DEPARTMENT OF DEVELOPMENTAL SERVICES
1600 NINTH STREET, Room 320, MS 3-9
SACRAMENTO, CA 95814
TDD 654-2054 (For the Hearing Impaired)
(916) 654-1954

October 26, 2012

Diane Campbell Anand, Director
Frank D. Lanterman Regional Center
3303 Wilshire Blvd., Ste. 700
Los Angeles, CA 90010

Dear Ms. Anand:

Thank you for submitting Frank D. Lanterman Regional Center's (FDLRC) response to the Department of Developmental Services' (Department) Home and Community-based Services Waiver, Targeted Case Management and Nursing Home Reform draft reports for the monitoring review conducted from June 4 - 8, 2012.

The Department has approved FDLRC's responses to the recommendations made in the draft reports. FDLRC's responses are incorporated in the final reports to be sent to your Board of Directors.

If you have any questions, please contact Shelton Dent, Manager, Residential Services and Monitoring Branch at (916) 654-2140.

Sincerely,

JIM KNIGHT
Assistant Deputy Director
Community Operations Division

cc: √ Haleh Hashemzedeh, FDLRC
John Shen, DHCS

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1600 NINTH STREET, Room 320, MS 3-9
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October 26, 2012

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' (DHCS) monitoring review of the Home and Community-based Services (HCBS) Waiver, Targeted Case Management and Nursing Home Reform programs conducted from June 4 – 8, 2012, at the Frank D. Lanterman Regional Center (FDLRC). The period of review was from February 1, 2011, through January 31, 2012.

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 of the receipt of the reports to:

Department of Developmental Services
Attn: Shelton Dent, Manager
Residential Services and Monitoring Branch
1600 Ninth Street, Room 320, MS 3-9
Sacramento, CA 95814

The cooperation of FDLRC's staff in completing the monitoring review is appreciated. If you have questions, please contact Shelton Dent, at (916) 654-2140.

Sincerely,

JIM KNIGHT
Assistant Deputy Director
Community Operations Division

Attachments

cc: Haleh Hashemzedeh, FDLRC
John Shen, DHCS

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

June 4 - 8, 2012

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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 June 4 - 8, 2012 at Frank D. Lanterman Regional Center (FDLRC). The monitoring team members were Linda Rhoades (Team Leader), Lisa Miller, and Kathy Benson from DDS, and Annette Hanson 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 (IPPs). 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 20 HCBS Waiver consumers. In addition, the following supplemental sample consumer records were reviewed: 1) three consumers who moved from a developmental center; 2) ten consumers who had special incidents reported to DDS during the review period of February 1, 2011 through January 31, 2012.

The monitoring team completed visits to three community care facility (CCFs) and seven day programs. The team reviewed four CCF and seven day program consumer records and interviewed and/or observed 16 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 sample consumer records were reviewed for 31 documentation requirements (criteria) derived from federal and state statutes and regulations and HCBS Waiver requirements. One criterion was rated as not applicable for this review. The sample records were 99% in overall compliance for this review.

FDLRC's records were 98% and 99% in overall compliance for the collaborative reviews conducted in 2010 and in 2008, respectively.

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

Four consumer records were reviewed at three CCFs for 19 documentation requirements (criteria) derived from Title 17, California Code of Regulations. Six criteria were rated as not applicable for this review. The sample records were 100% in overall compliance for the applicable criteria.

FDLRC's records were 100% in overall compliance for the collaborative reviews conducted in 2010 and in 2008.

Section IV – Day Program Consumer Record Review

Seven consumer records were reviewed at seven day programs for 17 documentation requirements (criteria) derived from Title 17, California Code of Regulations. Three criteria were rated as not applicable for this review. The sample records were 99% in overall compliance for the applicable criteria.

FDLRC's records were 100% in overall compliance for the collaborative reviews conducted in 2010 and in 2008.

Section V – Consumer Observations and Interviews

Sixteen 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. The interviewed consumers/parents indicated 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

FDLRC's nurse consultant was interviewed using a standard interview instrument. She responded to informational questions regarding the monitoring of consumers with medical issues, medications and behavior plans, the coordination of medical and mental health care for consumers, the provision of clinical supports to service coordinators, and the clinical team's participation in the Quality Enhancement Committee, which encompasses risk management activities.

