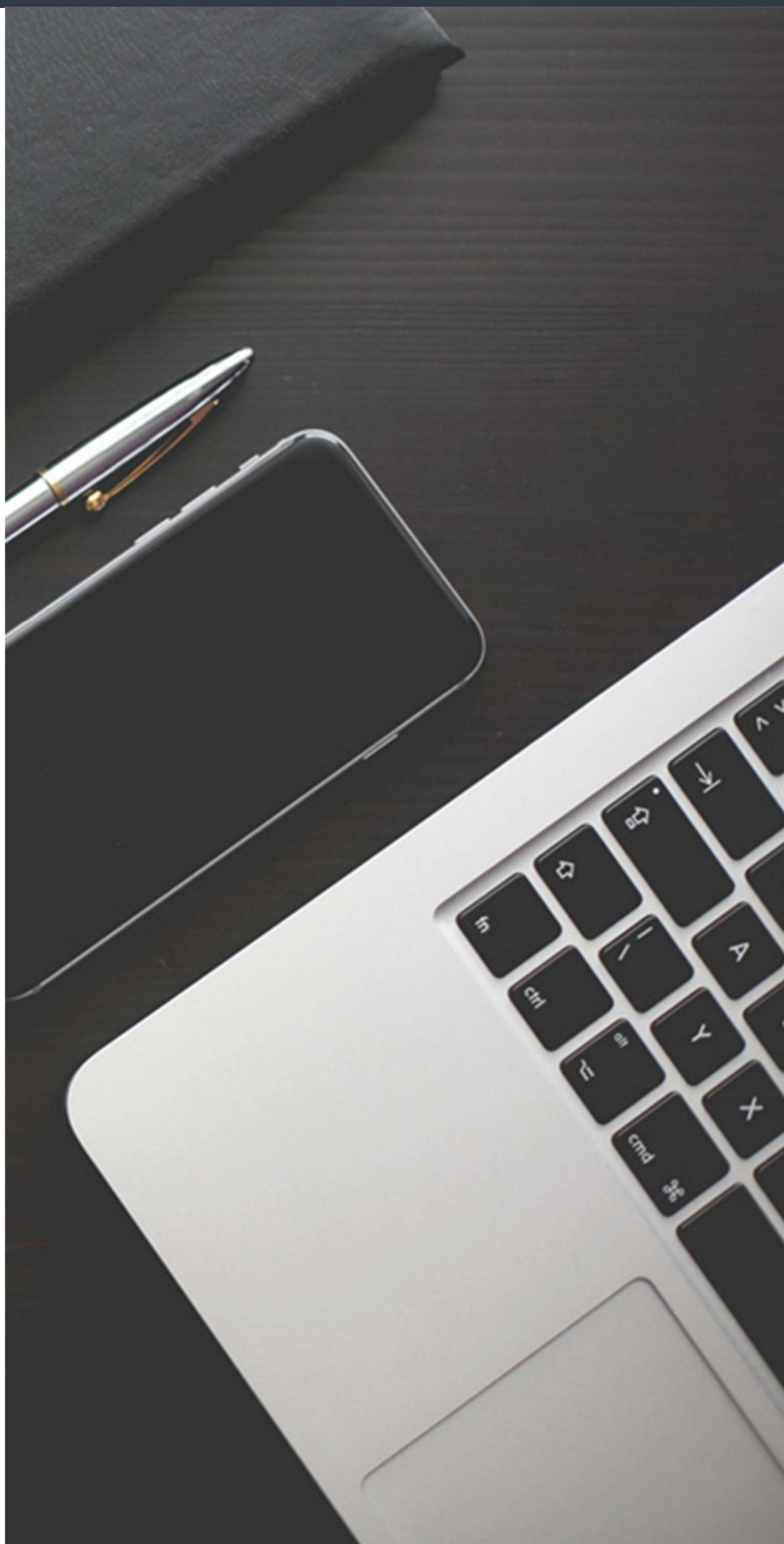
North Los Angeles County Regional Center Home and Community-Based Services 1915c Developmental Disabilities Waiver, Self- Determination Program Waiver, and 1915i State Plan Amendment Follow-Up Review Report



Conducted by: Department of Developmental Services

Review Date: August 25, 2025

DDS Department of Developmental Services

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SECTION I: REGIONAL CENTER RECORD REVIEW

The Department of Developmental Services conducted a follow-up review on the Home and Community-Based Services 1915(c) Developmental Disabilities (DD) Waiver, the Home and Community-Based Services 1915(c) Self-Determination Program (SDP) Waiver and 1915(i) State Plan Amendment (SPA) with North Los Angeles County Regional Center (NLACRC) on August 25, 2025, to ensure that issues raised during the collaborative review completed July 2024, have been addressed. For the review period of June 1, 2024, through May 30, 2025, 20 records for the 1915(c) DD Waiver, 20 records for the 1915(c) SDP Waiver, and 20 records for the 1915(i) SPA were selected to assess performance on the criteria detailed in the areas below.

