DEPARTMENT OF DEVELOPMENTAL SERVICES
1600 NINTH STREET, Room 320, MS 3-8
SACRAMENTO, CA 95814
TTY (916) 654-2054 (For the Hearing Impaired)
(916) 654-1954

April 2, 2019

Confidential Client Information
See California Welfare and Institutions
Code Sections 4514 and 5328

Mark Higgins, Board President
Frank D. Lanterman Regional Center
3303 Wilshire Blvd, Suite 700
Los Angeles, CA 90010

Dear Mr. Higgins:

Enclosed are the final reports from the joint Department of Developmental Services' (DDS) and Department of Health Care Services' monitoring review of the Home and Community-Based Services Waiver, 1915(i) State Plan Amendment, Targeted Case Management and Nursing Home Reform programs conducted from February 5–9, 2018, at Frank D. Lanterman Regional Center (FDLRC). The period of review was December 1, 2016 through November 30, 2017.

The reports discuss the criteria reviewed along with any findings and recommendations and include FDLRC's responses. DDS has approved FDLRC's responses to all of the recommendations. If there is a disagreement with the findings of the enclosed reports, a written "Statement of Disputed Issues" should be sent within 30 days from the date of this letter to:

Department of Developmental Services
Attn: Erin Paulsen, Chief
Federal Programs Monitoring Section
1600 9th Street, Room 320, MS 3-11
Sacramento, CA 95814

The cooperation of FDLRC's staff in completing the monitoring review is appreciated. If you have questions, please contact Erin Paulsen at (916) 654-2977.

Sincerely,

Original signed by:

JIM KNIGHT
Assistant Deputy Director
Community Services Division

Enclosures

cc: Melinda Sullivan, FDLRC
Jocelyn Doucette, FDLRC

Frank D. Lanterman Regional Center
Targeted Case Management and
Nursing Home Reform
Monitoring Review Report

Conducted by:

Department of Developmental Services

February 5–9, 2018

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Department of Developmental Services (DDS) conducted a federal compliance monitoring review of the Targeted Case Management (TCM) and Nursing Home Reform (NHR) programs from February 5–9, 2018, at Frank D. Lanterman Regional Center (FDLRC). The monitoring team selected 25 consumer records for the TCM review. A sample of nine records was selected for consumers who had previously been referred to FDLRC for an NHR assessment.

Purpose of the Review

Case management services for regional center consumers with developmental disabilities were added as a medical benefit to the Medi-Cal State Plan in 1986 under Title XIX of the Social Security Act. TCM services are those " . . . services which will assist individuals in gaining access to needed medical, social, educational, and other services." DDS implemented the TCM program statewide on July 1, 1988.

The NHR Pre-Admission Screening/Resident Review (PAS/RR) program involves determining whether an individual in a nursing facility with suspected developmental disabilities is developmentally disabled and requires specialized services.

Overview of the TCM/NHR Compliance Monitoring Protocol

The review criteria for the TCM and NHR programs are derived from federal and state statutes and regulations and the Centers for Medicare & Medicaid Services' guidelines relating to the provision of these services.

Findings

Section I – Targeted Case Management

Twenty-five consumer records, containing 1,295 units, were reviewed for three criteria. The sample records were 99 percent in compliance for criterion 1 (TCM service and unit documentation matches the information transmitted to DDS), 98 percent in compliance for criterion 2 (TCM service documentation is consistent with the definition of TCM service), and 100 percent in compliance for criterion 3 (TCM service documentation identifies the individual who wrote the note and the date the note was completed).

Section II – Nursing Home Reform

Nine consumer records were reviewed for three criteria. The nine sample records were 100 percent in compliance for criterion 1 (records contain evidence of DDS' NHR referrals), 100 percent in compliance for criterion 2 (reporting disposition of referrals to DDS), and 100 percent in compliance for criterion 3 (submission of billing claims forms).

SECTION I
TARGETED CASE MANAGEMENT

Criterion

1. The Targeted Case Management (TCM) service and unit documentation matches information transmitted to the Department of Developmental Services (DDS).

   Findings

   FDLRC transmitted 1,295 TCM units to DDS for the 25 sample consumers. Of this total, 1,284 (99 percent) of the units had documentation supporting the number of units reported to DDS. Eleven of the units did not have supporting documentation. A detailed description of this finding and the actions required will be sent under a separate cover letter to FDLRC.

Recommendation	Regional Center Plan/Response
FDLRC should ensure that the time claimed for units without supporting documentation is reversed.	The identified deficiencies were reviewed and appropriate action taken for those case records that did not have supporting documentation. FDLRC completed the "Deleting TCM Units" excel spreadsheet developed by DDS to reverse the TCM units on 10/26/18. The excel spreadsheet was transmitted with the monthly transmission reports at the end of October 2018. FDLRC manually made corresponding changes within the system. FDLRC service coordinators will receive training in the documentation of Title 19 ID notes (to ensure supporting documentation of case management activities are in clients' case records) within the first quarter of 2019.

2. The TCM service documentation billed to DDS is consistent with the definition of TCM service.

   Allowable TCM units are based on services which assist consumers to gain access to needed social, educational, medical or other services and include the following components: 1) assessment and periodic reassessment to determine service needs; 2) development and periodic revision of an individual program plan (IPP) based on the information collected through the assessment or reassessment; 3) monitoring and follow-up activities, including activities and contacts that are necessary to ensure that

the IPP is effectively implemented and adequately addresses the needs of the consumer; and, 4) referral and related activities to help the consumer obtain needed services. However, it is important to note that TCM does not include the direct provision of these needed services.

Findings

The 25 sample consumer records contained 1,295 billed TCM units. Of this total, 1,267 (98 percent) of the units contained descriptions that were consistent with the definition of TCM services. Of the billed units, 28 had descriptions of activities that were not consistent with the definition of TCM services. Detailed information on these findings and the specific actions required will be sent under a separate cover letter.

Recommendations	Regional Center Plan/Response
FDLRC should ensure that the time spent on the identified activities that are inconsistent with TCM services (sent separately) is reversed.	The identified deficiencies were confirmed and FDLRC completed the "Deleting TCM Units" excel spreadsheet developed by DDS to reverse the TCM units on 10/26/18. The excel spreadsheet was transmitted with the monthly transmission reports at the end of October 2018. FDLRC manually made corresponding changes within the system. FDLRC service coordinators will receive training in the documentation of Title 19 ID notes (detailed description of activity and the corresponding activity type) within the first quarter of 2019.

3. The TCM documentation identifies the service coordinator recording the notes and each note is dated.

Finding

The TCM documentation in the 25 sample consumer records identified the service coordinator who wrote the note and the date the service was completed.

Recommendation

None

SECTION II
NURSING HOME REFORM

Criterion

1. There is evidence of dispositions for the Department of Developmental Services' (DDS) Nursing Home Reform (NHR) referrals.

