Biennial Report to the Texas Legislature

2021-2022

Office of the Independent Ombudsman
for State Supported Living Centers

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Summary

Executive Summary & Recommendations

From the time my term began last year, I have had the pleasure of visiting most of the state supported living centers across Texas and meeting with directors in-person. The prevailing theme among these conversations was gratitude for SSLC staff members who have heroically persevered through this immensely challenging time. I also have the same gratitude for the ombudsman staff members who have been steadfast in their service.

We must acknowledge that the impact of the global pandemic has been tragic for the aging and disability population. We mourn the loss of 37 SSLC residents who lost their lives to Covid-19 and many others who lost family members. We also remember the staff members at the SSLCs who have passed. Frontline workers across the state have risked their lives and their families to protect the state's most vulnerable. We are grateful to the direct support professionals, nurses, housekeepers, administrators, and many other staff members who have provided essential care for people at the SSLCs despite on-going critical staffing shortages. We also recognize the family members who sacrificed normal visitation with their loved ones, and we hurt for the residents who spent too much time away from family.

In consideration of the 2,649 persons residing in the 13 SSLCs statewide, we provide a comprehensive view of three domains of our mandated audits – staff to client ratio, adequacy of staff training, and rights and due process. One document could not describe a complete picture of life at the centers, but it can highlight areas that need attention. The residents of these state-managed centers, along with their family members, staff, and leadership that make up the SSLC community, require resources to succeed in the state's mission of "providing hope and healing through compassionate, innovative, individualized care."

Our office determined that legislators can best utilize our findings and recommendations prior to the legislative session. Therefore, we revised the report publication schedule so that state leaders have the most recent data to aid in their examination of the state's investment in long-term care services. It is important to remember that this office was established by the 81st legislature in 2009 out of concern for the rights and well-being of residents of SSLCs. As the Health and Human Services Commission strives to improve the quality of life for Texans who depend on their service, our office continues to bring an independent perspective for decision-makers to rely-on.

The following are recommendations to the state legislature:

Staff to Resident Ratio

- Provide appropriations for pay increases for Direct Support Professionals to improve hiring and retention for these highly complex and crucial roles that impact the daily lives residents. Additionally, provide appropriations for localized pay increases at SSLCs that have critical staff shortages and unique barriers to hiring and retention.
- Direct HHS to implement plans to increase staff minimums at homes and shifts identified as most impacted by staffing shortage as identified by the use of holdover and/or pulled staff.

Adequacy of Staff Training

- Direct HHS to provide staff trainings that uses person-centered approaches to support individuals, including trainings specifically on supporting people who are alleged criminal offenders, including alleged sexual offenders, or who have similar backgrounds (such as time in jail or a state hospital); who are medically fragile; and who are adolescent aged.
- Devote resources to emphasize training Direct Support Professionals on residents' behavior support programs, including prevention strategies that incorporate the person's daily routines and preferences.
- Implement standardized comprehensive on-the-job training (OJT) for the specific job tasks of direct care staff that requires successful competency demonstration for completion. Require OJT trainers to demonstrate competency of training techniques and strategies before they are eligible to train new staff.

Resident Rights and Due Process

- Direct HHS to review and revise the annual and refresher staff training on Rights to incorporate person-centered practices and the elements of due process, including the resident's and guardian's perspectives prior to implementing a rights restriction; the circumstances in which a residents' rights may be restricted; the role and purpose of the Human Rights Committee; and designing and implementing specific, measurable, and individualized plans to remove or reduce restrictions.
- Instruct HHS to ensure that every SSLC resident and guardian are informed of the residents' rights and their acknowledgement is documented as prescribed in policy.

Respectfully Submitted,
Candace Jennings
Independent Ombudsman for State Supported Living Centers

Independent Ombudsman staff, from left to right: Adam Parks, Talya Hines, Brenda Frausto, Isabel Ponce, James Clark, Kellen Davis, Horacio Flores, Jill Antilley, Edward Leal, Susan Aguilar, Brian Morton, Deatrice Potlow, Brianna Teague, Jessica Rosa, Carrie Martin, Gevona Hicks, Seth Bowman, and Candace Jennings.

Introduction

Introduction & Overview

> *"The Office of Independent Ombudsman is established for the purpose of investigating, evaluating, and securing the rights of residents and clients of state supported living centers and the ICF-MR component of the Rio Grande State Center."*
>
> - Senate Bill 643, Section 555.051, 81st Legislature

Background and Legislative Mandate

The Office of the Independent Ombudsman for State Supported Living Centers was established by the passage of Senate Bill 643 of the 81st Legislature. The Office of the Independent Ombudsman (OIO) was created to provide oversight and protection for residents of the state supported living centers (SSLC). The appointed Independent Ombudsman reports directly to the governor and the state's elected leaders in the executive and legislative branches. Though the OIO and its staff are provided administrative support by Texas Health and Human Services Commission, they are not part of the agency. The OIO has its state office in Austin and an Assistant Independent Ombudsman (AIO) stationed at each center. AIOs report to the Deputy Independent Ombudsman and are independent from the SSLC.

Senate Bill 643, 81st Legislature, charges the OIO with conducting audits of each SSLC, which is also referred to as "Program Review" within the body of this report. The legislation requires the OIO to review, report findings, and make recommendations in these specific areas:

- the ratio of direct care employees to residents;
- the provision and adequacy of training to center employees, direct care employees, and, if the center serves alleged offender residents, the provision of specialized training to direct care employees;
- the centers' policies, practices, and procedures to ensure that each resident and client is encouraged to exercise their rights, including the right to file a complaint and the right to due process.

Organization of Report

The 2021-22 Biennial Report is divided into three parts. Each part evaluates one of the three legislatively charged areas of review and includes the following: the specific legislative charge, a description of the data collected to evaluate centers' adherence to established policy, the data collection findings. The data is analyzed both in aggregate for the SSLC system and by facility. Recommendations for policymakers of these findings are contained in the Executive Summary.

Methodology

Program Review consists of on-site evaluations, as well as continuous ongoing data collection. The ongoing data collection period was January 2021-August 2022. The reporting period will transition from calendar year to fiscal year, hence the current period ending in August 2022. In 2021, COVID-19 impacted the OIO's ability to gather ongoing data using traditional in-person procedures, such as face-to-face interviews, attending meetings in person, and conducting in-home observations. Although the procedures were modified in some instances to be conducted remotely, AIOs continued to collect ongoing and remote "onsite" audit data throughout 2021. In 2022, data collection resumed to in-person procedures.

Data Collection Overview and Sample

Six weeks prior to the onsite review, the OIO's Salesforce platform was used to generate a random sample of 5% of the center's population or 10 residents, whichever was higher. These individuals' records were used to collect the sample data. A total 156 residents were included in the 2021 sample and 154 were in the 2022 sample. As this report includes data from both 2021 and 2022, a total of 310 individual records were used as sample data during this biennial reporting period.

During the ongoing reporting period, AIOs collected data from their own center by observing Human Rights Committee (HRC) meetings, surveying direct support staff about their on-the-job training, and conducting observations of residents' homes where they gathered information about staffing ratios and service delivery. During 2021, some home observations were conducted remotely, and the information was obtained by speaking with

the staff person in charge of the home by phone. All home observations in 2022 were conducted in-person.

Document Review & SSLC Self- Reported Data

During the onsite reviews, AIOs reviewed documents related to the rights, restrictions, psychotropic medication, and behavior support plans for each resident in the sample to determine if the documentation was completed within the guidelines and standards of established policies and whether DSPs were able to correctly identify these documents.

Each center's administration completed a form to identify the number of residents living at the center who are alleged offenders, as well as other unique populations that may require additional supports, and whether specialized training was provided for direct care staff to support these residents.

Staff and Resident Interviews

During the onsite visits, AIOs interviewed residents in the sample to assess their knowledge of their rights and their degree of involvement in due process. An interview was attempted with every resident in the sample however not all of the residents were able to complete in the interview and/or were willing to participate. Additionally, five additional resident interviews from those not in the sample were interviewed at each SSLC throughout the year.

AIOs also interviewed direct support staff who provided services to residents in the sample during onsite visits. These interviews assessed the staff's knowledge of residents' rights and due process, as well as their knowledge of residents' plans and programs to determine if staff were receiving adequate training in these areas.

Finally, during the 2021 visits, AIOs also interviewed half of the Qualified Intellectual Disability Professionals (QIDP) at each SLC to assess their knowledge of policy relating to rights restrictions and due process in general.

Questionnaires

Throughout the year, AIOs surveyed one Direct Support Professional (DSP) a month who worked at the center for more than 45 days but less than 6 months about the on-the-job training (OJT) they received.

The primary contact person on file for each resident in the sample was mailed or emailed a survey to gather information about their knowledge of residents' rights, rights restrictions, and their understanding about how to file a complaint.

Observations

During the onsite visits and throughout the year, AIOs observed HRC meetings. Due process was assessed by identifying if due process elements required by policy were present in supporting documentation and committee discussions.

During home observations, data was collected to evaluate staffing ratios and their impact on service delivery. Throughout the year, the AIOs gathered data from the homes at their center. Each home was observed once in both 2021 and 2022[1]and AIOs strove to distribute observations across all three shifts. In 2021, these observations were done remotely over the phone by calling and interviewing the staff person in charge of the home, and in 2022 they were done in-person. At both in-person and remote observations, AIOs recorded data on the number of staff working in the home by observing the number of staff present and reconciling this with the staff member in charge of the shift and the number of staff signed in. Additionally, AIOs documented the minimum number of staff needed for that home and shift, according to the facility, and asked staff about impacts on service delivery related to the number of staff working that day and shift.

[1] Due to the sizes of the Denton SSLC and the Rio Grande State Center, monitoring requirements for ratio data collection and observation were adjusted. Denton has over 50 homes, and many of the homes are separate wings within the same building. The AIO at Denton collected ratio data for one home in each of the buildings. Rio Grande has only two homes, and so the AIO at Rio Grande collected ratio data for each home, on each shift, three times, a total of 18 ratios.

Part 1

Staff-to-Client Ratio

> *"The Office of the Independent Ombudsman shall conduct on-site audits at each center of the ratio of direct care employees to residents and evaluate the delivery of services to residents to ensure that residents' rights are fully observed."*
>
> Senate Bill 643, Section 555.059, 81st Legislature

The Office of the Independent Ombudsman for SSLCs continuously conducts observations to evaluate staff to resident ratios, staff deployment, and to determine how staffing impacts service delivery. Each center sets their own minimum client to staff ratios that follow ICF guidelines to meet the unique needs of residents in each home. The OIO audits the number of staff working at each home to evaluate whether centers are meeting the minimum staffing ratios. During the 2021 - 2022 reporting cycle, 395 total home observations were conducted. To determine the sufficiency of staffing ratios and service delivery, the following measures were evaluated:

1.1: The number of staff working in a home compared to the number of staff assigned to the home and shift by the facility.

1.2: The frequency with which float or holdover staff were used.

1.3: Whether residential service delivery was negatively impacted[2] due to a lack of staff.

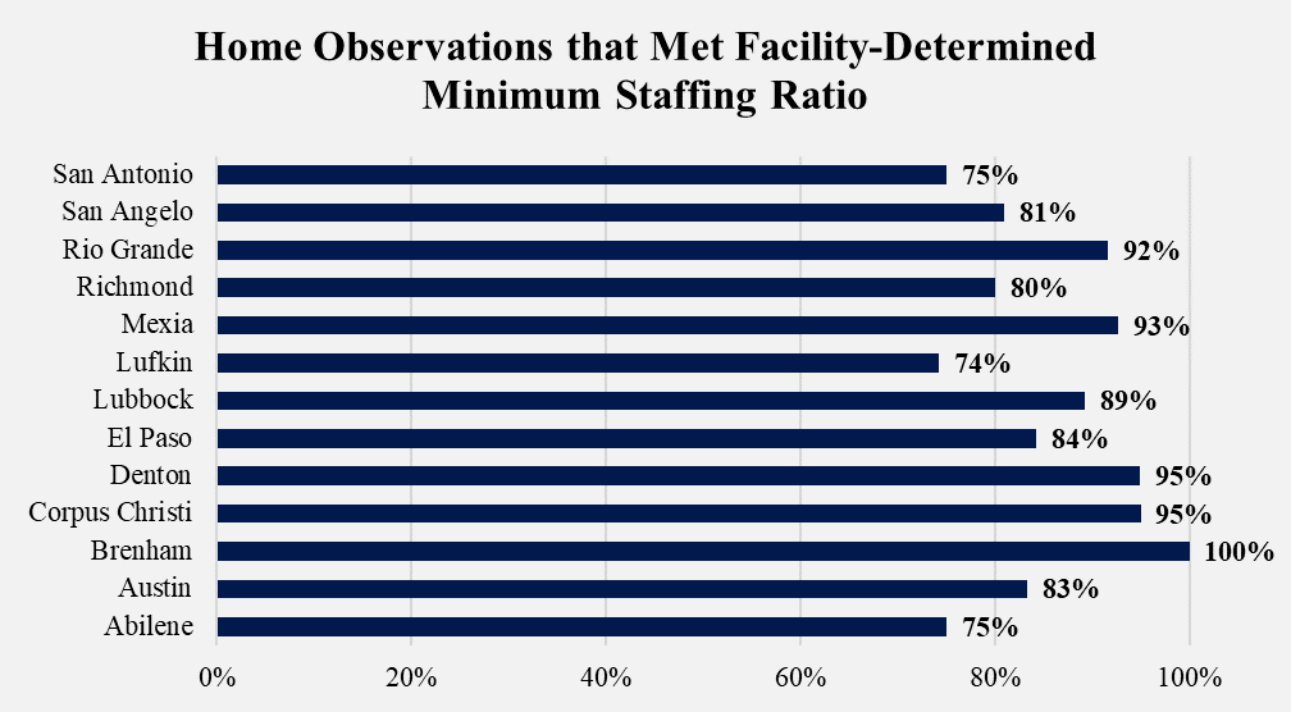
To evaluate these indicators, a 20-minute observation of each home was conducted on an ongoing basis throughout the reporting period, excluding homes that are in the sample whose observations are conducted onsite. Few in-person observations were conducted in 2021 due to ongoing covid-19 pandemic. However, due to vaccine availability, lower infection rates and increased safety measures, exclusively in-person observations resumed in 2022. Each home at every SSLC had either an in-person or remote observation conducted in both 2021 and 2022.

[2] Services that are negatively impacted refers to any support or programming that is missed, late, not completed or otherwise not carried out as intended or planned.

