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Violations at the Brenham SSLC

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Do you accept the treatment residents and staff receive at the Brenham SSLC?

After decades of owning businesses in October 2018 at the age of 60 I started working as a DSP1 at the Brenham SSLC and in April 2023 I was fired based on false allegations as many DSP's are. My time there was very rewarding, since 2018 the conditions at Brenham have deteriorated.

In the 2nd quarter of 2019 I was selected for a new home, Cottage F, it was opened to prepare selected male residents to move into a community home. It has two shifts, 600am—600pm and 600pm—600am with two staff members on each shift. 95% of the residents on Cottage F today are the same residents when it opened in 2019, nobody has moved to a community home. When it opened residents had weekly sessions with the behavior staff, but that stopped years ago and the daily behavior incidents increased. Residents wake up, take pills, hang out, take more pills, shower, sleep and then repeat it all again the next day. The residents mental and physical health have deteriorated, when you spend over four years with the same residents you have a unique perspective of their condition during that time.

Every month we pay $20,000 for a psychiatrist plus tens of thousands every month for their behavioral staff and nobody visits with the residents. No eye to eye contact, no studying body language, no understanding of the residents daily environment, nothing. How do you justify feeding them drugs instead of providing them the help they need? Brenham must be a profit center for pharmaceutical companies. In 2009 Texas entered into a Settlement Agreement with the Department of Justice to achieve targeted improvements at the SSLC's. Do you believe that being drugged and warehoused is an improvement?

Behavior staff use the information in the Care Tracker database to write their plans for residents but not all behavior incidents are entered. At times Care Tracker is down, sometimes it does not new save data, and some of the questions are crazy, between 1000pm—600am it asks if sunscreen is on the residents.

One Behavioral staff member was choked by a resident of Cottage F. I spent four years with that resident, he is smart, very aware of his behavior and laughs. He fights his peers, destroys property, one weekend he called 911 dozens of times forcing an ambulance to respond every time. For over four years I helped by deescalating and calming him down during his behavior situations, some staff yell and threaten him resulting in escalating his anger and outbursts.

Long term staff at Brenham are counting the days until they can retire, you are losing years of experience. Because of staff shortages DSP's are treated like property, they are forced to work 20 hour shifts. Many DSP's do not know when they will go home as they start their shift. The DSP turnover rate must be high, homes are short staffed, when an incident occurs you blame a DSP and fire them. The facility refuses to admit the short staffing because that triggers more inspections and policy changes from Austin.

Some instructors of the training classes have no experience with the subject they are teaching. At my last refresher class on restraints the instructor admitted she never used restraints. The DSP's in that class told her it was an insult

that they were being instructed by someone who never worked with any residents.

The DOJ and state inspections are a joke, Brenham is notified weeks in advance of when the inspectors are visiting, then managers go around campus checking homes and cleaning them. The DSP's are told if an inspector asks them a question and they do not know the answer never tell the inspector you do not know. Tell them " lets go find the answer ". My home manager told me that is not the same response.

Isn't it odd how the behavioral staff member who I asked many times why she does not spend time with residents on Cottage F is the same one who accused me of not helping on 3/31/23. Resident RJ was screaming he was going to kill resident AE. RJ is very violent and after the incident he received no help for his anger. RJ has a history of anger, everyone knows it. I was told that RJ punched his roommate JC and received no help for his continued anger. Behavioral staff fears him because he reports staff as abusive and he threatens them with physical violence.

Last year resident (SP) had to be flown to a hospital in Temple because he had a very serious respiratory infection, he had nasal surgery and the three daily saline rinses the doctor ordered was not provided. Resident MC on Cottage F is suppose to have two types of skin cream put on his feet after his evening shower. When an agency nurse works the creams are applied, the regular nurse disappears before the end of his shift and no cream is applied. One of the creams is in an aerosol can, the issuing date on the can was over a year old proving it is not used daily as required. The Home manager does nothing about this neglect.

Earlier this year on Cottage F resident ZM woke up with a bruised eye. I was one of the first staff members to see him the night before at 600pm and was there when he woke up, he claimed a CC hit him and it hurt. The investigation took over three months during which the DSP1's on Cottage F had to go work on another home and that home sent a staff member to Cottage F. I believe when a resident is abused that they are provided 1on1 protection during the investigation, but he was not. He was free to roam the campus alone exposing him to who abused him. I texted my home manager requesting to meet the inspector because I had some information, but she ignored my request. The investigation ended with no finding.

