

**BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA**

In the Matter of:

CLAIMANT

v.

INLAND REGIONAL CENTER,

Service Agency.

OAH No. 2019080085

DECISION

Robert Walker, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on September 5, 2019, in San Bernardino, California.

Keri Neal, Consumer Services Representative, Inland Regional Center, (IRC) represented the regional center.

Claimant's father represented claimant, who was present at the hearing.

The matter was submitted for decision on September 5, 2019.

ISSUE

Is the regional center required to provide claimant with a queen-size bed that is fully electric, i.e., that has electrically controlled head and foot adjustments and electrically controlled elevation?

SUMMARY

Claimant's parents sought a fully electric queen-size bed from his insurance company, Kaiser Permanente. Kaiser agreed to provide a semi-electric hospital bed, which is much narrower than a queen-size bed. Claimant's parents rejected that offer and asked the regional center to provide a fully electric, queen-size bed. A semi-electric bed can be modified to become a fully electric bed at a cost of approximately \$200, so that is a minor issue. One substantial issue has to do with whether claimant needs a queen-size bed, and claimant failed to prove that he does. His caregivers need to be taught to care for him without getting on the bed with him. A second substantial issue has to do with whether the bed claimant's parents requested is safe for claimant, and it is not. When the regional center provides equipment, it is obligated to provide equipment that meets the needs of the consumer. There is evidence that none of the beds are safe for claimant. The bed he has is not safe for him. And neither the bed his parents want nor the bed Kaiser offered to provide is safe. Equipment that is unsafe for a consumer does not meet his or her needs.

FACTUAL FINDINGS

Background

1. Claimant is a 23-year-old male. He is diagnosed with microcephaly, severe intellectual disability, epilepsy, uncontrolled generalized tonic-clonic seizures, sleep disturbances, and unspecified sleep apnea. He is fed through a gastrostomy feeding tube (g-tube). He has a g-tube receptacle permanently installed in his abdominal wall. The part of the apparatus that is visible is referred to as a bolus. Claimant's conditions were caused by an anoxic brain injury, a lack of oxygen, at birth.

2. Claimant requires constant supervision during waking hours to prevent injury or harm. At least once a month, he engages in self-injurious behaviors that require first aid. He scratches his hands and picks at his g-tube bolus. Once, he picked at the bolus until it broke. He has no sense of danger, and there is no expectation that he will ever learn to protect himself. Claimant's caregivers must administer his medications and feed him. Claimant has no control over his bowel or bladder. He requires total care in all areas of hygiene and grooming. He has always lived at home, and his parents have always been his primary caregivers. His father refers to him as "our angel on earth."

3. Claimant receives 56 hours per week of nursing care provided by a licensed vocational nurse and funded by Medi-Cal. He receives 80 hours per month of respite care provided by a licensed vocational nurse (LVN). He receives 283 hours per month of In-Home Supportive Services. He also receives \$1,100 per month of Supplemental Security Income. Claimant has private medical insurance with Kaiser Permanente.

4. Claimant has had various beds. He once had a Vail 2000 twin-size bed. It had a padded canopy with four mesh panels that could be closed with zippers. It could be completely enclosed to prevent claimant from falling out of bed. Claimant's mother testified that a time came when a twin-size bed was not large enough.

5. Currently, claimant has a regular queen-size bed. He needs a bed that can be adjusted to change the angle of the head and the foot. The head needs to be adjustable because claimant is at risk of apnea and because he is fed in his bed. The foot needs to be adjustable because claimant has a hypertonic condition in his lower extremities. Also, he needs a bed on which the platform can be adjusted to raise or lower the elevation of the entire bed. When claimant is out of bed, he sits in a stroller. Claimant can walk short distances with support, but he is virtually non-ambulatory. Claimant is five foot, six inches tall and weighs 155 pounds. Getting claimant into or out of bed is physically arduous and would be easier and safer if the surface of the bed were at the elevation of the back of his knees so that he could sit on the bed with his feet on the floor. However, when claimant's caregivers are dressing him, grooming him, or changing his diaper, the bed needs to be at a much higher elevation so that they do not have to bend over.

