

**Review of the Quality of Services at  
Lakeview Neuro-Rehabilitative Center and  
the  
Center's Capacity for Quality Improvement**

**Prepared for Governor Hassan**

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## **Section I: Introduction**

Governor Hassan became increasingly concerned about the quality of services provided to individuals who are served by Lakeview Neuro-Rehabilitative Center (LNC or Lakeview) as the result of a report of a death of a resident that occurred in 2012 that was investigated by the New Hampshire Disabilities Rights Center (DRC). The findings of this investigation highlighted numerous concerns regarding health care and assessment, programming, staff training and consistency, staff supervision, program monitoring and overall quality. The DRC made many substantive recommendations including closing the LNC program in New Hampshire.

In response the Governor stopped any further admissions to Lakeview from New Hampshire, required the health facilities licensing bureau to inform other states of this decision, and directed a three- phase review of services at LNC. The first phase was a licensing review completed by staff of the Department of Health and Human Services (DHHS), who were health facilities certification bureau staff not assigned to LNC, and an independent expert in quality assurance and program monitoring. This was completed in November 2014 and resulted in many findings of deficiencies and a requirement for LNC to develop and implement a Plan of Correction (POC). The second phase was an independent review of LNC and the third phase was an independent review of the state's monitoring and oversight efforts. This is a report of the second phase of the Governor's directive to review the services provided by LNC and the state's oversight of these services.

Governor Hassan has asked for an independent review of the quality of services offered at the Effingham Campus of Lakeview Neuro-Rehabilitative Center (LNC); the organization's ability to make quality improvements; and its ability to sustain these improvements over time by establishing an effective quality management and improvement system that rapidly identifies programmatic and managerial systemic concerns, plans and takes corrective action and provides continuous quality improvement (CQI). The goal of the quality assurance system is to assist the individuals who are served by LNC to be treated with respect and dignity, learn to stabilize and control their behaviors, learn skills that will increase their independence and ability to transition to the community, and experience satisfaction with the services they receive while residing at LNC.

There are numerous entities that interact with and utilize LNC. Lakeview serves a very challenging population of children and adolescents who have traumatic or acquired brain injury, neuro-psychiatric diagnoses, unpredictable destructive and sometimes violent behavior, and who have often experienced several living situations that have failed them. LNC serves individuals from New Hampshire and the surrounding New England states, and individuals from as far away as Oregon and Hawaii. The program is seen as a unique resource nationally by states that struggle to have sufficient funding, community resources and clinical expertise to support individuals with these unique needs and challenges.

It was important for me to talk to the many stakeholders involved with Lakeview, visit the campus, and review a number of relevant documents produced by various sources in order to have a comprehensive understanding of the services LNC offers and of LNC's place within a continuum of care both for New Hampshire residents and individuals placed from other states, and to analyze the organization's issues providing and maintaining quality services. I have interviewed administrative representatives from the New Hampshire Department of Health and Human Services (DHHS) including department leadership, complaint investigators, licensing inspectors, and abuse/neglect investigators; the New York State Justice Center (NYS Justice Center or NYS JC); and the Department of Mental Health and Addiction Services (DMHAS) in Connecticut. I also interviewed two members of the survey team that conducted an inspection of LNC in November 2014 at the request of Governor Hassan as the first phase of this review.

I have talked with staff from the DRC, the Brain Injury Association, Community Support Network, Inc., (CSNI) and Area Agencies Directors. I also interviewed former employees of Lakeview and DHHS who reached out to me. I offered a Family Forum, which was attended by seven family members and a legal representative, and conducted both telephone and personal interviews with family members and a public guardian who were unable to attend the forum.

Additionally, I spent two days at the Effingham Campus where I had the opportunity to interview key administrative staff, tour the school and adult day programs and each of the residential cabins, attend a risk review meeting and review the records for five of the individuals who currently reside at

LNC. I interviewed the Director of Fedcap who is providing managerial consultation to Lakeview to assist the organization to plan and implement its quality improvement strategy. I also interviewed a clinical director who recently resigned.

I have reviewed numerous policies, procedures, training materials and other documents related to the administrative and supervisory structure at Lakeview. I have also reviewed the first Plan of Correction that Lakeview submitted to DHHS that was not accepted and the final POC that was submitted on February 9, 2015 and accepted by DHHS. I appreciate the responsiveness of Lakeview's senior staff, especially Tina Trudel, PhD, President and Chief Operating Officer of Lakeview Neuro-rehabilitative Centers and Specialty Hospitals, in providing the necessary information to conduct this review. I also appreciate the time of the many DHHS and Area Agency administrators who have shared information as well as policies and procedures governing Lakeview. The DRC has been particularly informative and responsive. I deeply appreciate their perspective, findings and recommendations to improve quality oversight and quality improvement processes in New Hampshire to better serve New Hampshire citizens who have disabilities and who rely on the provider system to receive the services and supports they need.