Section VI C – Quality Assurance Interview

A quality assurance coordinator was interviewed using a standard interview instrument. She responded to informational 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

Three CCF and three day program service providers were interviewed using a standard interview instrument. The service providers responded to questions in the context of the sample consumers regarding their knowledge of the consumer, the annual review process and the monitoring of health issues, medications, progress, safety and emergency preparedness. The service providers were familiar with the consumers and knowledgeable about their roles and responsibilities.

Section VII B – Direct Service Staff Interviews

Three CCF and three 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 three day programs utilizing a standard checklist with 23 criteria that are consistent with HCBS Waiver requirements. All of 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 20 HCBS Waiver consumers and ten 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 nine of the ten incidents to FDLRC within the required timeframes. FDLRC subsequently transmitted all ten 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 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 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.

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.)	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. 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 (NOA) and fair hearing rights, level of care, individual program plans (IPPs) and periodic reviews and reevaluations of services. The information obtained about the consumers' needs and services is tracked as a part of the on-site program reviews.

II. Scope of Review

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

Living Arrangement	# of Consumers
Community Care Facility (CCF)	8
With Family	9
Independent or Supported Living Setting	3

2. The review period covered activity from February 1, 2011 – January 31, 2012.

III. Results of Review

The 20 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 indicating they received face-to-face reviews every 30 days after moving from a developmental center. One criterion was not applicable for this review.

- ✓ The sample records were in 100% compliance for 26 criteria. There are no recommendations for these criteria.
- ✓ Findings for four 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.a The consumer's qualifying conditions and any special health care requirements used to meet the level of care requirements for care provided in ICF/DD, ICF/DD-H, ICF/DD-N facilities are documented in the consumer's CDER and/or other assessments. (*SMM 4442.5*), (*42 CFR 441.302(c)*), (*Title 22, CCR, §51343*)

Finding

Nineteen of the 20 (95%) sample consumer records documented qualifying conditions that meet the level-of-care requirements. The record for consumer #15 identified "complex meds due to seizures" as the only qualifying condition.

2.5.a Recommendation	Regional Center Plan/Response
FDLRC should reevaluate the HCBS Waiver eligibility of consumer #15 to ensure that the consumer meets the level of care requirements. 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.	**FDLRC re-evaluated the HCBS Waiver eligibility for client #15 and the client does not meet the level of care requirements. Client does not have at least two distinct qualifying conditions that meet the level of care requirements and therefore, her HCBS Waiver eligibility was terminated. Please refer to the attached copy of the corrected DS 3770 form.**

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

Seventeen of the 19 (90%) applicable 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.

1. Consumer #13: "complex meds".

2. Consumer #19: "safety skills".

2.5.b Recommendations	Regional Center Plan/Response
FDLRC should determine if the items listed above 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 supports the original determinations should be submitted with the response to this report.	**For client #13, "complex meds" is not a qualifying deficit and therefore, he no longer meets the minimum requirements for the HCBS Waiver eligibility. Please refer to the attached copy of DS 3770 for the correction and the termination of HCBS Waiver eligibility for this client.** **For client #19, "safety skills" is not a qualifying deficit and therefore, corrections were made to the DS 3770 form. Client continues to have two other eligible deficits and continues to meet the minimum requirements for the HCBS Waiver eligibility. Please refer to the attached copy of the DS 3770 for the correction.**

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*)

Finding

Ten of the 11 (91%) applicable sample consumer records had quarterly face-to-face meetings completed and documented. However, the record for consumer #8 contained documentation of three of the four required meetings.

2.13.a Recommendation	Regional Center Plan/Response
FDLRC should ensure that all future face-to-face meetings are completed and documented each quarter for consumer #8.	**FDLRC will continue to train service coordinators to complete face-to-face meetings on quarterly basis for all clients residing outside the family home.** **Additionally, Regional Managers will continue to review service coordinators' work to ensure that all quarterly face-to-face meetings are completed and documented.**

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*)

Finding

Ten of the 11 (91%) applicable sample consumer records had quarterly reports of progress completed for consumers living in community out-of-home settings. However, the record for consumer #8 contained documentation of three quarterly reports of progress.