6. Claimant's caregivers must move him onto his bed more than six times per day. He has g-tube feedings six times per day, and those are done on his bed. He also needs to be on his bed for diaper changes, dressing, and personal grooming. Claimant's father, mother, and LVN caregivers get him in and out of bed. It is dangerous for claimant; there always is a risk that one of them will drop him. Once, his father did drop him. When claimant started to slip out of his father's grasp, his father maneuvered the fall so that he went down first, and he pulled claimant over him to break claimant's fall. There also is a risk that the caregiver will be injured. Claimant's

father is over 70 years old and has had two knee replacement surgeries. Claimant's mother had shoulder surgery and needs surgery on her ankles. Currently, the LVN caregivers are women of moderate size. None of these people should be lifting a 155-pound man.

7. Sometime before July 23, 2018, claimant's parents asked Kaiser to provide a Kalmia Therapeutic Sleep System adjustable bed. By a letter dated July 23, 2018, Kaiser denied the request. In the letter, Kaiser said it was denying the request "because the item is not a hospital bed. It is a household or furniture item." Kaiser said that claimant's coverage, through Medi-Cal, for Durable Medical Equipment provides that it does "not cover household or furniture items."

8. On January 2, 2019, claimant's parents asked Iwian Ong, M.D., claimant's primary care physician, to write a prescription for a Hi-Lo fully-electric, queen-size Flexabed. Dr. Ong wrote a prescription for "Hospital bed 4-way Hi-lo Mediflex – adjustable." On August 5, 2019, claimant's parents called Dr. Ong's attention to the fact that he had not written *queen-size* as they had requested. Dr. Ong said, "I will just write it in." On a copy of his January 2, 2019, prescription, he wrote *queen-size*.

9. At a February 4, 2019, Individual Program Plan (IPP) meeting, claimant's mother advised the regional center that she was requesting Kaiser to provide funding for an appropriate bed. At that point, she did not ask the regional center to provide a bed.

10. Medi-Cal, through Kaiser, agreed to provide claimant with a semi-electric hospital bed, i.e., one that has electronically controlled adjustment of the angle of the head and foot but a manual crank to adjust the elevation of the bed. Thus, claimant's insurer found there was a medical need for a semi-electric hospital bed. Claimant's

parents, however, refused to accept that bed. They appealed from the denial of their request for a queen-size, fully electric bed. By a decision dated March 29, 2019, an administrative law judge (ALJ), sitting for the Department of Health and Human Services, Office of Medicare¹ Hearings and Appeals, upheld the denial. In the Findings of Fact, the ALJ found that claimant had requested a queen-size bed. However, in the Analysis and Conclusions of Law, the ALJ did not mention the request that the bed be queen-size. In the Analysis and Conclusions of Law, the ALJ discussed only the conclusion that claimant was not entitled to a fully electric bed.²

Regional Center's Assessment of Claimant's Request for a Bed

11. At a June 10, 2019, physical therapy consultation, claimant's mother requested that the regional center provide claimant with a hi-lo fully electric, queen-size Flexabed.³

¹ The hearing was before the Office of Medicare Hearings and Appeals because, in San Bernardino County, Medicare is administered through Medi-Cal. But Medicare is the primary insurer.

² In view of the parents' contentions in the present proceeding, this seems odd. In the present proceeding, the evidence showed that it costs approximately \$200 to replace the hand crank with a motor, which would make the bed fully-electric. In the present proceeding, it was clear that the substance of the dispute had to do with the size of the bed, i.e., with Kaiser's having refused to provide a bed that was queen-size.

³ At the hearing, claimant's father said they would be happy with any fully electric, queen-size bed; he said they were not insisting on the Flexabed brand.

12. On June 10, 2019, Annette Richardson, an occupational therapist with the regional center, and Michelle Knighten, a physical therapist with the regional center, went to claimant's home and did an assessment.