1915(c) Developmental Disabilities Waiver Follow-Up Review Findings

2.2 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

Sixteen of the twenty (80 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 July 28, 2025. Accordingly, no recommendation is required;
2. Individual #15: The DS 2200 was not signed until July 23, 2025. Accordingly, no recommendation is required;
3. Individual #16: The DS 2200 was not signed until August 13, 2025. Accordingly, no recommendation is required; and,
4. Individual #18: The DS 2200 was not signed until August 7, 2025. Accordingly, no recommendation is required.

2.2 Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that the DS 2200 forms are properly signed and dated.	**The importance of ensuring the DS2200 is completed and documented by all individuals enrolled on the HCBS Waiver was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in**

	routine supervision meetings, as well as upon review of Medicaid Waiver cases. Supervisors will continue to discuss and ensure compliance with completion of DS2200 Forms. **Continued training will be provided to Service Coordinators and Supervisors regarding the timely completion of DS2200 Forms. CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.** **A designated email address (e.g. HCBSwaiver@nlacrc.org) was created specifically for our Medicaid Waiver Department to send encrypted emails with DS2200 Choice Forms to individuals/families for signature and return in addition to mailing through the United States Postal Service. Detailed letters sent to individuals/families to include a request to return document within a 30-day timeline. Service Coordinators to ensure receipt of completed DS2200 Choice Forms.**

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

Fourteen of the twenty (70 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 #8: The IPP was dated August 2, 2023. There was no documentation that an annual review of the IPP was conducted in 2024;

2. Individual #13: There was no IPP available covering the review period. There was no documentation that an annual review of the IPP was conducted in 2024;

3. Individual #14: The IPP was dated December 14, 2023. There was no documentation that an annual review of the IPP was conducted in 2024. An annual review was not completed until March 18, 2025;

4. Individual #15: The IPP was dated September 2, 2020. An annual review of the IPP was completed on September 7, 2022. There was no documentation that an annual review of the IPP was conducted in 2023. An IPP was not completed until August 22, 2024;

5. Individual #17: The IPP was dated June 23, 2022. An annual review of the IPP was completed on March 14, 2023. An annual review was not completed until June 18, 2024; and,

6. Individual #19: The IPP was dated November 29, 2022. There was no documentation that an annual review of the IPP was conducted in 2023. An IPP was not completed until July 8, 2024.

2.6.a Recommendation	Regional Center Plan/Response
NLACRC should ensure that IPPs for individuals #8, #13, #14, #15, #17, and #19 are reviewed at least annually by the planning team.	**The importance of timely/annual IPP renewal documentation (from the date of IPP, not the birth month) was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases. Supervisors will continue to discuss and ensure compliance with timely/annual IPP renewal documentation (from the date of IPP, not the birth month).** **Continued training will be provided to Service Coordinators and Supervisors regarding the timely/annual IPP renewal documentation (from the date of IPP, not the birth month). CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards,**

	which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026. **In addition, NLACRC has implemented a tracking database, Power BI Caseload Reports, to assist Case Management with DDS compliance. Power BI Caseload Reports now can track reports from month and year of completion and not the birth month.**
In addition, NLACRC should evaluate what actions may be necessary to ensure that IPPs are reviewed annually.	**The importance of timely/annual IPP renewal documentation (from the date of IPP, not the birth month) was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases. Supervisors will continue to discuss and ensure compliance with timely/annual IPP renewal documentation (from the date of IPP, not the birth month).** **Continued training will be provided to Service Coordinators and Supervisors regarding the timely/annual IPP renewal documentation (from the date of IPP, not the birth month). CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.** **In addition, NLACRC has implemented a tracking database, Power BI Caseload Reports, to assist Case Management with DDS compliance. Power BI Caseload Reports now can track reports**

	from month and year of completion and not the birth month.