2.13.b Recommendation	Regional Center Plan/Response
FDLRC should ensure that future quarterly reports of progress are completed for consumer #8.	**FDLRC will continue to train service coordinators to complete face-to-face meetings on quarterly basis for all clients residing outside the family home and to complete the quarterly reports for these meetings.** **Additionally, Regional Managers will continue to review service coordinators' work to ensure that all quarterly face-to-face meetings are completed and documented.**

Regional Center Consumer Record Review Summary Sample Size = 20 + 3 Supplemental Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.0	The consumer is Medi-Cal eligible. (*SMM 4442.1*)	20			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 (2.1a-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.	20			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.	20			100	None
2.1.c	The DS 3770 form documents annual re-certifications.	20			100	None
2.1.d	The DS 3770 documents short-term absences of 120 days or less, if applicable.	2		18	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)*)	20			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*), (*WIC §4646(g)*)			20	NA	None

Regional Center Consumer Record Review Summary Sample Size = 20 + 3 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*)	20			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-DDH, 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*)	19	1		95	See Narrative
2.5.b	The consumer's qualifying conditions documented in the CDER are consistent with information contained in the consumer's record.	17	2	1	90	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)*)	20			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*)	17		3	100	None
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. (*WIC §4646(g)*)	20			100	None
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.	8		12	100	None
2.7.c	The IPP is prepared jointly with the planning team. (*WIC §4646(d)*)	20			100	None
2.8	The IPP includes a statement of goals based on the needs, preferences and life choices of the consumer. (*WIC §4646.5(a)*)	20			100	None

Regional Center Consumer Record Review Summary Sample Size = 20 + 3 Supplemental Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.9	The IPP addresses the consumer'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).	19		1	100	None
2.9.b	The IPP addresses the special health care requirements.	5		15	100	None
2.9.c	The IPP addressed the services for which the CCF provider is responsible for implementing.	8		12	100	None
2.9.d	The IPP addressed the services for which the day program provider is responsible for implementing.	12		8	100	None
2.9.e	The IPP addresses the services for which the supported living services agency or independent living services provider is responsible for implementing.	3		17	100	None
2.9.f	The IPP addresses the consumer's goals, preferences and life choices.	20			100	None
2.9.g	The IPP includes a family plan component if the consumer is a minor. (*WIC §4685(c)(2)*)	5		15	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)*)	20			100	None
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)(4)*)	20			100	None
2.10.c	The IPP specifies the approximate scheduled start date for the new services. (*WIC §4646.5(a)(4)*)	8		12	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)(4)*)	20			100	None

Regional Center Consumer Record Review Summary Sample Size = 20 + 3 Supplemental Records						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
2.12	Periodic review 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 the consumer and his/her family are satisfied with the IPP and its implementation. (*WIC §4646.5(a)(6)*)	20			100	None
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)*	10	1	9	91	See Narrative
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)*	10	1	9	91	See Narrative
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. (*WIC §4418.3*)	3		20	100	None

SECTION III

COMMUNITY CARE FACILITY CONSUMER RECORD REVIEW

I. Purpose

The review addresses the requirements for community care facilities (CCFs) 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

Four consumer records were reviewed at three CCFs visited by the monitoring team. The facilities' consumer records were reviewed to determine compliance with 19 criteria. Six criteria were rated as not applicable for this review.

III. Results of Review

The consumer record was 100% in compliance for 13 criteria.

- ✓ 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 = 4; 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*)	4			100	None
3.1.a	The consumer record contains a statement of ambulatory or nonambulatory status.	4			100	None
3.1.b	The consumer record contains known information related to any history of aggressive or dangerous behavior toward self or others.	1		3	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.	4			100	None
3.1.d	The consumer record contains current emergency information: family, physician, pharmacy, etc.	4			100	None
3.1.e	The consumer record contains a recent photograph and a physical description of the consumer.	4			100	None
3.1.i	Special safety and behavior needs are addressed.	1		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)*)	4			100	None
3.3	The facility has a copy of the consumer's current IPP. (*Title 17,CCR, §56022(c)*)	4			100	None