I helped a DSP1 from Bowie with his EMR hearing, a resident who required two staff members to transfer was hurt when they fell while being transferred by the DSP1 working alone. Because of the staff shortage the shift leader assigned only one DSP. Every morning at 500am staff starts dressing the residents to place them in the day room for the nurse. The shift leader was on that home for over a year but she told the state investigator she did not know the process. The states video proved she lied, it caught her looking into the room twice. The Judge ended the hearing when she realized the shift leader lied, fired the DSP, and put him on the EMR list. The Judge refused our appeal to question the shift leader even though she was called as a witness by the state. The state investigator did not know the 1on1 policy, her conclusion states that the DSP who was sitting in the bedroom with her 1on1 resident could have kept the bedroom door open and sit in the bedroom doorway to also watch the residents who were sleeping in the day room. The 1on1 policy forbids staff assigned to a 1on1 resident being assigned to anything else, but your investigator did not know. The home manager admitted violating the 1on1 policy everyday, it is all in the records of the hearing. The home was short staffed, four staff members were required but only three staff were on the home. The DSP you fired was named as the best staff member on Bowie the month before and received a merit bonus. If you were honest you will remove him from the EMR list. Everyone knows state policy is violated every morning on Driscoll. Only one staff member works the mechanical lift to transfer a resident from their bed when state policy requires a minimum of two staff members. Residents have been injured but nothing changes, just blame and fire the DSP. It is Brenham's version of a coverup.

Housekeeping never disinfects the shared bathrooms, some DSP's on the overnight shift have to scrub the toilets with bleach, are DSPs hired to scrub toilets? I thought having bleach in a home was a violation.

Food is wasted everyday on Cottage F, the home manager lets the day shift take it home by justifying it will be thrown in the garbage anyway. When the kitchen sends the deep buffet aluminium pan filled with apple sauce it is trashed, the individual serving containers in the refrigerator are given to the residents.

I was lectured by a behavioral staff member because I reported angry verbal aggression between two residents as " peer to peer ", and I reported two residents throwing items at each other as a " peer to peer ". She said it is only " peer to peer " when there is actual physical contact between residents. I asked her if she knew the definition of " peer "? When the same residents continue having " peer to peer " aggression against each other it is a warning of escalating tensions between them yet the behavior " expert " was blind to that fact and provided no intervention to deescalate their anger? You consider that progress?

On Cottage F residents RJ and JC keep and eat food in their room without staff in the room, I believe that is a violation of state policy. The door to their room is locked, if they choke staff would not know. We found mold covered food in their room. JC sleeps in a chair because he has garbage piled on his bed. An inspector reported the room as a health violation and ordered it to be cleaned once a month, but it never is.

My unit director ~~Leesa~~ fired me in retaliation because I reported her to HR. On 3/24/22 I requested three days off, 6/24, 6/25, and 6/26 to celebrate our 45th wedding anniversary, ~~Leesa~~ denied it claiming that state policy required that I had to find someone to replace me. I could not find anyone. On 5/3/22 I asked my home manager again about my request, she said it was my problem not hers. On 6/16/22 I contacted ~~Laura~~ in HR, she said it was not state policy especially since I requested three months in advance. She asked me to emailed her my request and the text messages with my home manager. Four days later on 6/20/22 my home manager texted me that ~~Leesa~~ approved my request, I did not have to find anyone to replace me. On 6/30/22 ~~Leesa~~ and my home manager met with me, ~~Leesa~~ told me she was angry that I contacted ~~Laura~~ because she had to answer her questions. Because I contacted ~~Laura~~ ~~Leesa~~ said she will not promote me as the DSP3 for my shift. I was the acting DSP3 for months on Cottage F, I worked over four years there, I was more then qualified to be the DSP3 but ~~Leesa~~ would not even interview me.

In December 2022 I had emergency oral surgery requiring 2 days recovery under the doctors care. Even though I was not required to I still gave my home manager a note from the doctor for the 2 days off. She rejected the note, she demanded that the doctor must explain exactly why I needed 2 days off. I have the texts. I believe her demand for specific medical information is a HIPAA violation?

On Wednesday April 19, 2023 ~~Leesa~~ gave me the Disciplinary Action Notice letter. To build her case she used a 3 year old letter from 4/22/20 claiming I did not assist during a residents challenging behavior, a letter from 8/24/22 claiming I did not assist during a residents challenging behavior that the home manager actually caused when she failed to follow the 1on1 policy with the resident she was responsible for. And in the 3/31/23 incident between RJ and AE, the behavior specialist I called out for not spending time with the residents on Cottage F viewed a video of the incident and claimed I did not assist during the incident which took place outside Cottage F. The crazy part is that the video camera is 14 feet inside Cottage F, it's range of view is limited to the glass doors, it could not record me redirecting AE three times because we were to the left of the glass door out of the cameras range of view. There is a history of physical aggression between RJ and AE, when they go out on a trip RJ refuses to be in the same van with AE. RJ only eats breakfast at the dining table, if AE is sitting in the day room watching TV RJ refuses to eat, the home manager told us to chase AE out of the day room and make him sit outside by the front door. I believe that is a violation of AE's rights, but she does not care. Many times I asked, Where is the behavior staff? Their job is to help residents with their anger, in the private sector someone would be fired.

