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September 2, 2008

Adelaide Horn
Commissioner
Texas Department of Aging & Disability Services
P.O. Box 149030
Austin, Texas 78714-9030

Via CMRRR 7005 2570 0002 2377 6890

Randy Spence
Superintendent
Denton State School
3980 State School Rd.
Denton, Texas 76210-8826

Via CMRRR 7005 2570 0002 2377 6906

Dear Commissioner Horn and Randy Spence:

I recently visited the Denton State School (DSS) on two separate occasions (August 7-8, 2008 and August 22, 2008), to investigate abuse and neglect complaints received by Advocacy, Inc. (Advocacy). I want to provide you with my observations, request additional information, and request a meeting to discuss some of the concerns that my investigation raised. I have summarily discussed these concerns with Lorri Haden and informed her that I would be providing a more detailed report regarding my observations and concerns directly to you.

Please be aware that the opinions expressed in this letter are based on certain information found in the state school's policies and procedures, my tour of the state school, and brief and informal interviews with residents and staff. I have not yet engaged in a full and complete examination and investigation as needed before submitting a formal report. For example, I have not conducted a full review of randomly selected residents' records. Likewise, I would expect to conduct more extensive tours and interviews of residents and staff members prior to releasing a formal report. However, due to my observations of the under-staffing, physical plant, and lack of active treatment in the homes, I have concerns that the health or safety of the residents may be at risk. Accordingly, I want to make sure you were apprised of the conditions prior to my preparation of a formal report.

To begin with, I would like to thank Denton State School and its staff for allowing me unfettered access to the state school and for attempting to answer my questions with integrity and candor. I observed several direct care staff that appear to remain motivated and hard working despite the virtually impossible task they have been assigned. In several instances I was very impressed with the kindness and sensitivity with which some direct care workers treated residents. They were patient, informative, and made appropriate efforts to be calming and reassuring. For example, Tom Vincent Leyvea used a variety of methods to calm resident C.C. Laci and Weetie IN the 509C home, and LaShara and Shalissa IN the 511C home were also very inter-active with the residents of their homes.

Unfortunately I also observed direct care staff who were not engaged with the residents. Many direct care staff were seen watching television, making personal calls, and visiting with other staff instead of assisting or inter-acting with residents. This caused many residents to be unattended, left in their rooms waiting to be dressed, and/or waiting to timely receive their meals.

But, even if staff wanted to interact with the residents, it was impossible as staff are continually pulled from their normal housing assignments and reassigned to new homes where they are not familiar with the residents and are not trained on their care and treatment. This is particularly problematic since many of these residents have significant medical and behavioral issues. Compounding this problem is the fact that most of these residents are either entirely uncommunicative or have difficulty communicating, which drastically increases the potential for risk of harm to the residents.

We were also informed that in an attempt to meet the minimal staffing requirements, many direct care staff are asked to work additional eight (8) hour shifts. As a result, many direct care staff had been on the clock for 16 hours leaving them tired, irritable, and uninformed about the resident they are tasked to watch. Again, a hazardous combination when staff are working with individuals who have challenging medical and behavioral conditions.

Pulling staff from other units and/or having them work double shifts; however, did not even ensure adequate staffing. There were several instances where the required staffing levels were not maintained. For example:

- On August 7, 2008 at 5:45 p.m., home 510B was staffed with only one person, a direct care staff was required to supervise the entire home of six (6) residents;
- Homes 522C and 522A, the 10p-6a shift is supposedly required to only have one person, a direct care staff, working in a home of 10-12 residents. This was the case on August 7, 2008 when a resident on 522C needed changing. The staff person assigned to 522C could not lift and change the resident on her own. So, she requested and

received help from the only staff assigned to 522A. As a result, home 522A was left without any staff member for at least thirty minutes;

- On August 7, 2008 the Infirmary's 10p-6a shift is required to have 3 nurses, but only had 2 nurses. It is also required to have 4 direct care workers, but only 3 were assigned; and
- On August 22, 2008 at 9:30 a.m. the acute side of the Infirmary had only one direct care staff for 14 residents because they were down one staff member and the other staff member had to relieve a 1:1 staff member. On the long term care side of the Infirmary there was only 3 direct care staff members because one direct care staff was required to leave the floor to answer phones. Staff are also routinely taken away from their assignments to exchange oxygen tanks used by the residents. Empty tanks need to be taken off of the unit by direct care staff and this eliminates a direct care staff position for 15-20 minutes approximately four times a shift.

Although I did not observe any incidents of abuse or neglect occurring on these dates and times, this limited staffing will inexorably lead to the negligent care of the residents. Additionally, because of the inadequate staffing and inadequate space, active treatment is scarce to non-existent.

During my visit I also observed that record/checklist documentation was often not complete or not completed contemporaneously, as is required. When I asked how the checklists and record documentation were done, I was informed that "nobody can find them" and if found, staff either do not fill out the time missed or they fill in the information on all residents several hours later. Direct care staff who were assigned as a 1:1 to individuals in the Infirmary had not filled out the 15 minute check logs for their entire shift. When asked why they were not filling them out, they indicated that they were not aware that it was a requirement.

I also found that most staff do not wear their name badges where they can be seen. This makes it difficult for residents to know who is providing care and treatment to them, especially when staff turnover is so high. It also makes it difficult for residents or others to appropriately identify staff for whom there is an allegation of abuse or neglect.

Finally, although this situation has been resolved, it is imperative that you are aware of the previous situation on the Evergreen Home at Denton State School. This Home was under construction for approximately two months, July-August, 2008. Due to the construction on the Home, the residents of Evergreen were displaced and required to live 24/7 in the hallway of another Home during that time. A hallway is not appropriate housing for anyone. It does not provide for the dignity and privacy that these residents deserve. In the future, appropriate alternative housing arrangements must be made when there is construction on a Home.

When a State accepts admittance of residents into its facilities, it concomitantly accepts a legal duty to provide for that person's necessities, including medical, rehabilitative, and mental health care. Adequate staffing and appropriate active treatment is a must to ensure that the state is meeting the serious medical, habilitative, and psychological needs of these state school residents. Without additional staff, Advocacy does not believe that Denton State School can meet their constitutional obligations to their residents. Denton State School also needs to appropriately train its staff on how to provide active treatment and ensure that clients are receiving the rehabilitative care that is required to maintain their level of functioning.

I request that we set up a meeting to further discuss these concerns and what actions both Denton State School and DADS plans to implement to correct these problems. Based on my observations of lack of adequate staff, I am also making a formal request under 42 U.S.C. §§ 10801 and 15043 for any and all:

- All incident reports broken down for each unit and shift at the Denton State School for the past year;
- All staffing levels at the Denton State School broken down per unit and shift for the past year;
- Names and guardianship information for all residents in the Denton State School Infirmary;
- Names and guardianship information for all residents in the Denton State School Home 502.

Thank you for your time and attention in this matter.

Sincerely,



Beth Mitchell
Attorney at Law

BLM/kp

cc: Mary Faithfull, Executive Director, Advocacy, Inc.
Lorri Haden, Legal Services, DADS