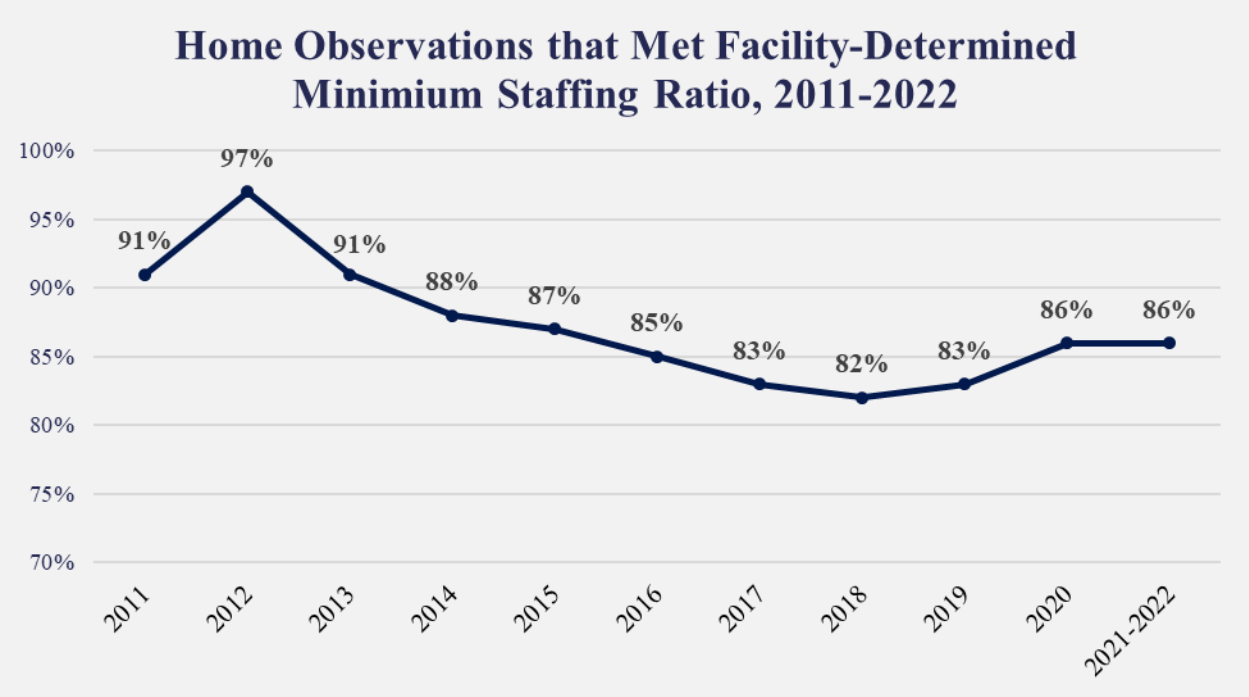
1.1: Minimum Number of Staff Required

Each center sets the minimum number of staff per home that, in their judgement, is sufficient to ensure the specific needs of residents are met and basic service delivery is carried out. The AIO documents the number of staff working, and the minimum number of staff required, as designated by the SSLC, as noted in the methodology section.

The data in this subsection represents both in-person and remote observations.



- The San Antonio, Abilene and Lufkin centers met minimum staffing ratios in less than 80% of the observations; Brenham SSLC met staffing minimums in all home observations conducted.



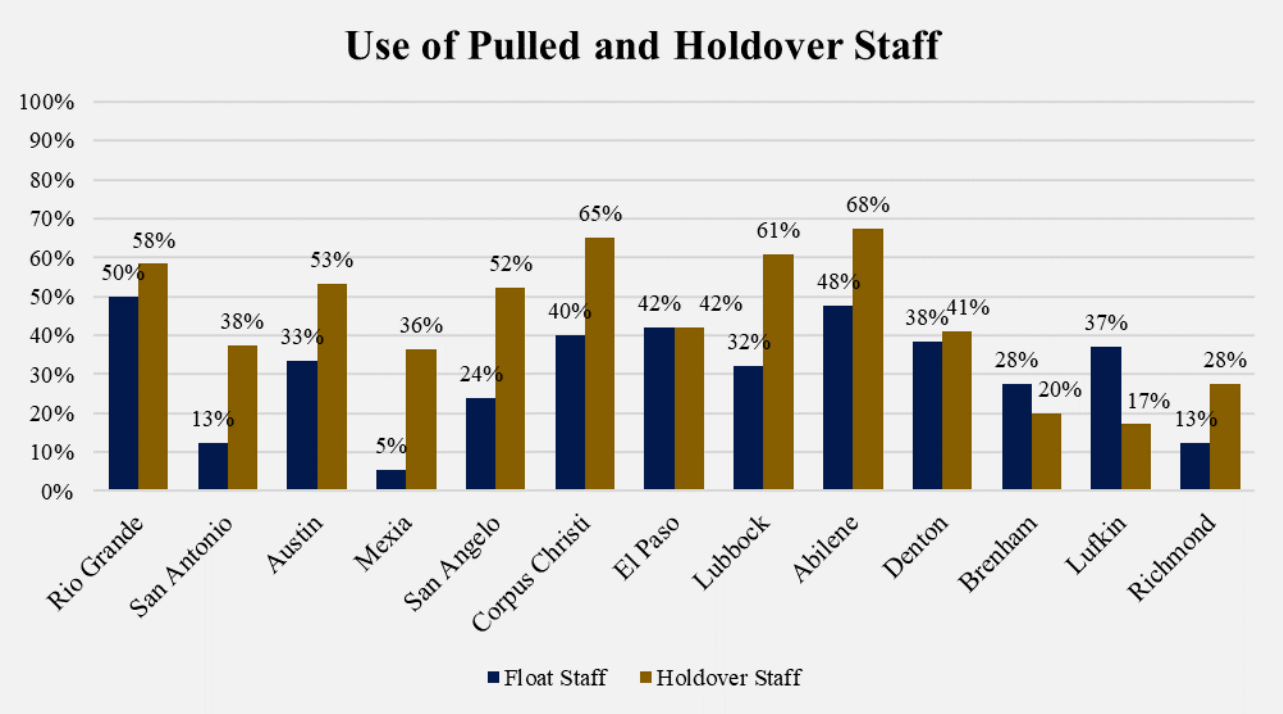
- The rate at which centers, in aggregate, met staffing minimums remained constant at 86% from 2020 to the 2021-2022 reporting period.
- In Aggregate, centers met minimum staff to client ratios at the highest rate of 97% in 2012.
- From 2011-2022, the centers met their own minimum staffing requirements in 87% of observations.

1.2: Use of Pulled and Holdover Staff

The use of pulled and/or holdover staff was recorded to gain a better understanding of staffing ratios and staff deployment. Staff who are moved from their assigned home to another home or area to provide coverage on a temporary basis are termed "pulled staff". "Holdover staff" refers to DSPs who are required to work beyond their assigned work hours and are held over their assigned 8- or 12- hour shift. All staff have a specific work schedule and assigned work location however, centers use a campus-style approach to staffing which allows staff to be moved from their assigned location to another and/or work overtime in order to provide coverage and meet minimum staffing ratios.

While the use of such staff is part of centers' normal deployment strategies, significant or frequent use of pulled staff creates the risk that residents are frequently provided services by staff who are unfamiliar with the residents and their programs, supports, and personal preferences. Overuse of holdover staff creates the risks of staff burnout and may increase the potential for abuse, neglect and exploitation and the potential for diminished residential services and support, in general.

- There were instances at Austin, Lubbock, Lufkin, Rio Grande, and San Angelo in which pulled staff were deployed but the homes still did not meet the required staffing minimums.
- All SSLCs except Brenham had at least one observation in which holdover staff were used and minimum staffing ratios were still not met.



- Aggregately, pulled staff were used in 29% of observations, while holdover staff were used in 42% of observations. Rio Grande had the highest percentage of observations where pulled staff were used at 50%, and Abilene used the highest proportion of observations with holdover staff at 68%.
- Mexia had the lowest percentage of observations with pulled staff at 5% and Lufkin had the fewest observations with holdover staff at 17%
- Brenham SSLC met minimum staffing requirements in 100% of the observations and used pulled staff and holdover staff in 28% and 20% of observations, respectively.

1.3: Services Negatively Affected Due to a Lack of Staff

The home staff in charge at the time of observation were asked a series of questions regarding whether ordinary residential service delivery was negatively impacted due to a lack of staff during that shift on the day of the observation. This data shows how residents' daily lives may be impacted by staff shortages and helps to determine if minimum staffing ratios established by the SSLCs are adequate.

Aggregately, each area of service delivery and programming, respectively, were negatively affected due to a lack of staff in at least 5% of observations.

- Across SSLCs, dining in the home was the area most affected by lack of staff at 9%, and medical appointments, outings and check and change were the least affected at 5%.
- In aggregate, lack of staff negatively affected outings (5%) and medical appointments (6%). Specifically, at Rio Grande SSLC outings were affected at 50% and medical appointments at 40%.
- At Abilene, Lufkin, Mexia, and Richmond there were instances in all service delivery areas that were negatively impacted due to lack of staff despite the minimum staffing ratios being met.

Part 2

Adequacy of Staff Training

"The Office of the Independent Ombudsman shall conduct on-site audits at each center of the provision and adequacy of training to direct care employees and, if the center serves alleged offender residents, the provision of specialized training to direct care employees."

- Senate Bill 643, Section 555.059, 81st Legislature

The Office of the Independent Ombudsman for SSLCs audits the provision of staff training to direct care employees to assess whether staff are adequately prepared to meet the complex and diverse needs of residents. During the 2021-2022 reporting period, 329 recently hired DSPs were surveyed, 217 admission records were reviewed, and SSLC staff self-reported information about their population and any specialized training developed at the local level. The following measures were evaluated to assess staff training:

2.1: The percentage of residents who may require additional support services and whether the SSLCs provide specialized training to staff members.

2.2: The percentage of DSPs who report satisfaction with On-the-job training (OJT).

2.3: The percentage of DSPs who were knowledgeable of individualized plans and programs in place for the residents they support.

2.1: Segments of the SSLC Population with Unique Needs

HHSC policy states that "the [SSLC] facility head, in consultation with the local Training and Development office, establishes local training requirements, above and beyond the minimum training requirements, in order to ensure the competence of employees to meet the special needs of the individuals or groups served at the facility".[3] People who are medically fragile, geriatric, minors, or alleged offenders sometimes require different supports than those without these characteristics. To ensure individuals in these identified groups receive adequate support services, centers were asked to indicate if they provided locally developed specialized training to staff to support these individuals.

Unique Segments of the SSLC Population

SSLC	Census	Alleged Offenders	Adolescents (10-21)	Medically Fragile	Geriatric (65+)
Abilene	248	0%	8%	29%	50%
Austin	162	1%	1%	4%	67%
Brenham	229	0%	12%	36%	39%
Corpus Christi	177	6%	2%	36%	49%
Denton	396	2%	1%	33%	60%
El Paso	99	0%	1%	16%	35%
Lubbock	200	3%	2%	33%	38%
Lufkin	237	0%	7%	73%	54%
Mexia	217	59%	11%	2%	17%
Richmond	297	1%	1%	3%	54%
Rio Grande	65	0%	3%	22%	20%
San Angelo	148	86%	1%	12%	21%
San Antonio	185	1%	2%	26%	43%
Aggregate	**2660**	**11%**	**4%**	**27%**	**45%**

- Individuals who are alleged offenders, adolescents (ages 10-21), medically fragile, and/or geriatric make up a significant part of the SSLC population.
    - There is standardized, statewide training curricula on providing services for residents who are geriatric.

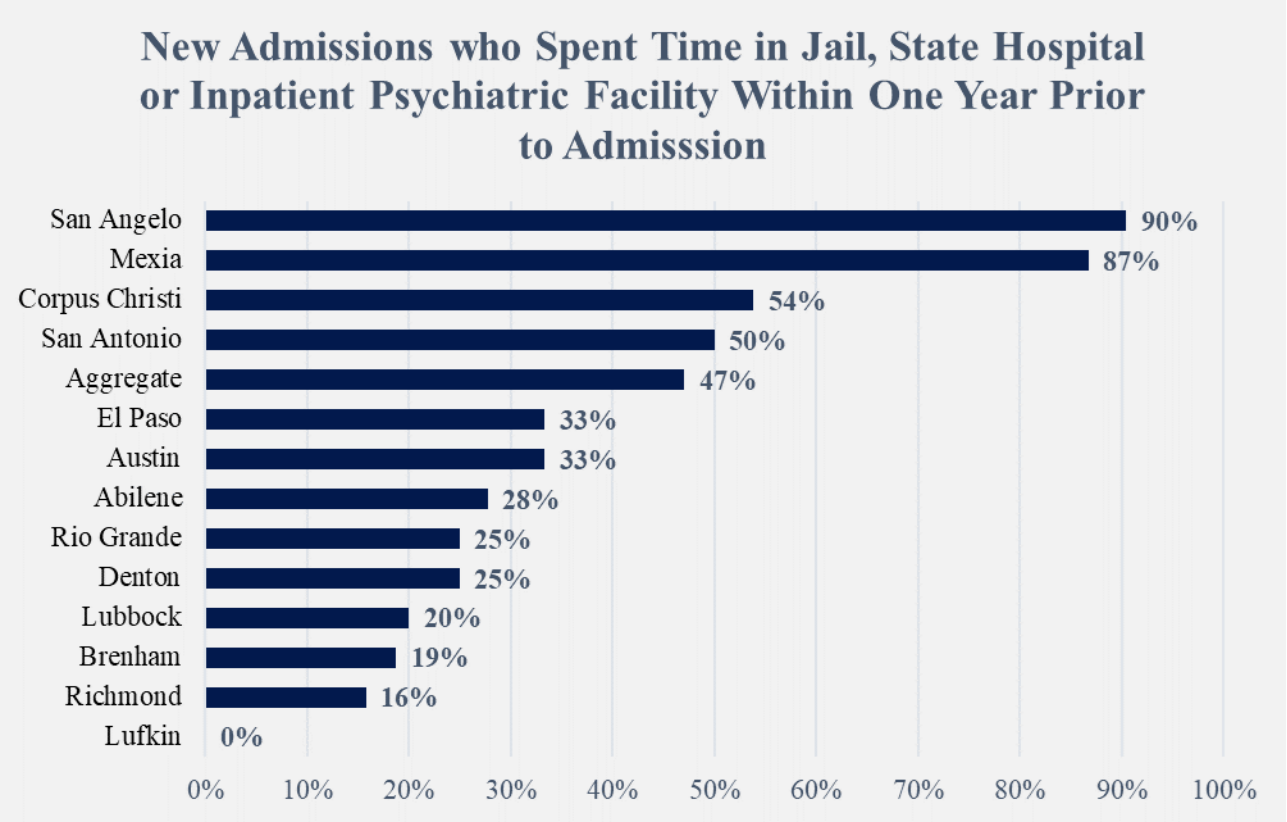
[3] CTD 2.0 Minimum Training Requirements for State Supported Living Centers in the Health and Human Services

- Most alleged offenders live at Mexia and San Angelo, the designated forensic facilities, but eight of the thirteen SSLCs have at least one alleged offender who lives at the facility.
    - Mexia and San Angelo are the only centers to have implemented locally developed training on how to provide services to alleged offenders.
    - Lufkin has the highest proportion of medically fragile residents at 73%.
- At least 50% or more of residents at Abilene, Austin, Denton, Lufkin, and Richmond are over the age of 65, and at least 20% of all SSLCs population is in that age group.
    - Mexia, Richmond, and San Angelo are the only SSLCs that provide locally developed training on providing services to support geriatric residents beyond the standard statewide training.
    - However, there is an established statewide training provided to all DSPs focused on supporting geriatric residents.
- The SSLCs with the highest proportion of adolescents were Mexia (12%) and Brenham (11%).
    - Mexia and San Angelo are the only centers that provide locally developed training on providing support services to adolescent-aged residents.

Mexia has been established as the male forensic facility and San Angelo is the female forensic facility. Both facilities take court-ordered admissions of individuals who have been charged with a crime, have been diagnosed with an intellectual disability, and have been deemed not competent to stand trial. In recent years, a large portion of new SSLC admissions include individuals who have spent time in jail or a state hospital/psychiatric facility within the year prior to admission but were not admitted to the facility on court-order. While these residents are not classified as alleged offenders, SSLC administrators, direct care staff and AIOs have identified these individuals as requiring similar supports due to their similar needs, challenges, and experiences that differ from those of residents with different backgrounds.

