

Background:

TCDD and Advocacy, Inc., staff will provide an overview of recent Department of Justice monitoring reports of State Supported Living Centers. Staff will also discuss with the Committee recent advocacy efforts in response to those reports and discuss any positions the Council would like to take in response. Additional information is provided in meeting materials.

<p><u>Public Policy Committee</u></p> <p><u>Agenda Item 6. B.</u></p>	<p><u>Expected Action:</u></p> <p>The Committee will receive an update regarding DOJ Monitoring activities of State Supported Living Centers and provide guidance as needed. The Committee may recommend that the Council take a specific position on the admissions of new individuals to State Supported Living Centers.</p>
<p><u>Council</u></p> <p><u>Agenda Item 8. A.</u></p>	<p><u>Expected Action:</u></p> <p>The Council will consider any recommendations from the Public Policy Committee concerning a position on admission of new individuals to State Supported Living Centers and determine final action.</p>

State Supported Living Center Monitoring Reports

Background

In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with intellectual and developmental disabilities pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement that covers 12 State Supported Living Centers.

As determined by the Settlement Agreement (SA), three Monitors are responsible for monitoring the Facilities' compliance with the SA and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor has assembled a team of experts and is responsible for conducting reviews of each of the Facilities assigned to him/her every six months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the monitors of the status of compliance with the SA. The purpose of this report is to outline the most significant concerns or issues brought forth by the baseline reviews on each of the State Supported Living Centers as well as detail the recommendations made to the state.

Summary of Findings

The Department of Justice Monitors identified a number of issues at each of the facilities reviewed. At a minimum, each facility had nine problem areas to address, with two facilities (Lubbock & Rio Grande SSLC) having 15 problem areas to address. In some instances, the monitors prioritized the issues to be addressed initially. They identified four problems observed at the Austin State Supported Living Center that could potentially place residents at risk of harm. The items below identify the issues that were systemic (those cited in 11 of the 12 facilities) as well as those raised in a majority of the facilities.

Systematic issues:

- Integrated Individual Service Plans: There is limited interdisciplinary coordination at the facilities with regard to the formulation of individuals' service plans or individual department assessments are not being coordinated into one comprehensive service plan.
- At-Risk Individuals: Facilities are struggling to assign individuals with the appropriate risk levels; ensure that individuals who are considered at-risk are getting the proper services and supports; or are not assessing individuals' risk levels in a timely manner.
- Physical and Nutritional Supports: Facilities were not systematically identifying individuals with physical and nutritional management concerns or properly addressing identified concerns. Such concerns include identifying choking hazards, maintaining adequate oral hygiene, or proper medication administration.
- Planning for Movement, Transition, and Discharge: Facilities are not properly planning for individuals to transition into the community or are not sufficiently monitoring the impact of the transitions that occur to evaluate whether individuals were provided with adequate supports to transition.
- Habilitation, Training, Education, and Skill Acquisition Programs: Skill acquisition programs are inadequate, sometimes with vague goals; individuals had no resources to be active; and some skills assessments were not performed regularly.

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Other problem areas (those cited in a majority of facilities):

- Abuse, Neglect, and Incident Management: The Mexia State Supported Living Center had 10 confirmed cases of physical abuse; five confirmed cases of emotional or verbal abuse; 16 confirmed allegations of neglect; and one confirmed case of exploitation. At other facilities, injury investigations were extended beyond the normal 30-day requirement; individuals had unexplained injuries; and insufficient analysis of incident causes prevented the identification and prevention of additional incidents.
- Medical & Nursing Care: Staffing shortages were a major source of the problems in nursing care, with many facilities utilizing involuntary overtime to maintain adequate staffing. Moreover, inexperienced staff was assigned to work with individuals with complex and challenging needs for support. Nursing Care of Health Maintenance Plans did not include clear objectives or were not adequate to meet individuals' total healthcare needs.
- Psychological Care and Services: One facility was performing untimely assessments due to understaffing. A number of facilities had an insufficient number of staff with basic knowledge of applied behavior analysis or intervention.
- Communication: A number of facilities were not offering augmentative communication systems to many individuals who needed them or could use them to communicate their basic needs.
- Pharmacy Services and Safe Medication Practices: Medication errors were underreported or were reported in an untimely manner. Moreover, there was inadequate communication when an individual's prescription was changed concerning the potential impact new medication would have in combination with other prescriptions or the effectiveness of the new prescription.
- Dental Care: Because some facilities did not have basic dental services available on site, individuals had poor dental hygiene. For example, at the San Antonio State Supported Living Center, all but two individuals observed at the facility had advanced periodontal disease and poor to non-existent oral hygiene.
- Use of Restraints: Although the use of restraints in the last year has reduced at most facilities, there was a 20 percent increase in the use of restraints between July 2009 and February 2010 compared to the same time frame in the previous year at the Mexia State Supported Living Center. Other facilities need to create or clarify the facility's restraint policies or to ensure that staff was properly trained on the policies.
- Guardianship: Facilities were not actively pursuing guardians for individuals who need them or had no plan in place for recruiting guardians.
- Quality Assurance: Facilities were not gathering data use to identify issues to address for systemic change or were not utilizing the data that was available to manage trends that emerged.

Recommendations for the State

- Integration of Services: The state was called upon to develop guidelines for facilities to utilize when preparing integrated services plans.
- Minimum Common Elements of Clinical Care: Each Facility must provide clinical services to individuals consistent with current, generally accepted professional standards of care. The state was in the process of setting up guidelines to this effect.
- Consent: The state was directed to create a policy regarding consent as it applied to the Settlement Agreement.
- Dental Services: The monitoring team recommended that the state give consideration to developing a statewide dental committee that includes the Dental Directors of each of the SSLCs to promote collaboration and consistency in policies and practices among the SSLC dentists.

For more information, visit <http://www.dads.state.tx.us/monitors/reports/>.