Community Care Facility Record Review Summary Sample Size: Consumers = 4; 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)*)	4			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.	4			100	None
3.5.a	Service Level 4 facilities prepare and maintain written quarterly reports of consumer progress. (*Title 17, CCR, §56026(c)*)			4	NA	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.			4	NA	None
3.5.c	Quarterly reports include a summary of data collected. (*Title 17, CCR, §56013(d)(4)*), (*Title 17, CCR, §56026*)			4	NA	None
3.6.a	The facility prepares and maintains ongoing, written consumer notes, as required by Title 17. (*Title 17, CCR §56026(a)*)	4			100	None
3.6.b	The ongoing notes/information verify that behavior needs are being addressed.	2		2	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*)			4	NA	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*)			4	NA	None
3.7.c	Follow-up activities were undertaken to prevent, reduce or mitigate future danger to the consumer. (*Title 17, CCR, §54327*)			4	NA	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 sample consumer records were reviewed at seven 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% in compliance for 13 of the 17 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.
- ✓ 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

Six of the seven (86%) sample consumer records contained a copy of the consumer's current IPP. The record for consumer #10 at day program #2 did not contain a copy of the current IPP. During the monitoring review, the IPP was faxed to the program. Accordingly, no recommendation is required.

Day Program Record Review Summary Sample Size: Consumers = 7; Day Programs = 7						
	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 for which the day program provider is responsible for implementing.	7			100	None

Day Program Record Review Summary Sample Size: Consumers = 7; Day Programs = 7						
	Criteria	**+**	**-**	**N/A**	**% Met**	**Follow-up**
4.1.g	The consumer record contains up-to-date case notes reflecting important events or information not documented elsewhere.	7			100	None
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)*)	6	1		86	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 ISP 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 for 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	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*)			7	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*)			7	NA	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, choice, and regional center services.

II. Scope of Observations and Interviews

Seventeen of the 20 consumers, or in the case of minors, their parents, were interviewed and/or observed at their day programs, employment sites, community care facilities (CCFs), or in independent living settings.

- ✓ Five adult consumers agreed to be interviewed by the monitoring teams
- ✓ Eight consumers did not communicate verbally or declined an interview, but were observed
- ✓ Four interviews were conducted with parents of minors
- ✓ Three consumers/parents of minors 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 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 provide 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 doctors, clinical team and web resources for medication information.

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 were knowledgeable about the special incident report (SIR) process and work with the vendors to ensure all special incidents are reported and appropriate follow-up activities are completed. Service coordinators are briefed on SIR trends that may affect their caseloads.

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.

III. Results of Interview

The FDLRC clinical team consists of physicians, registered nurses, psychiatrists, psychologists, a dental coordinator, an occupational and speech therapist.

Nurses may visit hospitalized consumers to assess their health status, consult with nursing staff and assist with discharge planning. Service coordinators can request a meeting with the clinical team to discuss consumers' complex medical issues as needed. Consumers with chronic medical issues are seen annually by a nurse; the visit includes an assessment, review of documentation, staff training and recommendations specific to the consumers' condition. Consumers that have moved from a developmental center are followed by a nurse for 1-2 years after moving to community placement. Clinical team members may collaborate with the consumers' physician as necessary.

The clinical team participates in the monitoring of medications. Service coordinators monitor medications during the IPP (Individual Program Plan) review process, and have access to the clinical team with any concerns. Nurses are available to review medications and may refer questionable medication regimes to a physician or psychiatrist for a secondary review. Medication training

may be offered to providers based on medication errors, 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. A psychiatrist reviews all behavior plans for consumers residing in a level four facility. Facilities that provide care for the dual diagnosed consumers are regularly visited by a nurse and the director of clinical services.

FDLRC's clinical team is available to regional center staff, consumers and caregivers 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 any staff training required, including new service coordinator orientation.