   Finding

   The nine sample consumer records contained a copy of the Pre-Admission Screening/Resident Review (PAS/RR) Level I form or NHR automated printout.

   Recommendation

   None

2. The disposition is reported to DDS.

   Finding

   The nine sample consumer records contained a PAS/RR Level II document or written documentation responding to DDS' request for a disposition.

   Recommendation

   None

3. The regional center submitted a claim for the referral disposition.

   Finding

   The billing information for all nine sample consumers had been entered into the AS 400 computer system.

   Recommendation

   None

SAMPLE CONSUMERS

TCM Review

#	UCI	#	UCI
1	[redacted]	14	[redacted]
2	[redacted]	15	[redacted]
3	[redacted]	16	[redacted]
4	[redacted]	17	[redacted]
5	[redacted]	18	[redacted]
6	[redacted]	19	[redacted]
7	[redacted]	20	[redacted]
8	[redacted]	21	[redacted]
9	[redacted]	22	[redacted]
10	[redacted]	23	[redacted]
11	[redacted]	24	[redacted]
12	[redacted]	25	[redacted]
13	[redacted]		

NHR Review

#	UCI
1	[redacted]
2	[redacted]
3	[redacted]
4	[redacted]
5	[redacted]
6	[redacted]
7	[redacted]
8	[redacted]
9	[redacted]

ATTACHMENT I

TCM DISTRIBUTION OF FINDINGS

CRITERION PERFORMANCE INDICATOR Sample Size: 25 Records Billed Units Reviewed: 1,295	# OF OCCURRENCES			% OF OCCURRENCES	
	YES	NO	NA	YES	NO
1. The TCM service and unit documentation matches the information transmitted to DDS.	1,284	11		99	1
2. The TCM service documentation billed to DDS is consistent with the definition of TCM service.	1,267	28		98	2
3. The TCM documentation identifies the service coordinator recording the notes and each note is dated.	1,295	0		100	0

NHR DISTRIBUTION OF FINDINGS

CRITERION PERFORMANCE INDICATOR Sample Size: 10 Records	# OF OCCURRENCES			% OF OCCURRENCES	
	YES	NO	NA	YES	NO
1. There is evidence of dispositions for DDS NHR referrals.	9			100	
2. Dispositions are reported to DDS.	9			100	
3. The regional center submits claims for referral dispositions.	9			100	

Frank D. Lanterman Regional Center
Home and Community-Based Services Waiver
Monitoring Review Report

Conducted by:

Department of Developmental Services
and
Department of Health Care Services
February 5–9, 2018

TABLE OF CONTENTS

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 February 5–9, 2018, at Frank D. Lanterman Regional Center (FDLRC). The monitoring team members were Nora Muir (Team Leader), Linda Rhoades and Ray Harris from DDS, and Annette Hanson and Raylyn Garrett 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 consumers' needs and program requirements are being met and that services are being provided in accordance with the consumers' 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 the 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 25 HCBS Waiver consumer records. In addition, the following supplemental sample consumer records were reviewed: 1) three consumers whose HCBS Waiver eligibility had been previously terminated; 2) three consumers who moved from a developmental center, and 3) ten consumers who had special incidents reported to DDS during the review period of December 1, 2016 through November 30, 2017.

The monitoring team completed visits to three community care facilities (CCF) and six day programs. The team reviewed three CCF and seven day program consumer records and interviewed and/or observed 18 selected sample consumers.

Overall Conclusion

FDLRC is in substantial compliance with the federal requirements for the HCBS Waiver program. Specific recommendations that require follow-up actions by FDLRC are included in the report findings. DDS is requesting documentation of follow-up actions taken by FDLRC 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 FDLRC has systems and procedures in place for implementing the state and HCBS Waiver requirements addressed in the self-assessment criteria.

Section II – Regional Center Consumer Record Review

Twenty-five sample consumer records were reviewed for 31 documentation requirements (criteria) derived from federal and state statutes and regulations and HCBS Waiver requirements. Criterion 2.9.a was 26 percent in compliance because 17 of the 23 applicable consumer records did not address the qualifying conditions in the IPP. One criterion was not applicable for this review.

The sample records were 95 percent in overall compliance for this review. FDLRC's records were 97 percent and 98 percent in overall compliance for the collaborative reviews conducted in 2016 and in 2014, respectively.

Section III – Community Care Facility (CCF) Consumer Record Review

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

FDLRC's records were 100 percent in overall compliance for the collaborative reviews conducted in 2016 and in 2014.

Section IV – Day Program Consumer Record Review

Seven consumer records were reviewed at six day programs for 17 documentation requirements (criteria) derived from Title 17, California Code of Regulations. The sample records were 98 percent in overall compliance for this review. Three criteria were not applicable for this review.

FDLRC's records were 99 percent in overall compliance for the collaborative reviews conducted in 2016 and in 2014.

Section V – Consumer Observations and Interviews

Eighteen sample consumers, 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 consumers were in good health and were treated with dignity and respect. All of the interviewed consumers/parents indicated that they were satisfied with their services, health and choices.

Section VI A – Service Coordinator Interviews

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

Section VI B – Clinical Services Interview

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

Section VI C – Quality Assurance (QA) Interview

The community services specialist was interviewed using a standard interview instrument. He responded to questions regarding how FDLRC 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

Five service providers at three CCFs and two day programs were interviewed using a standard interview instrument. The service providers responded to questions regarding their knowledge of the consumer, the annual review process, and the monitoring of health issues, medication administration, progress, safety and emergency preparedness. The staff was familiar with the consumers and knowledgeable about their roles and responsibilities.

Section VII B – Direct Service Staff Interviews

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

Section VIII – Vendor Standards Review

The monitoring team reviewed three CCFs and two day programs utilizing a standard checklist with 23 criteria that are consistent with HCBS Waiver requirements. The reviewed vendors 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 25 HCBS Waiver consumers and 10 supplemental sample consumers for special incidents during the review period. FDLRC reported all special incidents for the sample selected for the HCBS Waiver review. For the supplemental sample, the service providers reported all special incidents to FDLRC within the required timeframes, and FDLRC subsequently transmitted 9 of the 10 special incidents to DDS within the required timeframes. FDLRC's follow-up activities for the 10 consumer 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 Frank D. Lanterman Regional Center's (FDLRC) 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

FDLRC 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 FDLRC 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 Mental Retardation Professional (QMRP). 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 CCF annually to assure services are consistent with the program design and applicable laws and oversees 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
CONSUMER 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, consumer 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 consumer's needs and services is tracked as a part of the onsite program reviews.