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

Finding

Nineteen of the twenty (95 percent) applicable sample records contained a completed SARF or annual review report. However, individual #3 did not contain a SARF for the annual review dated September 18, 2024.

2.13.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 (CCF), family home agencies (FHA), or supported living and independent living settings. *[Cal. Code. Regs tit. 17, § 56047 (2023)]; [Cal. Code. Regs tit. 17, § 56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 023)]; (Contract requirement)*

Findings

Twelve of the twenty (60 percent) applicable sample records of individuals contained quarterly face-to-face meetings completed and documented. However, the following records did not meet the requirement as indicated below:

1. The records for individuals #4, #5, #6, #7, and #16 contained documentation of three of the four required meetings that were consistent with the quarterly timeline;

2. The record for individual #1 contained documentation of two of the four required meetings that were consistent with the quarterly timeline; and,

3. The record for individual #14 contained documentation of one of the four required meetings that were consistent with the quarterly timeline.

4. The record for individual #13 did not contain documentation of any of the four required meetings that were consistent with the quarterly timeline.

2.13.a Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that quarterly face-to-face meetings are completed for all applicable individuals.	**Continuous training regarding the importance of timely face-to-face quarterlies is being provided to Service Coordinators, Supervisors, and Directors**

	at unit meetings and Case Management Leadership Meetings. **The importance of timely quarterly face-to-face meetings and progress reports was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases. Supervisors will continue to discuss and ensure compliance with timely face to face quarterlies within their caseloads. CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.** **Supervisors to ensure implementation of monitoring timely completion of face-to-face quarterly meetings during scheduled supervision with each Service Coordinator.** **The Floater Service Coordinator position was implemented to provide support for uncovered caseloads to ensure compliance.** **Lastly, NLACRC has implemented a tracking database, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

2.13.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 (CCF), family home agencies (FHA), or supported living and independent living settings. *[Cal. Code. Regs tit. 17, § 56047 (2023)]; [Cal. Code. Regs tit. 17, § 56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 (2023)]; (Contract requirement)*

Findings

Twelve of the twenty (60 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 #4, #5, #6, #7, and #16 contained documentation of three of the four required reports of progress that were consistent with the quarterly timeline;

2. The record for individual #1 contained documentation of two of the four required reports of progress that were consistent with the quarterly timeline; and,

3. The record for individual #14 contained documentation of one of the four required reports of progress that were consistent with the quarterly timeline.

4. The record for individual #13 did not contain any documentation of any of the four required reports of progress that were consistent with the quarterly timeline.

2.13.b Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that quarterly reports of progress are completed for all applicable individuals.	**Continuous training regarding the importance of timely face-to-face quarterly meetings and reports is being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings.** **The importance of timely quarterly face-to-face meetings and progress reports was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases. Supervisors will continue to discuss and ensure compliance with timely face to face quarterlies within their caseloads.** **CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.**

	Supervisors to ensure implementation of monitoring timely completion of face-to-face quarterly meetings and reports during scheduled supervision with each Service Coordinator. **The Floater Service Coordinator position was implemented to provide support for uncovered caseloads to ensure compliance.** **Lastly, NLACRC has implemented a tracking database, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

Summary of Results for the 1915(c) Developmental Disabilities Waiver Follow-Up Review

The results of the August 2025 follow-up review indicate that the issues identified during the regular biennial monitoring review in August 2024 require further action to ensure quarterly face-to-face meetings and reports of progress are completed for individuals living in community out-of-home settings, i.e., Service Level 2-7 community care facilities (CCF), family home agencies (FHA), or supported living and independent living settings.

1915(c) Self Determination Waiver Follow-Up Review Findings

2.2 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

Twelve of the twenty (60 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:

5. Individual #1: The DS 2200 was not signed until July 28, 2025. Accordingly, no recommendation is required;

6. Individual #11: The individual served did not sign and date, or indicate choice of living arrangement on the DS 2200;

7. Individual #14: The DS 2200 was not signed until July 31, 2025. Accordingly, no recommendation is required;

8. Individual #15: The DS 2200 was not signed until July 28, 2025. Accordingly, no recommendation is required.

9. Individual #16: The DS 2200 was not signed until July 25, 2025. Accordingly, no recommendation is required;

10. Individual #17: The DS 2200 was not signed until August 6, 2025. Accordingly, no recommendation is required;

11. Individual #19: The DS 2200 was not signed until September 9, 2025. Accordingly, no recommendation is required; and,

12. Individual #20: The DS 2200 was not signed until August 14, 2025. Accordingly, no recommendation is required.

2.2 Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that the DS 2200 forms are properly signed and dated.	**The importance of ensuring the DS2200 is completed and documented by all individuals enrolled on the SDP Waiver was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of Medicaid Waiver cases. Supervisors will continue to discuss and ensure compliance with proper completion of DS2200 Forms.** **Continued training will be provided to Service Coordinators and Supervisors regarding the timely completion of DS2200 Forms. CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.**

