

Background:

The Committee will receive an update on recent Department of Justice monitoring team reports of State Supported Living Centers. Summaries of monitoring reports completed since last quarter's meetings are included in materials. Staff will also discuss with the Committee recent advocacy efforts and discussions in response to those reports.

Public Policy Committee**Agenda Item 8. C.****Expected Action:**

The Committee will receive an update regarding DOJ monitoring activities of State Supported Living Centers and provide guidance as needed.

Council**Agenda Item 20. B.****Expected Action:**

No action anticipated. Information item only.

State Supported Living Centers Update on Compliance Reports

In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate state-operated residential facilities serving people with intellectual and developmental disabilities (formerly, state schools) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In June 2009, the State of Texas/DADS and the DOJ entered into a Settlement Agreement (SA) that covers the 12 State Supported Living Centers (SSLC) and the ICF/MR component of Rio Grande State Center.

As determined by the Settlement Agreement, 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 the assigned facilities every six months and preparing written reports that detail their findings and recommendations.

The monitor teams examine activities in 20 different aspects of care provided to residents in each facility to determine the status of each facility's compliance with provisions of the U.S. DOJ Settlement Agreement. Some examples of these different aspects of care include Medical Care, Dental Services, Communication, and Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs. Within each section, there are a varying number of more specific provisions. Each provision is given a rating: substantial compliance or noncompliance with the terms of the Settlement Agreement. There are also provisions noted as "not rated" if the monitoring team did not have access to documentation to rate a provision.

Baseline reviews of the facilities were conducted in January through May 2010. Compliance reviews began in July 2010 to report on each facility's compliance with the SA. Highlights from these reports on the monitoring teams' concerns regarding the State Supported Living Centers are provided below. As of early October, compliance reports were available on four of the facilities.

Corpus Christi State Supported Living Center (CCSSLC)

The compliance review of CCSSLC documented improvements in 13 sections assessed by the monitoring team, including the development of abuse, neglect, and incident management policies and processes. Positive practices were also observed in the areas of medical, nursing, and dental care as well as integrated services, supports, and protections. Of the 159 provisions assessed by the monitoring team in the baseline review as requiring particular attention, 138 were characterized as noncompliant, which constitutes 87 percent of the provisions. In addition, the compliance review brought forth new concerns about the quality of medical care at CCSSLC due to inadequate staffing. Five mortalities in the previous year due to aspiration pneumonia or pneumonia raised the monitors' concern about the quality of care for medically complex individuals or individuals with respiratory complications. Investigations of abuse, neglect, and incident management were not completed in a timely or comprehensive manner. A lack of interdisciplinary coordination affected the determination of risk levels for individuals, physical and occupational therapy care, and communication. The monitoring team did not observe improvements in habilitation, training, education, and skill acquisition programs, noting that staff knowledge and competency continued to be insufficient. There also continued to be issues related to missing documents and the quality of information in individuals' records, which affected the ability of staff to determine the effectiveness of alternative interventions before the use of restraint was applied. Medication errors were not reported or addressed consistently. About 20 percent of the residents received no dental care in the last year. The report noted an improvement in post-move policies for individuals who transitioned to the community, but the facility's policies to identify essential services and supports prior to an individual's transition to the community need further development.

(Continued)

El Paso State Supported Living Center (EPSSLC)

The monitoring team noted a number of positive practices in place at EPSSLC, including abuse, neglect, and incident management policies and procedures. The report also highlighted improvements in moving individuals to the community and praised EPSSLC for creatively working with community partners. Of the 162 provisions assessed by the monitoring team, 139 provisions or 86 percent were found to be in noncompliance with the Settlement Agreement. Although EPSSLC addressed the concerns that monitors brought forth in the baseline review concerning abuse, neglect, and incident management as well as the less frequent use of restraint, the monitors cited five new sections that the facility must address: quality assurance; psychological care; planning for movement transition & discharge; skill acquisition; and communication. There was not an adequate, comprehensive quality enhancement plan in place. Protections, medical and psychiatric services, treatments and support were not integrated. Psychologists were not competent in applied behavior analysis. Because the pharmacy was not reporting medication errors consistently, the extent of medication errors was unknown. Only minimal dental services were provided. Skill acquisition plans at EPSSLC were not adequate to promote growth, development, and independence for residents. Very few individuals were in the referral process for transitioning to the most integrated community setting.