II. Scope of Review

1. Twenty-five HCBS Waiver consumer records were selected for the review sample.

Living Arrangement	# **of Consumers**
Community Care Facility (CCF)	9
With Family	12
Independent or Supported Living Setting	4

2. The review period covered activity from December 1, 2016 to November 30, 2017.

III. Results of Review

The 25 sample consumer records were reviewed for 31 documentation requirements derived from federal and state statutes and regulations and HCBS Waiver requirements. Three supplemental records were reviewed solely for documentation that FDLRC had either provided the consumer with written notification prior to termination of the consumer's HCBS Waiver eligibility or the consumer had voluntarily disenrolled from the HCBS Waiver. Additionally, three supplemental records were reviewed solely for documentation indicating that the consumer received face-to-face reviews every 30 days for the first 90 days after moving from a developmental center.

- ✓ The sample records were 100 percent in compliance for 23 criteria. There are no recommendations for these criteria. One criterion was not applicable for this review.

- ✓ Findings for seven 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

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

Findings

Twenty-three of the twenty-five (92 percent) sample consumer records documented level-of-care qualifying conditions that were consistent with information found elsewhere in the record. However, information contained in two consumer records (detailed below) did not support the determination that all of the issues identified in the CDER and DS 3770 could be considered qualifying conditions. Unless otherwise noted in the list below, the following were identified as qualifying conditions on the DS 3770, but there was no supporting information in the consumers' records (IPP, progress reports, vendor reports, etc.) that described the impact of the identified conditions or need for services and supports.

Consumer #6: "Assistance with medication" and "assistance with dressing."

Consumer #8: "Assistance with medication," "assistance with personal care" and "constant supervision in unfamiliar settings."

2.5.b Recommendation	Regional Center Plan/Response
FDLRC should determine if the items listed above for consumers #6 and #8 are appropriately identified as qualifying conditions. The consumers' DS 3770 forms should be corrected to ensure that any items that do not represent substantial limitations in the consumers' ability to perform activities of daily living and/or participate in community activities are no longer identified as qualifying conditions. If FDLRC determines that any of the issues above are correctly identified as qualifying conditions, documentation (updated IPPs, progress reports, etc.) that support the original determinations should be submitted with the response to this report. If the consumer does not have at least two distinct qualifying conditions that meet the level-of-care requirements, the consumer's HCBS Waiver eligibility should be terminated.	A Medicaid Waiver specialist reviewed the clients' documentation and made the appropriate changes to reflect the status of clients #6 and #8. Both clients continue to meet the level-of-care requirements to be Waiver eligible. The Medicaid Waiver specialist will consult with the service coordinator if she/he notices any change in level of care in current documents (IPP, Annual Review (AR) and CDER) during the recertification process to determine Waiver eligibility.

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 consumer's health status and CDER have been reviewed. (HCBS Waiver requirement)

Finding

Twenty-one of the twenty-two (96 percent) applicable sample consumer records contained a completed SARF. However, the record for consumer #24 did not contain a completed SARF.

2.6.b Recommendation	Regional Center Plan/Response
FDLRC should ensure that a SARF is completed and signed for consumer #24 during the annual IPP review process.	Client #24's case record was inactivated effective as of 3/6/18 due to a lack of contact. The service coordinator attempted to reach the client and family through correspondence; however, there was no response. No action taken.

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

Finding

Twenty-four of the twenty-five (96 percent) sample consumer records contained IPPs that were signed by FDLRC and the consumers or their legal representatives. However, the IPP for consumer #7 was not signed by the consumer and the regional center.

2.7.a Recommendation	Regional Center Plan/Response
FDLRC should ensure that consumer #7 and the regional center sign the current IPP and maintain a copy of the signature page on file.	The service coordinator obtained client's signature for the IPP agreement dated 9/26/17. As the service coordinators submit their documents (quarterlies, ARs and amendments), the regional manager will review IPP agreement signature forms for signatures. If signature(s) are missing, the regional manager will discuss with the service coordinator their attempts to obtain appropriate signatures. After three failed attempts, the service coordinator will schedule an interdisciplinary meeting to discuss what course of action the regional center will take. Upon any new service requests or change, if the IPP signature form is not signed, the service coordinator will discuss with client/family the inability to move forward unless the IPP has been reviewed, approved and signed. The service coordinator will discuss the matter with regional manager and the regional center's legal consultant.

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

Six of the twenty-three (26 percent) applicable sample consumer records contained IPPs that addressed the consumers' qualifying conditions. However, the IPPs for 17 consumers did not address supports for qualifying conditions identified in the record as indicated below:

1. Consumer #1: "Emotional outbursts" as mentioned in the care home's quarterly review dated November 6, 2017;

2. Consumer #4: "Eating" and "Safety Awareness" as mentioned in the annual review report dated October 9, 2017;

3. Consumer #7: "Personal care" as mentioned in the annual review report dated September 26, 2017;

4. Consumer #9: "Safety awareness" as mentioned in the annual review report dated January 31, 2017;

5. Consumer #10: "Personal care," "dressing" and "running/wandering" as mentioned in the annual review report dated September 22, 2017;

6. Consumer #11: "Assistance with medication" and "safety awareness" as mentioned in the annual review report dated January 2, 2017;

7. Consumer #12: "Seizures" as mentioned in the annual review report dated March 9, 2017;

8. Consumer #13: "Supervision during waking hours" as mentioned in the annual review report dated April 4, 2017;

9. Consumer #14: "Walking," "bladder and bowel control" and "personal care" as mentioned in the annual review report dated August 25, 2017;

10. Consumer #15: "Reminders for medication," "assistance with wheelchair" and "seizures" as mentioned on the annual review report dated April 18, 2017;

11. Consumer #19: "Blind," "wheelchair," "feeding" and "personal care" as mentioned in the annual review report dated June 28, 2017;

12. Consumer #20: "Safety awareness," "disruptive behaviors" and "emotional outbursts" as mentioned in the annual review report dated March 7, 2017;

13. Consumer #21: "Personal care" and "dressing" as mentioned in the annual review report dated March 13, 2017;

14. Consumer #22: "Assistance with medication" and "emotional outbursts" as mentioned in the annual review report dated November 3, 2017;

15. Consumer #23: "Assistance with personal care," "disruptive social behavior" and "emotional outbursts" as mentioned in the annual review report dated October 24, 2017;

16. Consumer #24: "Assistance with medication" and "someone nearby during waking hours" as mentioned in the annual review report dated October 21, 2016; and,

17. Consumer #25: "Personal care" as mentioned in the annual review report dated May 31, 2017.

2.9.a Recommendations	Regional Center Plan/Response
1. FDLRC should ensure that the IPPs for consumers #1, #4, #7, #9, #10, #11, #12, #13, #14, #15, #19, #20, #21, #22, #23, #24 and #25 include the services and supports in place for the issues as listed above.	Amendments were generated to include the supports and services in place to address the Medicaid Waiver qualifying deficits. Client #14 deceased (1/17/18), no action taken. Client #24's case record was inactivated effective as of 3/6/18 due to a lack of contact; no action taken.
2. In addition, FDLRC should evaluate what actions may be necessary to ensure that IPPs contain services and supports for all consumers.	The service coordinator's case management responsibility consists of evaluating and/or identifying generic resources and regional center funded services and reviewing service providers' reports for appropriateness and meeting the needs of the client. The regional managers were instructed to thoroughly review the IPP, Annual Review, CDER, and DS 3770 for consistent documentation in identifying the Medicaid Waiver deficits and level of care. Any change in level of care and/or a change in current regional center funded services will be

	documented in an amendment. The management team is working on developing a new IPP that will incorporate a current status component that will provide detailed information on the level of care, who will provide the supports and training and the frequency of services (generic and/or regional center funded).