	A designated email address (e.g. HCBSwaiver@nlacrc.org) was created specifically for our Medicaid Waiver Department to send encrypted emails with DS2200 Choice Forms to individuals/families for signature and return in addition to mailing through the United States Postal Service. Detailed letters are sent to individuals/families to include a request to return document within a 30-day timeline. Service Coordinators to ensure receipt of completed DS2200 Choice Forms.

2.7.a The IPP is prepared jointly with the planning team and 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)]*

Finding

Nineteen of the twenty (95 percent) applicable sample records of individuals contained IPPs that were signed by NLACRC and the individuals, or their legal representatives. However, the IPP for individual #9 dated September 26, 2024, was not signed by the individual and the regional center until August 1, 2025. 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
None

2.11.c The IPP team determines that an adjustment to this amount is necessary due to a change in the participant's circumstances, needs, or resources that would result in an increase or decrease in purchase of service expenditures, or the IPP team identifies prior needs or resources that were unaddressed in the IPP, which would have resulted in an increase or decrease in purchase of service expenditures. When adjusting the budget, the IPP team shall document the specific reason for the adjustment in the IPP. *[W.I.C. § 4685.8(m)(1)(A)(ii)(I) (2023)]*

Findings
None

2.13.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 (CCF), family home agencies (FHA), or supported living and independent living settings. *[Cal. Code. Regs tit. 17, § 56047 (2023)]; [Cal. Code. Regs tit. 17, § 56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 023)]; (Contract requirement)*

Findings

Twelve of the twenty (60 percent) applicable sample records of individuals contained quarterly face-to-face meetings completed and documented. However, the following records did not meet the requirement as indicated below:

1. The records for individuals #2, #3, #17, and #18 contained documentation of three of the four required meetings that were consistent with the quarterly timeline;

2. The records for individuals #5, and #16 contained documentation of two of the four required meetings that were consistent with the quarterly timeline; and,

3. The records for individuals #11, and #20 contained documentation of one of the four required meetings that were consistent with the quarterly timeline.

2.13.a Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that quarterly face-to-face meetings are completed for all applicable individuals.	**The importance of timely quarterly face-to-face meetings and progress reports was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases. Supervisors will continue to discuss and ensure compliance with timely face to face quarterlies within their caseloads.** **CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.**

	Supervisors to ensure implementation of this HCBS Waiver requirement for meetings/reports to occur based on the date of the IPP by monitoring timely completion of face-to-face quarterly meetings and reports when meeting with CSCs for supervision and upon review of cases. **The Floater Service Coordinator position was implemented to provide support for uncovered caseloads to ensure compliance.** **Lastly, NLACRC has implemented a tracking database, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

2.13.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 (CCF), family home agencies (FHA), or supported living and independent living settings. *[Cal. Code. Regs tit. 17, § 56047 (2023)]; [Cal. Code. Regs tit. 17, § 56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 (2023)]; (Contract requirement)*

Findings

Twelve of the twenty (60 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 #2, #3, #17, and #18 contained documentation of three of the four required reports of progress that were consistent with the quarterly timeline;

2. The records for individuals #5, and #16 contained documentation of two of the four required reports of progress that were consistent with the quarterly timeline; and,

3. The records for individuals #11, and #20 contained documentation of one of the four required reports of progress that were consistent with the quarterly timeline.

2.13.b Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that quarterly reports of progress are completed for all applicable individuals.	**The importance of timely quarterly face-to-face meetings and progress reports was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review**

	with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases. Supervisors will continue to discuss and ensure compliance with timely face-to-face quarterlies as well as timely completion of the reports within their caseloads. **CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.** **Supervisors to ensure implementation of this HCBS/SDP Waiver requirement for meetings/reports to occur based on the date of the IPP by monitoring timely completion of face-to-face quarterly meetings and reports when meeting with CSCs for supervision and upon review of cases.** **The Floater Service Coordinator position was implemented to provide support for uncovered caseloads to ensure compliance.** **Lastly, NLACRC has implemented a tracking database, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

Summary of Results for the 1915(c) SDP Waiver Follow-Up Review

The results of the August 2025 follow-up review indicate that the issues identified during the regular biennial monitoring review in August 2024 require further action to ensure quarterly face-to-face meetings and reports of progress are completed for individuals living in community out-of-home settings, i.e., Service Level 2-7 community care facilities (CCF), family home agencies (FHA), or supported living and independent living settings.

