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

Conducted by:

Department of Developmental Services
and
Department of Health Care Services

August 1-19, 2022

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EXECUTIVE SUMMARY

The Department of Developmental Services (DDS) and the Department of Health Care Services (DHCS) conducted the federal compliance monitoring review of the Home and Community-Based Services (HCBS) Waiver from August 1–19, 2022, at North Los Angeles County Regional Center (NLACRC). The monitoring team members were Natasha Clay (Team Leader), Nora Muir, Kelly Sandoval, Fam Chao, Hope Beale, and Bonnie Simmons from DDS, and Deeanna Tran, Crystal La, and Julie Ota from DHCS.

Purpose of the Review

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

Overview of the HCBS Waiver Programmatic Compliance Monitoring Protocol

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

Scope of Review

The monitoring team reviewed a sample of 63 HCBS Waiver individuals. In addition, the following supplemental sample records were reviewed: 1) four individuals who moved from a developmental center, 2) ten individuals who had special incidents reported to DDS during the review period of May 1, 2021, through April 30, 2022, and 3) six individuals who were enrolled in the HCBS Waiver during the review period.

The monitoring team completed visits to 11 community care facilities (CCF) and one day program. The team reviewed 12 CCF records, one day program record and interviewed and/or observed 42 selected sample individuals.

Overall Conclusion

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

Major Findings

Section I – Regional Center Self-Assessment

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

Section II – Regional Center Record Review

Sixty-three sample records were reviewed for 31 documentation requirements (criteria) derived from federal and state statutes and regulations and HCBS Waiver requirements. Three criteria were rated as not applicable for this review.
Criterion 2.2 was 44 percent in compliance because 35 of 63 applicable sample records did not contain a signed and/or dated DS 2200 form. Criterion 2.6.b was 67 percent in compliance because 15 of the 46 applicable sample records did not contain a completed SARF. Criterion 2.13.a was 71 percent in compliance because 10 of the 34 applicable sample records did not contain documentation of all required quarterly face-to-face visits. Criterion 2.13.b was 71 percent in compliance because 10 of the 34 applicable sample records did not contain documentation of all required quarterly reports of progress. Criterion 2.14 was 25 percent in compliance because 3 of the 4 sample records did not contain documentation of all the required meetings. The sample records were 91 percent in overall compliance for this review.

NLACRC's records were 95 percent and 98 percent in overall compliance for the collaborative reviews conducted in 2020 and in 2018, respectively.

New Enrollees: Six sample records were reviewed for level-of-care determination prior to receipt of HCBS Waiver services. NLACRC's records were 100 percent in overall compliance for this review.

Section III – Community Care Facility Record Review

Twelve records were reviewed at 11 CCFs for 19 documentation requirements (criteria) derived from Title 17, California Code of Regulations. The sample records were 100 percent in overall compliance for 19 criteria on this review.

NLACRC's records were 100 percent in overall compliance for the collaborative reviews conducted in 2020 and in 2018.

Section IV – Day Program Record Review

One record was reviewed at 1 day program for 17 documentation requirements (criteria) derived from Title 17, California Code of Regulations. The sample records were 100 percent in overall compliance for this review.

The closure of day programs due to the COVID-19 pandemic prevented the review of Section IV Day Program records and site visits for the 2020 review.

NLACRC's records were 99 percent and 98 percent in overall compliance for the collaborative reviews conducted in 2018 and in 2016, respectively.

Section V – Observations and Interviews

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

Section VI A – Service Coordinator Interviews

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

Section VI B – Clinical Services Interview

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

Section VI C – Quality Assurance Interview

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

Section VII A – Service Provider Interviews

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

Section VII B – Direct Service Staff Interviews

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

Section VIII – Vendor Standards Review

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

Section IX – Special Incident Reporting

The monitoring team reviewed the records of the 63 HCBS Waiver individuals and 10 supplemental sample records for special incidents during the review period. NLACRC reported all special incidents for the sample selected for the HCBS Waiver review. For the supplemental sample, the service providers reported all of the 10 incidents to NLACRC within the required timeframes, and NLACRC subsequently transmitted 9 of the 10 special incidents to DDS within the required timeframes. NLACRC's follow-up activities for the 10 incidents were timely and appropriate for the severity of the situation.

SECTION I

REGIONAL CENTER SELF-ASSESSMENT

I. Purpose

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

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

II. Scope of Assessment

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

III. Results of Assessment

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

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

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

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

SECTION II

REGIONAL CENTER RECORD REVIEW

I. Purpose

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

II. Scope of Review

1. Sixty-three HCBS Waiver records were selected for the review sample.

Living Arrangement	# of Individuals
Community Care Facility (CCF)	15
With Family	29
Independent or Supported Living Setting	19

2. The review period covered activity from May 1, 2021–April 30, 2022.

III. Results of Review

The 63 sample records were reviewed for 31 documentation requirements derived from federal and state statutes and regulations and HCBS Waiver requirements. Four supplemental records were reviewed solely for documentation indicating that the individual served received face-to-face reviews every 30 days after moving from a developmental center for the first 90 days. Six supplemental records were reviewed for documentation that NLACRC determined the level of care prior to receipt of HCBS Waiver services.

- ✓ The sample records were in 100 percent compliance for 13 criteria. There are no recommendations for these criteria. Two criteria were not applicable for this review.

- ✓ Findings for sixteen criteria are detailed below.

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

IV. Findings and Recommendations

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

Finding

Twenty-seven of the sixty-two (44 percent) sample records contained a completed DS 2200 form. There were identified issues regarding the DS2200 form for the following individuals:

1. Individual #1: The individual served was determined eligible on December 1, 2014. The DS 2200 form was signed and dated June 3, 2022. Accordingly, no recommendation is required;

2. Individual #2: The individual served was determined eligible on July 1, 2001. The DS 2200 form was signed and dated June 3, 2022. Accordingly, no recommendation is required;

3. Individual #3: The individual served was determined eligible on August 1, 1994. The DS 2200 form was signed and dated June 13, 2022. Accordingly, no recommendation is required;

4. Individual #4: The individual served was determined eligible on February 1, 2012. The DS 2200 form was signed and dated June 13, 2022. Accordingly, no recommendation is required;

5. Individual #6: The individual served was determined eligible on March 1, 1993. The DS 2200 form was signed and dated August 4, 2022. Accordingly, no recommendation is required;

6. Individual #7: The individual served was determined eligible on January 1, 1995. The DS 2200 form was signed and dated June 8, 2022. Accordingly, no recommendation is required;

7. Individual #8: The individual served was determined eligible on December 1, 2008. The DS 2200 form was signed and dated June 6, 2022. Accordingly, no recommendation is required;

8. Individual #9: The individual served was determined eligible on September 1, 2013. The DS 2200 form was signed and dated June 22, 2022. Accordingly, no recommendation is required;

9. Individual #10: The individual served was determined eligible on September 1, 2009. The DS 2200 form was signed and dated July 22, 2022. Accordingly, no recommendation is required;

10. Individual #11: The individual served was determined eligible on October 1, 2000. The DS 2200 form was signed and dated July 9, 2022. Accordingly, no recommendation is required;

11. Individual #12: The individual served was determined eligible on March 1, 2011. The DS 2200 form was signed and dated June 16, 2022. Accordingly, no recommendation is required;

12. Individual #13: The individual served was determined eligible on October 16, 2014. The DS 2200 form was signed and dated July 13, 2022. Accordingly, no recommendation is required;

13. Individual #15: The individual served was determined eligible on October 1, 1995. The DS 2200 form was signed and dated June 16, 2022. Accordingly, no recommendation is required;

14. Individual #16: The individual served was determined eligible on September 1, 2004. The DS 2200 form was signed and dated May 17, 2022. Accordingly, no recommendation is required;