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

Findings

Eleven of the thirteen (85 percent) applicable sample consumer records contained IPPs that addressed the consumers' day program services. However, the IPPs for consumers #2 and #3 did not include the services that the day program provider is responsible for implementing.

2.9.d Recommendation	Regional Center Plan/Response
FDLRC should ensure that the IPPs for consumers #2 and #3 address the services that the day program provider is responsible for implementing.	Amendments were generated to address the services that the day program provider is responsible for implementing. The management team is working on developing a new IPP that will incorporate a current status component that will provide detailed information on the level of care, who will provide the supports and training and the frequency of services (generic and/or regional center funded).

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

Findings

Twenty-two of the twenty-five (88 percent) sample consumer records contained IPPs that include all services and supports purchased by the regional center. However, the IPPs for the following consumers did not include the following supports purchased by the regional center:

1. Consumer #1: Transportation;

2. Consumer #9: CCF and day program services; and,

3. Consumer #11: Respite.

2.10.a Recommendation	Regional Center Plan/Response
FDLRC should ensure that the IPPs for consumers #1, #9 and #11 include a schedule of the type and amount of all services and supports purchased by the regional center.	Amendments were generated to include the supports and services purchased by the regional center. The current IPP developed in collaboration with KEA and the management team automatically populates all current purchase of service authorization(s) into the IPP and therefore, as a result, should significantly reduce the probability of deficiencies in this area in the future.

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

Findings

Twenty-four of the twenty-five (96 percent) sample consumer records contained documentation of periodic review and reevaluation of consumer progress at least annually. However, the record for consumer #24 did not contain documentation that the consumer's progress had been reviewed within the year.

2.12 Recommendation	Regional Center Plan/Response
FDLRC should ensure that a review and reevaluation of progress regarding planned services, timeframes and satisfaction for consumer #24 is completed and documented at least annually.	Client #24's case record was inactivated effective as of 3/6/18 due to a lack of contact. The service coordinator attempted to reach the client and family through correspondence; however, there was no response. No action taken.

Regional Center Consumer Record Review Summary Sample Size = 25 + 6 Supplemental Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.0	The consumer is Medi-Cal eligible. *(SMM 4442.1)*	25			100	None
2.1	Each record contains a Medicaid Waiver Eligibility Record (DS 3770), signed by a Qualified Mental Retardation Professional (QMRP), which documents the date of the consumer's initial HCBS Waiver eligibility certification, annual recertifications, the consumer'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 Mental Retardation Professional and the title "QMRP" appears after the person's signature.	25			100	None
2.1.b	The DS 3770 form identifies the consumer's qualifying conditions and any applicable special health care requirements for meeting the Title 22 level-of-care requirements.	25			100	None
2.1.c	The DS 3770 form documents annual re-certifications.	25			100	None
2.1.d	The DS 3770 documents short-term absences of 120 days or less, if applicable.	0		25	100	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)]*	25			100	None
2.3	There is a written notification of a proposed action and documentation that the consumer 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 consumer/parent/legal guardian or legal representative does not agree with all or part of the components in the consumer's IPP, or the consumer's HCBS Waiver eligibility has been terminated. *[SMM 4442.7; 42 CFR Part 431, Subpart E; W&I Code §4646(g)]*	3		25	100	None

Regional Center Consumer Record Review Summary Sample Size = 25 + 6 Supplemental Records						
	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)*	25			100	None
2.5.a	The consumer'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 consumer's CDER and other assessments. *(SMM 4442.5; 42 CFR 441.302(c); Title 22, CCR, §51343)*	25			100	None
2.5.b	The consumer's qualifying conditions documented in the CDER are consistent with information contained in the consumer's record.	23	2		92	See Narrative
2.6.a	IPP is reviewed (at least annually) by the planning team and modified as necessary in response to the consumer's changing needs, wants or health status. *[42 CFR 441.301(b)(1)(l)]*	25			100	None
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)*	21	1	3	96	See Narrative
2.7.a	The IPP is signed, prior to its implementation, by an authorized representative of the regional center and the consumer, or where appropriate, his/her parents or legal guardian or conservator. *[W&I Code §4646(g)]*	24	1		96	See Narrative
2.7.b	IPP addenda are signed by an authorized representative of the regional center and the consumer, or where appropriate, his/her parents, legal guardian, or conservator.	11		14	100	None
2.7.c	The IPP is prepared jointly with the planning team. *[W&I Code §4646(d)]*	25			100	None
2.8	The IPP includes a statement of goals based on the needs, preferences and life choices of the consumer. *[W&I Code §4646.5(a)]*	25			100	None

Regional Center Consumer Record Review Summary Sample Size = 25 + 6 Supplemental Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.9	The IPP addresses the consumer's goals and needs. *[W&I Code §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).	6	17	2	25	See Narrative
2.9.b	The IPP addresses special health care requirements.	2		23	100	None
2.9.c	The IPP addresses the services which the CCF provider is responsible for implementing.	9		16	100	None
2.9.d	The IPP addresses the services which the day program provider is responsible for implementing.	11	2	12	85	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.	4		21	100	None
2.9.f	The IPP addresses the consumer's goals, preferences and life choices.	25			100	None
2.9.g	The IPP includes a family plan component if the consumer is a minor. *[W&I Code §4685(c)(2)]*	7		18	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. *[W&I Code §4646.5(a)(4)]*	22	3		88	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. *[W&I Code §4646.5(a)(4)]*	25			100	None
2.10.c	The IPP specifies the approximate scheduled start date for the new services. *[W&I Code §4646.5(a)(4)]*	11		14	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. *[W&I Code §4646.5(a)(4)]*	25			100	None

Regional Center Consumer Record Review Summary Sample Size = 25 + 6 Supplemental Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.12	Periodic reviews and reevaluations of consumer progress are completed (at least annually) to ascertain that planned services have been provided, that consumer progress has been achieved within the time specified, and that the consumer and his/her family are satisfied with the IPP and its implementation. *[W&I Code §4646.5(a)(6)]*	24	1		96	See Narrative
2.13.a	Quarterly face-to-face meetings are completed for consumers 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)*	12		13	100	None
2.13.b	Quarterly reports of progress are completed for consumers 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)*	12		13	100	None
2.14	Face-to-face reviews are completed no less than once every 30 days for the first 90 days following the consumer's move from a developmental center to a community living arrangement*. (W&I Code §4418.3)*	3		25	100	None

SECTION III

COMMUNITY CARE FACILITY
CONSUMER RECORD REVIEW

I. Purpose

The review addresses the requirements for community care facilities (CCF) to maintain consumer records and prepare written reports of consumer 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

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

III. Results of Review

The consumer records were 100 percent in compliance for 16 criteria. Three criteria were not applicable for this review.

