Tri-Counties 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: February 9–27, 2026

Department of Developmental Services

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SECTION I: REGIONAL CENTER SELF-ASSESSMENT

Tri-Counties Regional Center (TCRC) responded to questions that align with the California Home and Community-Based (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 TCRC is available upon request.

SECTION II: REGIONAL CENTER RECORD REVIEW

For the review period of November 1, 2024, through October 31, 2025, a total of 50 records of individuals enrolled on the Home and Community-Based Services (HCBS) 1915(c) Developmental Disabilities (DD) waiver and receiving services at Tri-Counties Regional Center (TCRC), were reviewed for individual choice, HCBS Settings Rule requirements, notification of proposed action and fair hearing rights, level-of-care, individual program plans (IPP) and periodic reviews and reevaluations of services. In addition, 16 supplemental records of individuals disenrolled from the waiver were reviewed for documentation of either voluntary disenrollment or for being provided with a notice of proposed action prior to disenrollment, if disenrollment from the waiver resulted in a loss of service. Lastly, 10 additional supplemental records were reviewed for documentation that TCRC determined the individual met the HCBS Waiver level-of-care requirements prior to receiving HCBS Waiver supports.

The 50 records reviewed were 96 percent in overall compliance for this review. Findings for 12 criteria are detailed below.

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)]*

Findings

Forty-eight of the fifty (96 percent) sample records of individuals contained a CDER that had been reviewed annually. However, the records for individuals #22 and #40 did not contain documentation that the CDER had been reviewed annually.

2.4 Recommendation	Regional Center Plan/Response
TCRC should assure that the CDER for individuals #22 and #40 is reviewed annually.	TCRC will ensure that the CDERs for individuals #22 and #40 will be reviewed annually. This will be done through a periodic internal review. In addition, this is trained to at new Service Coordinator orientation and discussed at individual team meetings/trainings, Services and Supports Manager meetings and reminders to the Assistant Director Team. TCRC will ensure that all individuals that are on the Med Waiver have their CDERs reviewed and updated on an annual basis. In addition, staff will be reminded of the importance of filing the completed/reviewed CDER into the individual's chart for future accessibility.

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)*

Findings

Forty-eight of the fifty (96 percent) sample records of individuals documented level-of-care assessed needs that were consistent with information in the record. However, the assessed needs listed on the DS 3770 were not consistent in the following records:

1. Individual #23: "Takes medication with supervision" and "outbursts occur at least once a week, but do not typically require intervention." An addendum was completed on February 12, 2026, to address outbursts. A revised CDER and DS 3770 were completed February 23, 2026, to correct the assessed need to "takes medication with reminders." Accordingly, no recommendation is required; and,

2. Individual #32: "Disruptive behavior interferes with social participation at least one a month but not every week" and "chronic periodontitis." An addendum was completed on February 19, 2026, to address the assessed needs listed above. Accordingly, no recommendation is required.

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)]*

Finding

Forty-nine of the fifty (98 percent) sample records of individuals contained documentation that the individual's IPP had been reviewed annually by the planning team. However, for individual #16, there was no documentation that the IPP was reviewed annually. The previous IPP was dated April 5, 2023. The following IPP was not completed until September 17, 2025.

2.6.a Recommendation	Regional Center Plan/Response
TCRC should assure that the IPP for individual #16 is reviewed at least annually by the planning team.	TCRC will ensure that the IPP for individual #16 will be reviewed annually. This will be done through a periodic internal review. In addition, this is trained to at new Service Coordinator orientation and discussed at individual team meetings/trainings, Services and Supports Manager meetings and reminders to the Assistant Director Team. TCRC will ensure refresher training related to this topic occurs by 8/2026.

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

Thirty-four of the thirty-five (97 percent) applicable sample records contained a completed SARF or annual review report. However, the record for individual #40 contained a SARF that was completed late. The IPP was dated September 13, 2024, and the SARF was completed December 11, 2025.