13. Ms. Richardson holds a Bachelor of Science degree in occupational therapy and has a certificate in sensory processing and feeding. She has been an occupational therapist with the regional center for more than 18 years. She is a member of the regional center's clinical team. Ms. Richardson does home assessments and equipment assessments. She helps to run a pediatric clinic. She does screenings for adult claimants and trainings for staff and consumers' families. The equipment assessments are of three types. She does informational equipment assessments in which she tells families about resources that are available. She does equipment clinic assessments in which she coordinates communication among vendors, doctors, and insurers. In this case, she did an equipment assessment to evaluate a specific request.

14. Ms. Knighten holds a master's degree in physical therapy and is licensed by the State of California. She has been with the regional center for 16 years. She performs evaluations, runs an equipment clinic, and performs home assessments. She helps families solve problems.

15. Ms. Richardson and Ms. Knighten wrote an assessment report dated June 10, 2019, and both testified.

16. In Ms. Richardson and Ms. Knighten's report, they wrote about their observation of claimant's current bed. Claimant's standard queen-size bed has a padded headboard, and one side of the bed is against a wall. On the other side of the bed there is a three-foot fabric-covered railing, which is secured under the mattress. There are nine pillows on the bed to prevent claimant from accidentally falling off of the

bed. Claimant's mother reported that claimant previously had a twin bed but that it was not large enough because of the number of pillows needed to keep claimant safe and because of the need to be on the bed with him when one is feeding him.

17. At claimant's home, during the assessment, claimant's mother demonstrated how she, claimant's father, and the LVNs transfer claimant from his stroller to his bed. Claimant's mother helped claimant stand. She pivoted him around and moved him so that the back of his legs and buttocks were against the bed. The bed is too high for claimant simply to sit down on it, so with claimant and his mother standing face to face, his mother grasped claimant around his waist and lifted him onto the bed. Claimant's mother then rotated claimant to position him on the bed.

18. Claimant's mother told Ms. Richardson and Ms. Knighten that claimant needs a bed that can be raised and lowered because, to get him in and out of bed, the bed needs to be low enough for him to sit on it with his feet on the floor. On the other hand, when she or the LVNs are dressing him, grooming him, or changing his diaper, the bed needs to be high enough that they do not have to bend over.

19. Claimant's mother told Ms. Richardson and Ms. Knighten that, when she or one of the LVNs feeds claimant, he often tries to pull at his g-tube, which makes it difficult to feed him. She demonstrated how she and the LVNs position claimant in order to prevent him from pulling at the g-tube while they feed him. She moved claimant to the center of the bed and got on the bed. She sat next to claimant and used her body to isolate claimant's right arm to prevent him from using his right hand to pull at his g-tube. Claimant's mother then had both hands free to feed claimant and control his left hand.

20. Claimant's mother said there are two reasons claimant needs a queen-size bed. First, she and the LVNs need to be able to sit on the bed in order to isolate his right arm when they feed him. Second, claimant is very active and moves around in the bed, and they use nine pillows to keep him safe. A smaller bed would not be big enough for that and, therefore, would not be safe. There is a photograph of claimant in his bed that depicts a result of his moving around. Claimant is lying in bed with his head on his nightstand.

The Regional Center Denied Claimant's Request, and His Mother Appealed

21. In a Notice of Proposed Action (NOPA) dated July 9, 2019, the regional center advised claimant's mother that her request for a hi-lo, all electric, queen-size Flexabed was denied. The NOPA provided, in part:

Your request . . . is not directed toward the alleviation of [claimant's] developmental disability. . . . [T]he absolute necessity for a queen-size bed cannot be determined as most patients who require a hospital bed receive a twin-size hospital bed. . . . IRC believes a twin-size bed is appropriate in meeting [claimant's] needs. . . . [W]e do believe that accommodations can be made to make a twin-size bed safer for [claimant]. You may consider the use of mattress extenders, railing pads or gap padding to make it safer for him.