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

Community Care Facility Record Review Summary Sample Size: Consumers = 3; CCFs = 3						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
3.1	An individual consumer 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)*	3			100	None
3.1.a	The consumer record contains a statement of ambulatory or nonambulatory status.	3			100	None
3.1.b	The consumer record contains known information related to any history of aggressive or dangerous behavior toward self or others.	2		1	100	None
3.1.c	The consumer 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.	3			100	None
3.1.d	The consumer record contains current emergency information: family, physician, pharmacy, etc.	3			100	None
3.1.e	The consumer record contains a recent photograph and a physical description of the consumer.	3			100	None
3.1.i	Special safety and behavior needs are addressed.	3			100	None
3.2	The consumer 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)]*	3			100	None
3.3	The facility has a copy of the consumer's current IPP. *[Title 17, CCR, §56022(c)]*	3			100	None

Community Care Facility Record Review Summary Sample Size: Consumers = 3; CCFs = 3						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
3.4.a	Service Level 2 and 3 facilities prepare and maintain written semiannual reports of consumer progress. *[Title 17, CCR, §56026(b)]*	1		2	100	None
3.4.b	Semiannual reports address and confirm the consumer's progress toward achieving each of the IPP objectives for which the facility is responsible.	1		2	100	None
3.5.a	Service Level 4 facilities prepare and maintain written quarterly reports of consumer progress. *[Title 17, CCR, §56026(c)]*	2		1	100	None
3.5.b	Quarterly reports address and confirm the consumer's progress toward achieving each of the IPP objectives for which the facility is responsible.	2		1	100	None
3.5.c	Quarterly reports include a summary of data collected. *(Title 17, CCR, §56013(d)(4); Title 17, CCR, §56026)*	2		1	100	None
3.6.a	The facility prepares and maintains ongoing, written consumer notes, as required by Title 17. *[Title 17, CCR, §56026(a)]*	3			100	None
3.6.b	The ongoing notes/information verify that behavior needs are being addressed.	3			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)*			3	N/A	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)*			3	N/A	None
3.7.c	Follow-up activities were undertaken to prevent, reduce or mitigate future danger to the consumer. *(Title 17, CCR, §54327)*			3	N/A	None

SECTION IV

DAY PROGRAM
CONSUMER RECORD REVIEW

I. Purpose

The review criteria address the requirements for day programs to maintain consumer records and prepare written reports of consumer 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

Seven consumer records were reviewed at six day programs visited by the monitoring team. The records were reviewed to determine compliance with 17 criteria.

III. Results of Review

The consumer records were 100 percent in compliance for 13 criteria. Three criteria were not applicable for this review.

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

- ✓ Finding for one criterion is detailed below.

IV. Finding and Recommendation

4.2 The day program has a copy of the consumer's current IPP.
[Title 17, CCR, §56720)(b)]

Finding

Five of the seven (71 percent) applicable consumer records contained a copy of the consumer's current IPP. However, the records for consumers #3 and #5 at day program #3 did not contain a copy of their current IPP.

4.2 Recommendation	Regional Center Plan/Response
FDLRC should ensure that the records for consumer #3 and consumer #5 at day program #3 contain a current copy of the consumer's IPP.	The day programs for clients #3 and #5 were provided with current IPPs for their records on 11/20/18. SCs will be reminded to provide the day programs with current IPPs on a triennial basis.

Day Program Record Review Summary Sample Size: Consumers = 7; Day Programs = 6						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
4.1	An individual consumer file is maintained by the day program that includes the documents and information specified in Title 17. *(Title 17, CCR, §56730)*	7			100	None
4.1.a	The consumer record contains current emergency and personal identification information, including the consumer'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.	7			100	None
4.1.b	The consumer record contains current health information that includes current medications, known allergies; medical disabilities; infectious, contagious, or communicable conditions; special nutritional needs; and immunization records.	7			100	None
4.1.c	The consumer record contains any medical, psychological, and social evaluations identifying the consumer's abilities and functioning level, provided by the regional center.	7			100	None
4.1.d	The consumer record contains an authorization for emergency medical treatment signed by the consumer and/or the authorized consumer representative.	7			100	None
4.1.e	The consumer record contains documentation that the consumer and/or the authorized consumer representative has been informed of his/her personal rights.	7			100	None
4.1.f	Data is collected that measures consumer progress in relation to the services addressed in the IPP which the day program provider is responsible for implementing.	7			100	None
4.1.g	The consumer record contains up-to-date case notes reflecting important events or information not documented elsewhere.	7			100	None

Day Program Record Review Summary Sample Size: Consumers = 7; Day Programs = 6						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
4.1.h	The consumer record contains documentation that special safety and behavior needs are being addressed.	2		5	100	None
4.2	The day program has a copy of the consumer's current IPP. *[Title 17, CCR, §56720(b)]*	5	2		71	See Narrative
4.3.a	The day program provider develops, maintains, and modifies, as necessary, documentation regarding the manner in which it implements the services addressed in the IPP. *[Title 17, CCR, §56720(a)]*	7			100	None
4.3.b	The day program's individual service plan or other program documentation is consistent with the services addressed in the consumer's IPP.	7			100	None
4.4.a	The day program prepares and maintains written semiannual reports. *[Title 17, CCR, §56720(c)]*	7			100	None
4.4.b	Semiannual reports address the consumer's performance and progress relating to the services which the day program is responsible for implementing.	7			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)*			7	N/A	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)*			7	N/A	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)*			7	N/A	None

SECTION V

CONSUMER OBSERVATIONS AND INTERVIEWS

I. Purpose

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

II. Scope of Observations and Interviews

Eighteen of the twenty-five consumers, 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.

- ✓ Nine consumers agreed to be interviewed by the monitoring teams.
- ✓ Four consumers did not communicate verbally or declined an interview, but were observed.
- ✓ Five interviews were conducted with parents of minors.
- ✓ Seven consumers were unavailable for, or declined, interviews.