15. Individual #17: The individual served was determined eligible on October 1, 2000. The DS 2200 form was signed and dated June 14, 2022. Accordingly, no recommendation is required;

16. Individual #18: The individual served was determined eligible on August 1, 2012. The DS 2200 form was signed and dated May 19, 2022. Accordingly, no recommendation is required;

17. Individual #20: The individual served was determined eligible on October 1, 2000. The DS 2200 form was signed and dated July 19, 2022. Accordingly, no recommendation is required;

18. Individual #21: The individual served was determined eligible on July 1, 1996. The DS 2200 form was signed and dated July 15, 2022. Accordingly, no recommendation is required;

19. Individual #22: The individual served was determined eligible on January 1, 2012. The DS 2200 form was signed and dated June 16, 2022. Accordingly, no recommendation is required;

20. Individual #27: The record for individual served did not contain a DS 2200 form;

21. Individual #28: The individual served was determined eligible on October 1, 2000. The DS 2200 form was signed and dated May 10, 2022. Accordingly, no recommendation is required;

22. Individual #30: The individual served was determined eligible on October 1, 2000. The DS 2200 form was signed and dated June 18, 2022. Accordingly, no recommendation is required;

23. Individual #35: The individual served was determined eligible on October 1, 2013. The DS 2200 form was signed and dated June 28, 2022. Accordingly, no recommendation is required;

24. Individual #36: The individual served was determined eligible on February 1, 2018. The DS 2200 form was signed and dated July 6, 2022. Accordingly, no recommendation is required;

25. Individual #38: The individual served was determined eligible on February 1, 2012. The DS 2200 form was signed and dated June 22, 2022. Accordingly, no recommendation is required;

26. Individual #39: The individual served was determined eligible on May 1, 2007. The DS 2200 form was signed and dated June 7, 2022. Accordingly, no recommendation is required;

27. Individual #42: The individual served was determined eligible on October 1, 2007. The DS 2200 form was signed and dated June 19, 2022. Accordingly, no recommendation is required;

28. Individual #43: The individual served was determined eligible on December 1, 2005. The DS 2200 form was signed and dated June 5, 2022. Accordingly, no recommendation is required;

29. Individual #44: The individual served was determined eligible on February 1, 2011. The DS 2200 form was signed and dated July 15, 2022. Accordingly, no recommendation is required;

30. Individual #46: The individual served was determined eligible on October 1, 2005. The DS 2200 form was signed and dated July 20, 2022. Accordingly, no recommendation is required;

31. Individual #47: The individual served was determined eligible on December 1, 2008. The DS 2200 form was signed and dated July 21, 2022. Accordingly, no recommendation is required;

32. Individual #49: The record for individual served did not contain a DS 2200 form;

33. Individual #52: The record for individual served did not contain a DS 2200 form;

34. Individual #55: The individual served was determined eligible on May 1, 2014. The DS 2200 form was signed and dated June 3, 2022. Accordingly, no recommendation is required; and,

35. Individual #58: The individual served was determined eligible on September 1, 2016. The DS 2200 form was signed and dated June 6, 2022. Accordingly, no recommendation is required.

2.2 Recommendation	Regional Center Plan/Response
NLACRC should ensure that the DS 2200 forms for individuals #27, #49, and #52 are properly signed, and dated.	**#27 A new DS2200 form was completed and signed by consumer on 7/28/22 during a visit with Regional Center Vendor and submitted to Regional Center.** **#49 Service Coordinator attempted to receive signature on DS2200 several times to no avail. Family never responded to phone calls, emails, or letters sent in 8/2022 and 12/2022 requesting signature and to schedule required IPP meeting. Consequently, individual #49's case was inactivated and terminated from HCBS Waiver effective 1/31/23 due to no contact/no response to NOA.** **#52 Service Coordinator attempted to receive signature on DS2200 several times to no avail. A scheduled Annual Review Meeting on 7/28/22 was missed as parent's phone went straight to voicemail. Service Coordinator called and emailed parent several times to no avail. Letter and NOA returned back to Regional Center from the Post Office stamped "not deliverable as addressed." Address matched SANDIS address. Consequently, individual #52's case was inactivated and terminated from**

	HCBS Waiver effective 10/1/22 due to unable to contact.

2.4 Each record contains a current Client Development Evaluation Report (CDER) that has been reviewed within the last 12 months.
(SMM 4442.5; 42 CFR 441.302)

Finding

Fifty-four of the sixty-three (86 percent) sample records contained a CDER that had been reviewed within the last 12 months. However, the records for individuals #10, #13, #17, #24, #27, #28, #42, #43, and #47 did not contain documentation that the CDER had been reviewed during the year.

2.4 Recommendation	Regional Center Plan/Response
NLACRC should ensure that the CDER for individuals #10, #13, #17, #24, #27, #28, #42, #43, and #47 is reviewed annually.	**CDERs for all identified individuals were reviewed and updated annually. However, the 2021 CDERs were not uploaded into the electronic chart, Therefore and subsequently replaced with the 2022 CDER update. Unfortunately, once the CDER is updated in SANDIS, Regional Center is unable to retrieve the previous CDER. All CDER updates must be uploaded into Therefore. Preliminary findings on missing CDERs due to lack of saving previous CDER in Therefore before an update discussed at Case Management Leadership Huddle Meeting on 9/12/22. Continued training regarding the importance of reviewing/updating/uploading CDER annually being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Huddle Meetings.**

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

Findings

Fifty-eight of the sixty-one (95 percent) applicable sample records documented level-of-care qualifying conditions that were consistent with information found elsewhere in the record. However, information contained in four records (detailed below) did not support the determination that all the issues identified in the CDER and the Medicaid Waiver Eligibility Record (DS 3770) could be considered qualifying conditions. The following were identified as qualifying conditions on the DS 3770, but there was no supporting information in the individual's records (IPP, progress reports, vendor reports, etc.) that described the impact of the identified conditions or need for services and supports:

1. Individual #12: "hypertension;"

2. Individual #30: "braces/splints/cast/orthopedic shoe;" and,

3. Individual #31: "frequent turning in bed".

2.5.b Recommendations	Regional Center Plan/Response
NLACRC should determine if the items listed above are appropriately identified as qualifying conditions. The individual's DS 3770 form should be corrected to ensure that any items that do not represent substantial limitations in the individuals' ability to perform activities of daily living and/or participate in community activities are no longer identified as qualifying conditions. If NLACRC determines that the issues are correctly identified as qualifying conditions, documentation (updated IPPs, progress reports, etc.) that supports the original determinations should be submitted with the response to this report.	**#12 A review of 9/4/20 IPP and 9/21/21 Annual Review reports for individual #12 did not support the qualifying condition indicated on the CDER and DS3770. However, review of 9/29/22 Annual Review report includes the qualifying condition of hypertension. An Addendum is required for any change to the IPP. Unfortunately, review of 8/23/23 IPP report did not support the qualifying condition. An Addendum to 8/23/23 IPP report will be completed to accurately reflect qualifying condition. (attached)** **#30 A review of 10/13/18 IPP, 10/8/19 Annual Review, 10/6/20 Annual Review, 10/20/21 IPP, and 10/27/22 Annual Review reports did not support the qualifying condition indicated on the CDER and DS3770. An Addendum to 10/20/21 IPP report will be completed to accurately reflect qualifying condition. (attached)**

	#31 Individual passed away. Regional Center case closed and terminated from HCBS Waiver effective 6/25/23 due to hospitalized 6/26/23 and passed away in hospital 7/5/23.