1915(i) State Plan Amendment Follow-Up Review Findings

1.3 The IPP for every individual is reviewed, and revised as appropriate, 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

Eighteen of the twenty (90 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 two individuals were reviewed annually as indicated below:

1. Individual #11: The IPP was dated August 31, 2022. There was no documentation that an annual review of the IPP was conducted in 2023; and,

2. Individual #16: The IPP was dated December 18, 2023. There was no documentation that the IPP was reviewed annually. An annual review was not completed until March 24, 2025.

1.3 Recommendation	Regional Center Plan/Response
NLACRC should ensure that IPPs for individuals #11, and #16 are reviewed at least annually by the planning team.	**The importance of timely/annual IPP review documentation was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases.**

1.7.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)]*

Finding

Nineteen of the twenty (95 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 IPP for individual #15 did not include Community Integration Training Program for the months June 2024 through December 2024. An addendum was completed on August 14, 2025, addressing the purchased service. Accordingly, no recommendation is required.

1.9 Periodic reviews and reevaluations of progress for the individual 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. *[W.I.C § 4646.5(a)(6) (2023)]*

Findings
None

1.9.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 (CCF), family home agencies (FHA), or supported living and independent living settings. *[Cal. Code. Regs tit. 17, § 56047 (2023)]; [Cal. Code. Regs tit. 17, § 56095 (2023)]; [Cal. Code. Regs tit. 17, § 58680 (2023)]; (Contract requirement)*

Findings

Twelve of the twenty (60 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 #7, #13, #15, #16, and #20 contained documentation of three of the four required meetings that were consistent with the quarterly timeline;

2. The records for individuals #1, and #12 contained documentation of two of the four required meetings that were consistent with the quarterly timeline; and,

3. The record for individual #17 contained documentation of one of the four required meetings that were consistent with the quarterly timeline.

1.9.a Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that quarterly face-to-face meetings are completed for all applicable individuals.	**Continuous training regarding the importance of timely face-to-face quarterlies is being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings.** **The importance of timely quarterly face-to-face meetings and progress reports was discussed at the Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases. Supervisors will continue to discuss and**

	ensure compliance with timely face to face quarterlies within their caseloads. **CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy.** **The revised CSC Work Standards will go into effect February 1, 2026.** **Supervisors to ensure implementation of this 1915(i) SPA monitoring requirement for meetings/reports to occur based on the date of the IPP by monitoring timely completion of face-to-face quarterly meetings and reports when meeting with CSCs for supervision and upon review of cases.** **The Floater Service Coordinator position was implemented to provide support for uncovered caseloads to ensure compliance.** **NLACRC has implemented a tracking database, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

1.9.b Quarterly reports of progress are completed for individuals living in community out-of-home settings, i.e., Service Level 2-7 community care facilities or family home agencies or receiving supported living and independent living services. [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

Twelve of the twenty (60 percent) applicable sample records of individuals had quarterly reports of progress completed for individuals living in community out-of-home settings. However, the records for seven individuals did not meet the requirement as indicated below:

1. The records for individuals #7, #13, #15, #16, and #20 contained documentation of three of the four required reports of progress that were consistent with the quarterly timeline;

2. The records for individuals #1, and # 12 contained documentation of two of the four required reports of progress that were consistent with the quarterly timeline; and,

3. The record for individual #17 contained documentation of one of the four required reports of progress that were consistent with the quarterly timeline.