This report and my findings and recommendations are organized using the topic areas and findings of the latest licensing review. The licensing review conducted in November 2014 was very thorough. I agree with their findings based upon my tour of the Effingham campus, review of individual records, staff interviews and document review. Using the topic areas of these findings will give the review a structure that I hope will be most useful to the Governor and her key staff who will review and use my analysis in light of the vast amount of information I have gathered through interviews and document reviews and the complexity and depth of the issues requiring quality improvement at Lakeview. It will also provide continuity of the surveyors' findings, DHHS' expectations, and my findings, impressions and recommendations.

In separate sections that follow I summarize the findings of many reviews conducted by the NYS Justice Center, the impressions and recommendations of families, and explain the new CMS rules for community living. Deputy Commissioner Nihan asked me to include this last topic. New Hampshire uses HCBS waiver funding to support the individuals who are admitted to Lakeview. Changes to the definition of community living will impact the ability of New Hampshire to continue to use waiver funding for services provided at LNC.

## **Section II. Outstanding Issues Requiring Corrective Action and Systemic Solutions and Lakeview's Ability to Make and Sustain Quality Improvements**

Lakeview has outstanding issues in the areas of appropriate staffing, staff retention and recruitment; staff training, individual planning and programming; preparing individuals for successful community living, clinical and program supervision; behavioral programming within a model of non-restraint; abuse and neglect reporting and investigation; incident reporting and analysis; and quality improvement and assurance. These reflect the primary areas of responsibility of any organization purporting to serve individuals with disabilities. It is of grave concern that there are reported weaknesses in all these functions and that most of them appear to be long standing. Lakeview admits to these weaknesses in its most recent Plan of Correction. Lakeview's first POC was rejected by the DHHS as unacceptable. Lakeview has been able to develop a POC that has now been accepted by the State of New Hampshire. It appears this plan was developed with significant involvement of Fedcap that has been hired as a managerial and systems development consultant to Lakeview. While it is notable that Lakeview recognizes its need for this assistance it is also an indication of its own administration's inability to effectively analyze and plan its corrective strategy. DHHS and the Area Agencies will need to make a determination as the POC is implemented if Lakeview has or can develop its own staffs' competencies to effectively implement and sustain these corrective strategies.

DHHS directed Lakeview to take the following actions immediately:

1. Schedule and provide supervision to direct support professionals (DSP) beyond the level required and report staffing and shortage weekly to DHHS
2. Re-assess everyone for the appropriate level of supervision and only reduce the levels if it is clinically appropriate
3. Assess and revise staff training
4. Complete a Root Cause Analysis for all Level III and IV incidents
5. Report within one day and investigate within five days all allegations of abuse and neglect
6. Discharge individuals with high acuity needs until the program has adequate staff to meet the needs of the remaining individuals
7. Maintain the consulting contract with Fedcap as a third party monitor until Lakeview is in full compliance with the POC

These are all important immediate actions of the state to expect of Lakeview. However it is troubling that DHHS needs to issue these directives, especially 1,2,3,and 5 to an agency that has been a provider in NH for several years.

#### **A. Staff Retention ad Recruitment**

This is recognized long standing problem for Lakeview. In part it is caused by the remote location of the Effingham Campus. It is not near any major city or college area, which impedes recruitment. It loses more staff in the first two years of employment than other providers but its vacant rate becomes more comparable after this initial period of employment. The issue of staff vacancies is particularly critical for Lakeview given the nature of the population it serves. Individuals have intensive needs for staffing and are ill served and put at significant risk with inconsistent staffing levels. There are extensive training requirements for staff to work with the individuals who reside at Lakeview. Turnover rates this high makes it more challenging to maintain a competent workforce. Lakeview needs sufficient DSPs to provide for the supervision needed and to have additional staff to respond to crises without leaving other individuals unsupervised and unsafe.

Lakeview is making a strong commitment to recruit and retain staff. It is devoting a position to recruitment, reaching out to colleges in a wider geographic area; identifying transitional housing for newly hired staff; offering a referral and sign on bonus; and increasing DSP pay by \$.50 an hour. There are plans to do semi-annual employee surveys, monthly town meetings across shifts, and a commitment to follow up on staff concerns.