AIOs reviewed admission packets provided by SSLC staff to identify the number of residents who had experience with the criminal justice and/or mental health systems within one year prior to their SSLC admission. This data may even underestimate the number of new

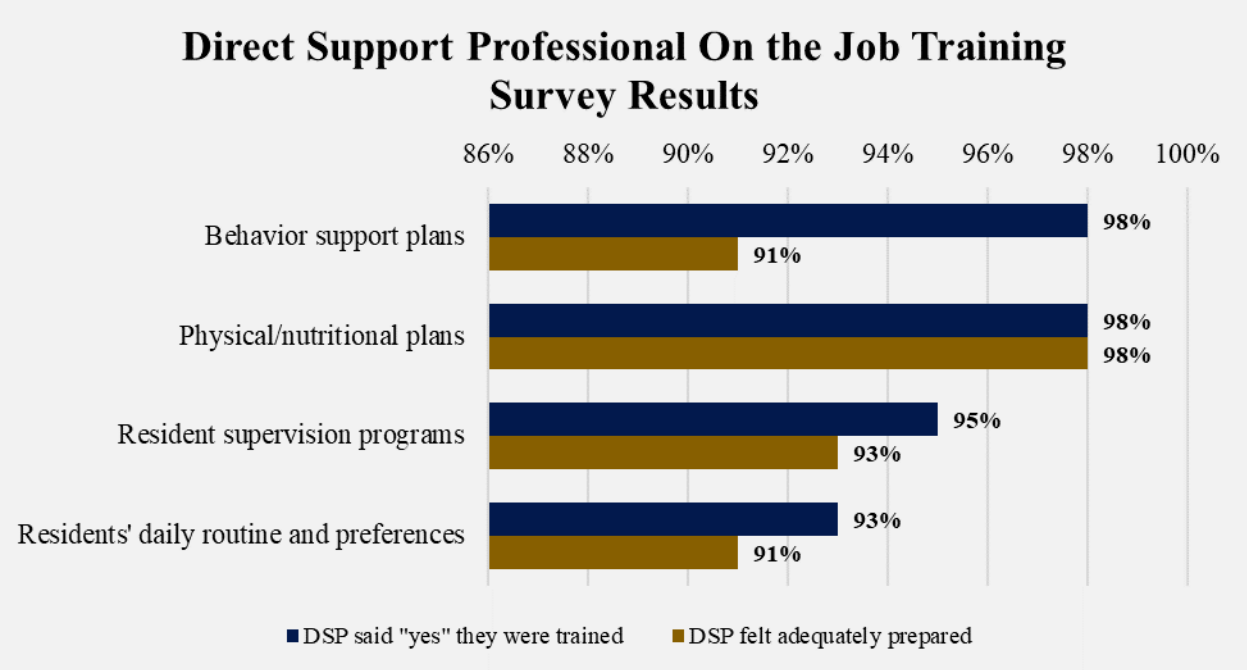
admissions who fit this description because information regarding some residents' prior involvement with these institutions may not be available when a resident is admitted.



- Of the SSLCs that are not designated forensic facilities, Corpus Christi (54%) and San Antonio (50%) had a relatively high proportion of new admission who fit this criterion.
- All SSLCs but Lufkin had at least one new admission since January 2021 who fit the criterion.
- About half of new admissions to the SSLC system fit this criterion, and residents with this type of history and who require unique supports continue to be a growing segment of the SSLC population

2.2: Direct Support Professional On-the-Job Training Surveys

A total of 329 DSPs who had been employed at their center between 45 days and six months were asked to complete a questionnaire regarding their on-the-job training. The survey asks DSPs to indicate if their OJT covered various aspects of residents' programming and rights and whether the training was adequate. For each of these questions, DSPs could answer "yes", "no", or "N/A". The survey also gave DSPs the opportunity to provide qualitative feedback about their OJT. Data collected from these surveys is used to evaluate whether OJT adequately prepared DSPs to provide support services to residents. In aggregate, 329 DSPs completed the OJT survey.



- In aggregate, more than 90% of surveyed DSPs said they received training and felt adequately prepared to implement behavior support plans, physical/nutritional plans, supervision programs, and residents' daily routines and preferences, respectively.
- Only 63% of DSPs surveyed at Abilene said they felt adequately prepared to implement behavior support plans, and 62% said they felt adequately prepared on residents' daily routines and preferences.

- Additionally, only 50% at Abilene said they were trained on rights restrictions.[4]

- At Mexia, only 72% of DSPs said they felt adequately prepared to support residents with their daily routines and preferences, and the same percentage said resident programs were explained to them.

- DSPs at Corpus Christi had the lowest rate (73%) of reporting they felt prepared to implement supervision programs.

Did On-the-Job Training Prepare DSP to Work at SSLC?

SSLC	DSP reported OJT Prepared Them to Work at SSLC
Abilene	73%
Austin	96%
Brenham	96%
Corpus Christi	88%
Denton	96%
El Paso	100%
Lubbock	96%
Lufkin	100%
Mexia	84%
Richmond	100%
Rio Grande	80%
San Angelo	100%
San Antonio	100%
Aggregate	**93%**

- Overall, 93% of surveyed DSPs felt OJT prepared them to work the shift at their assigned home.

  - At eight of the 13 SSLCs, at least one DSP said OJT did not prepare them to work the homes shift.

  - Abilene (73%) and Rio Grande (80%) have the lowest percentage of DSPs that felt prepared to work in their assigned home and shift.

Length of OJT as Reported by DSPs

SSLC	0-3 Days	4-7 Days	1-2 Weeks	3+ Weeks
Abilene	73%	27%	0%	0%
Austin	0%	0%	40%	60%
Brenham	4%	8%	68%	20%
Corpus Christi	19%	15%	42%	23%
Denton	8%	4%	48%	40%
El Paso	0%	4%	92%	4%
Lubbock	8%	13%	79%	0%
Lufkin	64%	32%	4%	0%
Mexia	12%	88%	0%	0%
Richmond	24%	69%	7%	0%
Rio Grande	4%	16%	52%	28%
San Angelo	4%	96%	0%	0%
San Antonio	42%	50%	8%	0%
Aggregate	**20%**	**33%**	**33%**	**13%**

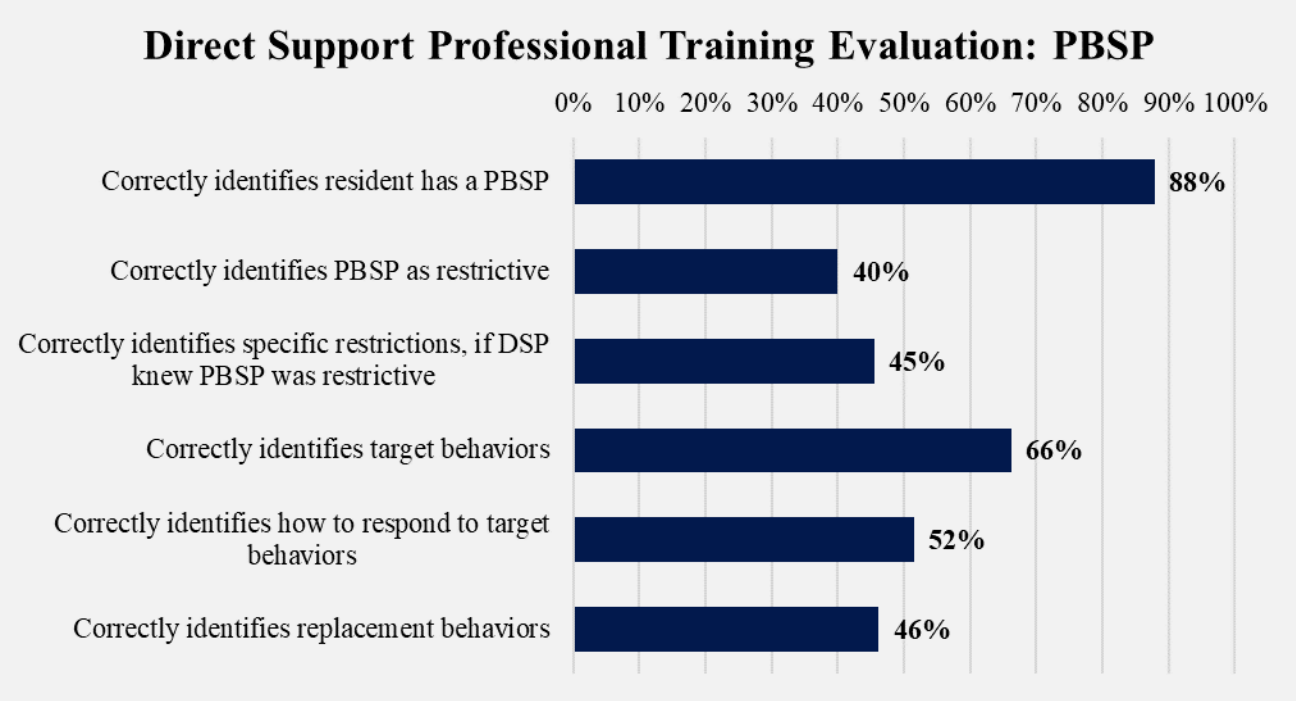
- Most DSPs across centers received less than seven days of OJT (53%).
  - Most DSPs surveyed at Abilene (70%) and Lufkin (64%) received three or fewer days of OJT.
  - Only a small portion of DSPs reported receiving more than seven days of OJT at Abilene (0%), Lufkin (4%), Mexia (0%), Richmond (7%), San Angelo (0%), and San Antonio (8%).
  - Across all centers DSPs reported receiving at least one day of OJT.
- Austin (100%) and El Paso (96%) had the highest rates of DSPs stating they received at least seven days of OJT.

2.3: Direct Support Professional Training Evaluation Interview

A sample of 5% of residents or 10 residents, whichever was greater, were selected at each center for the onsite audit. For each resident in the sample, a DSP who provided services to that resident was asked a series of questions regarding the details of the resident's positive behavior support plan (PBSP), crisis intervention plan (CIP), physical and nutritional management plan (PNMP), level of supervision (LOS), and physical mechanical restraint plan (PMRP). The AIO recorded whether the DSP correctly identified that a resident had a particular plan and whether the DSP correctly described key elements of those plans that a DSP is expected to know. This data is used to determine whether adequate training is provided to DSPs so they can appropriately support residents and implement their individualized plans.

DSP Training on Residents' Positive Behavior Support Plans (PBSPs)

A PBSP is a tool developed by Behavioral Health Services and should be followed by all staff who provide support for the individuals. The PBSP is an individualized plan designed to use non-punitive, positive reinforcement interventions to reduce or prevent the occurrence of target behaviors that are harmful to the resident and to increase positive behavioral outcomes.

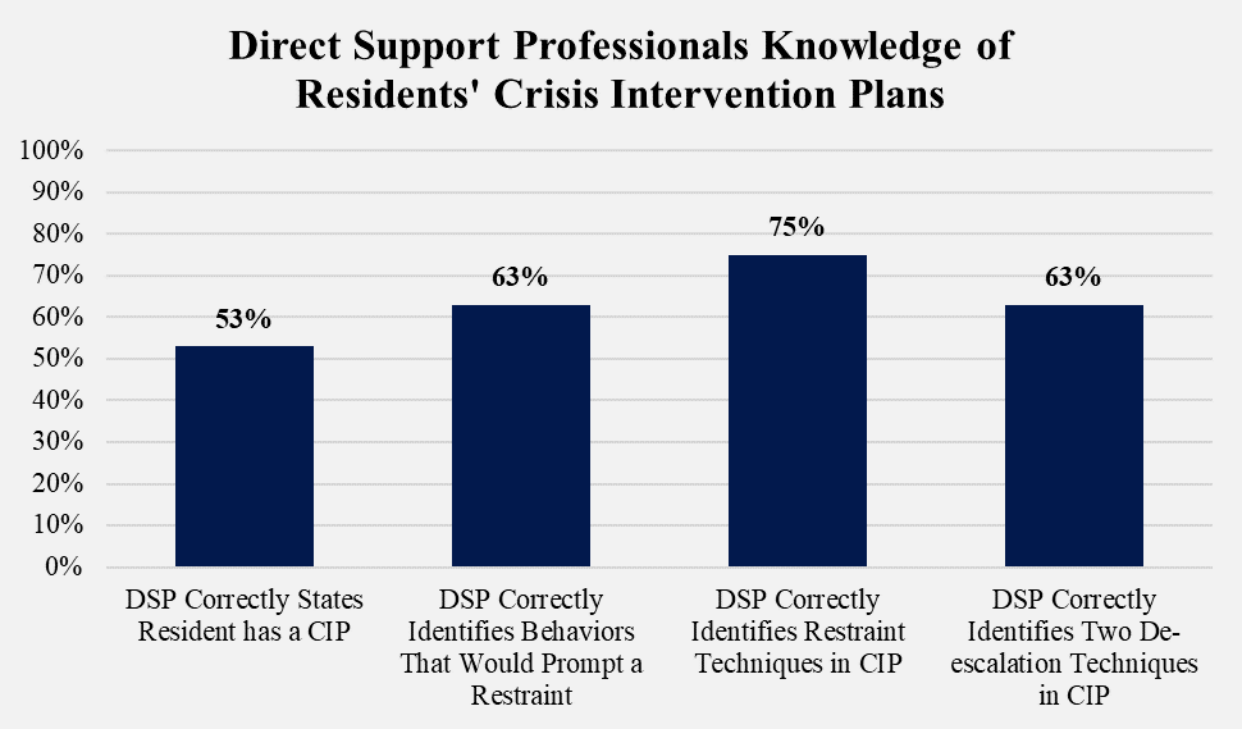


- Of the DSPs interviewed who provided support for a resident with a PBSP, 88% knew the resident had a PBSP while 12% did not.
- DSPs who provided services to residents with restrictive PBSPs correctly identified that the PBSPs were restrictive just 40% of the time, and of those who answered correctly, just 45% could identify the specific restrictions.
    - This indicates DSPs are either implementing restrictions without recognizing there are restrictions and/or they are not sufficiently implementing the plan.
- Aggregately, DSPs demonstrated knowledge of a residents' PBSP at concerningly low rates: 66% correctly identified the individuals' target behaviors, just over half (52%) identified how to respond to such behaviors, and 46% DSPs were able to identify the replacement behaviors listed in the plan.
    - These are the core elements of a PBSP; DSPs who cannot identify the essential components of the plan are then unable to consistently and adequately implement the residents' plan and promote positive behavioral outcomes.

- Disaggregate data reveals:
  - Less than half of DSPs interviewed at Denton (47%), San Angelo (45%), Lufkin (40%), San Antonio (40%), Abilene (33%) and Brenham (22%) correctly identified how to respond to an individual's target behaviors, as described in the PBSP.
  - El Paso was the only facility where 100% of DSPs interviewed correctly identified replacement behaviors in a resident's plan.
  - At seven of 13 SSLCs, less than half of DSPs interviewed correctly identified replacement behaviors: Brenham (44%), Richmond (38%), San Angelo (36%), Denton (35%), Lufkin (30%), San Antonio (20%), and Abilene (17%).