[¶] . . . [¶]

It is reported that Medicare authorized the provision of a semi-electric hospital bed, which features a manual crank system that raises and lowers the bed, as well as electrically adjustable head and foot. The family refused this bed [R]egional centers are prohibited from funding services that would otherwise be available from other . . . entities or programs

22. Claimant's mother filed an appeal, a fair Hearing Request.

Ms. Richardson's Testimony

23. Ms. Richardson testified that, when she does a specific-request equipment assessment, she seeks to determine whether the equipment requested is the best or only way to meet the family's needs.

24. Ms. Richardson described various beds. An adjustable bed is one on which the angle of the head and foot can be changed. There may be the added feature of being able to raise or lower the platform in order to adjust the elevation of the entire bed. These adjustments may be accomplished with hand cranks, or if a bed is equipped with electric motors, they can be accomplished with a remote control. It is common for a hospital bed to have motorized systems for changing the angle of the head and foot but only a hand crank for changing the elevation of the platform. Such beds are referred to as semi electric. The hand crank can be replaced with a motor for approximately \$200. A bed on which all three functions are motorized is referred to as fully electric. Hospital beds come in various widths. There are extra wide beds that can be prescribed for people who weigh more than 250 pounds. These are referred to as bariatric beds.

25. Side railings on a bed can create safety problems. Patients can become trapped in them. Ms. Richardson testified that hospital beds have railings that meet Federal Drug Administration entrapment compliance guidelines. A further problem is that railings do not enclose the entire bed.

26. Ms. Richardson testified that she could find no justification for recommending that claimant have a queen-size bed. She said a caregiver standing beside a hospital bed could control claimant and, at the same time, feed him through a g-tube.

27. Ms. Richardson suggested that claimant should be assessed for a transfer system, such as a Hoyer lift. Using a transfer system may be the safest way to move claimant in and out of bed; transfer systems are safer for patients and for caregivers. She said that, by settling on a system that involves lifting claimant, his parents "have made a wrong choice."

28. Ms. Richardson testified that none of the beds under consideration are safe for claimant – that a rail is not an adequate safety device for someone with claimant's conditions. Ms. Richardson testified, further, that she would want to consider a fully enclosed bed with netting all around, similar to the Vail bed claimant once had. Without doing an assessment, she does not know what size the bed should be.

29. Ms. Richardson testified that she had not been able to find a queen-size hospital bed.

30. Ms. Richardson was a persuasive witness. She has been an occupational therapist with the regional center for more than 18 years. She demonstrated a broad knowledge of the matters about which she testified. At the beginning of her testimony,

she focused on the fairly narrow scope of what she had been asked to assess, whether claimant needed the particular bed requested. When pressed, however, she expanded her testimony to address broader concerns she had. When asked very specific questions about her broader concerns, she refused to speculate. Rather, she testified that she could not answer such questions because there had been no assessment as to exactly what equipment claimant needs.

Ms. Knighten's Testimony

31. Ms. Knighten testified that the bed Kaiser offered can satisfy claimant's needs but that no bed can guarantee safety. An upgrade to motorize the system for adjusting the elevation of the bed costs approximately \$200. She said she knows of no medical evidence that would support a finding that claimant needs a queen-size bed.

The LVNs' Testimony

32. Suzanna Salazar, who has been an LVN for 10 years, testified. She has been one of claimant's caregivers for eight years. For seven years, she worked with claimant five days per week, eight hours per day. Currently, she works with claimant on Thursdays and Fridays from 4:00 to 9:00 p.m. She works with approximately six clients who have disabilities. She feeds claimant and changes his diaper. Those things are done on the bed, so in connection with doing them, she gets claimant in and out of bed, which involves lifting him. When Ms. Salazar started working with claimant, the work was much easier because he was 15 years old and much smaller. When she feeds claimant with the g-tube, she attaches the tube to the bolus on his abdomen. She restricts his right arm by placing it against the headboard and behind her back. She, then, can use both of her hands to feed him. She pours liquid into a large receptacle at the other end of the tube. She said that, if she did not restrict claimant's right arm, he

would try to pull out the g-tube and would grab the tube and spill the liquid from the funnel. Putting mittens on him might prevent him from pulling out the tube, but it would not prevent him from causing the liquid to spill. She said she could not feed him on a twin bed. She changes his diaper by rolling him from side to side. She said she could not change his diaper on a twin bed.

