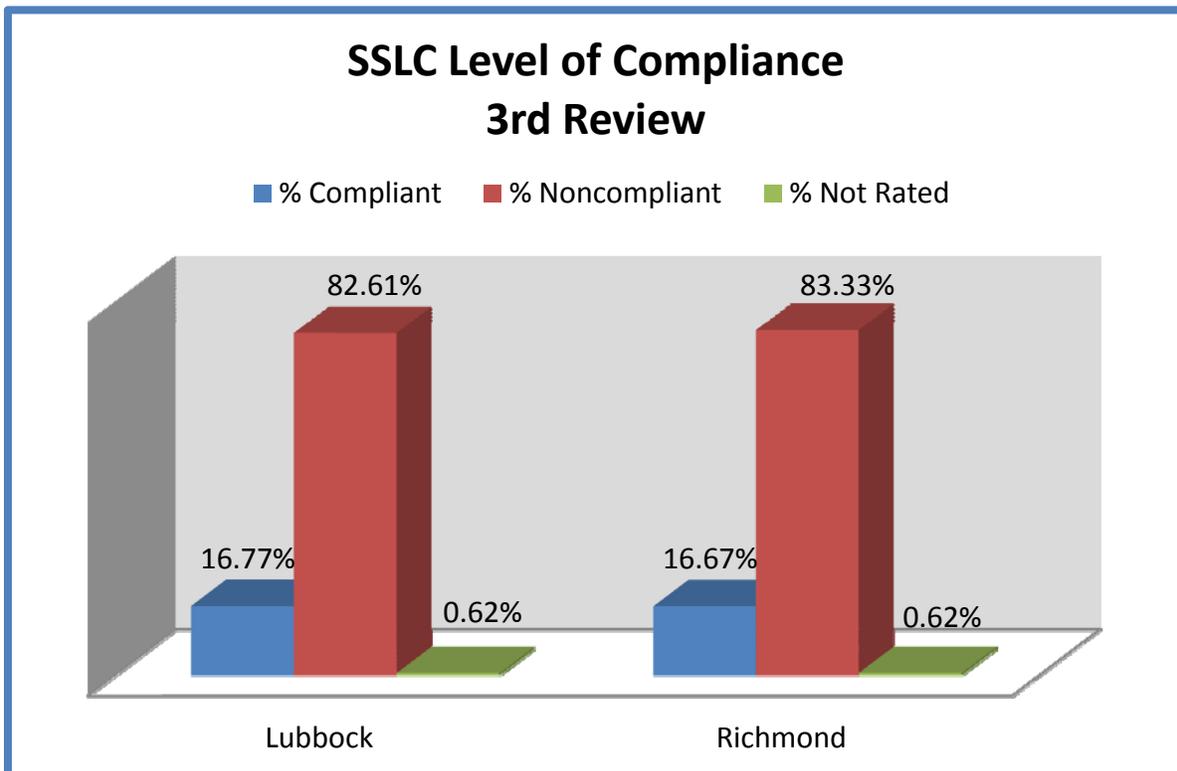


# State Supported Living Center Monitoring Update

The Department of Aging and Disability Services released monitoring reports for Lubbock and Richmond State Supported Living Centers in mid-January. The monitoring teams examine activities relating to 20 aspects of care provided to residents in each facility to determine the status of each facility's compliance with provisions of the U.S. Department of Justice (DOJ) Settlement Agreement (SA). Within each section, there are a varying number of more specific provisions. Each provision is rated in substantial compliance or noncompliance with the terms of the SA. The monitoring teams did not rate provisions for which they had insufficient information. This report summarizes the findings of the DOJ monitoring teams.



## Lubbock State Supported Living Center (LBSSLC)

LBSSLC was compliant in just below 17 percent of the provisions rated by the monitoring team, whereas almost 83 percent of provisions were rated as noncompliant. Though the monitoring team observed improvements in documenting the use of restraints and ensuring that staff were adequately trained to administer them, there were serious issues noted in ensuring that persons who received a restraint also received a medical assessment by a licensed medical professional within 30 minutes of the restraint. LBSSLC made progress in training staff about abuse, neglect, and incident management, however, there continued to be delays in initiating investigations. The report also indicates that documentation was found lacking in terms of determining whether there was a history of abuse and neglect. During the review period there were 25 confirmed cases of abuse, neglect, or exploitation; but the level of analysis associated with the incidents was not adequate enough to determine in which category each of the cases belong, nor were previous allegations documented well enough to determine whether patterns were present. LBSSLC struggled to complete annual medical reviews in a timely manner and to locate quarterly medical progress reviews. In the area of psychiatric care and services, LBSSLC made some

progress in developing and implementing comprehensive psychiatric assessments (CPAs) to better ensure compliance with the SA. 37 of the 126 individuals (29 percent) who received psychotropic medications had received a CPA. According to the monitors, full implementation of the CPA will be a significant step in achieving compliance in this area. Communication services were a critical concern of the monitoring team. Although many residents had adaptive communication devices, there were no direct therapy supports provided nor were there individualized provisions in place to measure the progress of persons using adaptive communication devices. The monitoring team reported that residents of LBSSLC were less engaged in activity than they should be. Although plans were developed and in place for improving habilitation, education, and skill acquisition, it was not clear that these plans were being implemented. There was no improvement in providing individuals with off-site vocational opportunities. Individual service plans did not successfully identify all of the protections, services, and supports that would be necessary for an individual to transition safely to the community. Since the last review, only two individuals transitioned to the community.

### **Richmond State Supported Living Center (RSSLC)**

Though RSSLC was rated substantially compliant in almost 17 percent of the provisions rated, 12 of the 20 areas assessed (60 percent) were viewed as 100 percent noncompliant. Areas in which RSSLC was totally noncompliant include: medical care, physical and occupational therapy, and dental services. Regarding the use of restraint at RSSLC, the monitoring team was unable to confirm whether staff serving as restraint monitors were properly trained or whether restraint that was applied to individuals was prohibited under medical orders. Many incidents were not reported to the Department of Family & Protective Services (DFPS) within one hour, as required, and there was a problem with getting a timely response from DFPS. The monitoring team observed concerns with clinical care, such as lack of timeliness in conducting medical assessments when there were changes in health status and assessments were not sufficiently comprehensive. Delivery of education, habilitation, and skill acquisition programs was inconsistent. Although there were examples of outstanding service assessment and implementation of skill acquisition programs, there were also examples where both the assessment and implementation were poor. Further, the monitoring team was not provided with evidence that individuals were engaged in training in a community setting. Although a number of individuals were referred for transition, staff were not adequately identifying needed protections, services, and supports for the most integrated community setting. The monitoring team found it necessary to consult with the post-move monitor at RSSLC to identify and quickly address a situation that posed potential harm to an individual.