**Findings, Analysis and Concerns:** I believe that Lakeview has and continues to strive to have a sufficient number of staff. I think this new focus on recruitment is necessary and Lakeview should be recognized for making a commitment to this effort by devoting one position to it and also for increasing DSP salaries. Lakeview should set goals for the number of staff it needs for its current population and the additional number it needs to increase to serve new individuals considering various acuity levels. Lakeview should report monthly on its success in recruiting as well as retaining staff. Its plans to conduct semi-annual employee surveys building off the survey conducted in February 2014, conduct town meetings and promptly follow up on staff concerns are steps to improve retention. Scheduling clinical and program administrative staff on second shift and weekends provides greater supervision, leadership and assistance to the residential DSPs.

Of equal importance will be preparing staff through adequate staff training to feel confident dealing with aggressive and impulsive behavior. Lakeview must also clarify its mission and direction and communicate this effectively to staff. I address these issues in greater depth later in this section.

Staff recruitment and retention of case managers, clinicians and management staff is also an ongoing area of concern for Lakeview that is not addressed in the POC. Tina Trudel provided me with information about the length of time individuals have held various positions, at my request. There are seven behavior specialist positions of which three have been in the position one year or less and one is vacant. There are seven case manager positions all of which are filled. However, four of the seven have worked at Lakeview for six months or less with two of them employed since February.

There is a pattern of inconsistency in administrative leadership, with the exception of the Administrative Director who has been with Lakeview since 1988. Until January he was the Administrative Director. He has since been moved to serve as the Director of Residential Resources (a newly created position) working Sundays and Monday-Thursday 12-8:30 PM. Lakeview is conducting a search to hire a new Administrative Director. Tina Trudel has been with the national Lakeview organization since 1992 but until recently has not been assigned to Effingham as her primary responsibility. The Clinical Director has been employed since 2012 and became the Clinical Director when an individual joined the staff as the Director of Youth Services. The individual who was the Director of Behavioral Services has been at LNC since 2010. He was recently transferred to serve as the Director of Adult Services given the retirement of the previous incumbent. Dr. Trudel reported there is no longer a need for the Director of Behavioral Services because Lakeview is instituting a team model for its behaviorists. The head of the Neuropsychiatric Intern Program has been there less than one year. The Director of Addiction Services recently resigned. The Director of Nursing has been at LNC for three years. The Director of Quality Assurance (QA) started in November 2014. The only other QA staff resigned in February 2015 and has not been replaced. Another key position was vacated in January 2105 when the Associate Administrator resigned. She was the Associate Administrator who worked directly for the Administrative Director. Dr. Trudel indicates this position is no longer needed.

I was able to interview one of the lead staff that resigned recently. His resignation was prompted by his concerns with Lakeview's lack of support or understanding of the ethical practices that guided his profession, the lack of administrative support and the lack of quality services. He was unable to get approval from the administration for clinical protocols he needed to establish for his program area. He served individuals with substance abuse and Lakeview did not have acceptable protocols for screening or medically supervised withdrawal. He was concerned with the impact of staff turnover and poorly trained staff. He was concerned that LNC does not have an Ethics Committee to review staff concerns.

These resignations and shifting of job responsibilities seems an indication of an agency that is struggling to remain viable. It is often

positive for an agency to change leadership in light of ongoing problem areas. However, Lakeview is not experiencing administrative leadership change in one weak area but in many areas within a relatively short period of time. Significant turnover has also occurred with Case Managers, the agency's source of contact and consistency for families, and with behavior specialists who are responsible to help individuals address the major challenges facing them. Lakeview needs to have consistent leadership, supervision, and management to sustain any significant changes to improve its quality. It will be more difficult to attract and retain clinicians, case managers and program supervisors if staff and new applicants fail to see consistency in the leadership of the agency and a clear direction communicated by the administration. It is of considerable concern that one of the two QA staff has resigned. Many of the elements of the POC are dependent on changes to the organization's approach to QA. I do not believe Lakeview currently has sufficient staff in this area to accomplish what it proposes to do. I will address this in detail in the Quality Assurance/Performance Improvement section.

## **B. Level of Supervision**

Lakeview is expected to assure sufficient staffing levels based on the acuity of need of the individuals. Reductions are to be made if clinically appropriate not because of resource shortages. Lakeview started clinical reviews for all residents in December to determine their needs for supervision and is now reviewing these supervision levels weekly through the Risk Management meetings. Various initiatives are planned to track and report on the levels of supervision.