DSP Training on Residents' Crisis Intervention Plans (CIP)

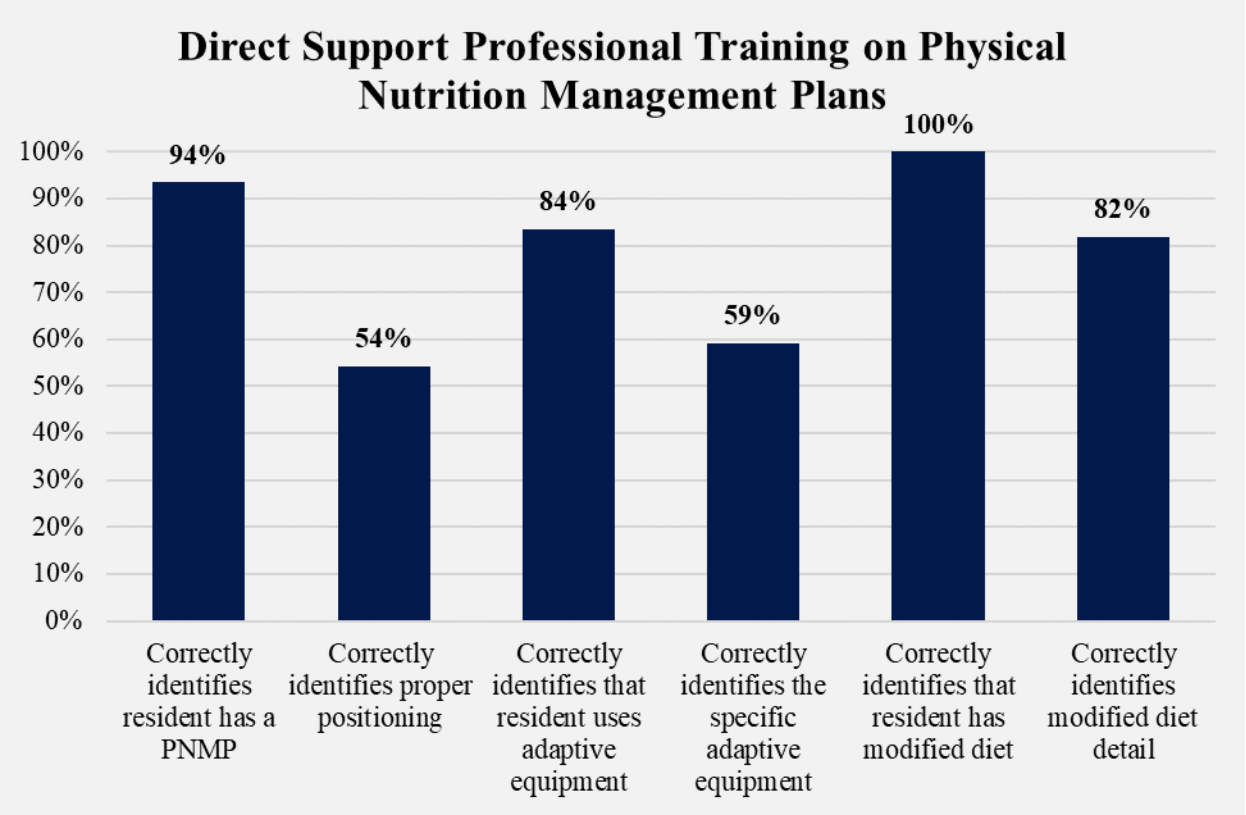
A CIP is an individualized plan that provides instructions to staff on how to use restraint procedures effectively and safely. CIPs should only be implemented when less restrictive and de-escalation procedures are ineffective, and the behavior presents an imminent risk of injury to themselves or others. CIPs are implemented when an individual has been restrained 3 times within a 30-day period.



- Of those in the sample with a CIP, only 53% of DSPs could identify that the resident had a CIP.
- Of the DSPs who correctly identified that a resident had a CIP, 63% identified the behaviors that would prompt a restraint, 75% identified the correct restraint technique used, and 63% identified at least two de-escalation techniques to prevent the need for a restraint.
- Aggregately, there is a concerning lack of consistency of DSP knowledge of CIPs, indicating that there is insufficient training to inform DSPs of which residents in their home have CIPs and how to implement those CIPs.
    - CIPs are deployed in immediate crisis situations, so DSP competency of these plans is crucial.
- Disaggregate data shows:
    - Just seven of the 13 SSLCs had a resident in the sample with a CIP: Abilene, Brenham, Corpus Christi, Richmond, Rio Grande, and San Angelo.
    - None of the DSPs at Abilene or Corpus Christi were able to correctly state that the resident had a CIP.

DSP Training on Residents' Physical Nutrition Management Plans (PNMP)

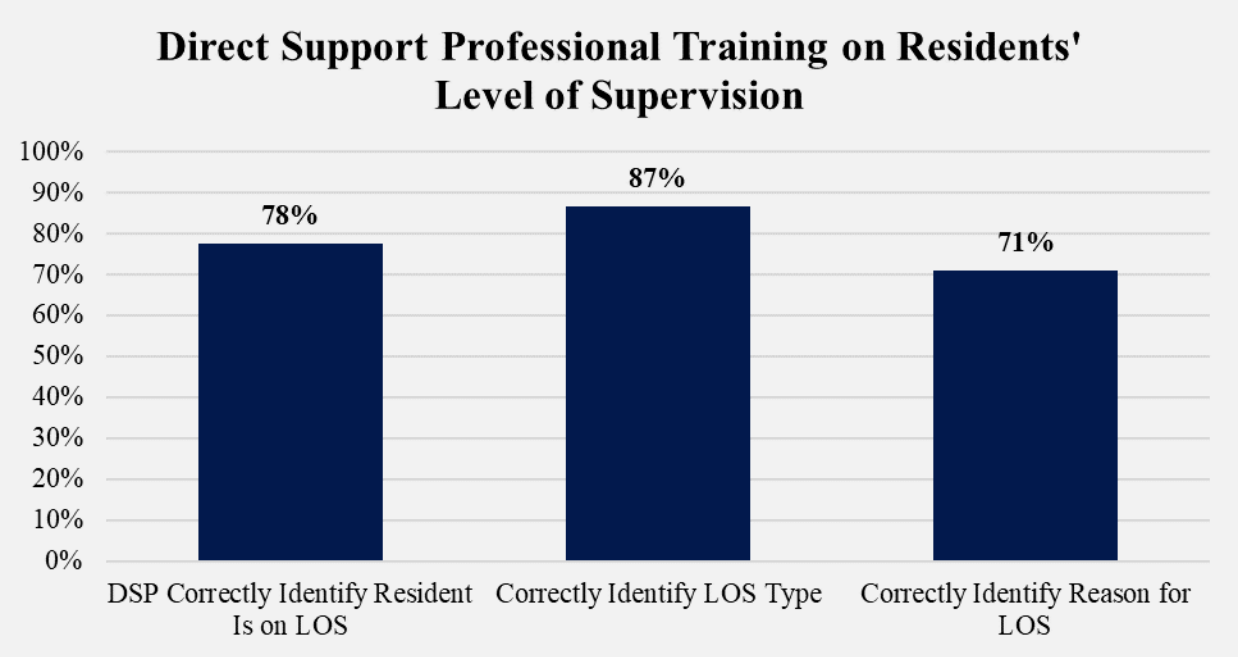
PNMPs are a set of techniques and instructions developed to facilitate safe eating, proper positioning, use of assistive equipment, and more. DSPs who provided services to residents in the sample with PNMPs were interviewed to assess their knowledge of key elements of the PNMP relating to dining, positioning, and adaptive equipment. DSPs were only asked about a specific element if the resident's PNMP included instructions in that area.



- Almost all DSPs interviewed who provided services to residents with a PNMP knew the resident had a PNMP (94%).
- While 84% of interviewed DSPs provide services for residents with adaptive equipment, only 59% could identify all the specific pieces of adaptive equipment used.
- DSPs generally demonstrated knowledge of resident's modified diets.
- DSPs were inconsistent in their ability to correctly identify proper positioning instructions for residents while dining, with only 54% correctly doing so.
- Disaggregate data shows:
  - All DSPs interviewed at Austin, Corpus Christi, Lubbock, and San Angelo were knowledgeable about diet modifications; DSPs at Rio Grande (67%), Lufkin (75%), Abilene (75%), and Lubbock (77%) demonstrated less competency in this area.
  - Less than half of DSPs at Rio Grande (46%), Abilene (33%), and Denton (33%) correctly identified proper positioning as described in the PNMP.

DSP Training on Residents' Level of Supervision (LOS)

A resident's LOS determines how closely the resident is supervised by staff on a day-to-day basis, at certain times of day, or in specific instances. There are different types of LOS. Routine LOS is defined as supervision with "with one-hour or two-hour verification checks", while an increased LOS is implemented when an individual requires more support and usually requires more frequent check-ins or constant one-to-one (or two-to-one) supervision. Almost all DSPs interviewed were staff who were regularly assigned to that person and home. Staff were only interviewed if the resident from the sample was currently on an increased LOS (beyond routine).



- Aggregately, DSPs interviewed knew the resident was on increased LOS in 78% of interviews.
    - It is concerning that 22% of DSPs interviewed did not know a resident they were responsible supervising was on increased LOS.
- Of the DSPs who knew the resident was on increased LOS, 87% correctly identified the type of LOS, and 71% correctly identified the reason for the LOS.
- Disaggregate data shows:

- All DSPs interviewed at Abilene, Brenham, Richmond, and San Angelo correctly identified the LOS of residents, while DSPs at Lufkin (67%) and Rio Grande (50%) reflected lower rates.
- Less than 100% of DSPs could identify the type of LOS at Denton (86%), Mexia (83%), San Angelo (71%), and Abilene (67%).
- At seven of 13 facilities, some DSPs could identify the reason for the LOS, with particularly low rates at Denton (57%), San Angelo (57%), and Abilene (50%).

Part 3

Rights and Due Process

> *"The Office of the Independent Ombudsman shall conduct on-site audits to ensure residents are encouraged to exercise their rights, including the right to file a complaint and provided the right to due process."*
>
> - Senate Bill 643, Section 555.059, 81st Legislature

The Office of the Independent Ombudsman for SSLCs audits the rights and due process practices of the centers to determine whether residents are encouraged to exercise their rights, including the right to file a complaint. A total of 310 residents' records were reviewed, including their behavior plans and prescribed psychotropic medications, as applicable, and 235 surveys were mailed to the primary contact person on record for residents in the sample[5]. There were 236 Human Rights Committee (HRC) meetings observed and 3100+ rights restriction related documents reviewed. The OIO evaluated the centers' efforts to encourage and inform residents and guardians of rights and due process practices using the following measurements:

3.1: Whether the SSLC has documented the resident's decision-making capacity and whether the resident or guardian has acknowledged receipt of rights and restrictions.

3.2: The extent to which guardians and family members were informed and educated on resident rights, rights restrictions, and how to file a complaint.

3.3: Whether due process was followed according to established policy for annual Rights Restriction Determinations (RRD), restrictive Behavioral Support Plans (BSP), and psychotropic medication documentation.

3.4: Whether residents were informed of their rights and were invited to participate in due process.

3.5: DSPs' knowledge of the residents' rights, restrictions, and due process.

[5] Not all residents in the sample had a primary contact person, guardian, LAR or AIP on record.

3.6: Qualified Independent Disability Professionals' (QIDPs) knowledge of policy relating to emergency restrictions and due process.

3.7: The extent to which the elements of due process were included in documentation reviewed and discussion during HRC meetings.

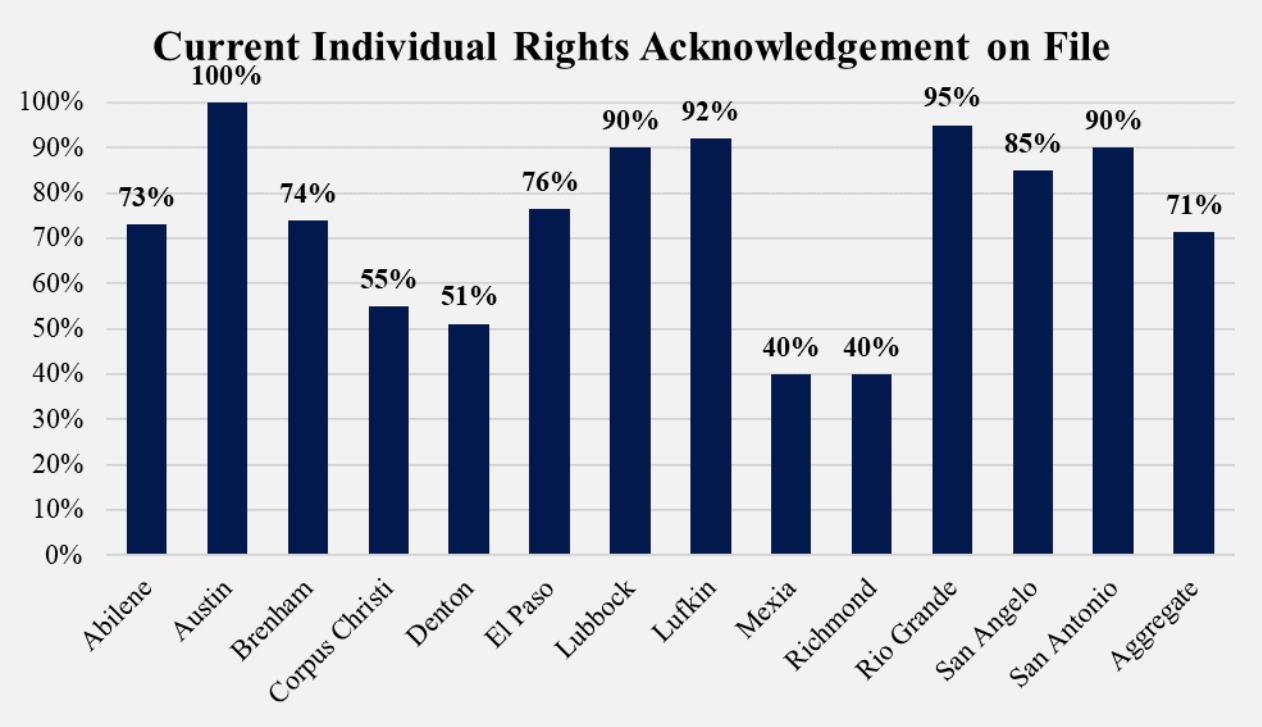
3.1: Review of Individual Decision-Making Assessment (IDA) and Individual Rights Acknowledgement (IRA) Forms

The SSLC statewide Rights Policy requires an IDA and an IRA to be completed upon admission, annually, and as needed. An IDA is completed by a residents' interdisciplinary team to assess "each individual's capacity to make decisions and provide consent" in the areas of medical decisions, finances, living arrangements, programming, and release of personal information. Furthermore, it documents the supports and training the individual needs to make decisions. The policy also requires HRC to acknowledge that it was completed. The IRAs provide documentation that the residents' rights, the circumstances in which they may be limited or restricted, and the procedures that must be followed to do so, have been explained to both the individual and their guardian.

Individual Decision-Making Assessment as Current and Acknowledged by HRC in Sample

SSLC	Current IDA	IDA Acknowledged by HRC
Abilene	92%	79%
Austin	100%	95%
Brenham	100%	91%
Corpus Christi	100%	70%
Denton	95%	95%
El Paso	100%	94%
Lubbock	85%	100%
Lufkin	100%	88%
Mexia	100%	95%
Richmond	100%	100%
Rio Grande	100%	100%
San Angelo	90%	100%
San Antonio	100%	90%
Aggregate	**97%**	**92%**

- The majority of SSLCs had 100% compliance with the policy that requires an annual IDA on all resident's records with the exception of Abilene (92%), Denton (95%), Lubbock (85%), and San Angelo (90%).
- The sample data demonstrates that only four out of 13 centers are 100% consistent with acknowledging IDAs in HRC meetings. Corpus Christi had the lowest percentage of IDA acknowledgement by HRC at 70%.