2.6.a The IPP is reviewed (at least annually) by the planning team and modified, as necessary, in response to the individual's changing needs, wants or health status. *[42 CFR 441.301(b)(1)(l)]*

Finding

Fifty-six of the sixty-two (90 percent) applicable sample records contained documentation that the individual's IPP had been reviewed annually by the planning team. However, there was no documentation that the IPPs for six individuals were reviewed annually, as indicated below:

1. Individual #9: The IPP was dated July 22, 2019. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on December 29, 2021. Accordingly, no recommendation is required;

2. Individual #24: The IPP was dated February 11, 2021. However, there was no documentation that the IPP was reviewed during the monitoring review period. A new IPP was completed on May 2, 2022. Accordingly, no recommendation is required;

3. Individual #26: The IPP was dated September 18, 2018. There was no documentation that the IPP was reviewed within the year. A new IPP was completed on March 4, 2022. Accordingly, no recommendation is required;

4. Individual #32: The IPP was dated March 30, 2020. There was no documentation that the IPP was reviewed during the monitoring review period;

5. Individual #37: The IPP was dated April 30, 2018. There was no documentation that the IPP was reviewed during the monitoring review period. A new IPP was completed on May 26, 2022. Accordingly, no recommendation is required; and,

6. Individual #53: The IPP was dated May 4, 2020. There was no documentation that the IPP was reviewed within the year. An annual review was completed on July 15, 2021. Accordingly, no recommendation is required.

2.6.a Recommendation	Regional Center Plan/Response
NLACRC should ensure that the IPP for individual #32 is reviewed at least annually by the planning team.	**The importance of timely/annual IPP reviewal documentation (from the date of IPP, not the birth month) was discussed at Case Management Leadership Huddle Meeting on 9/12/22. To ensure future compliance, continuing training will be provided to Service Coordinators and Supervisors regarding HCBS Waiver requirement. In addition, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

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-one of the forty-six (67 percent) applicable sample records contained a completed SARF. However, eleven records did not contain a SARF and records for five individuals did not contain a completed SARF as indicated below:

1. Individual #10: Missing SARF for annual review dated on June 9, 2021;
2. Individual #12: SARF dated September 21, 2021 was not signed. The SARF was signed and dated July 14, 2022. Accordingly, no recommendation is required;
3. Individual #21: Missing SARF for annual review dated February 1, 2022;
4. Individual #24: Missing SARF for annual review dated February 11, 2021;
5. Individual #32: Missing SARF for annual review dated March 30, 2022;
6. Individual #34: Missing SARF for annual review dated December 15, 2021;
7. Individual #36: The SARF dated August 30, 2021 was signed July 10, 2022. Accordingly, no recommendation is required;

8. Individual #42: Missing SARF for annual review dated on June 23, 2021;
9. Individual #44: SARF dated November 15, 2021 was not signed;
10. Individual #45: Missing SARF for annual review dated June 17, 2021;
11. Individual #46: Missing SARF for annual review dated on April 22, 2020;
12. Individual #49: Missing SARF for annual review dated December 14, 2021;
13. Individual #55: SARF dated January 18, 2022 was not signed. The SARF was signed and dated June 3, 2022. Accordingly, no recommendation is required;
14. Individual #56: Missing SARF for annual review dated July 22, 2021; and,
15. Individual #63: SARF dated March 11, 2021 was not signed. The SARF was signed and dated June 22, 2022. Accordingly, no recommendation is required.

2.6.b Recommendation	Regional Center Plan/Response
NLACRC should ensure that the SARF for individuals #10, #21, #24, #32, #34, #42, #44, #45, #46, #49, and #56 are completed during the annual IPP review process.	**#10 SARF for 6/9/21 missing. A new IPP was completed on 6/28/22. A SARF was not required at such time.** **#21 SARF for 2/1/22 missing. A new IPP was completed on 4/4/23. A SARF was not required at such time.** **#24 A quarterly report dated 2/10/21 was erroneously completed in place of required 2021 Annual Review. Subsequently, a SARF was not completed. A new IPP was completed on 5/3/22. A SARF was not required at such time.** **The importance of timely and accurate face to face meetings were discussed at Case Management Leadership Huddle Meeting on 9/12/22. Supervisors to ensure implementation of monitoring accurate and timely completion of reports during scheduled**

	supervision with each Service Coordinator. To ensure future compliance, continuing training will be provided to Service Coordinators and Supervisors regarding this HCBS Waiver requirement. In addition, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with DDS compliance. **#32 An Annual Review meeting was not held on 3/30/22 as indicated. A SARF and meeting are missing for required March 2022 meeting. A new IPP meeting was completed on 4/29/22. A SARF was not required at such time. The assigned Service Coordinator separated from the agency prior to completion of IPP report. The Officer of the Day has made attempts to schedule an IPP meeting and will continue to make attempts to bring case into DDS compliance. A 15 Day "No Contact" Letter was sent and individual #32 contacted NLACRC to request case/services remain open.** **#34 SARF for 12/15/21 missing. A new IPP was completed on 6/16/23. A SARF was not required at such time.** **#42 SARF for 6/23/21 missing. A new IPP was completed on 8/14/23. A SARF was not required at such time.** **#44 SARF for 11/15/21 not signed. Signature page signed/dated by individual #44/Service Coordinator. Service Coordinator to sign/date SARF and obtain signature/date for individual #44. Next IPP scheduled for 11/20/23. A SARF is not required at such time.**

	#45 SARF for 6/17/21 missing. A new IPP was completed on 7/6/22. A SARF was not required at such time. **#46 SARF for 4/22/20 missing. A new IPP was completed on 4/6/22. A SARF was not required at such time.** **#49 SARF for 12/14/21 missing applicable signatures. As a result of no response to phone calls, emails, letters, or NOA sent requesting contact with NLACRC, #49's case was inactivated and terminated from HCBS waiver effective 1/31/23.** **#56 SARF for 7/22/21 missing. A new IPP was completed on 6/28/22. A SARF was not required at such time.** **Preliminary findings on missing and/or incomplete SARFs discussed at Case Management Leadership Huddle Meeting on 9/12/22. Continued training regarding the importance of SARF completion for Annual Reviews not including the completion of a new IPP will be provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Huddle Meetings.**

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

Findings

Fifty-six of the sixty-three (90 percent) sample records contained IPPs that were signed by NLACRC and the individuals served or conservators. However, three IPPs were not signed by the individual served or by the legal representative/guardian:

1. Individual #1: The IPP dated May 7, 2020 was not signed by the individual served. The IPP was signed July 21, 2022, by the individual served. Accordingly, no recommendation is required;

2. Individual #2: The IPP dated January 23, 2020 was not signed by the individual served. The IPP was signed July 12, 2022, by the individual served. Accordingly, no recommendation is required;

3. Individual #9: The IPP dated December 29, 2021 was not signed by the individual served. The IPP for was signed June 12, 2022, by the individual served. Accordingly, no recommendation is required;

4. Individual #32: The IPP dated March 20, 2020 was not signed by the individual served. The IPP was signed June 20, 2022, by the individual served. Accordingly, no recommendation is required;

5. Individual #50: The IPP dated November 9, 2020 was not signed by the individual served. The IPP was signed May 31, 2022 by the individual served. Accordingly, no recommendation is required; and,

6. Individual #52: The IPP dated July 31, 2020, was not signed by the parent.

2.7.a Recommendation	Regional Center Plan/Response
NLACRC should ensure that the IPP for individual #52 is signed and dated by the individual served or by the legal representative/guardian. If the individual served does not sign, NLACRC should ensure that the record addresses the reason why the individual served did not or could not sign.	**#52 IPP meeting held telephonically as a result of COVID Pandemic. Signature page for 7/31/20 IPP mailed to family for completion. NLACRC case inactivated and terminated from HCBS Waiver effective 10/1/22 due to unable to contact.**

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

Findings

Forty-four of the forty-five (98 percent) applicable sample records contained IPP addenda signed by NLACRC and the individual or, where appropriate, his/her parents, legal guardian, or conservator. However, the record for individual #42, addendum dated August 20, 2021, was not signed by the individual served and the regional center.