**Findings, Analysis and Concerns:** This is an example of making a relatively straightforward task complicated to the point of being difficult to communicate, manage and review. Lakeview has re-assessed everyone's need for staff supervision. Lakeview plans to have Levels of Supervision reviewed weekly by Risk Management. It does not invest in or even reference the individual's team as the starting point for the review of an individual's need for staff supervision. Individuals who exhibit the need for individual supervision do not usually experience a decrease in that need over a short period of time. They are individuals who require the implementation of successful behavioral programs to

change or modify their behaviors over time before supervision levels can be reduced. This is not something that will normally change on a weekly, monthly or even quarterly basis.

It would make more sense to create a policy that supports the levels of supervision being established based on a thorough assessment of need and establishes the responsibility for the individual's team to review this semi-annually through a re-assessment of need and a review of behavioral data. A team would then be required to make a presentation to the Risk Management Committee if it believed the level of supervision could be reduced. Teams should review data more routinely to determine if an individual's level of supervision should be increased and have the opportunity to present its recommendations for the approval of the Risk Management Committee. The presentation by teams regarding these changes would be a more efficient use of the Risk Management Committee and would empower the individual's planning team to act on the person's behalf.

The POC references Level of Supervision (LOS) documentation forms, Shift Change Observation forms and attendance of QAPI staff at shift change meetings "to ensure the quality of the information exchange." They plan to do a random sample of shift change logs. I am unsure of the purpose of these forms or activities. Lakeview has limited QAPI staff and this is a questionable use of their time. Lakeview should instead vest the responsibility of assuring sufficient staffing with its program supervisors and clinical and program managers who are now responsible for evening and weekend shifts and hold these staff accountable for this critical responsibility.

It is beneficial to have more clinical and administrative staff available evenings and weekends to both add to the staffing compliment and to monitor that appropriate staffing levels are maintained. However, this does not assure sufficient staff to meet everyone's need for staff support. Lakeview does not address if it currently has enough staff positions filled to meet its current residents' needs for supervision on every shift. It does create an on-call staff pool but it is not clear if this is to address call outs and temporary staffing shortages or if there are not enough staff in its employ to fully meet current needs of its participants. The initiatives planned for staff training in the LOS policy, shift-by-shift

record keeping, and auditing does not address the essential issue of hiring and retaining the sufficient number of staff.

Lakeview needs to communicate the expectation that the LOS is maintained at all times. Supervisors should include in each shift report if and why this did not occur. There should be follow up and repercussions if the level of supervision was not provided due to staff shortages or for any reason that was not clinically determined.

### **C. Crisis Management**

DHHS expects Lakeview to comprehensively analyze its crisis management training and response to events to identify problem areas and inform the development of alternative strategies. Lakeview offers MANDT training to train staff in approaches to use with individuals who are demonstrating aggressive, self-injurious behaviors, or behaviors that will potentially harm others. Lakeview decided a few years ago to discontinue the use of physical restraint for which it deserves credit. It employed MANDT training starting in 2011 to train staff in safe holds and preventative interventions.

In its POC it commits to providing refresher training for support staff to be confident in their skills to prevent crises and de-escalate situations. It also commits to analyze data and study the pattern of responses to crises and train staff to improve in these areas. Lakeview has hired Durante Advantage Training certified in MANDT and Relias Training to provide web-based training on multiple topics. The Risk Management Committee will weekly review all program participants to address identified risks and LOS to predict and prevent crises. The remainder of the POC is about MANDT training and a process to debrief after any crisis. There is also a new crisis management process to be followed, which should improve the management of the crisis and appropriate and timely notice to families, funders and state agencies.

This section also addresses the expectations and role of the Crisis Response Teams. Lakeview expects to see reductions in the number of incidents and the reduction in the calls for the Crisis Response Team and if not will revamp the training. Changes are proposed for the Crisis Response Team so it will not impact individual supervision of others, will utilize the existing shift supervisors first and be sensitive to the

additional stimuli caused by the presence of extra staff during a crisis. Lakeview will use the data of the use of the crisis response system to determine if additional staff support is needed in some program locations. This is a positive change. Lakeview also commits to analyze the effectiveness of this response model and change it if it is not effective.