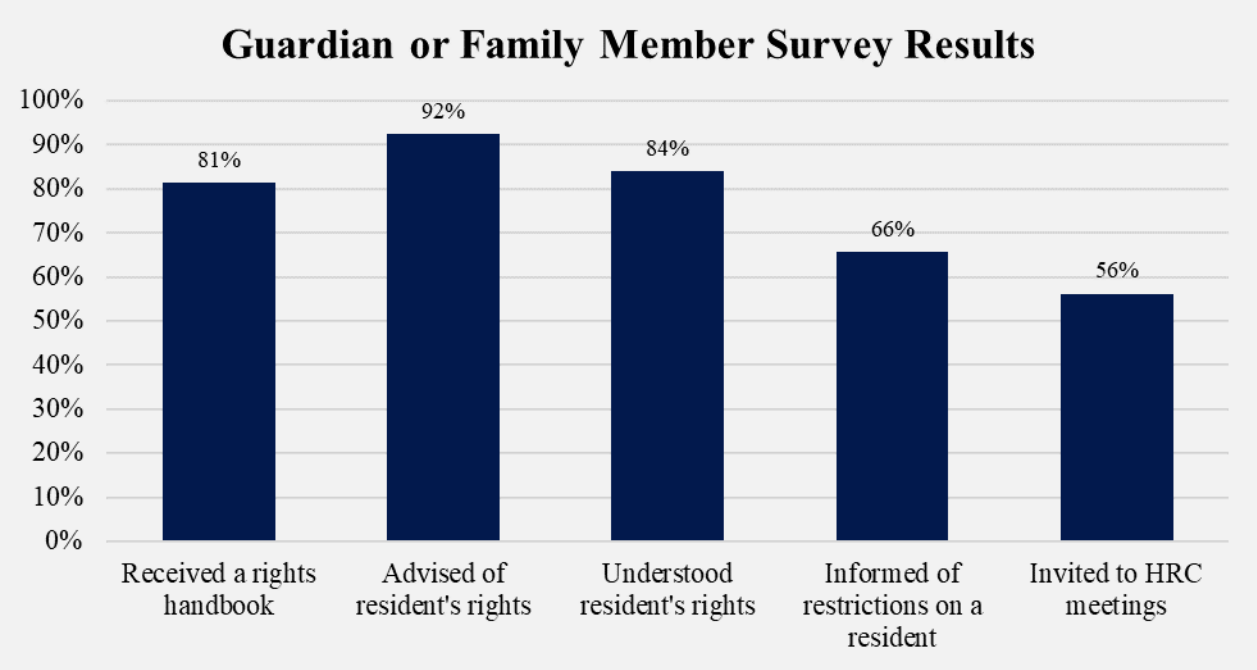
- In aggregate, 71% of residents in the sample had a current IRA on file, indicating that some centers are inconsistently informing residents and LARs/AIPs about individuals' rights, restrictions, and circumstances in which rights can be modified, in accordance with policy. This aggregate rate was decreased from 81% in 2020.

- Austin was the only center which conformed with IRA policy of the sampled residents' files across all centers. Mexia and Richmond (40%) reflected the lowest rates of residents in the sample with a current IRA on file.
- Many centers improved on this metric in 2021-22 in comparison to previous years. Notably, Lubbock, Lufkin, Rio Grande and San Antonio had current IRAs on file for over 90% of their samples this reporting period.
- From the 2020 to the current reporting period there have been significant decreases in the percentage of current IRAs on file. Mexia had the most significant decrease from 96% to 40%
- Aggregately, only 29% of current IRAs on file were signed by the resident, even though policy requires residents to sign or "make their mark" on the IRA to confirm the resident had their rights explained to them.

3.2: Guardian or Family Member Knowledge of Resident Rights and Restrictions

The SSLC statewide Rights Policy requires SSLCs to educate guardians and family members about resident rights, including providing them with a "Rights Handbook" upon admission and annually, as well as obtain and document guardian or family member input on any proposed rights restrictions. A survey was sent to the primary correspondent of residents in the sample who had someone on record. There were 64 responses were received from 235 surveys mailed and/or sent electronically via email (27% response rate). The survey assessed if the LAR/AIP were knowledgeable about resident rights, informed of proposed rights restrictions, and knew how to file a complaint.

- In the aggregate sample this reporting period, SSLCs have generally complied with policy of informing guardians or family members about residents' rights.
- Policy states that guardian or family member input is required for due process but only 66% of total primary contact survey respondents said they were informed of proposed rights restrictions, a decrease from the previous 2020 report.



- Some guardians or family members at Corpus Christi, Lufkin, Rio Grande, San Angelo, and San Antonio reported not understanding residents' rights.
- Respondents from Corpus Christ (50%), Lufkin (29%), Rio Grande (0%) and San Angelo (0%) reported the lowest rates of being informed of proposed rights restrictions.

Guardian or Family Member Knowledge of How to File a Complaint

SSLC	Number of Responses	Percentage of Respondents Who Correctly Identified How to File a Complaint
Abilene	7	57%
Austin	3	100%
Brenham	3	100%
Corpus Christi	4	50%
Denton	15	87%
El Paso	3	33%
Lubbock	2	100%
Lufkin	4	50%
Mexia	3	100%
Richmond	10	60%
Rio Grande	4	0%
San Angelo	2	0%
San Antonio	4	0%
Aggregate	**64**	**60%**

- Aggregately, 60% of respondents identified an appropriate person or entity to which they could file a complaint.
- Less than half of respondents from, El Paso, Rio Grande, San Angelo and San Antonio could correctly identify who to contact to file a complaint.
- All respondents from Austin, Brenham, Lubbock and Mexia indicated they knew how to file a complaint with the SSLC.

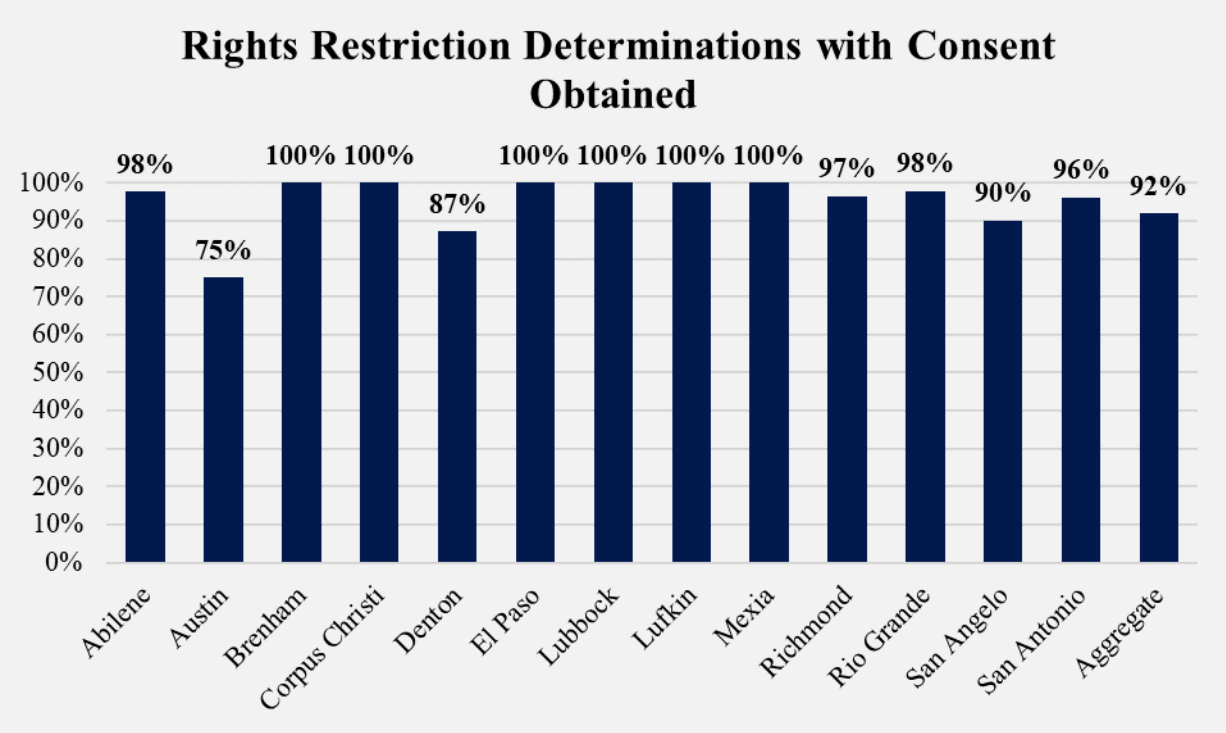
3.3: Review of Due Process Indicators of Annual Rights Restrictions, Behavior Plans and Psychotropic Medication

SSLCs must ensure due process when proposing and implementing annual rights restrictions in Rights Restriction Determinations (RRDs), Behavior Support Plans (BSPs), and psychotropic medications (PMs). AIOs reviewed the documentation for RRDs, BSPs, and PMs for residents in the sample for evidence of due process, as described in the Rights Policy. Evidence of due process includes obtaining consent for all restrictions prior to HRC review, ensuring restrictions have plans to remove/reduce the restriction and making sure all restrictions, including those in behavior plan and psychotropic medications, were reviewed by HRC.

Document Review of Rights Restriction Determinations (RRD)

A Rights Restriction Determination (RRD) outlines any rights restrictions the Interdisciplinary Team (IDT) has identified as necessary to support the individual. Every resident has an RRD completed upon admission and annually by their IDT. The statewide SSLC Rights Policy states that there must be a need for the restriction, a documented plan to lessen or remove the restriction, and it must be reviewed and approved by HRC before implementation, among other due process requirements.

- At 12 of 13 SSLCs, there was a current RRD on file for every resident in the sample and every restrictive RRD in the sample was reviewed by HRC.



- The majority of SSLCs obtained consent prior to HRC review for the RRD restrictions reviewed (90%). Austin had the lowest percentage at 75%.
- Aggregately, 87% of rights restrictions in RRDs in the sample had a documented plan to remove the restriction.

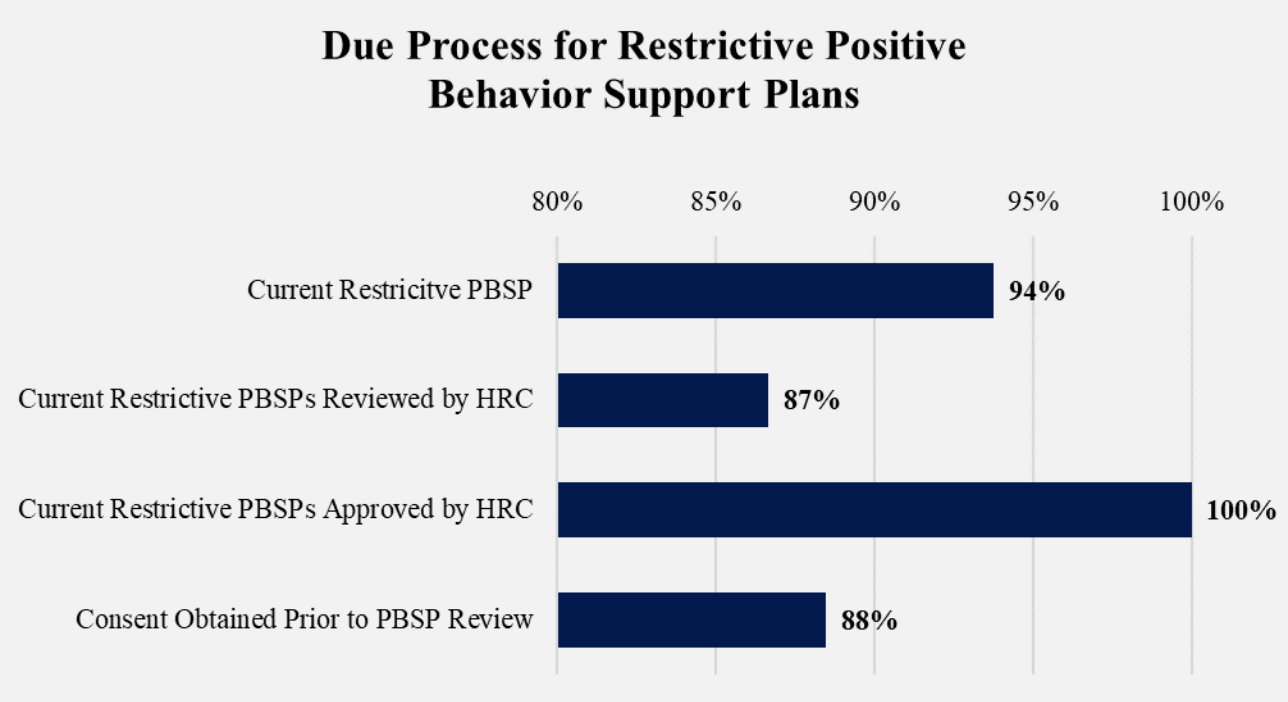
Document Review of Behavioral Support Plans and Psychotropic Medications

Behavioral Support Plans (BSPs), including Positive Behavioral Support Plans (PBSP) and Crisis Intervention Plans (CIP), are implemented to support individuals in managing complex behaviors. Some BSPs include rights restrictions and require due process and HRC approval prior to implementation. Psychotropic Medication given to residents are deemed restrictive because they are used to influence and modify behavior, cognition, or a person's affective state[6]. The data below is based on document review of PBSPs, CIPs, and psychotropic medication forms.

[6] A person's affective state refers to the underlying experience of feeling, emotion or mood.

Document Review of Positive Behavioral Support Plans

A PBSP is "a comprehensive, individualized plan that contains intervention strategies designed to modify the environment, teach or increase adaptive skills, and reduce or prevent the occurrence of target behaviors through interventions that build on an individuals' strengths and preferences."[7] PBSPs should not include aversive or punitive components, however some PBSPs may contain rights restrictions and must be reviewed and approved by HRC prior to implementation. In aggregate, 34 residents in the sample had a restrictive PBSP, though not every center had a resident in the sample with a restrictive PBSP.



- In aggregate, 94% of restrictive PBSPs were current, 87% of current restrictive PBSPs had evidence of HRC review.
- All PBSPs reviewed by HRC were approved. However, consent was not obtained for all current restrictive PBSP prior to HRC review.
- Consequently, San Angelo approved 100% of PBSPs reviewed by HRC however, consent was obtained prior to HRC only 57% of the sample data collected.

[7] SSLC Operational Policy Definitions, Revised 1/26/21, page 40.

Document Review of Crisis Intervention Plans (CIP)

A CIP may be a "component of a resident's Individual Support Plan (ISP)[8]. The CIP provides instructions for staff on how to effectively and safely use restraint procedures when less restrictive prevention or de-escalation procedures have failed, and the individual's dangerous behavior continues to present an imminent risk of physical injury to the individual or others."[9]

An individual who has experienced crises that have resulted in a restraint three times or more within a 30-day period will have a CIP. A CIP includes de-escalation techniques and approved physical and/or chemical restraints. CIPs are inherently restrictive and require due process, including HRC review of the due process elements and HRC approval for implementation. Sixteen residents in the sample required a CIP.

- CIPs were found in the sample at seven out of 13 SSLCs. In aggregate, 93% of CIPs on file were current. Only 50% of CIPs in the sample at Denton were current.