2.7.b Recommendation	Regional Center Plan/Response
NLACRC should ensure that the IPP addendum for individual #42 is signed and dated.	**Addendum signature page for 8/20/21 electronically signed by Service Coordinator but missing individual #42's signature. Signature page mailed out for completion/return. Received completed/returned signature page with a 6/7/22 signature date.** **Preliminary findings on missing Addendum Signature Pages discussed at Case Management Leadership Huddle Meeting on 9/12/22. Continued training regarding the importance of Addendum Signature Page completion being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Huddle Meetings. Service Coordinators to ensure receipt of completed signature page.**

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

Findings

Fifty-four of the sixty-one (89 percent) applicable sample records contained IPPs that addressed the qualifying conditions. However, the IPPs for seven individuals did not address supports for qualifying conditions identified in the record as indicated below:

1. Individual #3: The IPP dated October 6, 2020, does not address the qualifying condition "medications with supervision;" as noted in the quarterly reviews dated October 28, 2021, and April 18, 2022. A new IPP was completed June 11, 2022 adding "medications with supervision." Accordingly, no recommendation is required.

2. Individual #13: The IPP dated May 12, 2021, does not address the qualifying conditions "disruptive behavior," "physical aggression," "self-injurious

behavior," "running/wandering away," and "emotional outbursts;" as noted in the quarterly review dated February 9, 2022. An addendum was completed May 19, 2022 adding "disruptive behavior," "physical aggression," "self-injurious behavior," "running/wandering away," and "emotional outbursts. Accordingly, no recommendation required.

3. Individual #23: The IPP dated October 16, 2019, does not address the qualifying condition "wetting and soiling;" as noted in the annual review dated October 19, 2021.

4. Individual #25: The IPP dated February 25, 2021, does not address the qualifying condition "habitual lying;" as noted in the annual review dated March 28, 2022;

5. Individual #26: The IPP dated March 2, 2022, does not address the qualifying conditions "physical aggression," and "self-injurious behavior;" as noted in the semi-annual progress report dated August 2021.

6. Individual #31: The IPP dated June 26, 2020, does not address the qualifying conditions "Gastroesophageal Reflux Disease" and "walker;" as noted in the annual review dated June 26, 2020.

7. Individual #57: The IPP dated January 9, 2019, does not address the qualifying conditions "wetting at night," and "aggression and hostility;" as noted in the annual review dated January 19, 2021.

2.9.a Recommendation	Regional Center Plan/Response
NLACRC should ensure that the IPPs for individuals #23, #25, #26, #31, and #57 addresses the services and supports in place for the conditions identified above.	**#23 Review of 10/16/19 IPP did not reveal an inconsistency regarding "wetting and soiling" as the condition was not applicable at such time. However, the Annual Review completed on 10/19/21 indicates "wetting and soiling" is a new condition related to the side effect of new medication. A new IPP completed on 10/13/22 include and discuss qualifying condition "wetting and soiling."** **#25 Review of 3/25/21 IPP revealed an inconsistency regarding "habitual lying." However, the Annual Review completed on 3/28/22 indicates individual #25 has a history of "habitual lying" in**

	order to obtain attention. An Addendum is required for any change to the IPP. Unfortunately, review of 3/9/23 IPP report did not include or discuss history of "habitual lying." An Addendum to 3/9/23 IPP to be completed to accurately reflect qualifying condition. **#26 Review of 3/4/22 IPP revealed an inconsistency regarding "physical aggression" and "self-injurious behavior" as it only mentions court mandated Anger Management Classes. Addendum completed 7/6/23 to include and address conditions. Individual #26 no longer displays behaviors with additional supports provided by ILS Provider and court ordered classes. These qualifiers have been removed and a corrected DS3770 will be placed in the electronic chart.** **#31 An addendum to IPP dated 6/16/21 was completed on 9/13/21 to include and address qualifying conditions "Gastroesophageal Reflux Disease" and "walker". Case closed and terminated from HCBS Waiver effective 6/25/23 due to hospitalized on 6/26/23. Individual #31 passed away in hospital on 7/5/23.** **#57 Review of 1/9/19 IPP revealed an inconsistency regarding "wetting at night" and "aggression and hostility." A new IPP completed on 1/24/22 include and discuss qualifying conditions "wetting at night" and "aggressing and hostility."**

	NLACRC has implemented a new "Person Centered IPP Writing Refresher Course" to reinforce Case Management knowledge and understanding of writing person centered IPPs in order to achieve DDS compliance.

2.9.b The IPP addresses the current special health care requirements, health status and needs as appropriate.

Findings

Ten of the twelve (83 percent) applicable sample records contained IPPs that addressed the individual's special health care requirements. However, the IPPs for the following two individuals did not address special health care requirements for the conditions noted:

1. Individual #13: special diet and special eating utensils

2. Individual #30: braces/splints/cast/orthopedic shoe

2.9.b Recommendation	Regional Center Plan/Response
NLACRC should ensure that the IPPs for individuals #13 and #30 address the special health care requirements as noted.	**#13 IPPs dated 5/21/20, 5/12/21, and 5/19/22 addressed a special diet, however, did not address special eating utensils. An Addendum to the 5/19/22 report completed to accurately reflect qualifying condition.** **#30 IPPs dated 10/13/18 and 10/20/21 did not address braces/splints/cast/orthopedic shoe. An Addendum to the 10/20/21 IPP will be completed to accurately reflect qualifying condition.** **NLACRC has implemented a new "Person Centered IPP Writing Refresher Course" to reinforce Case Management knowledge and understanding of writing person centered IPPs in order to achieve DDS compliance.**

2.9.d The IPP addresses the services which the day program provider is responsible for implementing. *[WIC §4646.5(a)(2)]*

Findings

Twenty-three of the twenty-four (96 percent) applicable sample records contained IPPs that addressed day program services. However, the IPP for individual #36 did not address the services which the day program provider is responsible for implementing. An addendum dated July 7, 2022 was completed addressing the services the day program is responsible for implementing. Accordingly, no recommendation is required.

2.10.a The IPP includes a schedule of the type and amount of all services and supports purchased by the regional center. *[WIC §4646.5(a)(4)]*

Findings

Fifty-six of the sixty-three (89 percent) IPPs included a schedule of the type and amount of all services and supports purchased by NLACRC. However, IPPs for eight individuals did not indicate NLACRC funded services as indicated below:

1. Individual #1: Transportation and Supplemental Residential Support;
2. Individual #13: Transportation Company;
3. Individual #16: Dentistry. An addendum was completed on July 14, 2022, addressing the purchased service. Accordingly, no recommendation is required;
4. Individual #20: Home Health Agency;
5. Individual #44: Behavior Management Program;
6. Individual #49: Personal Assistant; and,
7. Individual #53: Adaptive Skills Training.