33. On cross-examination, Ms. Salazar acknowledged that she changes other clients' diapers on twin beds. But, she said, her other clients are much smaller than claimant and passive; "there is no comparison."

34. Elva Shul, who has been an LVN for one year, testified. She has been one of claimant's caregivers for nine months. She works with claimant Monday through Friday from 8:00 a.m. to 4:00 p.m. She showers claimant, shaves him, dresses him, feeds him, and changes his diaper. She feeds him four times per day; three of those feedings are with a g-tube. She changes his diaper three or more times per day. Other than showering, almost everything is done on the bed. When Ms. Shul puts claimant back in bed, she lifts him. She testified that she should not be doing that because, according to her employer's regulations she is restricted to lifting no more than 50 pounds. Ms. Shul testified that, when she is putting claimant in bed, she worries about falling.

35. Ms. Shul testified that she could not do the g-tube feeding with claimant in a twin bed because it is necessary to be on the bed with him and lean against his right arm. She said claimant is strong and playful; he tries to grab things, your hair, the g-tube, other things.

36. On cross-examination, Ms. Shul acknowledged the following: They could use mittens to prevent claimant from pulling at his g-tube, but he could still move his

arm around. They could feed him in his stroller. If the elevation of the bed could be lowered, she could sit in a chair and lean against claimant's right arm while feeding him.

Claimant's Mother's Testimony

37. Claimant's mother's testimony was consistent with what she told Ms. Richardson and Ms. Knighten during their assessment visit.

38. Claimant's mother also testified as follows. They previously rented a hospital bed similar to the one Kaiser agreed to provide. It was not adequate. Claimant has had four hospitalizations for surgeries. Each time, he was in a hospital bed, and each time the nurses were unable to take care of him. "I had to do it." A hand crank for changing the elevation of the bed would not be satisfactory because, while one was busy operating the hand crank, claimant might fall off of the bed. Claimant needs a fully electric, queen-size bed. Claimant's mother testified that no one has assessed claimant adequately. In order to do an adequate assessment, one would need to spend an entire day with him.

39. Claimant's mother supplemented her testimony with a written statement dated August 28, 2019. In that statement, she said, "side rails are a safety hazard as (claimant) gets tangled in the bars." She said, further, that claimant "is prone to fall out of bed; he wiggles a great deal, pushes himself up on his hands and elbows and can easily get himself into dangerous positions."

Claimant's Father's Testimony

40. Claimant's father testified lovingly and respectfully about claimant. Claimant's father reiterated and emphasized much of what claimant's mother had said.

Acting in Claimant's Best Interest

41. Whether claimant needs a transfer system is not an issue that is specifically raised by claimant's appeal. And whether his caregivers need training is not an issue that is specifically raised by claimant's appeal. However, questions have been raised concerning those matters, and claimant's parents and service coordinator should make sure they are addressed.

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. Claimant has the burden of proof. (Evid. Code, § 115 & § 500.) Claimant is seeking an order requiring the regional center to provide a service that is not provided for in claimant's IPP and that is not currently being provided.

2. The standard of proof is proof by a preponderance of the evidence. (Evid. Code, § 115.)

Overview of a Regional Center's Obligation to Provide Services

3. The Lanterman Developmental Disabilities Services Act, Welf. & Inst. Code, § 4500, et seq. (Lanterman Act), is an entitlement act. People who qualify under it are entitled to services and supports. (*Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.)

4. The purpose of the statutory scheme is twofold: to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community and to enable them to approximate the pattern of everyday

living of nondisabled persons of the same age and to lead more independent and productive lives in the community. (*Association for Retarded Citizens, supra*, 38 Cal.3d, at p. 388.)