III. Results of Observations and Interviews

All consumers and parents of minors interviewed indicated satisfaction with their living situation, day program, work activities, health, choices, and regional center services. The consumers' overall appearance reflected personal choice and individual style.

SECTION VI A

SERVICE COORDINATOR INTERVIEWS

I. Purpose

The interviews determine how well the service coordinators know their consumers, 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 five Frank D. Lanterman Regional Center (FDLRC) service coordinators.

2. The interview questions are divided into two categories.

   - ✓ The questions in the first category are related to the consumers 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 their respective consumers. They were able to relate specific details regarding the consumers' 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 consumers' needs, preferences and satisfaction with services outlined in the IPP. For consumers in out-of-home placement settings, service coordinators conduct quarterly face-to-face visits and develop written assessments of consumer progress and satisfaction. In preparation for the quarterly visits, service coordinators review their previous progress reports, pertinent case notes, special incident reports, and vendor reports of progress.

3. To better understand issues related to consumers' use of medication and issues related to side effects, the service coordinators utilize FDLRC's medical director and online resources for medication.

4. The service coordinators monitor the consumers' services, health and safety during periodic visits. They are aware of the consumers' health issues. The service coordinators are 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 consumers 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 consumers.

II. Scope of Interview

The monitoring team interviewed Frank D. Lanterman Regional Center's (FDLRC) Nurse Consultant.

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

III. Results of Interview

The FDLRC clinical team consists of physicians, registered nurses, psychologists, a psychiatrist, a pharmacist, a registered dental hygienist, and a speech and occupational therapist.

The clinical team functions as a resource for the service coordinators, and is available to assess consumers with medical concerns. Nurses may visit hospitalized consumers to evaluate health status, consult with staff and assist with discharge planning. Service coordinators can present cases to the interdisciplinary team during the clinical review meeting for consumers with complex medical needs. Consumers with chronic unstable medical conditions are seen annually by a nurse. The visit includes an assessment, review of documentation, staff training and recommendations specific to the consumer's condition. Consumers that have moved from a developmental center are followed by a nurse for up to two years after discharge. Clinical team members may collaborate with the consumer's physician as necessary.

The clinical team participates in the monitoring of medications, particularly psychotropic medications. Service coordinators review medications during the IPP and annual review process, and have access to the clinical team with any concerns. Staff can contact the pharmacist with medication-related concerns.

Nurses are also available to review medications and may refer questionable medication regimens to a physician or psychiatrist for a secondary review. Medication training may be offered to providers based on SIRs, compliance issues, or other concerns.

The clinical staff is also available to service coordinators for consultation regarding consumer's behavioral or mental health needs. After review, the clinical team may recommend additional services to support the needs of the consumer. Behavior plans are reviewed and monitored by the psychologists, psychiatrists, and the psychiatric nurse. All level 4 community care facilities (CCF) are visited by the psychiatric nurse who reviews consumer records, behavior reports and medications. In addition, the nurse participates in discharge planning for all psychiatric hospitalizations. Telepsychiatry is available to consumers, either at the regional center or at their home.

FDLRC's clinical team is available to regional center staff, consumers and providers regarding preventive care, accessing community resources and consumer health issues. The nurses are available to attend annual reviews or quarterly visits with the service coordinators, if needed, for consultation. The clinical services staff is available for staff training as needed, including new employee orientation. Recent topics have included: diabetes, major medical conditions, and medications.

FDLRC has improved access to preventive healthcare resources for consumers through the following programs:

- ✓ FDLRC's registered dental hygienist providing dental screenings at the regional center, performing onsite CCF visits and making referrals to community dentists when indicated;
- ✓ Collaboration with UCLA School of Medicine and Dentistry;
- ✓ Dental fairs held at regional center;
- ✓ Partnership with Children's Hospital of Los Angeles; and,
- ✓ Preventative healthcare protocols.

The Director of Clinical Services is involved in FDLRC's Risk Management Committee. All medical SIRs are reviewed by the Director of Clinical Services and a registered nurse. Further review by a physician and recommendations may be made as indicated. A quarterly analysis of SIRs is completed and documented in a report which is provided to the Quality Management Committee, with follow-up action as needed.

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 service specialist who is an integral part of the team responsible for conducting QA activities at FDLRC.

III. Results of Interview

1. The annual Title 17 visits are conducted by community service specialists. The specialists use a monitoring tool to review vendor files, licensing reports, medication logs, behavior plans, staffing schedules, personnel files, continuous notes, individual program plans, consultant reports, special incident reports (SIR), along with specific facility requirements (physical plants, food supply and storage, health and safety and resident rights). When staff identifies concerns, corrective action plans (CAP) are issued or technical assistance is provided. Additionally, unannounced visits are conducted at facilities where there are issues that require follow-up.

2. FDLRC also conducts a minimum of two unannounced quality assurance visits at each home every year. Additional unannounced visits may be conducted as necessary. FDLRC utilizes a vendor tracking log and assigns vendor homes to QA staff who monitor the logs and ensure that all visits are completed timely. The QA Manager monitors the timeliness of all visits.

3. FDLRC uses information collected from QA monitoring to provide technical assistance to providers and for potential topics for monthly classes. Classroom topics include medication administration and side effects, behavior management, SIRs, forms and documentation, staff training requirements, and individual service plans. Trainings are held the second Tuesday of each month and include service providers.

4. The specialists follow up on SIRs and collaborate with Community Care Licensing and/or law enforcement, as needed. They provide technical assistance to vendors for issues related to special incidents. FDLRC uses a

database to track monitoring visits, SIRs and CAPs which are reviewed quarterly by the QA manager.

5. The QA managers are responsible for analyzing data from SIRs and QA monitoring. When issues are identified, the information is presented to the unit manager, who is part of the risk management team, in order to develop possible remedial measures. SIR data has been used to highlight trends in areas such as medication errors, preventable accidents, and behavioral antecedents, and is used to develop training for vendors.

SECTION VII A

SERVICE PROVIDER INTERVIEWS

I. Purpose

The interviews determine how well the service provider knows the consumers; 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 five service providers at three community care facilities and two day programs where services are provided to the consumers that were visited by the monitoring team.

2. The interview questions are divided into two categories.

   - ✓ The questions in the first category are related to sample consumers 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 their consumer.

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

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

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

5. The service providers were prepared for emergencies, monitored the safety of the consumer, 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 consumers 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 four direct service staff at two community care facilities and two day programs where services are provided to the consumer that was visited by the monitoring team.

2. The interview questions are divided into two categories:

   - ✓ The questions in the first category are related to sample consumers 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 their consumer.

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

3. The direct service staff demonstrated that they understood the importance of communication with all individuals concerned with the consumer.

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 consumers 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 three CCFs and two day programs.

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

III. Results of Review

All of the CCFs and the day programs were found to be in good condition with no immediate health and safety concerns.