2.10.a Recommendation	Regional Center Plan/Response
NLACRC should ensure that the IPPs for individuals #1, #13, #20, #44, #49 and #53 include a schedule of the type and amount of all services and supports purchased by NLACRC.	**#1 IPP dated 5/7/20 indicates individual #1 will transport self to and from work/day program. NLACRC started funding transportation September 2020 through May 2022. An Addendum dated 12/7/20 funding for Supplemental Residential Support.**

	A new IPP dated 5/15/23 indicates individual #1 utilizes Access as a form of transportation and CCF will provide transportation to/from appointments, when needed. NLACRC funds CCF placement, Access Reimbursement, and BUILD SEP. **#13 IPPs dated 5/12/21 and 5/19/22 indicates CPES Napa Home will transport to/from day program (transportation effected by COVID Pandemic). NLACRC funds for CPES Napa Home (includes transportation). An Addendum to the 5/19/22 IPP report completed to accurately reflect time limited Transportation Company from 7/1/21 through 5/31/22 funding of EPG Distribution.** **#20 Addendums completed to identify amounts of services and supports purchased by NLACRC, included Home Health Agency.** **#44 Addendum completed to identify amounts of services and supports purchased by NLACRC, included Behavior Management Program.** **#49 Addendum completed to identify amounts of services and supports purchased by NLACRC, included Personal Assistant. Since, individual #49's case was inactivated and terminated from HCBS Waiver effective 1/31/23 due to no contact/no response to NOA.** **#53 Addendum completed to identify amounts of services and supports purchased by NLACRC, included Adaptive Skills Training.**

	Report provided to DDS Auditors for review subsequent to the August 2022 audit. **NLACRC has implemented a new "Person Centered IPP Writing Refresher Course" to reinforce Case Management knowledge and understanding of writing person centered IPPs in order to achieve DDS compliance.**

2.12 Periodic reviews and reevaluations of progress are completed (at least annually) to ascertain that planned services have been provided, that progress has been achieved within the time specified, and the individual and his/her family are satisfied with the IPP and its implementation. *[W&I Code §4646.5(a)(6)]*

Finding

Fifty-nine of the sixty-two (95 percent) applicable sample records contained documentation of periodic review and reevaluation of progress at least annually. However, the records for individuals #26, #32 and #53 did not contain documentation that progress for the individuals served had been reviewed within the year.

2.12 Recommendation	Regional Center Plan/Response
NLACRC should ensure that a review and reevaluation of progress regarding planned services, timeframes, and satisfaction for individuals #26, #32, and #53 is completed and documented at least annually.	**#26 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #26 completed in 2019 and 2020 for 2018 IPP. 2021 Annual Review missed. A new IPP completed March 2022.** **#32 Annual Review of progress regarding planned services, timeframes, and satisfaction for individual #32 completed in 2021 for 2020 IPP. 2022 Annual Review held, however Service Coordinator separated from agency prior to completing written report. Next IPP scheduled in 2023.** **#53 Annual Review of progress regarding planned services,**

	timeframes, and satisfaction for individual #53 completed in 2021 and 2022 for 2020 IPP. A new IPP completed in 2023. **The importance of timely/annual review of progress regarding planned services, timeframes, and satisfaction was discussed at the Case Management Leadership Huddle Meeting on 9/12/22. To ensure future compliance, continuing training with be provided to Service Coordinators and Supervisors regarding HCBS Waiver requirement. In addition, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

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

Findings

Twenty-four of the thirty-four (71 percent) applicable sample records had quarterly face-to-face meetings completed and documented. However, the records for ten individuals did not meet the requirement as indicated below:

1. The records for individuals #10, #21, #28, #31, and #33 contained documentation of three of the required meetings.

2. The record for individuals #9, #14, and #24 contained documentation of two of the required meetings.

3. The record for individual #26 contained documentation of one of the required meetings.

4. The record for individual #32 did not contain documentation of any of the required meetings.

2.13.a Recommendations	Regional Center Plan/Response

NLACRC should ensure that all future face-to-face meetings are completed and documented each quarter for individuals #9, #10, #14, #21, #24, #26, #28, #31, #32, and #33.	**Continued training regarding the importance of timely quarterlies being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Huddle Meetings.**
In addition, NLACRC should evaluate what actions may be necessary to ensure that quarterly face-to face meetings are completed and documented for all applicable individual served.	**The importance of timely quarterly face-to-face meetings and progress reports discussed at Case Management Leadership Huddle Meeting on 9/12/22. Supervisors to ensure implementation of monitoring timely complete of reports during scheduled supervision with each Service Coordinator. Continued training provided to Service Coordinators and Supervisors regarding this HCBS Waiver requirement from date of IPP. Floater Service Coordinator positions implemented to provide support for uncovered caseloads in an attempt to ensure compliance. Last, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

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

Findings

Twenty-four of the thirty-four (71 percent) applicable sample records had quarterly reports of progress completed for individuals living in community out-of-home settings. However, the records for ten individuals did not meet the requirement as indicated below:

1. The records for individuals #10, #21, #28, #31, and #33 contained documentation of three of the required quarterly reports of progress.

2. The record for individuals #9, #14, and #24 contained documentation of two of the required quarterly reports of progress.

3. The record for individual #26 contained documentation of one of the required quarterly reports of progress.

4. The record for individual #32 did not contain documentation of any of the required quarterly reports of progress.

2.13.b Recommendations	Regional Center Plan/Response
NLACRC should ensure that future quarterly reports of progress are completed for individuals #9, #10, #14, #21, #24, #26, #28, #31, #32, and #33.	**Continued training regarding the importance of timely quarterlies being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Huddle Meetings.**
In addition, NLACRC should evaluate what actions may be necessary to ensure that quarterly reports of progress are completed for all applicable individuals served.	**The importance of timely quarterly face-to-face meetings and progress reports discussed at Case Management Leadership Huddle Meeting on 9/12/22. Supervisors to ensure implementation of monitoring timely complete of reports during scheduled supervision with each Service Coordinator. Continued training provided to Service Coordinators and Supervisors regarding this HCBS Waiver requirement from date of IPP. Floater Service Coordinator positions implemented to provide support for uncovered caseloads in an attempt to ensure compliance. Last, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

2.14 Face-to-face reviews are completed no less than once every 30 days for the first 90 days following the individual's move from a developmental center to a community living arrangement. *(WIC §4418.3)*

Finding

Four records were reviewed to confirm face-to-face meetings were conducted no less than once every 30 days for the first 90 days following the individual's move from a developmental center to a community living arrangement. However, the records for three individuals did not meet the requirement as indicated below:

1. The records for individuals DC #2 and DC #3 contained documentation of two of the required face-to-face meetings.

2. The record for individual DC #1 contained documentation of one of the required face-to-face meetings.

2.14 Recommendations	Regional Center Plan/Response
NLACRC should ensure that face-to-face meetings are conducted no less than once every 30 days for the first 90 days for all individuals moving from a developmental center to a community living arrangement.	**Continued training regarding the importance of timely 30, 60, and 90 day meetings being provided to Service Coordinators, Supervisors, and Directors at unit meetings and Case Management Leadership Huddle Meetings.**
In addition, NLACRC should evaluate what actions may be necessary to ensure that face-to-face meetings are completed for all applicable individuals served.	**The importance of timely 30, 60, and 90 day face-to-face meetings and progress reports discussed at Case Management Leadership Huddle Meeting on 9/12/22. Supervisors to ensure implementation of monitoring timely complete of reports during scheduled supervision with each Service Coordinator. Continued training provided to Service Coordinators and Supervisors regarding this HCBS Waiver requirement. Last, NLACRC has implemented a tracking data base, Power BI Caseload Reports, to assist Case Management with DDS compliance.**