Abilene State Supported Living Center (ABSSLC)

The compliance report noted that ABSSLC was noncompliant in 141 of the 160 provisions evaluated, or in 88 percent of the provisions. ABSSLC made improvement in the less frequent use of restraint, although the use of restraint for dental services remained high. The report noted that the facility is engaged in positive practices in a number of areas, including abuse, neglect, and incident management as well as psychiatric, psychological, medical, and nursing care. A new concern of the monitors is associated with the investigation of abuse and neglect, which is not commenced in a timely manner. Death investigations were not sufficiently thorough. Other new concerns discussed in the monitoring report include problems with clinical services and record keeping. The monitors noted that the mortality review process should be timelier and provide recommendations for staff to minimize the risk of harm for individuals with physical and nutritional support needs. Additionally, the monitors recommended that a greater focus be placed on the prevention of illness, rather than a focus on acute care. Skill acquisition programs and community placement preparations were inadequate. Individuals who could benefit from alternative and augmentative communication systems did not have access to them. Improvements were noted in the facility's work to move individuals to the most integrated setting in that staff was listing obstacles to the individual and plans to overcome them, however the monitors noted that this process needs refinement.

Brenham State Supported Living Center (BSSLC)

Since the baseline review of BSSLC, a number of new issues were raised by the monitoring team. The compliance report showed that BSSLC was noncompliant in 151 of 164 provisions, or 92 percent. Although concerns with the facility's operations in residential consent, injury management, and clinical services have improved, seven new problematic sections were recorded. The frequency of restraint use has increased by 63 percent from January through June 2010 when compared to the previous six-month period. There were several instances of late reporting of abuse and neglect, which is a concern because it potentially exposes individuals to an alleged perpetrator longer than allowed by policy. The report also noted concerns with clinical and nursing care, dental services, and pharmacy services. Problems were also noted about the staff not working in an interdisciplinary manner; rather, the staff was working in a multi-disciplinary manner, which led to inconsistency in comprehensive care. The review also raised questions about skill acquisition programs, pointing out that meaningful training opportunities which promote the development of personal adaptive skills were not available. The report noted that there was a better policy in place for comprehensive assessment documents to ensure individuals are in the most integrated setting. However, the team encouraged improvement in interdisciplinary assessment and individualized assessments.

Compliance Reports for each of the facilities are posted online at

<http://www.dads.state.tx.us/monitors/reports/index.html>. The Settlement Agreement is at <http://www.dads.state.tx.us/homepage/FinalSettlementAgreement.pdf>.

Safer conditions at Corpus Christi institution where residents with mental disabilities were once forced into fight clubs

06:05 PM CDT on Monday, September 13, 2010

By ROBERT T. GARRETT / The Dallas Morning News

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AUSTIN — Conditions are much safer at a Corpus Christi institution where late-night “fight clubs” were forced on residents with mental disabilities, officials said Monday.

Supervisors work night shifts, employees are trained to report abuse and there is continuous monitoring of 247 newly installed video surveillance cameras, said director Iva Benson.

“We report even if there’s a bruise that we find and no one knows what happened,” said Benson, who heads the former Corpus Christi state school, now called a state supported living center.

“We want every incident investigated by outside entities because we do not tolerate that abuse and neglect,” she said.

Benson spoke after Texas Department of Aging and Disability Services officials conducted a media event to mark release of an independent monitor’s report about how well the facility is complying with a five year, \$112 million state settlement with the U.S. Department of Justice. It was the first follow-up check to be completed at one of the 13 facilities for the developmentally disabled.

“This facility has many challenges to resolve,” said Chris Traylor, commissioner of the state department. “But we are off to a great start.”

In March 2009, a federal investigation of dangerous conditions inside the facilities was in its fourth year when the fight clubs in Corpus Christi were disclosed. Night-shift employees at one dorm instigated the bouts with direct commands and pranks aimed at spurring the residents to turn on each other, police said.

The police inquiry was launched after a local retailer turned over a lost cellphone, which contained almost 20 videos of fights. The images eventually landed in the national news, and at least 11 employees quit or were fired. Of six who faced criminal charges, at least two are serving prison sentences.

“That was a very, very regrettable and serious incident,” said Benson, who has headed the facility for three years. “And it certainly does not reflect what’s happening at the facility today, as the report shows.”

Today, two or three staff members monitor the video cameras around the clock, she noted.

Chris Adams, assistant state commissioner over the 13 residential institutions, said that as a result of watching the monitors, facility employees have reported nine possible incidents of abuse and neglect to the Department of Family and Protective Services since Nov. 1. Of them, one was confirmed, he said, without providing details.

The outside monitoring team said it conducted an interview with 10 staff members. Of them, five said they’d reported abuse. The monitors said that when they asked employees where they must

report suspicions, workers often flipped over their ID badges and pointed to instructions and the protective services hotline phone number.

The monitors said employee comments and other things, including the posting of zero-tolerance posters around the campus, “suggested vigilance” in reporting abuse.

However, they urged Benson and her staff to work harder to discourage retaliation against employees who report co-workers’ misdeeds. Monitors reviewed 70 protective-services investigations involving the Corpus Christi facility, and said they found in two of them troubling comments by employees that hint at a lingering fear of reprisals.

“The culture amongst staff of protecting one another as opposed to individuals served can be very strong, and apparently was at Corpus Christi in recent years,” the monitors said. “Facility management will need to continue to be creative about shifting this culture to one in which the individuals’ safety and well-being is paramount.”

