for DP #1 submits reports of special incidents to the regional center within the required timeframes.	DP #1: A CAP was issued to the Day Program on 10/16/2024 for delayed response to KRC. KRC staff held training on 10/30/2024 including DP#1 with vendors to ensure that they understand rules and regulations required for SIR and timeliness of reporting to KRC. DP #1 held their own personnel training on 11/15/2024.
In addition, KRC should evaluate what actions may be necessary to ensure that vendors submit reports of special incidents to the regional center within the required timeframes.	KRC held a training for vendors on the SIR regulations and timelines on 10/16/2024. KRC will continue to provide technical assistance to vendors as needed by interpreting SIR regulations. Additionally, KRC will continue its practice of issuing corrective action plans to vendors who fail to meet requirements.

SECTION V: OBSERVATIONS AND INTERVIEWS WITH INDIVIDUALS

Fourteen of the twenty-six individuals supported by Kern Regional Center, or in the case of minors, their parents, were interviewed and/or observed at their day programs, employment sites, community care facilities, or in independent living settings to verify that the individuals appeared to be supported and healthy and if applicable, the setting was compliant with the Home and Community-Based Services Settings requirements. Interview questions focused on the individuals' satisfaction with their living situation, day program or work activities, health, choice, and regional center services.

Finding

All of the individuals and 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.

SECTION VI: REGIONAL CENTER STAFF INTERVIEWS

SECTION VI A: SERVICE COORDINATOR INTERVIEWS

The monitoring team interviewed 11 service coordinators (SC). The interviews determined that all of the SCs are knowledgeable about the desires, preferences, life circumstances and service needs of the individuals they support. The SCs had knowledge of the processes for individual program planning and periodic review as well as monitoring the health and safety of individuals and monitoring that the service providers who support them comply with Home and Community-Based Services (HCBS) 1915(c) Developmental Disabilities Waiver and Settings requirements.

SECTION VI B: CLINICAL SERVICES INTERVIEW

The monitoring team interviewed the Medical Director to ensure that the regional center has practices in place to provide clinical support to individuals and service coordinators. The interview determined the regional center conducts routine monitoring of individuals with medical issues, monitoring of medications, monitoring of behavior plans, coordination of medical and mental health, improvements in access to preventive health care resources, and ensures that clinical services play a role in special incident reporting and the Risk Management Committee to address the ongoing health and safety of individuals who are on the HCBS 1915(c) Waiver.

SECTION VI C: QUALITY ASSURANCE INTERVIEW

The monitoring team interviewed the Assistant Director of Community Services to ensure the regional center has practices in place to conduct Title 17 and HCBS Waiver and Settings monitoring and quality assurance activities. The interview determined the regional center conducts routine Title 17 monitoring of community care facilities, including two unannounced visits, service provider training, corrective action plans as required and technical assistance is provided when needed. In addition, the regional center verifies provider qualifications, resource development activities, and quality assurance among programs and providers where there are no regulatory requirements to conduct monitoring. Quality assurance also participates in special incident reporting and the Risk Management Committee to address the ongoing quality assurance needs of individuals who are on the HCBS Waiver.

SECTION VII: VENDOR STAFF INTERVIEWS

SECTION VII A: SERVICE PROVIDER INTERVIEWS

The monitoring team interviewed service providers at two community care facilities (CCF) and three day programs. The interviews determined that all service providers assess the needs of the individual in their program, participate in the development of an individual program plan (IPP), foster independence and an environment where the individual is treated with dignity and respect, advocate for and oversee the training and implementation of policies and procedures that ensure the health, safety, and rights of the individual are being planned for and met in accordance with the Home and Community-Based Services (HCBS) 1915(c) Developmental Disabilities Waiver and Settings requirements.

SECTION VII B: DIRECT SUPPORT PROFESSIONALS INTERVIEWS

The monitoring team interviewed direct support professionals at two CCFs and three day programs. The interviews determined that all direct support professionals are familiar with and respect the individuals they are supporting, understand the individual's goals and objectives on their IPP, understand the service delivery and HCBS Waiver and Settings requirements, are prepared to address safety issues, engage in emergency preparedness, and are knowledgeable about safeguarding medications.

SECTION VIII: VENDOR PROGRAM MONITORING REVIEW

The monitoring teams reviewed a total of two community care facilities (CCF) and three day programs to determine if the settings are Home and Community-Based Services (HCBS) Settings requirement compliant, and are supporting individuals in a safe, healthy and positive environment where their privacy, rights and choices are respected, they have control of their personal resources and individual preferences and styles are reflected in CCFs where individuals live. All of the CCFs and the day programs were found to be in good condition with no immediate health and safety concerns.

8.6 Federal Requirement #6: Residential Agreement

The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. *(Title 17, CCR, § 56019(c)(1)) (Title 42, CFR, § 441.301(c)(4)(vi)(A))*

Finding

See finding and recommendation for the vendor's non-compliance detailed in community care facility record review, criterion 3.2.b.

SECTION IX: SPECIAL INCIDENT REPORTING

The records of the 26 individuals supported by Kern Regional Center (KRC) and selected for the Home and Community-Based Services (HCBS) 1915(c) Developmental Disabilities (DD) Waiver sample were reviewed to verify that special incidents have been reported. A supplemental sample of 10 records of individuals receiving services were also reviewed to verify that special incident reports (SIR) 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 appropriate and complete. In addition, the monitoring team verified that an incident report was completed for all individuals on the HCBS Waiver supported by KRC who passed away during the review period.

Summary of Findings

KRC reported all special incidents in the sample of 26 records selected for the HCBS 1915(c) DD Waiver review to the Department. KRC's vendors reported 8 of the 10 (80 percent) incidents in the supplemental sample to the regional center within the required timeframes. KRC reported all (100 percent) incidents in the supplemental sample to the Department within the required timeframe. KRC's follow-up activities on incidents in the supplemental sample were appropriate for the severity of the situations for all 10 (100 percent) incidents. In addition, KRC reported all deaths of individuals on the HCBS Waiver during the review period.

Findings

SIR #2: The incident occurred on December 16, 2024. However, the vendor did not submit a written report to KRC until December 19, 2024.

SIR #4: The incident occurred on October 11, 2024. However, the vendor did not submit a written report to KRC until October 14, 2024.

Recommendation	Regional Center Plan/Response
KRC should ensure that the vendors for SIR #2 and SIR #4 report special incidents within the required timeframes.	SIR #2: KRC did not complete a CAP for SIR # 2 vendor; however, KRC will ensure that SIRs are completed on time and with the proper documentation through proper corresponding CAP procedures. SIR#4: KRC issued a consultation to SIR #4 for the late reporting to KRC on 02/04/2025. KRC will ensure that SIRs are completed on time and with the proper documentation through proper corresponding CAP procedures.

	KRC did not provide a CAP but did provide a consultation because KRC did not meet it's 10-day reporting timeline to issue a CAP.

SECTION X: SUPPLEMENTARY ISSUE

This section contains any supplementary issues identified by the monitoring team during the review that are not specifically addressed by the standard review protocol criteria or directly related to the individuals selected for the review but should be reviewed and addressed by the regional center.

Comments

None