Regional Center Record Review Summary **Sample Size = 67** *(see Section II, Part III)*						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.0	The individual is Medi-Cal eligible. *(SMM 4442.1)*	63		4	100	None
2.1	Each record contains a Medicaid Waiver Eligibility Record (DS 3770), signed by a Qualified Intellectual Disabilities Professional (QIDP), which documents the date of the individual's initial HCBS Waiver eligibility certification, annual recertifications, the individual's qualifying conditions and short-term absences. *(SMM 4442.1), [42 CFR 483.430(a)]*	Criterion 2.1 consists of four sub-criteria (2.1.a-d) that are reviewed and rated independently.				
2.1.a	The DS 3770 is signed by a Qualified Intellectual Disabilities Professional and the title "QIDP" appears after the person's signature.	63		4	100	None
2.1.b	The DS 3770 form identifies the individual's qualifying conditions and any applicable special health care requirements for meeting the Title 22 level of care requirements.	62		5	100	None
2.1.c	The DS 3770 form documents annual re-certifications.	62		5	100	None
2.1.d	The DS 3770 documents short-term absences of 120 days or less, if applicable.			67	NA	None
2.2	Each record contains a dated and signed Medicaid Waiver Consumer Choice of Services/Living Arrangements form, (DS 2200). *(SMM 4442.7), [42 CFR 441.302(d)]*	27	36	4	44	See Narrative
2.3	There is a written notification of a proposed action and documentation that the individual has been sent written notice of their fair hearing rights whenever choice of living arrangements is not offered, services or choice of services are denied, the individual/parent/legal guardian or legal representative does not agree with all or part of the components in the individual's IPP, or the individual's HCBS Waiver eligibility has been terminated. *(SMM 4442.7), (42 CFR Part 431, Subpart E), [WIC §4710(a)(1)]*			67	NA	None

Regional Center Record Review Summary **Sample Size = 67** *(see Section II, Part III)*						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.4	Each record contains a current Client Development Evaluation Report (CDER) that has been reviewed within the last 12 months. *(SMM 4442.5), (42 CFR 441.302)*	54	9	4	86	See Narrative
2.5.a	The individual's qualifying conditions and any special health care requirements used to meet the level of care requirements for care provided in an ICF/DD, ICF/DD-H, and ICF/DD-N facility are documented in the individual's CDER and other assessments. *(SMM 4442.5), [42 CFR 441.302(c)], (Title 22, CCR, §51343)*	62		5	100	None
2.5.b	The individual's qualifying conditions documented in the CDER are consistent with information contained in the individual's record.	58	3	6	95	See Narrative
2.6.a	IPP is reviewed (*at least annually*) by the planning team and modified as necessary in response to the individual's changing needs, wants or health status. *[42 CFR 441.301(b)(1)(l)]*	56	6	5	90	See Narrative
2.6.b	The HCBS Waiver Standardized Annual Review Form is completed and signed annually by the planning team to document whether or not a change to the existing IPP is necessary, and health status and CDER have been reviewed. (*HCBS Waiver requirement*)	31	15	17	67	See Narrative
2.7.a	The IPP is signed, prior to its implementation, by an authorized representative of the regional center and the individual, or where appropriate, his/her parents or legal guardian or conservator. *[WIC §4646(g)]*	57	6	4	90	See Narrative
2.7.b	IPP addenda are signed by an authorized representative of the regional center and the individual, or where appropriate, his/her parents, legal guardian, or conservator.	44	1	22	98	See Narrative
2.7.c	The IPP is prepared jointly with the planning team. *[WIC §4646(d)]*	62		5	100	None
2.8	The IPP includes a statement of goals based on the needs, preferences and life choices of the individual. *[WIC §4646.5(a)]*	62		5	100	None

Regional Center Record Review Summary **Sample Size = 67** *(see Section II, Part III)*						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.9	The IPP addresses the individual's goals and needs. *[WIC §4646.5(a)(2)]*	Criterion 2.9 consists of seven sub-criteria (2.9.a-g) that are reviewed independently.				
2.9.a	The IPP addresses the qualifying conditions identified in the CDER and Medicaid Waiver Eligibility Record (DS 3770).	54	7	6	89	See Narrative
2.9.b	The IPP addresses special health care requirements.	10	2	55	83	See Narrative
2.9.c	The IPP addresses the services which the CCF provider is responsible for implementing.	15		52	100	None
2.9.d	The IPP addresses the services which the day program provider is responsible for implementing.	23	1	43	96	See Narrative
2.9.e	The IPP addresses the services which the supported living services agency or independent living services provider is responsible for implementing.	20		47	100	None
2.9.f	The IPP addresses the individual's goals, preferences and life choices.	62		5	100	None
2.9.g	The IPP includes a family plan component if the individual is a minor. *[WIC §4685(c)(2)]*	16		51	100	None
2.10.a	The IPP includes a schedule of the type and amount of all services and supports purchased by the regional center. *[WIC §4646.5(a)(4)]*	56	7	4	89	See Narrative
2.10.b	The IPP includes a schedule of the type and amount of all services and supports obtained from generic agencies or other resources. *[WIC §4646.5(a)(5)]*	62		5	100	None
2.10.c	The IPP specifies the approximate scheduled start date for the new services. *[WIC §4646.5(a)(5)]*	42		25	100	None
2.11	The IPP identifies the provider or providers of service responsible for implementing services, including but not limited to vendors, contract providers, generic service agencies and natural supports. *[WIC §4646.5(a)(5)]*	62		5	100	None

Regional Center Record Review Summary **Sample Size = 67** *(see Section II, Part III)*						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.12	Periodic review and reevaluations of progress are completed *(at least annually)* to ascertain that planned services have been provided, that progress has been achieved within the time specified, and the individual served and his/her family are satisfied with the IPP and its implementation. *[WIC §4646.5(a)(8)]*	59	3	5	95	See Narrative
2.13.a	Quarterly face-to-face meetings are completed for individuals living in community out-of-home settings, i.e., Service Level 2, 3 or 4 community care facilities, family home agencies or supported living and independent living settings. *(Title 17, CCR, §56047), (Title 17, CCR, §56095), (Title 17, CCR, §58680), (Contract requirement)*	24	10	33	71	See Narrative
2.13.b	Quarterly reports of progress are completed for individuals living in community out-of-home settings, i.e., Service Level 2, 3 or 4 community care facilities, family home agencies or supported living and independent living settings. *(Title 17, CCR, §56047), (Title 17, CCR, §56095), (Title 17, CCR, §58680), (Contract requirement)*	24	10	33	71	See Narrative
2.14	Face-to-face reviews are completed no less than once every 30 days for the first 90 days following the individual's move from a developmental center to a community living arrangement. *(WIC §4418.3)*	1	3	67	25	See Narrative

SECTION III

COMMUNITY CARE FACILITY RECORD REVIEW

I. Purpose

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

II. Scope of Review

Twelve records were reviewed at eleven CCFs visited by the monitoring team. The facilities' records were reviewed to determine compliance with 19 criteria.

III. Results of Review

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

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

IV. Findings and Recommendation

None

Community Care Facility Record Review Summary Sample Size: = 12						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
3.1	An individual file is maintained by the CCF that includes the documents and information specified in Title 17 and Title 22. *[Title 17, CCR, §56017(b)], [Title 17, CCR §56059(b)], (Title 22, CCR, §80069)*	12			100	None
3.1.a	The record contains a statement of ambulatory or non-ambulatory status.	12			100	None
3.1.b	The record contains known information related to any history of aggressive or dangerous behavior toward self or others.	4		8	100	None
3.1.c	The record contains current health information that includes medical, dental and other health needs of the consumer including annual visit dates, physicians' orders, medications, allergies, and other relevant information.	12			100	None
3.1.d	The record contains current emergency information: family, physician, pharmacy, etc.	12			100	None
3.1.e	The record contains a recent photograph and a physical description of the consumer.	12			100	None
3.1.i	Special safety and behavior needs are addressed.	4		8	100	None
3.2	The record contains a written admission agreement completed for the consumer that includes the certifying statements specified in Title 17 and is signed by the consumer or his/her authorized representative, the regional center and the facility administrator. *[Title 17, CCR, §56019(c)(1)]*	12			100	None
3.3	The facility has a copy of the consumer's current IPP. *[Title 17,CCR, §56022(c)]*	12			100	None