Aggregately, only 62% of the CIPs reviewed had consent obtained prior to HRC review however all CIPs reviewed by HRC were approved by the Human Rights Committees.

Document Review of Psychotropic Medications

Implementation of psychotropic medication requires the same due process as any other restriction. This due process including obtaining consent and HRC review of the essential elements of due process and approval before the initial administration and thereafter. The only exceptions are psychotropic medication that are administered during an emergency behavioral health crisis or are court mandated. Roughly two thirds of the residents in the sample, 201 (61%), were prescribed at least one psychotropic medication.

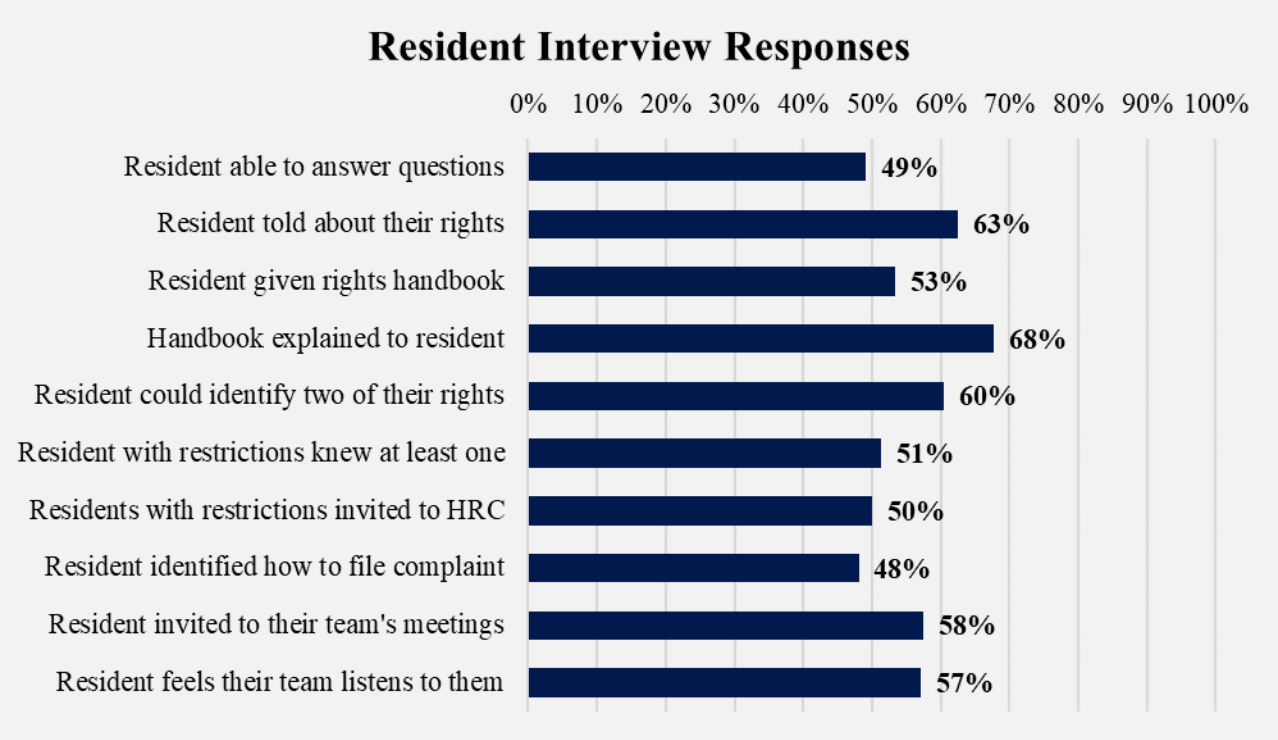
- 99% of psychotropic medications had current documentation on file, and of those, 98% were reviewed by HRC.

[8] The ISP is a holistic, individualized plan developed by the IDT that sets out all the protections, supports and services to be provided to the individual in an integrated manner.
[9] SSLC Operational Policy Definitions, Revised 1/26/21, page 14.

- Consistent with the previous reporting period, aggregately 97% of psychotropic medications had consent prior to HRC review. San Angelo had the lowest number of psychotropic medication forms with consent prior to HRC review at 88%.
- Austin, Denton, Lufkin and Mexia had residents in their sample that psychotropic medications that had not been reviewed by HRC, meaning psychotropic medication is being prescribed without due process or individuals are not receiving medication they may need.
- All psychotropic medications in the sample at Abilene, Corpus Christi, El Paso, Richmond and San Antonio were compliant with psychotropic medication due process policies, and all psychotropic medication forms were current, had consent prior to HRC review and were approved by HRC.

3.4: Resident Rights Interview

During the onsite visits at each center, residents from the sample were interviewed to assess if the centers have educated them about their rights and if the residents are involved in their planning and program development. Additionally, in 2022, five additional supplementary resident interviews were conducted to ensure adequate resident representation. Only residents who were able and willing to answer the questions were interviewed. In the 2021-2022 reporting period, 144 resident interviews were completed.



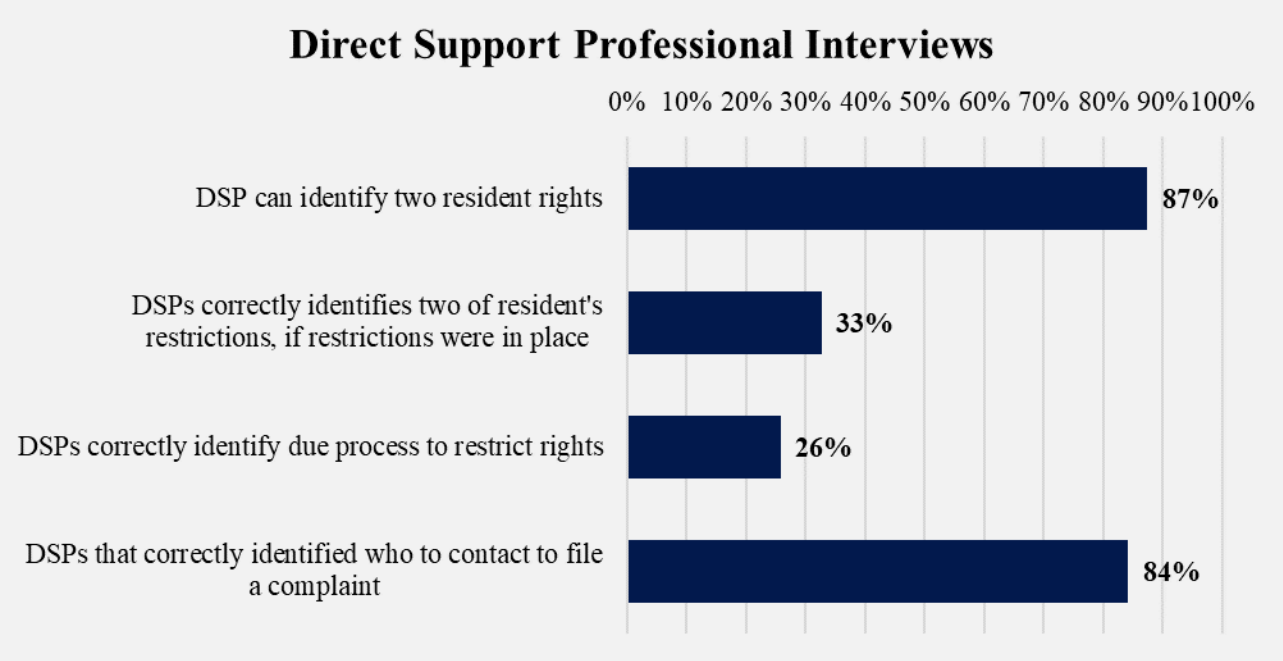
- About half of residents in the sample were able to complete an interview.
- Only 63% of residents said they were told about their rights, and just 53% stated they had been given a rights handbook, as required by policy.
- Of residents with rights restrictions in place, only half could name at least one, and only half state they were invited to HRC meetings where their rights restrictions are discussed.

- A slightly higher proportion of residents stated they were invited to their team's meetings (58%), but only 57% said they feel their team listens to them about what is important to them.
- Less than half (48%) could correctly identify who they could contact to file a complaint.
    - Disaggregate data shows:
    - None of the residents interviewed at El Paso or San Antonio who had rights restrictions stated they were invited to HRC meetings.
    - There was no SSLC where most residents correctly identified how to file a complaint.
    - Austin was the only center where all residents interviewed said they had received a rights handbook.
    - Brenham was the only center where every resident interviewed said they were invited to their team's meetings, and similarly it was the only center where 100% stated they felt their team listened to what was important to them.
- Overall, the data indicates many residents are not adequately informed about their rights and involved in due process relating to their rights and rights restrictions.

3.5: DSP Interview

For every resident in the onsite visit sample, a DSP who provided support services for that resident was interviewed to assess the DSP's knowledge of the resident's rights and minimum due process standards to restrict an individual's rights. In the 2021-2022 reporting period, 312 DSP Interviews were conducted.

DSPs were asked to: identify two examples of the resident's rights; identify two currently implemented rights restrictions (if the resident had restrictions); identify minimum due process requirements to restrict rights; and identify an appropriate person to contact to file a complaint on behalf of a resident.



- Most DSPs (87%) could identify two rights that residents' have, and who to contact to file a complaint on a resident's behalf (84%).
- Only one third of DSPs providing services to residents with current rights restrictions were able to identify two of an individual's rights restrictions (or one restriction if the resident had only one restriction), which is concerning as the DSP is critical to implementing restrictions and programming.

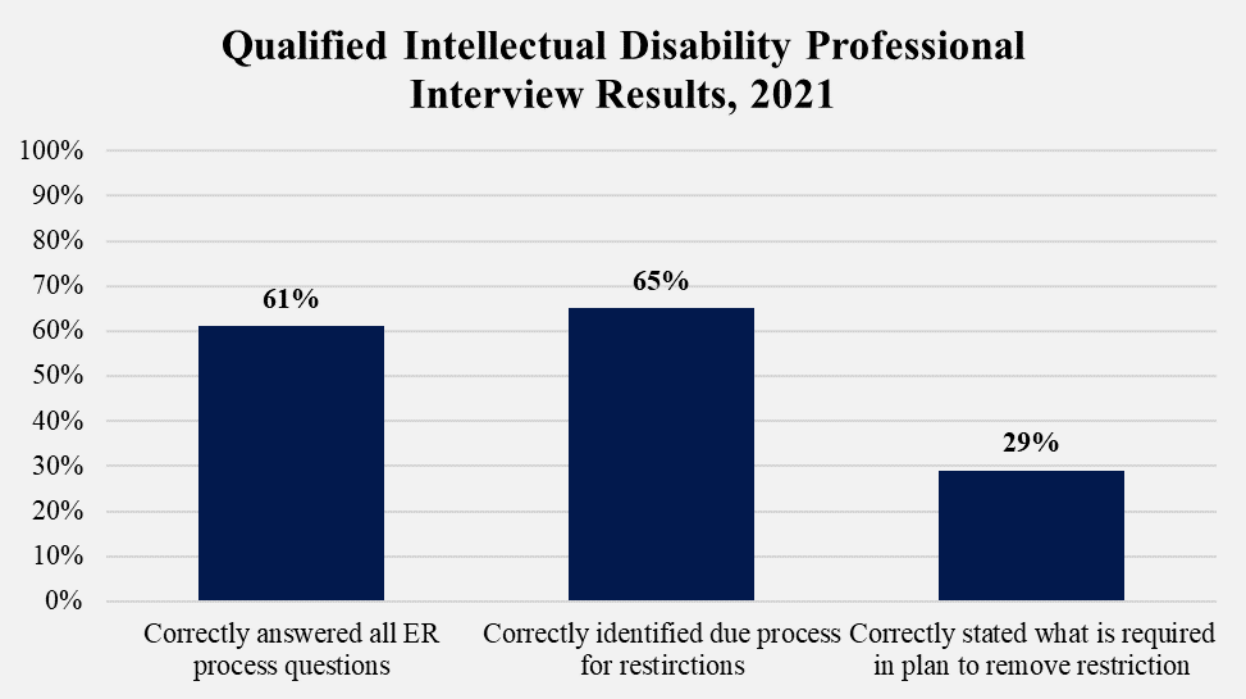
- Only 26% of DSPs could correctly state the required due process steps needed to restrict a resident's rights[10], raising the concern that some DSPs may implement rights restrictions that have not gone through due process.
- Disaggregate data shows:
  - Mexia was the only center where more than half of DSPs (54%) who supported a resident with restrictions could identify at least two restrictions; just 9% at Austin and 13% and Brenham could do so.
  - There was not a single SSLC where a majority of DSPs could identify the due process to restrict a resident's rights.
- At Corpus Christi and San Antonio, 100% of interviewed DSPs where able to identify an appropriate person to file a complaint on a resident's behalf; Abilene had the lowest rate at 54%.
- The data shows that DSPs generally have adequate knowledge of rights and filing a complaint, but most DSPs did not demonstrate knowledge of rights restrictions and due process.

[10] The steps are (1) restriction is proposed by the resident's interdisciplinary team and (2) the restriction is reviewed and approved by the human rights committee.

3.6: Qualified Intellectual Disability Professional Interview

Qualified Intellectual Disabilities Professionals (QIDP) are responsible for coordinating and monitoring residents' programs and services. QIDPs were interviewed to assess their knowledge of policies relating to rights restrictions and due process, as specified in the statewide SSLC Rights Policy. During the onsite visits, half the QIDPs at the center who carried a caseload were interviewed. QIDP interviews were only conducted during the 2021 onsite reviews.

QIDPs were asked to identify key elements of emergency restriction (ER) policy and due process[11], due process for non-emergency restrictions to be put in place[12], and what was required in a plan to remove a restriction.



[11] These elements are: when the use of an emergency restriction is appropriate, how long can an emergency restriction be in place, and how long after an emergency restriction implemented should the interdisciplinary team meet.

[12] These due process elements are: the interdisciplinary team meets, a referral for restriction is submitted to the human rights committee, consent for the restriction is obtained, and the committee approves the restriction.

- In aggregate, QIDPs who were interviewed did not demonstrate consistent knowledge of rights restriction due process.
    - Only 61% of QIDPs interviewed correctly answered all questions about due process and procedural requirements for ERs.
    - A slightly higher 65% correctly identified due process requirements for rights restrictions that were not categorized as an ER.
- Only a minority of QIDPs (29%) were able to correctly state the requirements needed in a plan to remove a rights restriction.
- Aggregately, this data suggests concerns about QIDPs' knowledge of due process and the policies and procedures described in the statewide Rights Policy.

3.7: Due Process in Human Rights Committee Meetings Observations

The Human Rights Committee's (HRC) purpose is to protect residents' rights through an impartial review of proposed rights restrictions and to ensure adherence to due process. Each HRC should be made up of at least the center's Human Rights Officer (HRO), a person who has received intellectual disability services or the LAR of an individual who has received services, and a person unaffiliated with the center and has no ownership or controlling interest with the facility.