5. Persons with developmental disabilities have “a right to dignity, privacy, and humane care,” and services and supports, when possible, should be provided in natural community settings. (Welf. & Inst. Code, § 4502, subd. (b).) Persons with developmental disabilities have “a right to make choices in their own lives” concerning “where and with whom they live.” (Welf. & Inst. Code, § 4502, subd. (j).)

6. Regional centers should assist “persons with developmental disabilities and their families in securing those services and supports . . . [that] maximize opportunities and choices for living, working, learning, and recreating in the community.” (Welf. & Inst. Code, § 4640.7, subd. (a).) Regional centers should assist “individuals with developmental disabilities in achieving the greatest self-sufficiency possible and in exercising personal choices.” (Welf. & Inst. Code, § 4648, subd. (a)(1).)

7. In *Williams v. Macomber* (1990) 226 Cal.App.3d 225, 232-233, the court of appeal addressed the Lanterman Act and said:

In order for the state to carry out many of its responsibilities as established in this division, the Act directs the State Department of Developmental Services to contract with “appropriate private nonprofit corporations for the establishment of” a “network of regional centers.” (§§ 4620, 4621.) Regional centers are authorized to “[p]urchase . . . needed services . . . which regional center determines will best” satisfy the client's needs. (§ 4648.) The

Act declares: "It is the intent of the Legislature to encourage regional centers to find innovative and economical methods" of serving their clients. (§ 4651.) The Act directs that: "A regional center shall investigate every appropriate and economically feasible alternative for care of a developmentally disabled person available within the region." (§ 4652.)

[¶] . . . [¶]

[T]he Regional Center's reliance on a fixed policy is inconsistent with the Act's stated purpose of providing services "sufficiently complete to meet the needs of each person with developmental disabilities." (§ 4501.) The Act clearly contemplates that the services to be provided each client will be selected "on an individual basis." (*Association for Retarded Citizens v. Department of Developmental Services, supra*, 38 Cal.3d 384, 388.)

A primary purpose of the Act is "to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family." (*Association for Retarded Citizens v. Department of Developmental Services, supra*, 38 Cal.3d 384, 388.) In strong terms, the Act declares: "The Legislature places a high priority on providing opportunities for children with developmental disabilities to live with their families" requiring the state to "give a very high priority to the development and expansion of programs designed to assist families in caring for

their children at home.” (§ 4685, subd. (a).) In language directly applicable to the present case, section 4685, subdivision (b), states that “regional centers shall consider every possible way to assist families in maintaining their children at home, when living at home will be in the best interest of the child.” (§ 4685, subd. (b).)

The Lanterman Act “grants the developmentally disabled person the right to be provided at state expense with only such services as are consistent with its purpose.”

(Association for Retarded Citizens v. Department of Developmental Services, supra, 38 Cal.3d 384, 393.) As noted previously, a primary purpose of the Act is to “minimize the institutionalization of developmentally disabled persons and their dislocation from family.”

8. The Act provides examples of services and supports that should be considered.

“Services and supports for persons with developmental disabilities” means specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. The determination of which services and supports are necessary

for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, physical, occupational, and speech therapy, training, education, supported and sheltered employment, mental health services, recreation, counseling of the individual with a developmental disability and of his or her family, protective and other social and sociolegal services, information and referral services, follow-along services, adaptive equipment and supplies, advocacy assistance, including self-advocacy training, facilitation and peer advocates, assessment, assistance in locating a home, child care, behavior training and behavior modification programs, camping, community integration services, community support, daily living skills training, emergency and crisis intervention, facilitating circles of support, habilitation, homemaker services, infant stimulation programs, paid roommates, paid neighbors, respite, short-

term out-of-home care, social skills training, specialized medical and dental care, supported living arrangements, technical and financial assistance, travel training, training for parents of children with developmental disabilities, training for parents with developmental disabilities, vouchers, and transportation services necessary to ensure delivery of services to persons with developmental disabilities. (Welf. & Inst. Code, § 4512, subd. (b).)