2.6.b Recommendation	Regional Center Plan/Response
TCRC should assure that the SARF for individual #40 is completed during the annual IPP review process.	TCRC will ensure that the SARF for individual #40 will be completed during the annual IPP review process. This will be done through a periodic internal review. In addition, this is trained to at new Service Coordinator orientation and discussed at individual team meetings/trainings, Services and Supports Manager meetings and reminders to the Assistant Director Team. TCRC will ensure refresher training related to this topic occur by 8/2026.

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

Forty-seven of the fifty (94 percent) sample records of individuals contained IPPs that were signed by TCRC and the individuals or, where appropriate, the individual's parents, legal guardian, conservator or the authorized representative. However, there were issues with the following IPPs as indicated below:

1. Individual #4: The IPP dated October 15, 2025, was not signed by the conservator until December 17, 2025. Accordingly, no recommendation is required;

2. Individual #16: The IPP dated September 17, 2025, was not signed by the individual and the regional center until December 19, 2025. Accordingly, no recommendation is required; and,

3. Individual #33: The IPP dated June 6, 2024, was not signed by the conservator until January 13, 2026, and regional center until January 8, 2026. Accordingly, no recommendation is required.

2.7.b IPP addenda are signed by an authorized representative of the regional center and the individual or, where appropriate, the individual's parents, legal guardian, conservator or authorized representative. *[W.I.C. § 4646(g) (2023)]; [42 C.F.R. § 441.301(c)(2)(ix) (2025)]*

Findings

Thirty-one of the thirty-four (91 percent) applicable sample records for individuals contained IPP addenda signed by TCRC and the individual or, where appropriate the individual's parents, legal guardian, conservator or the authorized representative. However, there were issues with the following IPP addenda as indicated below:

1. Individual #28: IPP addendum dated January 8, 2025, was not signed by the individual and regional center until January 9, 2026. Accordingly, no recommendation is required;

2. Individual #32: IPP addendum dated September 30, 2025, was not signed by the individual until December 9, 2025. Accordingly, no recommendation is required; and,

3. Individual #39: IPP addendum dated October 14, 2025, was not signed by individual and regional center until January 7, 2026. Accordingly, no recommendation is required.

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 Waiver Requirement)*

Findings

Forty-seven of the fifty (94 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:

1. Individual #25: The IPP dated April 16, 2024, did not address the assessed need "outbursts". An addendum was completed February 12, 2026, to address the assessed need. Accordingly, no recommendation is required;

2. Individual #32: The IPP dated March 18, 2025, did not address the assessed need "14- Other special treatment/testing requirement." An addendum dated December 23, 2025, and a CDER dated March 18, 2025, were corrected to remove the assessed need. Accordingly, no recommendation is required; and,

3. Individual #49: The IPP dated February 3, 2025, did not address the assessed need "physical aggression." An addendum was completed on February 10, 2026, to address the assessed need. Accordingly, no recommendation is required.

2.9.b The IPP addresses special health care requirements and safety risks. *[W.I.C. § 4646.5(a)(2) (2023)]; [42 C.F.R. § 441.301(c)(2)(vi) (2025)]*

Findings

Seventeen of the nineteen (90 percent) applicable sample IPPs for individuals addressed the individuals' special health care requirements and safety risks. However, IPPs for the following individuals did not address the special health care requirements and safety risks identified below:

1. Individual #31: "71- Other Health Requirement – not listed." A CDER dated November 18, 2025, was corrected to remove the special health care requirement. Accordingly, no recommendation is required; and,

2. Individual #32: "14- Other Special Treatment/Testing Requirement." An addendum dated December 23, 2025, and a CDER dated March 18, 2025, were corrected to remove the assessed need. Accordingly, no recommendation is required.

2.9.d The IPP reflects the services and supports that will assist the individual to achieve identified goals, and the providers of those services and supports. The vendor shall be responsible for establishing, maintaining, and modifying, as necessary, documentation regarding the manner in which it will assist each individual in achieving the individual's IPP objective(s) for which the vendor is responsible. *[42 C.F.R. § 441.301(c)(2)(v) (2025)]; [Cal. Code. Regs tit 17, § 56720(a) (2023)]*

Finding

Twenty-two of the twenty-three (96 percent) applicable sample records of individuals contained IPPs that addressed the individuals' day program services. However, the IPP for individual #9 did not address the services which the day program provider is responsible for implementing. An addendum was completed February 24, 2026, to address the day program services. Accordingly, no recommendation is required.