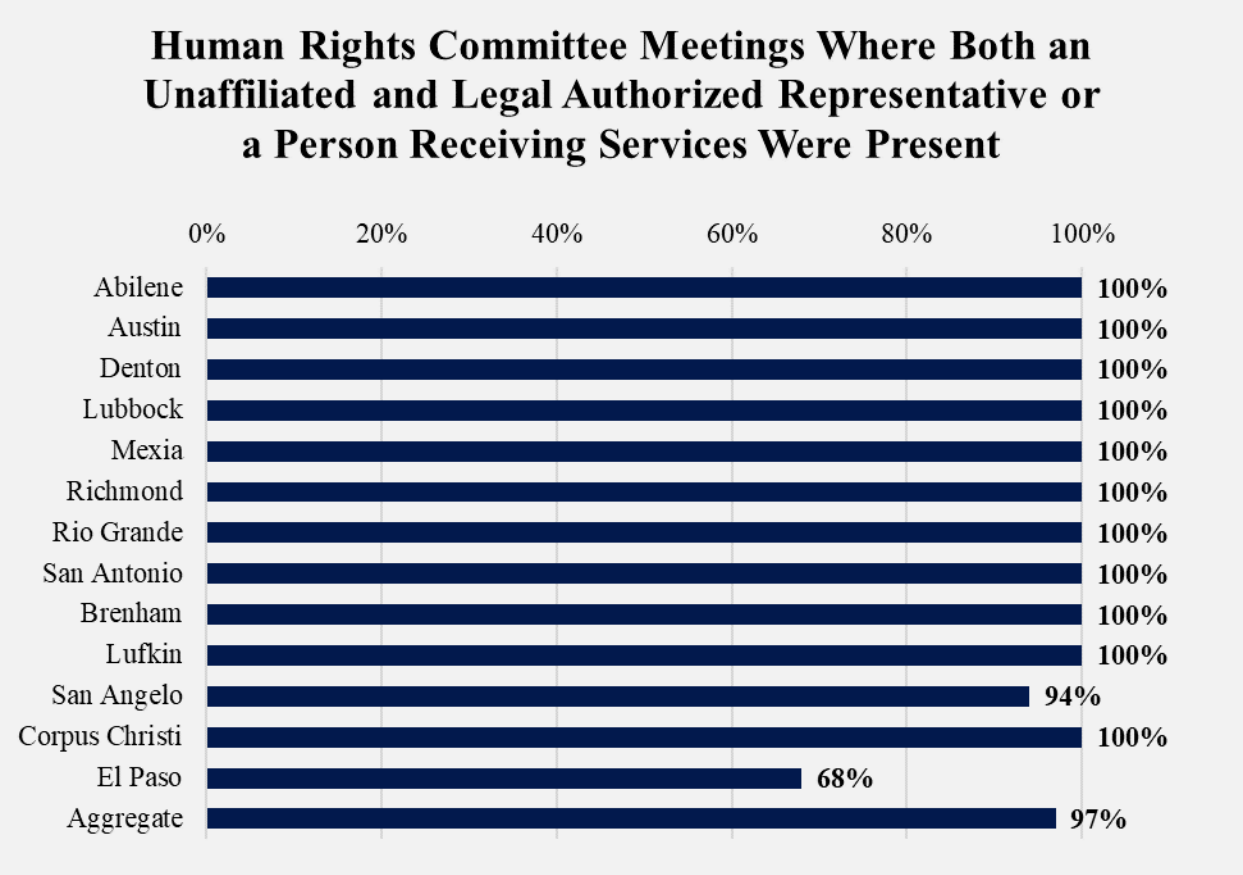
AIOs observed HRC meetings throughout the reporting period to assess the Committee's diligence in ensuring due process. AIOs evaluated due process by verifying if essential elements of due process, as established in policy, were provided in documentation and evident in HRC discussion.

The following data was used to evaluate due process in HRC meetings:

- HRC meetings had the required quorum to make the proceedings of that meeting legitimate, per the statewide Rights Policy.
- Emergency Restrictions (ER) were reviewed by HRC within five business days, sufficient justification for the ER was provided, and there was documentation that the IDT met to discuss the restriction within one business day, as prescribed in policy.
- Required due process elements were present in HRC documentation and discussion for Restrictive Behavior Support Plans (BSP), HRC referrals for rights restrictions, and restrictions in annual Rights Restriction Determinations (RRD).

HRC Quorum

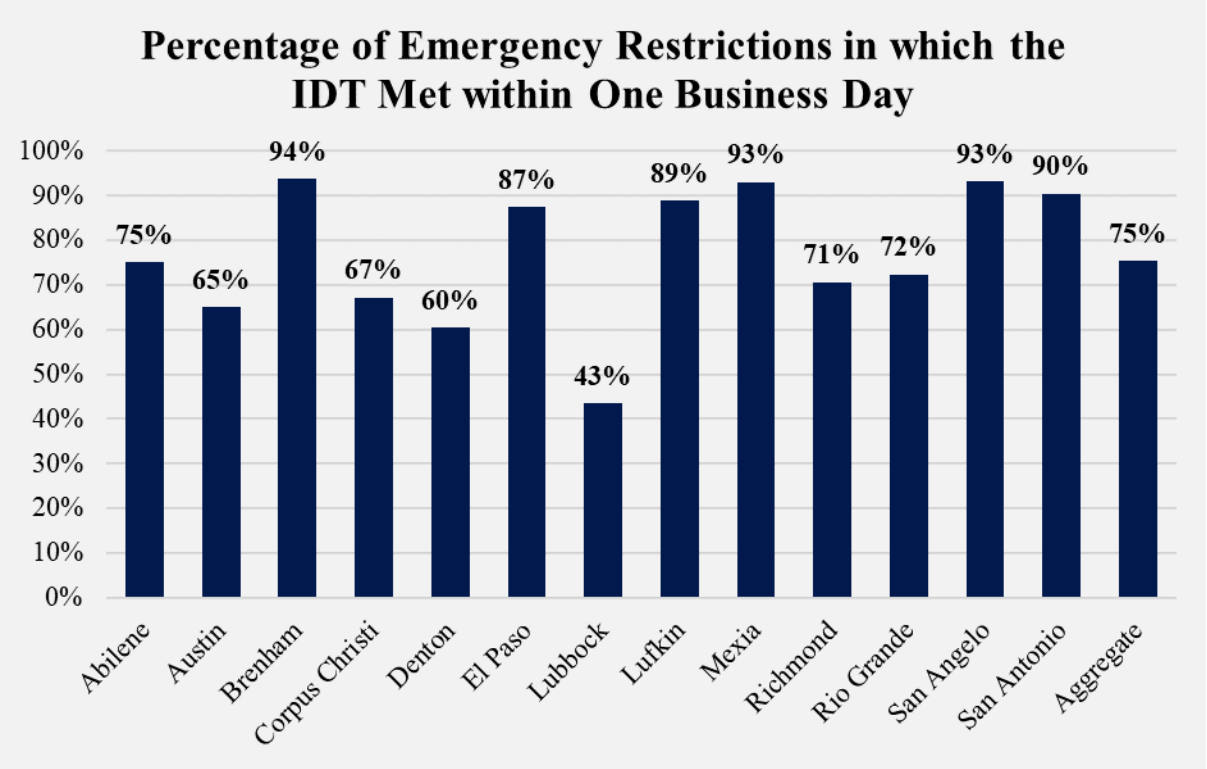
HRC meetings are required to have a quorum to help protect the rights of individuals and ensure due process. AIOs observed and collected data from 236 HRC meetings in reporting period.



- Aggregately 97% of SSLCs had a quorum present at HRC meetings. 12 out of 13 SSLCs had a quorum present over 90% of the time.
- At El Paso only 68% of HRC meetings had a quorum present despite the policy and due process requirement.

HRC Review of Emergency Restrictions

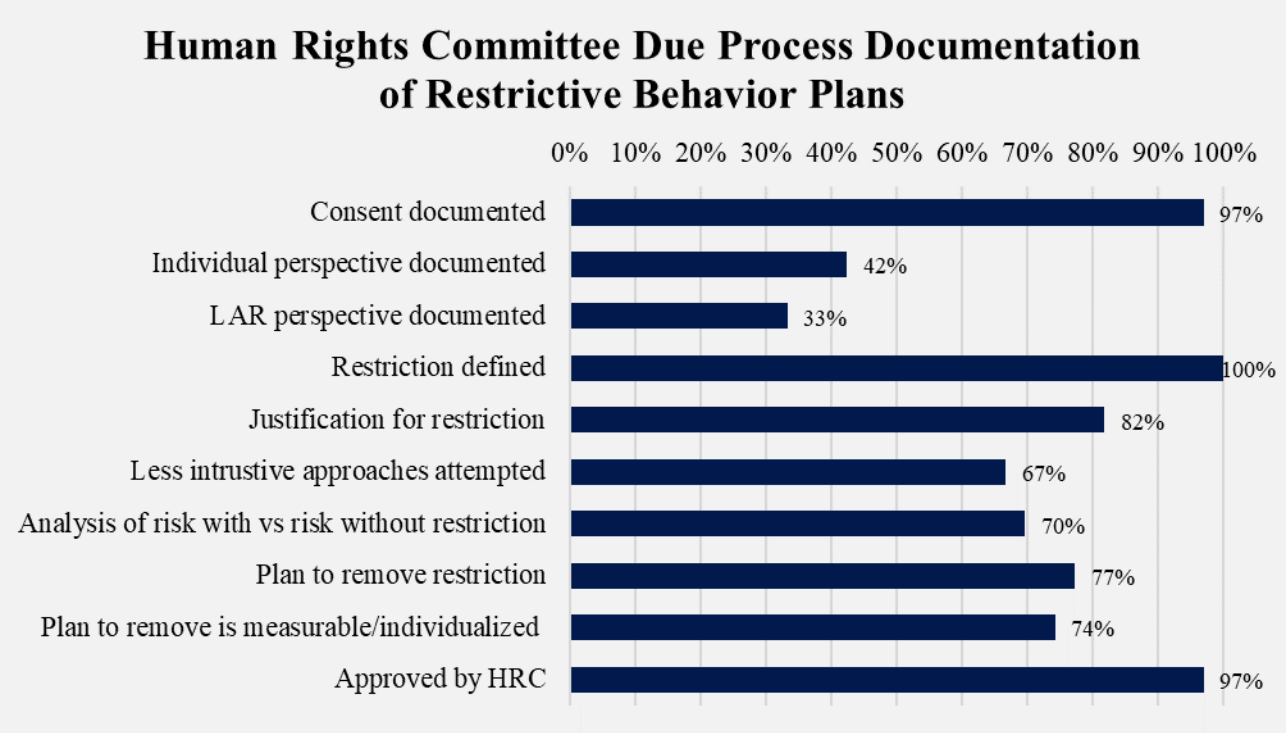
Emergency Restrictions (ER) are implemented in response to an unanticipated emergency. The statewide SSLC Rights Policy requires that ERs be discussed by the resident's IDT within one business day to determine if the restriction remains appropriate and what the team needs to do to best support the individual moving forward. A total of 1137 ERs were reviewed during HRC at meetings observed in the reporting period, 2021-22.

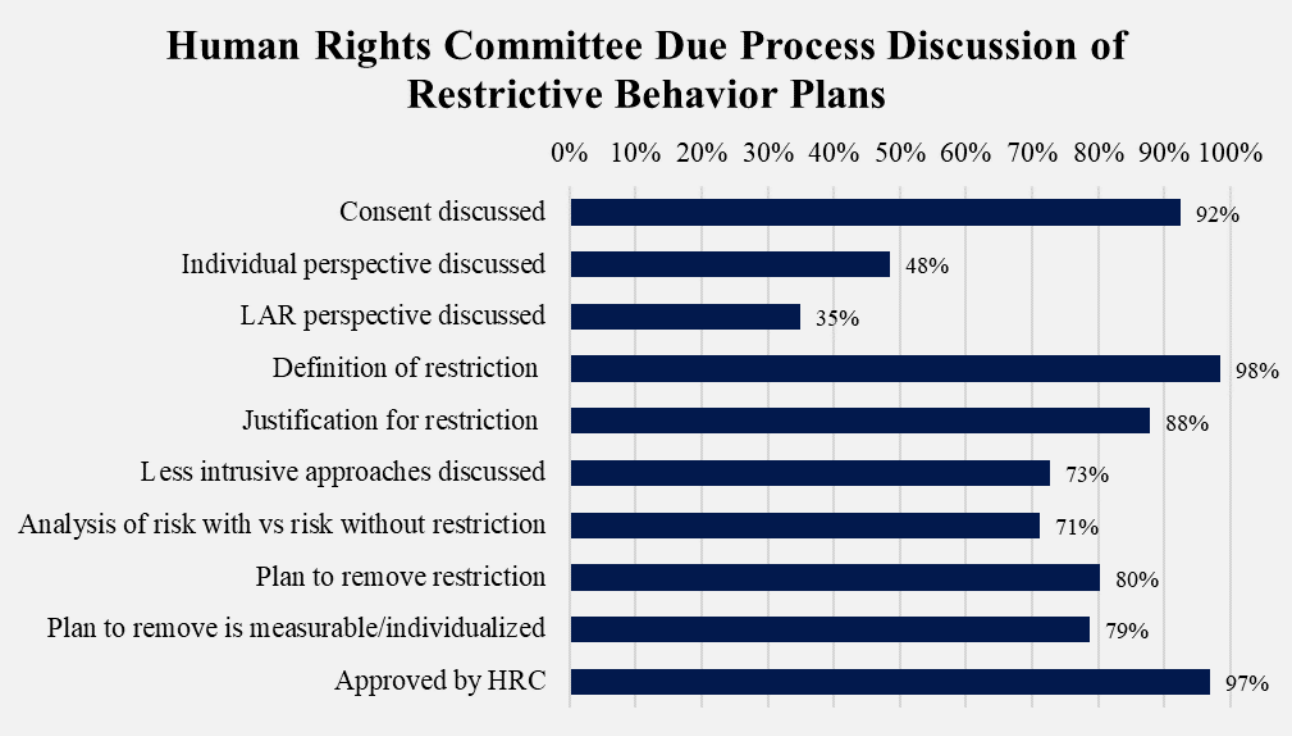


- Aggregately, 99% of ERs discussed at HRC meetings provided a reason for the restriction and 97% provided sufficient justification for the restriction.
- For 75% of ERs, the IDT meet to discuss the restriction within one business day, within the allotted timeframe required by policy.
- At Lubbock the IDT met within one business day less than half of instances of ERs in the sample data (43%).
- Policy states that ERs should be reviewed by HRC within 5 days; the average number of days between the date the ER was implemented and the HRC meeting date aggregately was 4. Rio Grande had the highest average number of days at 10.