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

- ✓ Contracts with the Neuropsychiatric Institute at University of California Los Angeles to provide psychiatric and behavioral health care for consumers
- ✓ FDLRC's dental coordinator performs dental screenings at the regional center
- ✓ Collaboration with University of California Los Angeles School of Medicine, Dentistry, and Nursing
- ✓ Partnership with Children's Hospital of Los Angeles
- ✓ Preventative healthcare protocols

The clinical team is involved in FDLRC's Quality Enhancement Committee, which encompasses risk management activities. All special incidents reports (SIRs) are reviewed by the Director of Clinical Service and a registered nurse. Further review by a physician and recommendations may be made as indicated. Staff members also participate on the morbidity and mortality review committee. Any issues or trends that are identified through their role in risk management may become topics for future trainings.

SECTION VI C

QUALITY ASSURANCE INTERVIEW

I. Purpose

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

II. Scope of Interview

The monitoring team interviewed a quality assurance coordinator who is part of the team responsible for conducting FDLRC's QA activities.

III. Results of Interview

1. The annual Title 17 visits are conducted by service coordinators who function as facility liaisons to CCFs. They also conduct a minimum of two unannounced visits annually. The community resource manager may conduct additional unannounced visits to facilities with identified issues that require further follow-up review.

2. Service coordinators and the community resource manager investigate special incident reports (SIRs) in collaboration with Community Care Licensing or law enforcement, as needed. They commonly conduct follow-up for SIRs related to specific consumers or vendors with a history of problems.

3. The community resource manager is responsible for analyzing data from SIRs and QA monitoring. When issues of concern are identified, the information is presented to the Quality Enhancement Committee in order to assist in identifying possible remedial measures.

4. Additionally, FDLRC uses information collected from the various monitoring activities, such as cross reporting and sharing reports with Community Care Licensing on a quarterly basis, to provide technical assistance and round table forums for providers. Topics have included the quality review process and SIR training.

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 annual 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, how they monitor safety and safeguard medications.

II. Scope of Interviews

1. The monitoring team interviewed six service providers at three community care facilities (CCF) and three day programs where services are provided for 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 the sample consumer 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 respective consumers.

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 consumers.

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

4. The service providers communicated with people involved in the consumers' lives and monitored progress documentation.

5. The service providers were prepared for emergencies, monitored the safety of consumers, 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 knows the consumers and their understanding of the IPP and service delivery requirements, how they communicate, and their level of preparedness to address safety issues, their understanding of emergency preparedness, and knowledge about safeguarding medications.

II. Scope of Interviews

1. The monitoring team interviewed six direct service staff at three community care facilities (CCF) and three day programs where services are provided for the consumers 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 consumer 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 respective consumers.

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

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

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 (CCFs) and day programs are serving consumers in a safe, healthy and positive environment where their rights are respected.

II. Scope of Review

1. The monitoring teams reviewed a total of three CCFs and three day programs.

2. The teams used a monitoring review checklist consisting of 23 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 (SIRs) of deaths received by the Department of Developmental Services (DDS).

2. The records of the 20 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 ten 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, and 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 20 records selected for the HCBS Waiver review to DDS.

3. FDLRC's vendors reported nine of the ten (90%) incidents in the supplemental sample within the required timeframes.

4. FDLRC reported all ten (100%) 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 ten incidents.

IV. Finding and Recommendation

Consumer #26: The incident occurred on May 6, 2011. However, the vendor did not submit a written report to FDLRC until May 9, 2011.

Recommendation	Regional Center Plan/Response
FDLRC should ensure that the vendor for consumer #26 reports special incidents within the required timeframes.	**FDLRC's Community Services Department forwards written documentation regarding provider's responsibilities for Special Incidents Reporting on an annual basis. Additionally, annual trainings are available to all providers.** **Lastly, when applicable, service coordinators follow-up with appropriate providers to go over the timelines and protocols of Special Incident Reporting. This issue has been addressed with this provider to ensure that the provider for this client submit written special incident reports within the required timeframes.**

SAMPLE CONSUMERS AND SERVICE PROVIDERS/VENDORS

HCBS Waiver Review Consumers

#	UCI	CCF	DP
1	5815683	2	
2	6002828	3	
3	6016935	1	
4	7926190	2	
5	6008692		1
6	6040364		6
7	6040737		4
8	6097441		
9	5072020		3
10	6008890		2
11	6031181		7
12	7926395		5
13	6016836		
14	7816739		
15	7829344		
16	6043691		
17	6047276		
18	6047837		
19	6053812		
20	6097993		