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

Findings

Forty-two of the fifty (84 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 IPPs did not include TCRC funded services as indicated below:

1. Individual #2: Adult Development Center and Special Residential Facility were not included for the months November 2024 through January 2025 in the triennial IPPs dated August 10, 2021, and February 3, 2025. Addenda were completed

December 17, 2025, and February 12, 2026, to address the purchased services. Accordingly, no recommendation is required;

2. Individual #9: Transportation was not included for the months November 2024 through June 2025 in the triennial IPP dated October 16, 2023. An addendum was completed February 24, 2026, to address the purchased service. Accordingly, no recommendation is required;

3. Individual #12: In-home Respite was not included for the months November 2024, and April 2025 through May 2025 in the triennial IPP dated May 23, 2023. An addendum was completed February 13, 2026, to address the purchased service. Accordingly, no recommendation is required;

4. Individual #14: Adult Development Center was not included for the month of October 2025, Independent Living Services was not included for the months of November 2024 and October 2025, and Licensed Vocational Nurse was not included for the months March 2025 through October 2025 in the triennial IPP dated December 10, 2024. Addenda dated July 21, 2025, and September 22, 2025, were corrected and an IPP addenda was completed February 10, 2025, to address the purchased services. Accordingly, no recommendation is required;

5. Individual #17: Participant Directed Day Care Services was not included for the month of May 2025 in the triennial IPPs dated January 25, 2022, and August 6, 2025. An addendum was completed February 17, 2026, addressing the purchased service. Accordingly, no recommendation is required;

6. Individual #23: Community Integration Training Program was not included for the months of December 2024 through March 2025 in the triennial IPP dated March 19, 2024. An addendum dated November 20, 2024, was corrected to address the purchased service. Accordingly, no recommendation is required;

7. Individual #30: Crisis Team was not included for the months September 2025 through October 2025 in the triennial IPP dated May 5, 2023. A revised signature page was corrected on February 17, 2026, to reflect accurate end dates of the purchased service. Accordingly, no recommendation is required; and,

8. Individual #45: Financial Management Service Fiscal/Employer Agent type and amount was not included in the IPPs dated October 14, 2023, and October 30, 2025. A revised signature page was corrected on February 11, 2026, to address the purchased service. Accordingly, no recommendation is required.

2.10.a Recommendation	Regional Center Plan/Response
TCRC should evaluate what actions may be necessary to assure that IPPs include a schedule of the type and amount of all services and supports purchased by TCRC.	Service Coordinator and Managers will compare IPPs and purchase of service at time of implementation to ensure that all purchases of services have been incorporated accurately into the IPP. Should an error be found, Service Coordinator will complete necessary corrections.

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

Twenty-six of the thirty-four (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 #1, #6, #20, #25, #27, #29, and #35 contained documentation of three of the four required meetings that were consistent with the quarterly timeline; and,

2. The record for individual #33 contained documentation of one of the four required meetings that were consistent with the quarterly timeline.

2.12.a Recommendations	Regional Center Plan/Response
TCRC should assure that all future face-to-face meetings are completed and documented each quarter for individuals #1, #6, #20, #25, #27, #29, #33, and #35.	TCRC will ensure that all future face-to-face meetings are completed and documented each quarter for individuals #1, #6, #20, #25, #27, #29, #33, and #35.

Further action is required by TCRC to assure that quarterly face-to-face meetings are completed and documented for all applicable individuals.	TCRC will monitor this through monitoring of TCRC's Service Coordinator JeffNet dashboard as well as the Quarterly/Annual review dashboard. This is trained to at new Service Coordinator orientation and discussed at individual team meetings/trainings, Services and Supports Manager meetings. In addition, Service and Supports managers will audit to this during annual recertification. TCRC will ensure refresher training related to this topic occur by 8/2026.