Community Care Facility Record Review Summary Sample Size: 12						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
3.4.a	Service Level 2 and 3 facilities prepare and maintain written semiannual reports of progress. *[Title 17, CCR, §56026(b)]*	7		5	100	None
3.4.b	Semiannual reports address and confirm the progress toward achieving each of the IPP objectives for which the facility is responsible.	7		5	100	None
3.5.a	Service Level 4 facilities prepare and maintain written quarterly reports of progress. *[Title 17, CCR, §56026(c)]*	4		8	100	None
3.5.b	Quarterly reports address and confirm the progress toward achieving each of the IPP objectives for which the facility is responsible.	4		8	100	None
3.5.c	Quarterly reports include a summary of data collected. *[Title 17, CCR, §56013(d)(4)], (Title 17, CCR, §56026)*	4		8	100	None
3.6.a	The facility prepares and maintains ongoing, written notes, as required by Title 17. *[Title 17, CCR §56026(a)]*	12			100	None
3.6.b	The ongoing notes/information verify that behavior needs are being addressed.	5		7	100	None
3.7.a	Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. *(Title 17, CCR, §54327)*	1		11	100	None
3.7.b	A written report of the special incident is submitted to the regional center within 48 hours after the occurrence of the special incident. *(Title 17, CCR, §54327)*	1		11	100	None
3.7.c	Follow-up activities were undertaken to prevent, reduce or mitigate future danger to the individual. *(Title 17, CCR, §54327)*	1		11	100	None

SECTION IV

DAY PROGRAM
RECORD REVIEW

I. Purpose

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

II. Scope of Review

One record was reviewed at one day program visited by the monitoring team. The records were reviewed to determine compliance with 17 criteria. Three criteria were not applicable for this review.

III. Results of Review

The record was 100 percent in compliance for fourteen criteria. Three criteria were rated as not applicable for this review.

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

IV. Findings and Recommendations

None

Day Program Record Review Summary Sample Size: 1						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
4.1	An individual file is maintained by the day program that includes the documents and information specified in Title 17. *(Title 17, CCR, §56730)*	1			100	None
4.1.a	The record contains current emergency and personal identification information including the individual's address, telephone number; names and telephone numbers of residential care provider, relatives, and/or guardian or conservator; physician name(s) and telephone number(s); pharmacy name, address and telephone number; and health plan, if appropriate.	1			100	None
4.1.b	The record contains current health information that includes current medications, known allergies; medical disabilities; infectious, contagious, or communicable conditions; special nutritional needs; and immunization records.	1			100	None
4.1.c	The record contains any medical, psychological, and social evaluations identifying the individual's abilities and functioning level, provided by the regional center.	1			100	None
4.1.d	The record contains an authorization for emergency medical treatment signed by the individual served and/or the authorized representative.	1			100	None
4.1.e	The record contains documentation that the individual and/or the authorized representative has been informed of his/her personal rights.	1			100	None
4.1.f	Data is collected that measures progress in relation to the services addressed in the IPP which the day program provider is responsible for implementing.	1			100	None

Day Program Record Review Summary Sample Size: 1						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
4.1.g	The record contains up-to-date case notes reflecting important events or information not documented elsewhere.	1			100	None
4.1.h	The record contains documentation that special safety and behavior needs are being addressed.	1			100	None
4.2	The day program has a copy of the individual's current IPP. *[Title 17, CCR §56720(b)]*	1			100	None
4.3.a	The day program provider develops, maintains, and modifies as necessary, documentation regarding the manner in which it implements the services addressed in the IPP. *[Title 17, CCR, §56720(a)]*	1			100	None
4.3.b	The day program's individual service plan or other program documentation is consistent with the services addressed in the individual's IPP.	1			100	None
4.4.a	The day program prepares and maintains written semiannual reports. *[Title 17, CCR, §56720(c)]*	1			100	None
4.4.b	Semiannual reports address the individual's performance and progress relating to the services for which the day program is responsible for implementing.	1			100	None
4.5.a	Special incidents are reported to the regional center within 24 hours after learning of the occurrence of the special incident. *(Title 17, CCR, §54327)*			1	NA	None
4.5.b	A written report of the special incident is submitted to the regional center within 48 hours after the occurrence of the special incident. *(Title 17, CCR, §54327)*			1	NA	None
4.5.c	There is appropriate follow-up to special incidents to resolve issue and eliminate or mitigate future risk. *(Title 17, CCR, §54327)*			1	NA	None

SECTION V

OBSERVATIONS AND INTERVIEWS

I. Purpose

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

II. Scope of Observations and Interviews

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

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

III. Results of Observations and Interviews

Thirty-four of the thirty-six individuals/parents of minors interviewed, indicated satisfaction with their living situation, day program, work activities, health, choice, and regional center services. However, individual #27 and individual #34 were not satisfied with some of their services or the living situation. The appearance for all of the individuals that were interviewed and observed reflected personal choice and individual style.

IV. Findings and Recommendation

Individual #27 stated that he was not satisfied with the supportive living services agency. Based on this interview, a referral for follow-up was requested by DDS. The follow-up review was completed by NLACRC to address the individual's concern. Accordingly, no recommendation is required.

Individual #34 stated that he was not satisfied with his current living situation.

Recommendation	Regional Center Plan/Response
NLACRC should follow up with individual #34 regarding his concerns.	**#34 Service Coordinator contacted individual #34 on 8/30/22 to follow up and address concerns. Service Coordinator provided individual #34 with a list of apartments. Quarterly face-to-face meeting held on 9/28/22 to implement plan to locate new living arrangement. Individual #34 agreed to work with NLACRC funded SLS agency to identify another home of choosing. As a result of behavioral concerns, individual #34 has had a change in SLS providers (Creative Choice, Modern Services). Referral sent to Right Choice in Home Care and accepted. New SLS agency will assist in identifying another home of choosing.**

SECTION VI A

SERVICE COORDINATOR INTERVIEWS

I. Purpose

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

II. Scope of Interviews

1. The monitoring team interviewed 11 NLACRC service coordinators.

2. The interview questions are divided into two categories.

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

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

III. Results of Interviews

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

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

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

3. The service coordinators monitor services, health and safety during periodic visits. They are aware of the individuals' health issues. The service coordinators were knowledgeable about the special incident reporting process

and work with the vendors to ensure all special incidents are reported and appropriate follow-up activities are completed

SECTION VI B

CLINICAL SERVICES INTERVIEW

I. Purpose

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

II. Scope of Interview

1. The monitoring team interviewed an NLACRC Registered Nurse.

2. The questions in the interview cover the following topics: routine monitoring of individuals with medical issues; medications and behavior plans; coordination of medical and mental health care for individuals; circumstances under which actions are initiated for medical or behavior issues; clinical supports to assist service coordinators; improved access to preventive health care resources; role in Risk Management Committee and special incident reports.

III. Results of Interview

1. The NLACRC clinical team consists of the Clinical Services Director, Director of Medical Services, physicians, registered nurses, behaviorists, psychologists, a psychiatrist, a dentist, and a dental hygienist.

2. Individuals who have significant health problems are referred for a nursing evaluation by the service coordinators. The clinical team and service coordinators work closely with providers and/or families to provide consultation, training, local resources and follow-up, as needed. Nurses also provide staff training on topics such as restricted health care conditions, medications, and falls. The registered nurses are available to visit hospitalized individuals and assist in the discharge planning process. They are also available to collaborate with the individuals' primary physician to assist with coordination of care.

3. The regional center nurses are available to review medication issues upon request from the service coordinator. The nurse reviews all medication Special Incident Reports (SIR) and provides onsite medication training for providers, as needed.