Supplemental Sample DC Consumers

#	UCI
21	6275027
22	6038517
23	6042204

HCBS Waiver Review Service Providers

CCF #	Vendor
1	H16693
2	HD0246
3	H16746

Day Program #	Vendor
1	H16761
2	H16691
3	HD0176
4	PD1494
5	H16771
6	HE0318
7	H16114

SIR Review Consumers

#	UCI	Vendor
24	6093810	HD0238
25	6019863	HD0322
26	6021935	HD0240
27	6044157	PD0422
28	6005136	H16554
29	6011126	H16643
30	5455522	N/A
31	6095009	HX0118
32	6041602	PD1682
33	6097441	HX0118

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

Conducted by:

Department of Developmental Services

June 4 - 5, 2012

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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 June 4-5, 2012, at Frank D. Lanterman Regional Center (FDLRC). The monitoring team selected 20 consumer records for the TCM review. A sample of ten records was selected for consumers who had previously been referred to FDLRC for a 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 Center for Medicare & Medicaid Services guidelines relating to the provision of these services.

Findings

Section I – Targeted Case Management

Twenty consumer records, containing 1,315 billed units, were reviewed for three criteria. The sample records were 100% in compliance for criterion 1 (TCM service and unit documentation matches the information transmitted to DDS), 90% in compliance for criterion 2 (TCM service documentation is consistent with the definition of TCM service), and 100% 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

Ten consumer records were reviewed for three criteria. The ten sample records were 100% in compliance for criterion 1 (records contain evidence of DDS' NHR referrals), 100% in compliance for criterion 2 (reporting disposition of referrals to DDS), and 100% 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).

   Finding

   FDLRC transmitted 1,315 TCM units to DDS for the twenty sample consumers. All of the recorded units matched the number of units reported to DDS.

   Recommendation

   None.

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.

   Finding

   The sample of twenty consumer records contained 1,315 billed TCM units. Of this total, 1,184 (90%) of the units contained descriptions that were consistent with the definition of TCM services. One hundred and thirty-one of the billed units had descriptions of activities that were not consistent with the definition of TCM services. Detailed information on these findings and the actions required will be sent under a separate cover letter.

Recommendation	Regional Center Plan/Response
FDLRC should ensure that the time spent on the identified activities that are inconsistent with TCM claimable services (sent separately) is reversed.	**FDLRC reversed the identified units. FDLRC ensures that Service Coordinators attend New Service Coordinator Orientation and Training, which includes a section**

	on proper documentation and Title 19 billable units. **Lastly, additional training is provided as needed.**

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

Finding

The TCM documentation in the twenty sample consumer records identified the service coordinator or other individual who wrote the note and the date the note 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 ten 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 ten sample consumer records contained a PASRR 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 the ten sample consumers had been entered into the AS 400 computer system.

   Recommendation

   None

SAMPLE CONSUMERS
TCM Review

#	UCI
1	5815683
2	6002828
3	6016935
4	7926190
5	6008692
6	6040364
7	6040737
8	6097441
9	5072020
10	6008890
11	6031181
12	7926395
13	6016836
14	7816739
15	7829344
16	6043691
17	6047276
18	6047837
19	6053812
20	6097993

NHR Review

#	UCI
1	6055146
2	6002026
3	7921080
4	7317850
5	H003266
6	6012280
7	H003205
8	6021760
9	H003040
10	H003052

ATTACHMENT I

TCM DISTRIBUTION OF FINDINGS

CRITERION PERFORMANCE INDICATOR Sample Size: 20 Records Billed Units Reviewed: 1,315	# OF OCCURRENCES			% OF OCCURRENCES	
	YES	NO	NA	YES	NO
1. The TCM service and unit documentation matches the information transmitted to DDS.	1,315	0		100	0
2. The TCM service documentation billed to DDS is consistent with the definition of TCM service.	1,184	131		90	10
3. The TCM documentation identifies the service coordinator recording the notes and each note is dated	1,315	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.	10	0		100	
2. Dispositions are reported to DDS.	10	0		100	
3. The regional center submits claims for referral dispositions.	10	0		100	