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 Frank D. Lanterman Regional Center (FDLRC) 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 25 consumers 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 consumers 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 consumer is protected from adverse consequences, and that risks are either minimized or eliminated.

III. Results of Review

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

2. FDLRC reported all special incidents in the sample of 25 records selected for the HCBS Waiver review to DDS.

3. FDLRC's vendors reported all 10 (100 percent) of the applicable incidents in the supplemental sample within the required timeframes.

4. FDLRC reported 9 of the 10 (90 percent) incidents to DDS within the required timeframes.

5. FDLRC's follow-up activities on consumer incidents were appropriate for the severity of the situations for the 10 incidents.

IV. Finding and Recommendation

Consumer #SIR 10: The incident occurred on March 3, 2017. However, FDLRC did not submit a written report to DDS until March 14, 2017.

Recommendation	Regional Center Plan/Response
FDLRC should ensure that all special incidents are reported to DDS in a timely manner.	All service coordinators received training in special incident reporting and timelines on 9/13/18.

SAMPLE CONSUMERS AND SERVICE PROVIDERS/VENDORS

HCBS Waiver Review Consumers

#	UCI	CCF	DP
1	[redacted]	3	
2	[redacted]	1	
3	[redacted]		3
4	[redacted]	4	
5	[redacted]		3
6	[redacted]		4
7	[redacted]	N/A	
8	[redacted]		6
9	[redacted]		5
10	[redacted]		2
11	[redacted]		
12	[redacted]		
13	[redacted]		1
14	[redacted]		
15	[redacted]		
16	[redacted]		
17	[redacted]		
18	[redacted]		
19	[redacted]		
20	[redacted]		
21	[redacted]		
22	[redacted]		
23	[redacted]		
24	[redacted]		
25	[redacted]		

Supplemental Sample Terminated Waiver Consumers

#	UCI
T-1	[redacted]
T-2	[redacted]
T-3	[redacted]

Supplemental Sample Developmental Center Consumers

#	UCI
DC-1	[redacted]
DC-2	[redacted]
DC-3	[redacted]

HCBS Waiver Review Service Providers

CCF #	Vendor
1	H16546
2	N/A
3	H25126
4	PD1147

Day Program #	Vendor
1	H00324
2	H16200
3	PD2200
4	H25265
5	S25154
6	H16691

SIR Review Consumers

#	UCI	Vendor
SIR 1	[redacted]	HD0176
SIR 2	[redacted]	H22636
SIR 3	[redacted]	PD0829
SIR 4	[redacted]	HD0028
SIR 5	[redacted]	PD2855
SIR 6	[redacted]	PD3543
SIR 7	[redacted]	ML1261
SIR 8	[redacted]	HD0387
SIR 9	[redacted]	H16643
SIR 10	[redacted]	HD0024

Frank D. Lanterman Regional Center
Home and Community-Based Services
1915(i) State Plan Amendment
Monitoring Review Report

Conducted by:

Department of Developmental Services
and
Department of Health Care Services

February 5–9, 2018

TABLE OF CONTENTS

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) 1915(i) State Plan Amendment (SPA) program from February 5–9, 2018, at Frank D. Lanterman Regional Center (FDLRC). The monitoring team members were Nora Muir (Team Leader), Linda Rhoades and Ray Harris from DDS.

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 the services needed for eligible individuals with developmental disabilities in California. All HCBS 1915(i) SPA services are provided through this system. It is the responsibility of DDS to ensure, with the oversight of DHCS, that the 1915(i) SPA is implemented by regional centers in accordance with Medicaid statute and regulations.

Overview of the HCBS 1915(i) SPA Programmatic Compliance Monitoring Protocol

The compliance monitoring review protocol is comprised of sections/components designed to determine if the consumers' needs and program requirements are being met and that services are being provided in accordance with the consumers' individual program plan (IPP). Specific criteria have been developed for the review sections listed below that are derived from federal/state statutes and regulations and from the Centers for Medicare & Medicaid Services' directives and guidelines relating to the provision of HCBS 1915(i) SPA services.

Scope of Review

The monitoring team conducted a record review of a sample of 10 HCBS 1915(i) SPA consumers. In addition, a supplemental sample of consumer records was reviewed for five consumers who had special incidents reported to DDS during the review period of December 1, 2016 through November 30, 2017.

Overall Conclusion

FDLRC is in substantial compliance with the federal requirements for the HCBS 1915(i) SPA program. Specific recommendations that require follow-up actions by FDLRC are included in the report findings. DDS is requesting documentation of follow-up actions taken by FDLRC in response to each of the specific recommendations within 30 days following receipt of this report.

Major Findings

Section I – Regional Center Consumer Record Review

Ten sample consumer records were reviewed for 24 documentation requirements (criteria) derived from federal and state statutes and regulations and HCBS 1915(i) SPA requirements. Two criteria were rated as not applicable for this review.

The sample records were 99 percent in overall compliance for this review.

Section II – Special Incident Reporting

The monitoring team reviewed the records of the HCBS 1915(i) SPA consumers and five supplemental sample consumers for special incidents during the review period. FDLRC reported all special incidents for the sample selected for the HCBS 1915(i) SPA review. For the supplemental sample, the service providers reported all five incidents to FDLRC within the required timeframes, and FDLRC subsequently transmitted all five special incidents to DDS within the required timeframes. FDLRC's follow-up activities on consumer incidents were timely and appropriate for the severity of the situation.

SECTION I

REGIONAL CENTER
CONSUMER 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) 1915(i) State Plan Amendment (SPA) services. The criteria address requirements for eligibility, consumer choice, notification of proposed action and fair hearing rights, individual program plans (IPP) and periodic reviews and reevaluations of services. The information obtained about the consumers' needs and services is tracked as a part of the onsite program reviews.

II. Scope of Review

1. Ten HCBS 1915(i) SPA consumer records were selected for the review sample.

2. The review period covered activity from December 1, 2016 to November 30, 2017.

III. Results of Review

The sample consumer records were reviewed for 24 documentation requirements derived from federal and state statutes and regulations and HCBS 1915(i) SPA requirements. Two criteria were not applicable for this review.

- ✓ The sample records were 100 percent in compliance for 20 applicable criteria. There are no recommendations for these criteria.

- ✓ The findings for two 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

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

Finding

One of the two (50 percent) applicable sample consumer records had quarterly face-to-face meetings completed and documented. However, the record for consumer #5 contained documentation of only two of the required meetings.

1.9.a Recommendation	Regional Center Plan/Response
FDLRC should ensure that all future face-to-face meetings are completed and documented each quarter for consumer #5.	Service coordinators (SC) will receive training on the Medicaid Waiver requirements in completing quarterly reports within the mandated timelines. Regional managers will review the tracking system with each SC individually by the 10th of the month to ensure meetings were held for the previous month and make the necessary arrangements, if a quarterly meeting was not held within 30 days, to maintain compliance.