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

Twenty-five of the thirty-four (74 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 requirement as indicated below:

1. The records for individuals #1, #6, #20, #25, #27, #29, #35, and #41 contained documentation of three of the four required quarterly reports of progress that were consistent with the quarterly timeline; and,

2. The record for individual #33 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
TCRC should assure that future quarterly reports of progress are completed for individuals #1, #6, #20, #25, #27, #29, #33, #35, and #41.	TCRC will ensure that all future face-to-face meetings are completed and documented each quarter for individuals #1, #6, #20, #25, #27, #29, #33, #35, and #41.

Further action is required by TCRC to assure that quarterly face-to-face meetings are completed and documented for all applicable individuals.	TCRC will monitor this through monitoring of TCRC's Service Coordinator JeffNet dashboard as well as the Quarterly/Annual review dashboard. This is trained to at new Service Coordinator orientation and discussed at individual team meetings/trainings, Services and Supports Manager meetings. In addition, Service and Supports managers will audit to this during annual recertification. TCRC will ensure refresher training related to this topic occur by 8/2026.

New Enrollee Findings

All 10 records (100 percent) contained a DS 3770 documenting that the level-of-care was determined prior to the receipt of HCBS DD services.

Disenrollment Findings

Of the 16 records reviewed, there was one disenrollment that resulted in a loss of service. This record was evaluated for the waiver disenrollment criteria. The one record (100 percent) contained a DS 2200 documenting that the individual, and/or their legal guardian/representative, chose to terminate their Medicaid Waiver participation.

SECTION III: COMMUNITY CARE FACILITY RECORD REVIEW

The monitoring team visited five community care facilities (CCF) and reviewed six individual records for individuals supported by Tri-Counties Regional Center (TCRC) 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 six 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 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 six (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 #3 at CCF #2;
3. Individual #8 at CCF #2;
4. Individual #4 at CCF #3;
5. Individual #5 at CCF #4; and,

6. Individual #11 at CCF #5.

3.2.b Recommendations	Regional Center Plan/Response
TCRC should assure that individual file records maintained by CCF #1 for individual #1, CCF #2 for individuals #3 and #8, CCF #3 for individual #4, CCF #4 for individual #5, and CCF #5 for individual #11 contain documentation of agreement for eviction procedures and appeals process.	TCRC has updated the TCRC Residential Admission Agreement to include information on eviction procedures and individual appeal rights. The updated TCRC Residential Admission Agreement will be provided to the Department and made available to the TCRC Service Coordinators for all future residential placements. New Residential Admission Agreements will be completed for individuals #1, #3, #4, #5, #8, and #11.
In addition, TCRC should assure that individual file records maintained by all CCFs contain documentation of agreement for eviction procedures and appeals process.	The updated admission agreement will be used for all new residential placements. Additionally, during the HCBS review visits, the TCRC Quality Assurance team will ensure all residential admission agreements reviewed include information on eviction procedures and appeal rights to ensure compliance in this area is met. If an admission agreement does not meet this requirement, the TCRC Quality Assurance team member will work collaboratively with the provider to remediate the issue in a timely manner. If remediation is not met by the designated timeline, a corrective action plan will be issued within ten (10) days of the finding of non-compliance.

SECTION IV: DAY PROGRAM RECORD REVIEW

The monitoring team visited seven day programs (DP) and reviewed 10 records for individuals supported by Tri-Counties Regional Center (TCRC) who are receiving services from those day programs. The monitoring team reviewed the records to assure 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 10 records reviewed were 93 percent in overall compliance for 12 criteria. Findings for four criteria are detailed below.

4.1.c The individual's record contains psychological, social, or medical evaluations provided by the regional center that identify the individual's ability and functioning level. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(C) (2023)]*

Finding

Nine of the ten (90 percent) sample records for individuals contained documentation that the individuals' records contained psychological, social, or medical evaluations provided by the regional center that identified the individuals' abilities and functioning levels. However, the record for individual #31 at DP #7 did not contain any current psychological, social, or medical evaluations provided by the regional center that identified the individual's ability and functioning level.