Requirement that Regional Centers be Cost Conscious

9. While the Lanterman Act emphasizes the services and supports to which consumers are entitled, the act also requires regional centers to be cost conscious.

10. It is the intent of the Legislature to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources. (Welf. & Inst. Code, § 4646, subd. (a).)

11. When selecting a provider of consumer services and supports, the regional center, the consumer, or where appropriate, his or her parents, legal guardian, conservator, or authorized representative shall consider, "the cost of providing services or supports of comparable quality by different providers, if available." (Welf. & Inst. Code, § 4648, subd. (a)(6)(D).)

12. The Lanterman Act requires regional centers to do a number of things to conserve state resources. For example, it requires regional centers to "recognize and build on . . . existing community resources." (Welf. & Inst. Code, § 4685, subd. (b).)

13. None of these provisions concerning cost-effectiveness detracts from the fact that eligible consumers are entitled to the services and supports provided for in the Lanterman Act. These provisions concerning cost-effectiveness do teach us, however, that cost-effectiveness is an appropriate concern in choosing how services and supports will be provided. There is a tension between the requirement that services and supports be cost effective and the proposition that entitlement is determined by what is needed to implement a consumer's individual program plan. The cost-effectiveness of a particular service or support must be measured against the extent to which it will advance the goal specified in the IPP, and consideration must be given to alternative means of advancing the goals.

A Regional Center is the Provider of Last Resort

14. If a needed service or support cannot be obtained from another source, a regional center must provide it. (*Association for Retarded Citizens, supra*, 38 Cal.3d at p. 390.) A regional center is the provider of last resort.

15. In drafting an IPP, a regional center is to include all services the consumer needs in order to achieve the goals set forth in the Lanterman Act. A regional center is to include services it hopes to obtain from generic sources. It is to include services it hopes will be forthcoming from natural supports. It is to include services it hopes will be provided through other resources. And the IPP is to specify from whom a regional center hopes to obtain each service. (Welf. & Inst. Code, §§ 4646, subd. (d); 4646.5, subd. (a)(4).) If a service is needed to achieve the goals specified in the Lanterman Act, however, it is a Lanterman act service even though a regional center hopes to obtain it from a generic agency.

16. If a regional center is unable to obtain a service from the source from which it hoped to obtain it, the regional center must obtain it from some other source. When a generic agency or natural support fails to provide a service that a regional center had hoped it would provide, that does not mean the regional center may just let the consumer go without. It is the responsibility of a regional center to *implement* the IPP. If a regional center cannot *obtain* the service from any other source, it still must *implement* the IPP. It still must *secure* the service. If all else fails, it must *purchase* the service. "[E]ach consumer shall have a designated service coordinator who is responsible for providing or ensuring that needed services . . . are available to the consumer." (Welf. & Inst. Code, § 4640.7, subd. (b).)

[S]ervice coordination shall include those activities necessary to implement an individual program plan, including but not limited to . . . securing, thorough purchasing or by obtaining from generic agencies or other resources, services and supports specified in the person's individual program plan. (Welf. & Inst. Code, § 4647, subd. (a).)

In order to achieve the stated objectives of a consumer's individual program plan, regional center shall conduct activities including, but not limited to . . . securing needed services. (Welf. & Inst. Code, § 4648, subd. (a).)

17. Welfare and Institutions Code section 4640.6, subdivision (d), provides:

For purposes of this section, "service coordinator" means a regional center employee whose primary responsibility

includes preparing, implementing, and monitoring consumers' individual program plans, securing and coordinating consumer services and supports, and providing placement and monitoring activities.

18. Welfare and Institutions Code section 4648, subdivision (b), provides that, among the activities a regional center is required to conduct is advocacy for, and protection of, the civil, legal, and service rights of persons with developmental disabilities. Welfare and Institutions Code section 4640.7, subdivision (b), provides that a regional center is to provide each consumer with a designated service coordinator who is responsible for providing services or for ensuring that needed services and supports are available. The work of the service coordinator shall include securing services and supports. Welfare and Institutions Code section 4647, subdivision (a), provides that generic agencies are among the sources from which a service coordinator is to secure services and supports.