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

Finding

One of the two (50 percent) applicable sample consumer records had quarterly reports of progress completed for consumers living in community out-of-home settings. However, the record for consumer #5 contained documentation of only two of the required quarterly reports of progress.

1.9.b Recommendation	Regional Center Plan/Response
FDLRC should ensure that future quarterly reports of progress are completed for consumer #5.	SCs will receive training on the Medicaid Waiver requirements in completing quarterly reports within the mandated timelines. Regional

	managers will review the tracking system with each SC individually by the 10th of the month to ensure meetings were held for the previous month and make the necessary arrangements, if a quarterly meeting was not held within 30 days, to maintain compliance.

Regional Center Consumer Record Review Summary Sample Size = 10 Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
1.0	The consumer is Medi-Cal eligible. *(SMM 4442.1)*	10			100	None
1.1	Each record contains a "1915(i) State Plan Amendment Eligibility Record" (DS 6027 form), signed by qualified personnel, which documents the date of the consumer's initial 1915(i) SPA eligibility certification and annual reevaluation, eligibility criteria, and short-term absences. *[SMM 4442.1; 42 CFR 483.430(a)]*	Criterion 1.1 consists of four sub-criteria (1.1.a-d) that are reviewed and rated independently.				
1.1.a	The DS 6027 is signed and dated by qualified regional center personnel.	10			100	None
1.1.b	The DS 6027 form indicates that the consumer meets the eligibility criteria for the 1915(i) SPA.	10			100	None
1.1.c	The DS 6027 form documents annual reevaluations.	10			100	None
1.1.d	The DS 6027 documents short-term absences of 120 days or less, if applicable.			10	NA	None
1.2	There is written notification of a proposed action and documentation that the consumer has been sent written notice of their fair hearing rights whenever services or choice of services are denied or reduced without the agreement of the consumer/authorized representative, or the consumer/authorized representative does not agree with all, or part, of the components in the consumer's IPP. *[42 CFR Part 431, Subpart E; W&I Code §4646(g)]*			10	NA	None
1.3	IPP is reviewed (at least annually) by the planning team and modified, as necessary, in response to the consumer's changing needs, wants or health status. *[42 CFR 441.301(b)(1)(l)]*	10			100	None
1.4.a	The IPP is signed, prior to its implementation, by an authorized representative of the regional center and the consumer, or where appropriate, his/her parents, legal guardian, or conservator. *[W&I Code §4646(g)]*	10			100	None

Regional Center Consumer Record Review Summary Sample Size = 10 Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
1.4.b	IPP addendums are signed by an authorized representative of the regional center and the consumer, or where appropriate, his/her parents, legal guardian, or conservator.	7		3	100	None
1.4.c	The IPP is prepared jointly with the planning team. *[W&I Code §4646(d)]*	10			100	None
1.5	The IPP includes a statement of goals based on the needs, preferences, and life choices of the consumer. *[W&I Code §4646.5(a)(2)]*	10			100	None
1.6	The IPP addresses the consumer's goals and needs. *[W&I Code §4646.5(a)(2)]*	Criterion 1.6 consists of six sub-criteria (1.6.a-f) that are reviewed independently.				
1.6.a	The IPP addresses the special health care requirements, health status and needs as appropriate.	2		8	100	None
1.6.b	The IPP addresses the services which the CCF provider is responsible for implementing.	1		9	100	None
1.6.c	The IPP addresses the services which the day program provider is responsible for implementing.	1		9	100	None
1.6.d	The IPP addresses the services which the supported living services agency or independent living services provider is responsible for implementing.	1		9	100	None
1.6.e	The IPP addresses the consumer's goals, preferences, and life choices.	10			100	None
1.6.f	The IPP includes a family plan component if the consumer is a minor. *[W&I Code §4685(c)(2)]*	2		8	100	None
1.7.a	The IPP includes a schedule of the type and amount of all services and supports purchased by the regional center. *[W&I Code §4646.5(a)(4)]*	10			100	None
1.7.b	The IPP includes a schedule of the type and amount of all services and supports obtained from generic agencies or other resources. *[W&I Code §4646.5(a)(4)]*	10			100	None
1.7.c	The IPP specifies the approximate scheduled start date for new services and supports. *[W&I Code §4646.5(a)(4)]*	7		3	100	None

Regional Center Consumer Record Review Summary Sample Size = 10 Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
1.8	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. *[W&I Code §4646.5(a)(4)]*	10			100	None
1.9	Periodic reviews and reevaluations are completed (at least annually) to ascertain that planned services have been provided, that consumer progress has been achieved within the time specified, and that the consumer and his/her family are satisfied with the IPP and its implementation. *[W&I Code §4646.5(a)(6)]*	10			100	None
1.9.a	Quarterly face-to-face meetings with the consumer are completed for consumers living in community out-of-home settings, i.e., Service Level 2, 3 or 4 CCFs, family home agencies or supported living and independent living settings. *(Title 17, CCR, §56047; Title 17, CCR, §56095; Title 17, CCR, §58680; Contract requirement)*	1	1	8	50	See Narrative
1.9.b	Quarterly reports of progress toward achieving IPP objectives are completed for consumers living in community out-of-home settings, i.e., Service Level 2, 3 or 4 CCFs, family home agencies or supported living and independent living settings. *(Title 17, CCR, §56047; Title 17, CCR, §56095; Title 17, CCR, §58680; Contract requirement)*	1	1	8	50	See Narrative

SECTION II

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. The records of the 10 consumers selected for the HCBS 1915(i) State Plan Amendment (SPA) sample were reviewed to determine that all required special incidents were reported to Department of Developmental Services (DDS) during the review period.

2. A supplemental sample of five consumers 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 consumer is protected from adverse consequences, and that risks are either minimized or eliminated.

III. Results of Review

1. FDLRC reported all special incidents in the sample of five records selected for the HCBS 1915(i) SPA review to DDS.

2. FDLRC's vendors reported all five (100 percent) special incidents in the supplemental sample within the required timeframes.

3. FDLRC reported all five (100 percent) incidents to DDS within the required timeframes.

4. FDLRC's follow-up activities on consumer incidents were appropriate for the severity of the situations for the five incidents.

SAMPLE CONSUMERS
1915(i) State Plan Amendment Review Consumers

#	UCI
1	[redacted]
2	[redacted]
3	[redacted]
4	[redacted]
5	[redacted]
6	[redacted]
7	[redacted]
8	[redacted]
9	[redacted]
10	[redacted]

SIR Review Consumers

#	UCI	Vendor
SIR 1	[redacted]	N/A
SIR 2	[redacted]	H25126
SIR 3	[redacted]	PD1682
SIR 4	[redacted]	HD0230
SIR 5	[redacted]	HD0184