4.1.c Recommendation	Regional Center Plan/Response
TCRC should assure the record for individual #31 at DP #7 contains current documentation of psychological, social, or medical evaluations provided by the regional center that identifies the individuals' ability and functioning level.	Service Coordinator for individual #31 will work with the Day Program to ensure that the Day Program has all proper documentation on file related to the individual. Service Coordinator will provide the Day Program with appropriate documentation by 5/31/2026.

4.1.d The individual's record contains authorization for emergency medical treatment signed by the individual and/or the authorized representative of the individual. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(D) (2023)]*

Findings

Seven out of the ten (70 percent) sample records for individuals contained documentation of authorization for emergency medical treatment signed by the

individual and/or the authorized representative of the individual. However, the following records did not meet the requirement as indicated below:

1. The record for individual #17 at DP #3 contained an authorization for emergency medical treatment that was signed by the individual's parent, but not the individual, who is not conserved;

2. The record for individual #26 at DP #6 did not contain an authorization for emergency medical treatment. A signed copy was provided on February 18, 2026. Accordingly, no recommendation is required; and,

3. The record for individual #32 at DP #7 contained an authorization for emergency medical treatment that was signed by the individual, but not the individual's conservator.

4.1.d Recommendations	Regional Center Plan/Response
TCRC should assure the records for individuals #17 at DP #3 and individual #32 at DP #7 contains an authorization for emergency medical treatment that is signed by the individual and/or the authorized representative of the individual.	Service Coordinator for individuals #17 and #32 will work with the Day Program to ensure that the Day Program has authorizations for emergency medical treatment on file and appropriately signed by the individual and/or the authorized representative of the individual. Service Coordinator will work with the Day Program to ensure this occurs by 5/31/2026.
In addition, TCRC should assure that individual file records maintained by all DPs contain authorization for emergency medical treatment signed by the individual and/or the authorized representative of the individual.	The TCRC Quality Assurance team will conduct monitoring of all day service settings subject to the Home and Community-Based Services (HCBS) requirements at least annually. As part of these reviews, Quality Assurance staff will review a sample of individual records and verify that the required emergency medical treatment form is completed and signed by the individual and/or their authorized representative.

4.1.e The individual's record contains documentation that the individual and/or the authorized representative for the individual has been informed of his/her personal rights including an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(E)]; [42 C.F.R. § 441.301(c)(4)(iii)]*

Findings

Eight of the ten (80 percent) sample records for individuals contained documentation that the individual and/or their authorized representative had been informed of their personal rights. However, the following records did not meet the requirement as indicated below:

1. The record for individual #17 at DP #3 contained a personal rights form that was signed by the individual's parent, but not the individual, who is not conserved; and,

2. The record for individual #26 at DP #6 did not have documentation that the individual and/or their authorized representative had been informed of their personal rights. A signed copy was provided on February 18, 2026. Accordingly, no recommendation is required.

4.1.e Recommendations	Regional Center Plan/Response
TCRC should assure the record for individual #17 at DP #3 contains documentation that the individual and/or their authorized representative have been informed of their personal rights.	Service Coordinator for individuals #17 will work with the Day Program to ensure that the Day Program has documentation on file that the individual and/or their authorized representative have been informed of their personal rights. Service Coordinator will work with the Day Program to ensure this occurs by 5/31/2026.
In addition, TCRC should assure that individual file records maintained by all DPs contain documentation that the individual and/or their authorized representative have been informed of their personal rights.	The TCRC Quality Assurance team will conduct monitoring of all day service settings subject to the Home and Community-Based Services (HCBS) requirements at least annually. As part of these reviews, Quality Assurance staff will review a sample of individual records and verify that the required personal rights form has been properly completed and signed by the individual and/or their authorized representative.

4.2 The day program has a copy of the individual's current IPP. *[Cal. Code. Regs tit. 17, § 56730)(c)(1)(F)]*

Finding

Nine of the ten (90 percent) sample records of individuals contained a copy of the individual's current IPP. However, the record for individual #31 at DP #7 did not contain a copy of their current IPP.