1.9.b Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that quarterly reports of progress are completed for all applicable individuals.	**Continuous training regarding the importance of timely face-to-face quarterlies and report completion is being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Meetings.** **The importance of timely quarterly face-to-face meetings and progress reports was discussed at Case Management Leadership Meeting on 9/9/25 with the expectation for Supervisors to review with their teams in Unit meetings and ongoing in routine supervision meetings, as well as upon review of cases. Supervisors will continue to discuss and ensure compliance with timely face to face quarterlies within their caseloads.** **CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.** **Supervisors to ensure implementation of this 1915(i) SPA monitoring requirement**

	for meetings/reports to occur based on the date of the IPP by monitoring timely completion of face-to-face quarterly meetings and reports when meeting with CSCs for supervision and upon review of cases. **The Floater Service Coordinator position was implemented to provide support for uncovered caseloads to ensure compliance.** **NLACRC has implemented a tracking database, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

Summary of Results for the 1915(i) State Plan Amendment Follow-Up Review

The results of the August 2025 follow-up review indicate that the issues identified during the regular biennial monitoring review in August 2024 require further action to ensure quarterly face-to-face meetings and reports of progress are completed for individuals living in community out-of-home settings, i.e., Service Level 2-7 community care facilities (CCF), family home agencies (FHA), or supported living and independent living settings.

SECTION II: SPECIAL INCIDENT REPORTING

The records of the 60 individuals selected for the HCBS 1915c Developmental Disabilities (DD) Waiver, the HCBS 1915c Self-Determination Program (SDP) Waiver, and the 1915(i) State Plan Amendment (SPA) follow-up were reviewed to verify that special incidents have been reported. A supplemental sample of 10 records for the 1915(c) DD Waiver Follow-Up Review and 5 records for the 1915(i) SPA Follow-Up Review were also reviewed to verify 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 appropriate and complete. In addition, the monitoring team verifies that an incident report was completed for all individuals on the 1915(c) Waivers and 1915(i) SPA supported by NLACRC who passed away during the review period.

1915(c) Developmental Disabilities Waiver Follow-Up Review Summary of Findings

NLACRC reported all deaths for individuals on the waiver during the review period. NLACRC reported all special incidents in the sample of 20 records selected for the HCBS Waiver follow-up review to the Department. NLARC's vendors reported nine of the ten (90 percent) incidents in the supplemental sample to the regional center within the required timeframes. NLACRC reported all 100 percent) incidents in the supplemental sample to the Department within the required timeframe. NLACRC's follow-up activities on incidents in the supplemental sample were appropriate for the severity of the situations for all 10 (100 percent) incidents.

Finding

SIR #4: The incident occurred on October 12, 2024. However, the vendor did not submit a written report to NLACRC until October 15, 2024.

1915(i) State Plan Amendment Follow-Up Review Summary of Findings

NLACRC reported all deaths for individuals on the waiver during the review period. NLACRC reported all special incidents in the sample of 20 records selected for the HCBS Waiver follow-up review to the Department. NLACRC's vendors reported all (100 percent) incidents in the supplemental sample to the regional center within the required timeframes. NLACRC reported all (100 percent) incidents in the supplemental sample to the Department within the required timeframe. NLACRC's follow-up activities on incidents in the supplemental sample were appropriate for the severity of the situations for all five (100 percent) incidents.

Findings
None

Recommendation	Regional Center Plan/Response
NLACRC should evaluate what actions may be necessary to ensure that SIRs are reported to NLACRC within the required timeframe.	**The Risk Assessment team will reach out to the vendors to provide guidance on T-17 reporting guidelines and recommend staff training to ensure compliance.** **The Risk Assessment (RA) team will review process and transmit Special Incident Reports (SIR's) within the T-17 reporting window. SIR submission timelines will be reviewed with the RA team and Case Management will be reminded of the critical importance of promptly informing RA of Special Incidents to ensure compliance with reporting requirements.** **CSC's will receive training in January 2026 on NLACRC's revised SOP for CSC Work Standards, which states that work product will be in compliance with HCBS audit requirements and NLACRC policy. The revised CSC Work Standards will go into effect February 1, 2026.** **Email to Vendor: We are reaching out regarding the incident report you submitted for (UCI and /or Consumer Name) on (Date), which was received outside of the T-17 reporting window. As a reminder, NLACRC must be notified within 24 hours of an incident occurring and a written report must be submitted within 48 hours to ensure compliance with reporting standards and to facilitate a timely response. We understand that circumstances may sometimes arise that could lead to delays, however, timely reporting is required and is essential to mitigate risks and ensure that all necessary actions can be taken properly. To help avoid delays in the future, we recommend that your team review and familiarize themselves with the reporting requirements. We suggest providing additional training on the reporting**

	guidelines to ensure that all staff are fully aware of the timelines and procedures. Our Risk Assessment department will be forwarding T-17 guidelines and we recommend that you review these with your staff. Thank you for your attention to this matter, and for your continued partnership. We appreciate your cooperation in adhering to these reporting guidelines in the future.