Dr. Ong's Prescription

19. Dr. Ong's prescription, as modified, reads as follows: "*Hospital bed 4-way Hi-lo Mediflex – adjustable. queen size*" (Italics added.)

20. Ms. Richardson testified that she had been unable to find a queen-size hospital bed. Claimant offered no evidence that there is such a thing.

21. Dr. Ong did not testify, so there was no explanation as to why he concluded that claimant needed a special bed and no clarification of the apparent internal inconsistency in his prescription.

22. Dr. Ong's prescription is not entitled to great weight.

Analysis of Claimant's Need for a Queen-Size Bed

23. Claimant failed to prove that he needs a queen-size bed. Ms. Richardson testified that she could find no justification for recommending that claimant have a queen-size bed. She said a caregiver standing beside a hospital bed could control claimant and, at the same time, feed him through a g-tube. Ms. Knighten testified that the bed Kaiser offered can satisfy claimant's needs.

24. Other than Dr. Ong's prescription, there was no evidence of a professional opinion that claimant needs a queen-size bed. And as noted above, Dr. Ong's prescription is not entitled to great weight. While hospital beds come in a few widths, Ms. Richardson testified that she could not find a queen-size hospital bed, and her testimony was credible. So that leaves a significant question about Dr. Ong's prescription for a "Hospital bed . . . queen size." And Dr. Ong did not testify to clarify what he meant.

25. The other evidence in support of claimant's needing a queen-size bed was based on claimant's parents' and LVN caregivers' experience in developing ways to feed claimant, keep him safe, and change his diaper. They, especially claimant's parents, certainly are to be commended for their dedication to claimant. One wonders how many people would have been able to do what they have done and continue to do. But it is legitimate to ask whether the methods they have developed through trial and error are what claimant needs. And Ms. Richardson, after assessing what they were doing and their explanations for why they were doing it, could find no justification for recommending that claimant have a queen-size bed. She said a caregiver standing beside a hospital bed could control claimant and, at the same time, feed him through a g-tube.

Analysis of Whether the Bed That Was Requested is Safe For Claimant

26. A “regional center shall secure services and supports that meet the needs of the consumer” (Welf. & Inst. Code, § 4646, subd. (a).)

27. The bed claimant’s parents requested would not be safe for claimant. He has a severe intellectual disability. He requires constant supervision during waking hours to prevent injury or harm. He has no sense of danger, and there is no expectation that he will ever learn to protect himself.

28. The bed claimant’s parents requested does not have appropriate features to prevent claimant from falling out of bed. Partial side rails can be installed. His parents will augment those with pillows. At night they will put a sheet over him and tuck the sheet under the mattress. But these things are not adequate. In claimant’s mother’s August 28, 2019, written statement, she said that “side rails are a safety hazard as (claimant) gets tangled in the bars.” She said, further, that claimant “is prone to fall out of bed; he wiggles a great deal, pushes himself up on his hands and elbows and can easily get himself into dangerous positions.” The anticipated safety devices are the same as those claimant now has, and a photograph shows how inadequate they are. It is a photograph of claimant lying in bed with his head on his nightstand.

29. Ms. Richardson testified that none of the beds under consideration are safe for claimant – that a rail is not an adequate safety device for someone with claimant’s conditions. Ms. Richardson testified, further, that she would want to consider a fully enclosed bed with netting all around, similar to the Vail bed claimant once had.

30. A bed that is unsafe for a consumer is not a support that meets his or her needs.

Addressing Claimant's Best Interest

31. Whether claimant needs a transfer system and whether his caregivers need training are matters that are beyond the scope of this proceeding. And there has been no assessment of what size bed claimant needs. Claimant's consumer services coordinator and claimant's parents would serve claimant's interests by addressing those matters.

ORDER

The regional center's denial of claimant's request for a fully electric, queen-size bed is upheld.

DATE: September 18, 2019

ROBERT WALKER
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.