They urged administrators to “strongly train and remind staff” that retaliation is forbidden. In some instances, managers may need to reassign staff members or increase supervision, the monitors said.

No staff members have been reassigned to protect against retaliation, said department spokeswoman Allison Lowery.

“We just got this report on Friday so [administrators] haven’t had an opportunity to take specific steps,” she said.

However, Lowery noted the report says Benson told monitors she won’t condone retaliation and twice has asked the inspector general of health and human services to investigate alleged retaliation.

“The facility will continue driving home the message that it’s not acceptable,” Lowery said.

The monitors’ report said the Corpus Christi campus is complying with many, though not all, of scores of requirements imposed by last summer’s settlement agreement between the state and federal governments.

The center has hired more dental care professionals and, while it still doesn’t have a staff psychiatrist, has improved nursing care, the report said.

When the fights were disclosed, state lawmakers were well on their way to passing an emergency safety bill that required more background checks of employees and ratified Gov. Rick Perry’s decision to install the cameras.

Lawmakers found money to hire 1,160 more employees and, in a nod to advocates who wanted to close facilities, an additional \$250 million to provide community-based care for nearly 8,000 people stuck on long waiting lists.

Article can be viewed online here:

<http://www.dallasnews.com/sharedcontent/dws/news/texasouthwest/stories/091310dntexcorpuschristi.ee308625.html>



Review of state school positive overall, with reservations

By Celinda Emison

Friday, September 24, 2010

The first compliance review for the Abilene State Supported Living Center was positive overall, but officials with the Texas Department of Aging and Disability Services say there is more work to be done.

The Abilene State Supported Living Center, formerly known as the Abilene State School, was reviewed in August for the first time as part of a five-year settlement agreement with the U.S. Department of Justice reached in June 2009.

Chris Traylor, commissioner of the Department of Aging and Disability Services, visited the Abilene facility Friday to deliver the news on the review. He applauded the efforts of the staff to comply with the settlement agreement.

“These guys have done a job that this community should be proud of,” Traylor said adding that full compliance could take up to seven years.

“There are no quick fixes,” Traylor said. “The changes will be substantive and deliberate.”

Under the \$112 million settlement agreement, the state’s 13 facilities must focus on issues of health care and restraint, and make sure each facility has a competent and well-trained staff at all times. The settlement agreement also calls for reduced use of restraints on residents; improvements in medical, dental and psychiatric care; tougher penalties for failure to report abuse; and speedier conclusions of abuse investigations. The agreement also ordered the facilities to hire about 1,000 new care workers as well as “monitors” to track how the facilities are complying with the settlement. The reviews will be conducted every six months for the next four and a half years.

Abilene is among the first of the state’s 13 facilities to undergo the compliance review. The findings of the monitoring team that assessed the Abilene facility in August were released Friday.

“Abilene has been done relatively early so it is hard to see how they stacked up to other facilities,” Traylor said.

Although the Abilene facility earned “substantial compliance” in several areas, including issues involving restraint, abuse and neglect, nursing, record keeping, pharmacy and psychological services, there were some deficiencies.

“There are areas where we have more work to do,” said Chris Adams, assistant commissioner for state supported living centers.

The report cites some policies and procedures in the compliant areas, as “in need of improvement.” Adequate medical and psychiatric care is needed, the findings showed.

“We have had some difficulty hiring psychiatrists,” Adams said.

In December 2008, the Abilene State School was cited for seven deficiencies in the Justice Department report. The deficiencies included failure to provide active treatment; failure to provide consistent client training; failure to review and revise individual program plans; failure to provide a clean environment; failure to comply with the Life Safety Code for fire safety; and failure to provide clients’ health care services.

The Justice Department report came after abuse and neglect issues were found at the Denton and Corpus Christi facilities. After allegations were made against employees at those facilities, all 13 of the state’s facilities went under the microscope.

From September 2007 to September 2008, at least 114 residents died at the facilities, the DOJ report cited. Fifty-three of the deaths were deemed preventable and indicated lapses in proper care, the report said.

In June 2009, Gov. Rick Perry signed Senate Bill 643 enacting several protective measures for residents of the newly renamed state supported living centers, including: establishing the Office of Independent Ombudsman; enhancing abuse and neglect investigations; creating a hot line number to report allegations of misconduct; requiring video surveillance cameras to prevent, deter and detect abuse and neglect, and requiring FBI fingerprint background checks and random drug testing on employees.

During a tour Friday, officials at the Abilene facility said 375 cameras have been installed in the hallways and common areas. The surveillance cameras go live in two weeks.

Officials at the Abilene facility said complying with the settlement is a learning process.

“We are learning from the issues that were brought up and are making great progress,” said John Hennington, assistant director of administration. “It will be an ongoing process for a number of years.”

Material from The Associated Press was used in this report.