4.2 Recommendation	Regional Center Plan/Response
TCRC should assure that the records for individual #31 at DP #7 contain a current copy of the individual's IPP.	Service Coordinator for individuals #31 will work with the Day Program to ensure that the Day Program has a copy of the individual's current IPP file. Service Coordinator will work with the Day Program to ensure this occurs by 5/31/2026.

SECTION V: OBSERVATIONS AND INTERVIEWS WITH INDIVIDUALS

Thirty of the fifty individuals supported by Tri-Counties Regional Center (TCRC), 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

Twenty-nine of the thirty 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 the individuals that were interviewed and observed reflected personal choice and individual style. However, individual #27 was dissatisfied with their current level of independent living services (ILS) support.

Recommendation	Regional Center Plan/Response
TCRC should follow up with individual #27 regarding concerns with their ILS support.	Findings from interview will be shared with Service Coordinator, Services and Supports Manager, and Assistant Director of Services and Supports for individual #27. Service Coordinator will reach out to individuals/families in order to schedule a planning team meeting to address concerns by 5/31/2026.

SECTION VI: REGIONAL CENTER STAFF INTERVIEWS

SECTION VI A: SERVICE COORDINATOR INTERVIEWS

The monitoring team interviewed 10 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 clinical director and psychologist to assure 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 assures 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 lead quality assurance specialist 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 five community care facilities (CCF) and seven day programs. The interviews determined that 11 of the 12 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 assure 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. However, the interview with the CCF administrator for individual #3 did not meet the criteria for federal requirement #7 as indicated below:

7.A.10.a Privacy (Federal Requirement #7)

Finding

CCF #2 for individual #3: Individual did not have a lock on their bedroom door and no modification was documented in their current IPP. Tri-Counties Regional Center submitted an addendum dated February 19, 2026, which addresses the modification for Federal Settings Requirement #7. Accordingly, no recommendation is required.

SECTION VII B: DIRECT SUPPORT PROFESSIONALS INTERVIEWS

The monitoring team interviewed direct support professionals at five CCFs and seven 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 five community care facilities (CCF) and seven 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.

The 12 vendors reviewed were 95 percent in overall compliance for this review and 93 percent compliance for the HCBS Settings requirements. Findings for three criteria are detailed below.

8.3.b Federal Requirement #3: Individual Rights

The individual's record contains documentation that the individual and/or the authorized representative for the individual has been informed of his/her personal rights including an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. *[Cal. Code. Regs tit. 17, § 56730(c)(1)(E) (2023)]; [42 C.F.R. § 441.301(c)(4)(iii) (2025)]*

Findings

See finding and recommendation for the vendors' non-compliance detailed in day program record review, criterion 4.1.e.

8.6 Federal Requirement #6: Residential Agreement

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 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 C.F.R. § 441.301(c)(4)(vi)(A)]*

Findings

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

8.7.a Federal Requirement #7: Privacy

Bedroom doors are lockable by the individual with only appropriate staff having keys to doors. *[42 C.F.R. § 441.301(c)(4)(vi)(B)(1) (2025)]*

Finding

Four of the five (80 percent) community care facilities had locks on bedroom doors with a process in place for only appropriate staff to have access to keys. However, individual #3, at CCF #2, did not have a lock on their bedroom door and no modification was documented in their current IPP. Tri-Counties Regional Center (TCRC) submitted an addendum dated February 19, 2026, which addresses the modification for Federal Settings Requirement #7. Accordingly, no recommendation for individual #3 is required.

8.7.a Recommendation	Regional Center Plan/Response
TCRC should assure that CCFs have locks on bedroom doors with a process in place for only appropriate staff to have access to keys. If there is no lock on an individual's bedroom door, there is a modification documented in their current IPP.	The TCRC Quality Assurance team members will monitor all licensed residential settings required to meet the HCBS requirements, at minimum, on an annual basis. During the HCBS on-site monitoring reviews, the Quality Assurance team member will ensure all individual's bedrooms have a lockable door with only the resident and appropriate staff having access to the key. If there is no lock on a bedroom door and there is no modification documented in the IPP, the TCRC Quality Assurance team member will work collaboratively with the provider to remediate the issue in a timely manner. If remediation is not met by the designated timeline, a corrective action plan will be issued within ten (10) days of the finding of non-compliance.