4. The clinical staff assists service coordinators with individuals' behavior and mental health needs. The psychiatrist is available for emergency consultation and follow-up until the individual is transitioned to community resources. He is also available to review psychotropic medication concerns. The behavioral team reviews behavior plans and makes recommendations to regional center staff, families and providers, as necessary. Onsite behavioral training is also available to providers. A behaviorist is available to participate in parenting groups and provides in-home evaluations and observations, as needed. If generic resources are unavailable, the regional center may provide funds for outpatient and inpatient mental health services.

5. The clinical team supports service coordinators on an ongoing basis. Service coordinators can access team members to assist them with health, dental, and nursing needs. They are also available to assist with coordinating generic resources, nursing, managed care and autism services. The clinical team participates in new employee orientation and offers ongoing trainings to all staff.

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

    - ✓ Maintaining a list of Medi-Cal providers;
    - ✓ Conducting multi-disciplinary evaluations;
    - ✓ Funding for physical therapy, adaptive equipment and other needs if no other resources are available;
    - ✓ Resource library available for families and providers;
    - ✓ Dental training for vendors and families;
    - ✓ Partnering with local home health agencies; and,
    - ✓ Providing funding for dental services, as needed.

    The Clinical Services Director participates on the Risk Management Committee. Members of the clinical team review health, medication and behavior-related special incidents. All deaths are reviewed by a physician and nurse from the clinical team. The regional center utilizes Mission Analytics Group, Inc., the State's risk management contractor, to analyze special incidents for trends and makes recommendations for appropriate follow-up and training, as

needed. Recent trainings have included fall prevention, medication administration, and SIR reporting requirements.

SECTION VI C

QUALITY ASSURANCE INTERVIEW

I. Purpose

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

II. Scope of Interview

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

IV. Results of Interview

1. Community Services Specialists conducts the annual Title 17 visits and the two required unannounced visits. Service coordinators are assigned as liaisons to residential facilities and are responsible for conducting unannounced visits at community care facilities. Each review utilizes standardized report forms and checklists based on Title 17 regulations. The dates of the reviews are tracked in a database monitored by the QA supervisor. Additional unannounced visits are completed as needed.

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

3. The community services specialist completes investigations, determines findings, provides written documentation of any areas of the review, submits corrected action plans, reviews the investigation report with a facility administrator, plans a follow up visit to ensure compliance with Title 17 regulations, and provides any additional technical assistance as needed. When substantial inadequacies are identified, corrective action plans (CAP) are developed by the community services specialist.

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

trends and opportunities for training to mitigate risk. A designated community services specialist is a member of the Risk Management Committee which is overseen by the Risk Assessment Unit.

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

SECTION VII A

SERVICE PROVIDER INTERVIEWS

I. Purpose

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

II. Scope of Interviews

1. The monitoring team interviewed six service providers at six community care facilities and one day program where services are provided to individuals that were visited by the monitoring team.

2. The interview questions are divided into two categories.

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

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

III. Results of Interviews

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

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

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

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

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

SECTION VII B

DIRECT SERVICE STAFF INTERVIEWS

I. Purpose

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

II. Scope of Interviews

1. The monitoring team interviewed six direct service staff at six community care facilities and one day program where services are provided to the individuals that were visited by the monitoring team.

2. The interview questions are divided into two categories:

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

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

III. Results of Interviews

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

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

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

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

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

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

SECTION VIII

VENDOR STANDARDS REVIEW

I. Purpose

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

II. Scope of Review

1. The monitoring teams reviewed a total of six CCFs and one day program.

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

III. Results of Review

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

IV. Findings and Recommendations

8.1.c Maintenance

At CCF #5, it was observed that the toilet seat in the bathroom was in poor repair.

8.1.c Recommendation	Regional Center Plan/Response
NLACRC should ensure that all equipment at CCF #5 is in good repair.	**MET: Upon the identification of this finding the provider removed and replaced the item shortly after the monitoring visit which was confirmed by NLACRC Quality Assurance (QA) Specialist and Supervisor. NLACRC QA Unit conducted 4 subsequent visits (Unannounced Visits and Annual Reviews) to the home and found no issues or concerns – home was in good repair.**

	NLACRC QA Unit will continue to monitor homes in accordance with the regulation to confirm services are provided in accordance with their approved vendored program planning, protect health and safety, and ensure residential services are provided in well maintained homes. Should findings be identified, NLACRC QA will collaborate with the provider to immediately bring them into compliance.

SECTION IX

SPECIAL INCIDENT REPORTING

I. Purpose

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

II. Scope of Review

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

2. The records of the 63 individuals selected for the Home and Community-Based Services (HCBS) Waiver sample were reviewed to determine that all required special incidents were reported to DDS during the review period.

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

III. Results of Review

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

2. NLACRC reported all special incidents in the sample of 63 records selected for the HCBS Waiver review to DDS.

3. NLACRC's vendors reported all (100 percent) applicable incidents in the supplemental sample within the required timeframes.

4. NLACRC reported nine of the ten (90 percent) incidents to DDS within the required timeframes.

5. NLACRC's follow-up activities on incidents were appropriate for the severity of the situations for the ten incidents.

IV. Finding and Recommendation

SIR #4: The incident occurred on December 3, 2021. However, NLACRC did not report the incident to DDS until December 8, 2021.

Recommendation	Regional Center Plan/Response
NLACRC should ensure that all incidents are reported to DDS within the required timeframes.	**Continued training regarding the importance of timely submission to DDS within the required timeframe for all special incidents being provided to Case Management and Risk Assessment Specialist/Unit.**

SAMPLE RECORDS AND SERVICE PROVIDERS/VENDORS

HCBS Waiver Review

#	UCI	CCF	DP
1	8192942	9	
2	5079199	1	
3	5729090	2	
4	7871807		
5	7836059	3	
6	7825623	7	
7	7815541	6	
8	7879025	11	
9	8121410		
10	5041249	4	
11	7853872	4	
12	6921926	10	
13	7832041	5	
14	7883287	8	
15	7807035		1
16	5461306		
17	6022354		
18	8137270		
19	7814387		
20	6604334		
21	7852585		
22	8134177		
23	7839640		
24	7805138		
25	7407374		
26	7883400		
27	7602032		
28	7899631		
29	7899456		
30	6605299		
31	7824113		
32	7602264		
33	5348040		
34	7430269		
35	7894772		
36	7887214		2
38	7898382		

#	UCI	CCF	DP
39	4873824		
40	5728753		
41	5858212		
42	7871001		
43	7886526		
44	7882556		
45	8139242		
46	5348586		
47	7876863		
48	8152181		
49	8116864		
50	8112153		
51	8205967		
52	8218032		
53	8134852		
54	7909645		
55	7880444		
56	7875835		
57	8141580		
58	8139659		
59	8180752		
60	7620769		
61	7875135		
62	8138625		
63	7873752		

Supplemental Sample Developmental Center records

#	UCI
DC-1	8112988
DC-2	8139429
DC-3	7815681
DC-4	7884221

Supplemental New Enrollees Sample

#	UCI
NE-1	1968809
NE-2	5361571
NE-3	5381637
NE-4	5556444
NE-5	6048702
NE-6	5028402

HCBS Waiver Review Service Providers

CCF #	Vendor
1	HL0350
2	HL0950
3	PL1206
5	PL2000
6	HL0235
7	HL0355
8	HL0824
9	HL0471
10	HL0789
11	HL0575

Day Program #	Vendor
1	HL0304
2	HL0126

SIR Review sample

#	UCI	Vendor
SIR 1	5759444	PL1293
SIR 2	7886998	PL1000
SIR 3	7925756	HL0708
SIR 4	7303632	H32804
SIR 5	7845597	PL0751
SIR 6	7615611	HL0630
SIR 7	7853971	PL0654
SIR 8	8192012	HL0415
SIR 9	7833163	HL0216
SIR 10	7888844	H32772