For four years we had challenging behaviors everyday on Cottage F, hundreds of them since 2019 and I was accused only three times of failing to help. How pitiful is that, this is how staff at Brenham are treated.

At the Wednesday April 19th meeting ~~Leesa~~ refused to let me see the video, she told me that I was not allowed on Campus but refused to explain why. She gave me two days until Friday April 21st at 600pm to submit my rebuttal letter, Monday was a holiday and she would read my letter on Tuesday April 25th. But the next day, Thursday April 20th, I received an email from payroll explaining that they took my vacation and comp hours to pay me for the days I was scheduled to work until the end of April. ~~Leesa~~ fired me the day of our meeting before I could write my rebuttal letter. She used the shotgun approach accusing me of violating work rules #1 & #29, but she refused to explain how. She accused me of violating work rule #2, stating I was not current with my required training, pure BS. It is obvious she never checked, by April I had already completed all of my required training for the whole year, I even completed online management courses I was not required to take. I have a print out of the records proving she lied, ~~Leesa~~ just wanted to throw mud to justify firing me. This is how the DSP's are trashed at Brenham, speak up and they fire you. I will come to Austin and provide all the evidence about the fraudulent Bowie case and that ~~Leesa~~ lied.

Mental illness is a serious problem, in the National Alliance on Mental Health February 2021 report 43.4% of Texans report symptoms of anxiety or depression. 64.7% of Texans age 12—17 who have depression did not receive any care last year. This past May 2023 the Texas Advisory Committee to the U.S. Commission on Civil Rights published a report " Mental Healthcare in the Texas Juvenile Justice System " it states on page 2 Summary of Findings " most youths in the Texas Juvenile Justice System have clear mental health needs but there are not enough resources and staff to provide proper treatment for their mental health needs, being in a state run facility may further traumatize the youth and increase mental health needs, the state run facilities provide an unsafe environment for

both the youth and staff. You are not providing the proper care for the juveniles in the criminal justice system so now you are placing them in Brenham? How are you going to stop these adjudicated delinquents from running off campus and causing problems? There are residents are constantly escaping campus now and running around the Brenham area. They have been found down 36 towards Bellville, at Hobby Lobby, the Dairy Bar, running on private property, now you are going to house juveniles from the criminal justice system in Brenham who will escape campus? Are you changing the Brenham State Supported Living Center into the Brenham Criminal Justice Center? Brenham has no campus security, there is no fence to stop them from running off campus, it was not built to be a jail.

Does Texas State Senator Lois Kolkhorst know about your plan to house criminals in the Brenham SSLC? Does she support it? We had a special training class to deal with the violent behaviors these new residents will bring, I have the handbook. How will you react if an escaped resident is injured or injures a local resident when they run off campus? Based on history you will blame a DSP, fire them, put them on the EMR list and declare the problem solved.

Most staff at Brenham are not willing to speak up and risk their jobs, they can never replace the salary and the benefits they receive at Brenham, all they have to do is be quiet and follow orders. I certainly understand their predicament, they have families to support and bills to pay. I am not writing this for myself, I am 66 years old, I have owned businesses, worked with CEO's of major corporations, been to the homes of former Presidents. Working at Brenham knowing I could shine a little sunshine into the lives of the residents was very rewarding. It is the residents who continue to be neglected and abused because of failed management at Brenham. We need to provide them services they require.

Since I was fired one of the residents on Cottage F who is autistic was molested twice, his parents were told it was his fault. I spent four years with RS, he is a very gentle individual, blaming him is an insult and BS. And another Cottage F resident has molested two female residents from Childress. You are not providing the residents with the help they need and their behavior continues to get worse.

Now after four years the goal of Cottage F to prepare the residents to move into to a community home has been declared a failure and it will soon be just another home that medicates and warehouses the residents. Your failure has doomed them to living at Brenham, they have the ability to be independent but your failure to provide the help they need has killed their chances of a better life.

I assume you will ignore my email but you cannot deny knowing about the conditions at Brenham SSLC. Maybe an honest investigation of what actually occurs at Brenham is required, just show up at the front door without warning the facility weeks in advance. Why are residents fed drugs while the behavior staff provides no help for them? There are residents in their early 20's that have lived at Brenham since they were young teenagers who have the ability to learn but do not receive any help. I thought we are suppose to support life, respect life, help save lives. Is that just until they are born, then we neglect them?

Are you proud of the way the residents and staff are treated at the Brenham SSLC? Do you really care?

I believe the state of Texas is violating the 2009 Settlement Agreement with the Department of Justice.