SECTION IX: SPECIAL INCIDENT REPORTING

The records of the 50 individuals supported by Tri-Counties Regional Center (TCRC) and selected for the Home and Community-Based Services 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. If applicable, the monitoring team verified that an incident report was completed for all individuals on the HCBS Waiver supported by TCRC who passed away during the review period.

Summary of Findings

Tri-Counties Regional Center (TCRC) reported all special incidents in the sample of 50 records selected for the HCBS 1915(c) DD Waiver review to the Department. TCRC's vendors reported seven of the 10 (70 percent) incidents in the supplemental sample to the regional center within the required timeframes. TCRC reported all (100 percent) incidents in the supplemental sample to the Department within the required timeframe. TCRC's follow-up activities on incidents in the supplemental sample were appropriate for the severity of the situations for all (100 percent) incidents.

Findings

1. SIR #6: The incident occurred on July 7, 2025. However, the vendor did not submit a written report to TCRC until July 29, 2025;

2. SIR #9: The incident occurred on January 2, 2025. However, the vendor did not submit a written report to TCRC until January 6, 2025; and,

3. SIR #10: The incident occurred on July 1, 2025. However, the vendor did not submit a written report to TCRC until July 16, 2025.

Recommendations	Regional Center Plan/Response
TCRC should assure that the vendors for SIR #6, SIR #9 and SIR #10 report special incidents within the required timeframes.	The TCRC Quality Assurance team members will inform the vendors for SIR #6, SIR #9 and SIR #10 of the need for timely reporting and ensure the vendors receive the necessary information or training to ensure reporting timelines are met moving forward. TCRC will continue to work with vendors to ensure timely submission of SIRs to the Regional Center. When SIRs are received late, the Risk Management team as well as the Quality Assurance team will collaborate to follow up with the vendors as necessary.
In addition, TCRC should assure that their vendors report all special incidents to the regional center within the required timeframe.	The TCRC Quality Assurance team will work collaboratively with the TCRC Services & Supports team members to ensure vendor compliance with reporting special incidents within the required timeframe. When concerns are identified, the team members will provide technical assistance. TCRC will follow up with the specific vendors related to SIR reporting guidelines by end of May 2026.

SECTION X: SUPPLEMENTARY ISSUES

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

Section II: Regional Center Record Review

During the record review for the Home and Community-Based Services 1915(c) Developmental Disabilities Waiver, it was observed that there was an inaccuracy between the date coverage of the purchased service coverage for Supported Living Services (SLS) in the body of the individual program plan (IPP) dated February 13, 2024, and its corresponding signature page for individual #34. In the body of the IPP, SLS is covered from February 1, 2024, through January 31, 2027. However, on the signature page, SLS is covered from August 1, 2023, through January 31, 2024.

Recommendation	Regional Center Plan/Response
TCRC should assure that the date coverages for purchased services are consistent between the IPP and the IPP signature page for individual #34.	TCRC will ensure that the IPP and the IPP signature page for individual #34 is consistent between documents. Service Coordinators and managers will ensure this is completed through a periodic internal review. Service Coordinator and Managers will compare IPPs and IPP Signature Page at time of implementation to ensure that all purchase of service dates are aligned and have been incorporated accurately into the IPP. Should an error be found, Service Coordinator will complete necessary corrections.

8.7.a Federal Requirement #7: Privacy

Bedroom doors are lockable by the individual with only appropriate staff having keys to doors. *(Title 42, CFR, § 441.301(c)(4)(vi)(B)(1))*

During the monitoring review site visit at Community Care Facility #2, the monitoring team observed that two of the residents' doors, who were not a part of the sample, did not contain locks. When pointed out, the service provider and quality assurance staff

confirmed there were no modifications in place in the individuals' individual program plans. Addenda dated February 19, 2026, were completed for both individuals, documenting the modifications in place. Accordingly, no recommendation is required.