By: Ellis S.C.R. No. 45

CONCURRENT RESOLUTION

WHEREAS, Certain current and former residents of Texas state schools allege that:

(1) there are 11 state schools and two state centers in Texas that serve as residential treatment facilities for persons with developmental disabilities and are operated by the Department of Aging and Disability Services, including Abilene State School, Austin State School, Brenham State School, Corpus Christi State School, Denton State School, El Paso State Center, Lubbock State School, Lufkin State School, Mexia State School, Richmond State School, Rio Grande State Center, San Angelo State School, and San Antonio State School;

(2) individuals with developmental disabilities in a state institution have a constitutional right to due process as provided by the Fourteenth Amendment to the United States Constitution, which includes the right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, reasonable protection from harm, and adequate food, shelter, clothing, and medical care;

(3) on March 17, 2005, March 11, 2008, and August 20, 2008, the Department of Justice notified Governor Rick Perry of its intent to conduct investigations of these state schools and centers under the Civil Rights of Institutionalized Persons Act (42 U.S.C. Section 1997 et seq.);

(4) the Department of Justice issued its findings in

the Lubbock State School investigation on December 11, 2006, and its findings concerning the other state schools and centers on or about December 1, 2008;

(5) the Department of Justice concluded that numerous conditions and practices at these state schools and centers violate the constitutional and federal statutory rights of their residents and substantially depart from generally accepted professional standards of care in that they fail to:

(A) provide adequate health care, including nursing services, psychiatric services, general medical care, physical therapy, and physical and nutritional management;

(B) protect residents from harm;

(C) provide adequate behavioral services, freedom from unnecessary or inappropriate restraint, and habilitation; and

(D) provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs;

(6) these state schools and centers fail to:

(A) provide basic oversight of resident care and treatment critical to ensuring the reasonable safety of their residents;

(B) identify risks to prevent foreseeable harm to their residents; and

(C) respond appropriately once harm to a resident has occurred;

(7) in 2006 and 2007, the Centers for Medicare and

Medicaid Services identified significant care and safety deficiencies at more than two-thirds of the state schools and centers, including instances of immediate jeopardy, which placed certain facilities in danger of losing Medicaid certification and funding because the facility's noncompliance with one or more requirements or conditions of participation in Medicaid had caused or was likely to cause serious injury, harm, impairment, or death to an individual receiving care in the facility;

(8) residents of state schools and centers have suffered significant injuries from inadequate supervision, neglect, possible abuse, and improper use of restraints as a result of inadequate oversight and deficient risk and incident management practices;

(9) the staff of state schools and centers has failed to carefully monitor residents' risk for choking, failed to respond appropriately once the staff discovered an apparent choking episode, and failed on several occasions to identify and monitor residents after serious pica incidents, which is the craving or ingestion of nonfood items and can expose a resident to a substantial risk of choking and dying;

(10) many residents at state schools and centers suffer significant, preventable injuries resulting from seizures and falls and are not referred to physicians in a timely manner following these injuries, which only prolongs the residents' pain and suffering, and in at least one case in June 2007 a resident died due to blunt force trauma to the head as the result of a fall;

(11) from January through September 2008, a total of

10,143 restraints were applied to 751 residents, and residents have suffered black eyes, abrasions, scratches, swelling, bruises, broken bones, and even death related to use of restraints in state schools and centers;

(12) staffing shortages at state schools and centers, due in part to inadequate recruitment, retention, and training, have greatly compromised nursing care, and inadequate nursing staff has resulted in hospitalization of residents for unexplained weight loss, multiple episodes of pneumonia, abdominal distension, and broken bones, and some residents have died;

(13) from January to September 2008, residents of state schools and centers were hospitalized on at least 1,409 occasions, many of these being for preventable conditions such as bowel impaction and obstruction, pneumonia and aspiration pneumonia, gastroesophageal reflux disease, seizures, and fractures due to osteoporosis;

(14) at least 114 residents died at one state school during fiscal year 2008, and 53 of those deaths were related to aspiration, pneumonia, respiratory failure, sepsis, bowel obstruction, or failure to thrive, all of which are generally preventable conditions that result due to lapses in care or failure to put medical interventions in place in a timely manner;