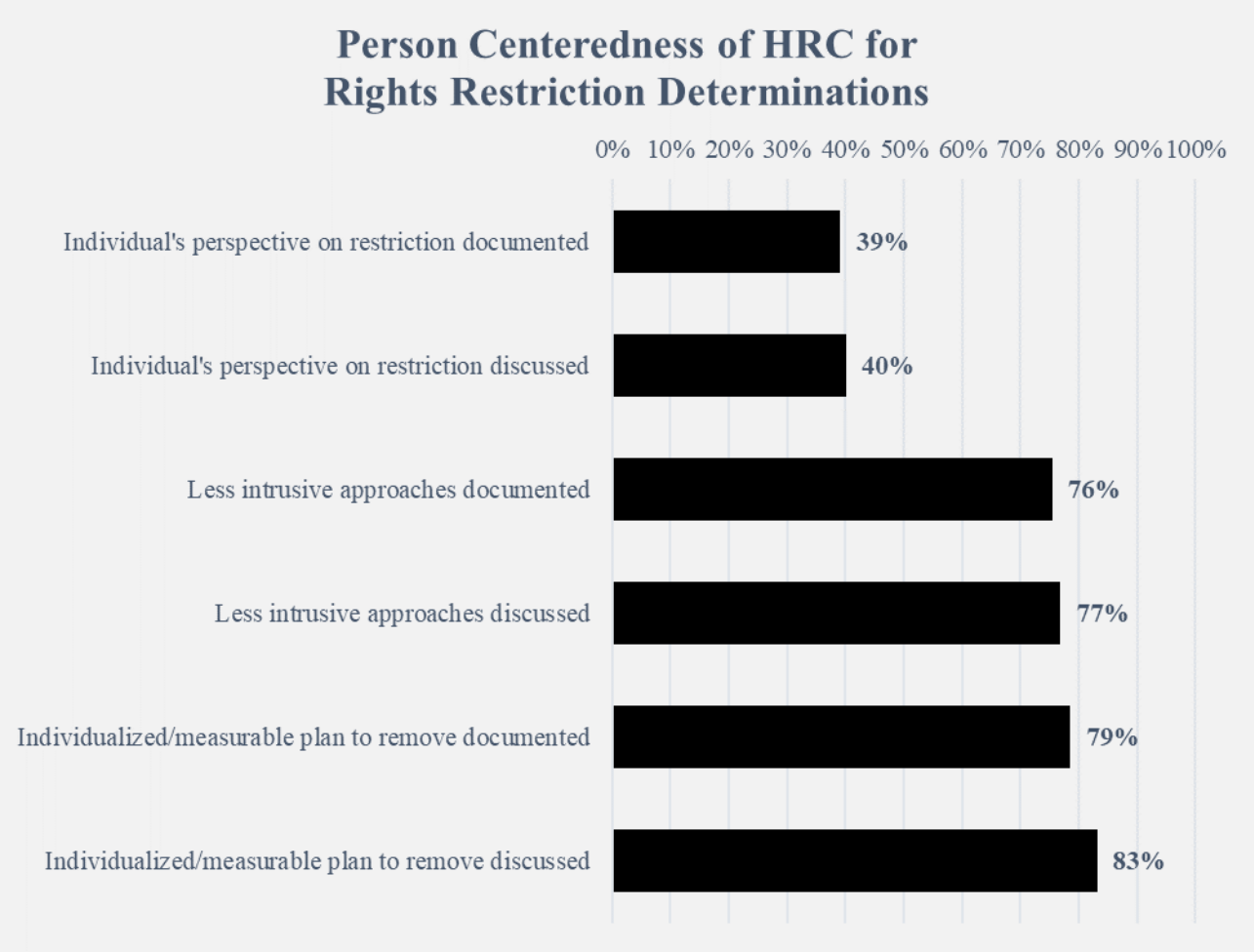
HRC Review of Restrictive Behavioral Support Plans

Behavioral Support Plans (BSPs) include Positive Behavioral Support Plans (PBSP) and Crisis Intervention Plans (CIP). This data reflects HRC review of restrictive BSPs only. Data was collected from 15 restrictive BSPs presented during HRC in the reporting period, 2021-22.


Human Rights Committee Due Process Documentation of Restrictive Behavior Plans
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Consent documented 97%
Individual perspective documented 42%
LAR perspective documented 33%
Restriction defined 100%
Justification for restriction 82%
Less intrustive approaches attempted 67%
Analysis of risk with vs risk without restriction 70%
Plan to remove restriction 77%
Plan to remove is measurable/individualized 74%
Approved by HRC 97%


Human Rights Committee Due Process Discussion of Restrictive Behavior Plans
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Consent discussed 92%
Individual perspective discussed 48%
LAR perspective discussed 35%
Definition of restriction 98%
Justification for restriction 88%
Less intrusive approaches discussed 73%
Analysis of risk with vs risk without restriction 71%
Plan to remove restriction 80%
Plan to remove is measurable/individualized 79%
Approved by HRC 97%

- Many due process elements were not consistently discussed by HRC, yet 97% of restrictive BSPs presented at HRC were approved.
- Documented consent was obtained for 97% of the restrictive BSPs and consent was discussed by the committee at 92%.
- The elements of due process that were least present during HRC discussion were the LAR and individual perspective.
- Compared to the previous reporting period, the percentage of restrictive BSPs with a plan to remove or reduce discussed has increased from 33% to 80%.



HRC Review of Referrals for Restriction

A referral is a proposed rights restriction outside of the annual Individual Service Plan (ISP) and RRD[13]. Referrals must be reviewed and approved by HRC before implementation and are subject to the same due process requirements as restrictive BSPs and RRDs. In 2021-22, AIOs observed HRC review of 679 referrals for restrictions outside of the annual planning period.

- Aggregately, 96% of referrals were approved by HRC however, the individuals' perspective was documented only 40% of the time.
- Consent was obtained prior to HRC review for 90% of referrals. Corpus Christi obtained consent in 100% of Program Review HRC observations.
- All restrictions should have an individualized and measurable plan to remove or reduce the restriction however, only 74% of referrals included this in HRC documentation and 76% in discussion.
- Aggregately, the next IDT review of the restriction was documented 48% of the time however policy requires this documentation
- The average number of days from the date of the referral for the restriction and the HRC meeting date was 7 days, though policy states HRC must review a referral within 5 days. San Angelo had the highest average number of days between date of referral and HRC at 27 days, Lubbock had the lowest average with 2 days.

HRC Review of Rights Restriction Determinations

RRDs are developed upon admission, and annually, and contains a resident's rights restrictions and the plan to reinstate the residents' rights and other details regarding the purpose of the restriction. During this reporting period, AIOs reviewed 942 RRD restrictions in HRC.

- The RRD sample data showed the individual's perspective about the proposed restriction was discussed for 40% of restrictions while the LAR's perspective was discussed 31% of the time.

[13] Although BSPs and psychotropic medications are submitted as referrals, they have been separated for the purposes of this report.

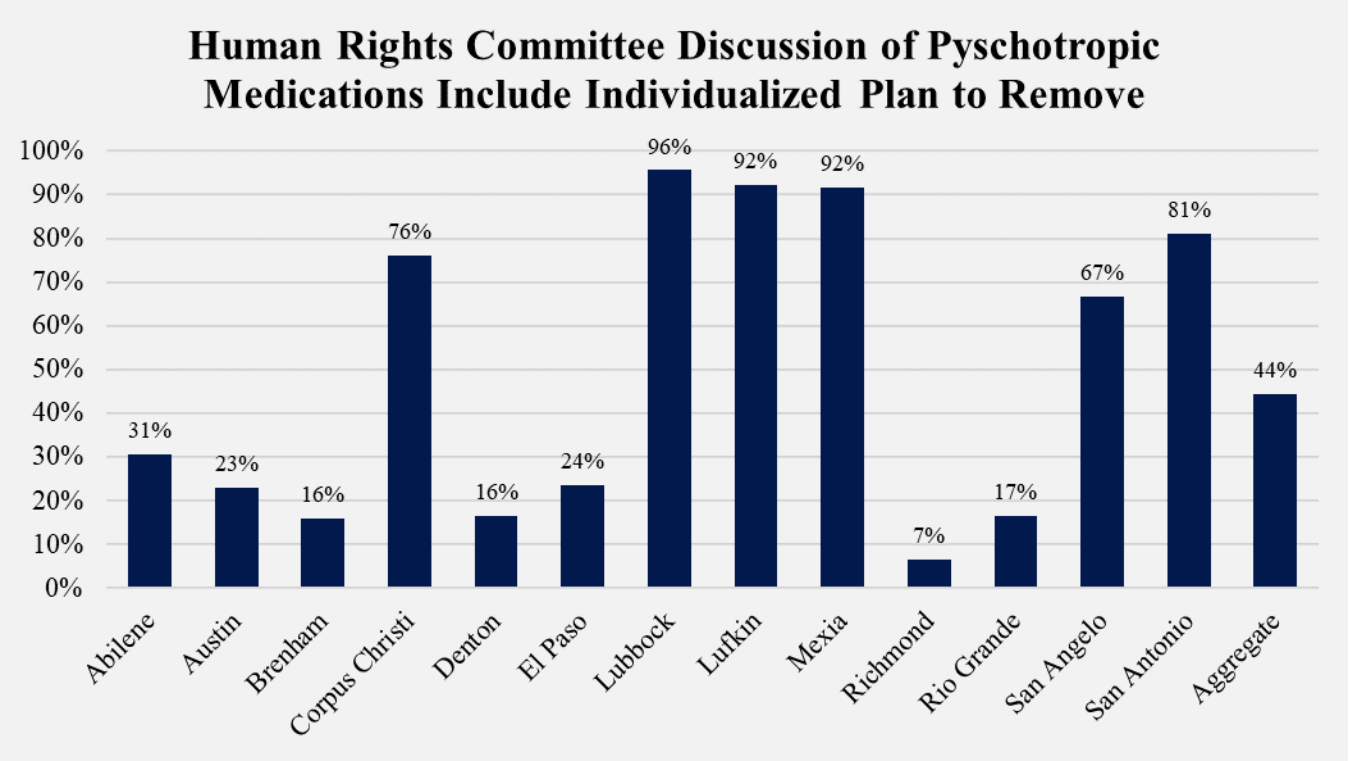
- Abilene, Brenham, Lufkin, San Antonio, and San Angelo approved 100% of RRD restrictions reviewed despite those HRCs not addressing all due process elements in documentation and discussion.
- Aggregately, there is less than 60% documentation and discussion in HRC sample data for the risk with vs the risk without the restriction due process element.
- The average number of business days from the annual ISP date and completed restrictive RRD to HRC review was 16, which is higher than the requirement that the review be within 15 business days.[14]
    - At Corpus Christi, the median number of days between the ISP and HRC review of the RRD was 93 business days, which far exceeds the timeline set by policy.
    - The median number of days to HRC review the RRD also exceeded 15 business days at El Paso (22 business days) and Austin (16 business days).

HRC Review of Psychotropic Medications

Implementation of psychotropic medication requires the same HRC due process as any other restriction unless the medication is court-mandated or administered during an emergency behavioral crisis. There were 539 psychotropic medication reviews observed during HRC in 2021-22.

- 76% of psychotropic medications were approved by HRC.
- Overall, an individualized/measurable plan to remove a psychotropic medication under HRC review was discussed only 44% of the time and documented in 63% of the sample HRC data.

[14] SSLC Policy 045.4 Rights



- Aggregately, data showed that the due process elements that were least present in documentation and discussion of psychotropic medications during HRC were individual/LAR perspective and measurable and individualized plans to remove/reduce medications.
- Plan to remove or reduce the psychotropic medication (53%) and analysis of the risk with vs without (59%) were also discussed at low rates.
- Mexia approved 100% of psychotropic medications in the sample data without the individuals' perspective documented.
- Only 4% of psychotropic medication restrictions at Austin SSLC had plan to remove the restriction and the removal plan was individualized/measurable.

Appendix: Acronyms & Glossary

(AIP) Actively Involved Person – a person with significant ongoing involvement with a resident, and serves as an advocate, and is knowledgeable and sensitive to the individual's preferences, values and strengths

Alleged offender – an individual who has been charged with a crime, has been diagnosed with an intellectual disability and have been deemed not competent to stand trial, and have been transferred to the SSLC by a court order (Chapter 46B or 46C Code of Criminal Procedures or Chapter 55, Family Code).

(CIP) Crisis Intervention Plan – a component of the individuals' ISP that provides instructions for staff on how to effectively and safely use restraint procedures when less restriction prevention or de-escalation strategies have failed and the individual's dangerous behavior continues to present an imminent risk of injury to the individual or others.

(DSP) Direct Support Professional – an SSLC staff person who provides direct care, including implementing various support plans, programming and personal care to individuals living at the SSLC

(ER) Emergency Restriction – an immediate intervention required for the protection of an individual or others resulting from an anticipated situation.

Guardian – an individual appointed and qualified as a guardian of a person under the Texas Estates Probate Code, Title 3, Chapter XII.

Holdover staff – staff that are required to work beyond their assigned work hours or asked to come in prior to their assigned shift.

(HRC) Human Rights Committee – a committee with the purpose of protecting residents' rights through an impartial review of proposed rights restrictions and ensure adherence to due process.

(HRO) Human Rights Officer – an SSLC employee with the primary function of ensuring resident's rights are promoted and protected, including the right to due process, and serves as the HRC chairperson

(ICA) Individual Capacity Assessment – a form completed upon admission and annually by the IDT, in which they discuss and document in what areas an individual has compacity to make decisions, or what supports are needed to make those decisions, including the need for guardianship.

(IDT) Interdisciplinary team – a team consisting of an individual, the individuals LAR, the qualified intellectual disability professional (QIDP), other professionals dictated by the individual's strengths, preferences and needs, and staff who regularly and directly provide services and supports to the individual. The IDT is responsible for making recommendations for services based on the personal goals and preferences of the individual using a person-directed planning process.

(IRA) Individual Rights Acknowledgement – a form completed upon admission and annually demonstrating the individual and LAR/AIP/guardian have been informed of the resident's rights, circumstances in which a right may be restricted, and the procedures that must be followed to limit rights.

(ISP) Individual Support Plan – developed by the IDT that sets out all of the protections, supports and services to be provided to the individual in an integrated manner.

(LAR) Legally Authorized Representative – a person authorized by law to act on behalf of an individual, including a parent, guardian or managing conservator.

(LOS) Level of supervision – a LOS means that a resident requires more than routine supervision. Per the SSLC State Office LOS guidance policy, routine supervision is generally referred to as verification checks every one to two hours, as determined by the residents' interdisciplinary team (IDT). One-to-one (1:1) LOS typically requires a designated staff person to be within arm's length of resident and "cannot be assigned supervision of other individuals and must not have other responsibilities that preclude carrying out 1:1 supervision."

(OIO) Office of the Independent Ombudsman for State Supported Living Centers –The state agency administratively attached to HHSC to provide independent oversight of the state supported living centers to protect the rights of residents and fulfil the requirements of S.B. 643, 81st Leg.

(OJT) On-the-job training – refers to DSP training that occurs in the home, typically after new hires have completed required classroom new employee orientation.

(PBSP) Positive Behavior Support Plan – a comprehensive, individualized plan that contains intervention strategies designed to modify the environment, teach or increase adaptive skills, and reduce or prevent the occurrent of target behaviors through interventions that build on an individual's strengths and preferences without using aversive or punishment contingences.

Psychotropic medication – a medication that is prescribed for the treatment of symptoms of psychosis or other severe mental or emotional disorders that is used to exercise an effect on the central nervous system to influence and modify behavior, cognition or affective state when treating symptoms of mental illness.

Pulled staff – staff that are moved from their assigned home to another home or area to provide coverage on a temporary basis.

(QIDP/Q) Qualified Intellectual Disability Professional – the IDT member responsible for integrating, coordinating and monitoring the assigned individual's active treatment program and assisting with ISP meeting facilitation.

Quorum – the minimum members of the HRC that must be present at meetings to make the proceedings of that meeting valid; an HRC quorum consists of the HRO (or designee), a person who has received IDD services or the LAR of an individual who has received services, and a person unaffiliated with the center and has no ownership or controlling interest with the facility.

(RRD) Rights Restriction Determination – a document completed upon admission and annually by the IDT and contains all discussions about, restrictions for an individual.

(SOTP) Sexual Offender Treatment Program – a program provided by trained staff at the San Angelo SSLC, specially for residents who are alleged sexual offenders.

(SSLC) State Supported Living Center – the 13 certified intermediate care facilities that provide 24-hour direct care to individuals living with intellectual disabilities (ICF/IID).

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22D0612