(15) a significant number of residents of state schools and centers have been hospitalized for nutritional management issues, which are due in part to meal cards that are too superficial to assist staff working with residents they do not know well and direct care staff who have little knowledge or

appreciation of the critical importance of meal textures, how residents should be positioned during meal times, or how to identify and document indicators of possible aspiration, including coughing, wheezing, watery eyes, and food refusal;

(16) the adequacy of pharmacy services at state schools and centers is compromised by the fact that many residents receive psychotropic medications with a vague diagnosis or no diagnosis at all, which is contrary to generally accepted professional standards, that once a pharmacist alerts a physician to a drug interaction or possible contraindication many facilities do not have a method to track whether a physician has responded to that alert, and that as a result facility residents may receive inappropriate or ineffective medication needlessly;

(17) psychiatric services at state schools and centers frequently fall substantially short of generally accepted professional standards of care, and psychiatrists do not adequately consider critical factors such as an individual resident's medical issues, physical injuries, family and psychiatric history, and comprehensive medication regime, which results in incomplete and possibly inaccurate assessments;

(18) the lack of collaboration and communication between psychiatrists and psychologists concerning medication, psychotherapy, and other non-medication-related treatment options severely compromises the quality of care residents at state schools and centers receive and is a substantial deviation from accepted standards of care, because treatment altered by one specialty could destabilize treatment from the other specialty;

(19) from July through September 2008, residents of state schools and centers were reportedly injured at least 4,847 times as a result of other residents' aggression, which demonstrates that violent behavioral events are a daily occurrence at many state schools and centers, and these reported incidents do not include the number of other violent behavioral events that did not result in injuries and therefore were not reported;

(20) state schools and centers do not meet or comport with generally accepted professional standards in the area of behavioral assessments and interventions, monitoring and evaluation, or professional review of behavioral support plans by individuals with expertise in applied behavior analysis and in the development and implementation of behavioral supports, and psychology department staff of some state schools and centers significantly lack expertise in applied behavior analysis;

(21) existing habilitation programs at state schools and centers are insufficient in that they do not focus on basic skills of independence, such as dressing oneself or learning to cross the street safely, but include repetitious assignments that, separated from any practical purpose, engender frustration, boredom, and behavioral outbursts;

(22) the Department of Justice has described the quality of skill-acquisition training programs at state schools and centers as "often strikingly poor" and has noted that these programs fall far short of generally accepted standards of care and federal regulations;

(23) state schools and centers typically fail to

provide residents with adequate and appropriate training in communication skills and services, which can result in a resident's inability to convey basic needs and concerns, increase the likelihood that the resident will engage in maladaptive behaviors as a form of communication, put the resident at risk of bodily injury and psychological harm, result in difficulty for staff in recognizing and diagnosing health issues, and hinder the individual's ability to be integrated into community settings;

(24) although the volume of the allegations by the Centers for Medicare and Medicaid Services varies with each facility, the nature and severity of the allegations are consistently significant, and the state's own statistics demonstrate that these problems are system-wide;

(25) the Department of Justice has characterized the frequency and severity of critical incidents at state schools and centers as "disturbingly high" and has noted that these incidences are often directly related to insufficient staffing;

(26) more than 800 employees of state schools and centers have been suspended or fired for abusing residents of those facilities since fiscal year 2004, and more than 439 employees of state schools and centers have been fired during fiscal years 2006 and 2007 for abuse, neglect, or exploitation of residents;

(27) state records indicate that there were 450 confirmed incidents of abuse or neglect in state schools and centers in fiscal year 2007, and in July, August, and September of 2008, state schools and centers opened at least 501 investigations into alleged incidents of abuse, neglect, or mistreatment; and

(28) in the letter from the Department of Justice to Governor Rick Perry, the department has given Governor Perry notice that the attorney general may institute a lawsuit under the Civil Rights of Institutionalized Persons Act (42 U.S.C. Section 1997 et seq.) if the department's concerns as addressed in that letter are unresolved; now, therefore, be it

RESOLVED by the Legislature of the State of Texas, That current and former residents of Texas state schools and centers who have been injured as a result of their residency in those facilities, and the guardians or family members of those current and former residents, are granted permission to sue the State of Texas and Department of Aging and Disability Services subject to Chapter 107, Civil Practice and Remedies Code; and, be it further

RESOLVED, That the commissioner of aging and disability services and the attorney general be served process as provided by Section 107.002(a)(3), Civil Practice and Remedies Code.