**Findings, Analysis and Concerns:** Lakeview has been using MANDT training since 2011 yet it is included in this section as though it is new training for staff. There is no assessment of what has or has not worked for staff and how to address these weaknesses, although Durante and Fedcap are reviewing past incident reports. Staff have reported to NYS Justice Center investigators that they do not feel confident dealing with individuals who are aggressive. From my review I do not find that there are effective strategies in place to prevent crises a part from MANDT training. There appears to be a lack of proactive or engaging programming for individuals outside of their day program. A lack of stimulating, meaningful and rewarding activity often leads to inappropriate behavior. There are a number of elopements, some of which have led to injury or exposure to the cold for individuals because there is no restraint of individuals or an alternative safe way to contain them in the program area. Lakeview is not assuring the safety of its residents at the current time and its plan for crisis management does not indicate improved comprehensive analysis or strategies to accomplish this.

There are numerous individuals at Lakeview who require 1:1 or visual supervision who live together in residential settings serving several individuals. This creates difficult situations due to the number of people in one setting, the constant presence of staff to help keep people safe, and the continuation of environments that do not provide for much privacy and do not help people to learn to rely on internal coping skills rather than the immediate intervention of others to control behavior.

Lakeview does have a policy that establishes the role of the Rapid Response Teams: Policy 3.15. It establishes a team of individuals who are available each shift to respond to a crisis or emergency. It includes staff who do not have responsibility for individual supervision during the shift. The availability of these staff is critical to keep individuals safe

who are in crisis while not reducing the supervision that other individuals require.

Another aspect of crisis management is suicide prevention. Lakeview Policy 7.12 is Suicide Precautions. It addresses most aspects of suicide prevention and has ongoing involvement of a psychiatrist or other licensed clinician. It should include a protocol for a room sweep of potentially dangerous objects (the policy states a check of clothing and personal possessions), clarity of arranging back up coverage for necessary staff breaks, and notification to individual's families, service coordinators or other out of state contacts.

Lakeview reports it should commit to assist staff to better prevent crisis. However there is no specific activity or plan in the POC to act on this commitment. There is no discussion of the individual's planning team's responsibility to design goals and objectives to address behavioral issues that can lead to behavioral crises or to even develop an individual crisis management plan. There is no reference to training staff in positive behavioral interventions and approaches. Relias Learning is mentioned as a training resource with no specificity as to what training they will offer and its relevance to crisis management.

#### **D. Incident Reporting**

DHHS expects Lakeview to develop a comprehensive program of staff training, monitoring, evaluation, data aggregation and analysis regarding the incident report system through its Quality Improvement function, and develop a quality plan to look at events and give insights as to who, when, where, and LOS staffing to inform program improvements.

Lakeview has asked Fedcap, Durante Advantage Training and the QA Department to review incident reports for the last year to identify patterns and need for training, program changes and supervisory attention. Recommendations were to be made to the administration by February 27<sup>th</sup>. The initial review indicated the need for MANDT retraining. The long- term action is to develop the Electronic Health Record (EHR) to support data entry of this information to support a comprehensive analysis and to produce QAPI reports. Lakeview plans to have the QAPI Department analyze the data and trends of incidents.

This will be presented first weekly then monthly to the Leadership Call, Operations Meeting and Risk Management Committee. Aggregate data will be shared with staff through staff meetings and written communication. Supervisors will be trained in April to effectively present this information to teams for the purpose of performance improvement.

**Findings, Analysis and Concerns:** There is no plan to address training staff in incident reporting or investigating incidents. The existing policy is not clear and should be both revised and shared with all staff through training.

The existing responsibilities for Incident Reporting are addressed in Lakeview's Policy 4.20: Behavioral Event Tracking. This includes responsibilities for general behavioral data reporting and more serious incident reporting, using a variety of forms. The reporting of behaviors for the purpose of monitoring and the reporting of incidents that are serious and require investigation, review and follow up should be in a separate policy. This would provide much better clarity to staff, with a focus and clear direction to staff regarding their responsibilities.

The existing policy requires reporting and investigation for Level III and IV incidents. The definitions for Level III incidents are confusing. It includes reporting incidents that are "not addressed by a behavioral plan and are increasing in clinical meaningfulness." Abuse, neglect is included under Level III and Level IV without specific definition for what is the distinction between the levels for this type of incident.

There is a comprehensive list of incidents, timeframes for reporting and completing investigations, and sharing the findings with external stakeholders. Lakeview does not require immediate notification to external stakeholders for Level III incidents, and is not specific about which Level IV incidents need to be reported. The policy states incidents "may require notification to state licensing and protective services depending on the nature of the incident." This vagueness does not offer proper direction to staff. There is no mention in this policy of reporting to families although Lakeview's Policy 4.24: Staff Practices Internal Investigation Process, state Case Managers will be told to report on a "case by case basis". There is no direction to inform Service

Coordinators for NH residents or the individual's Case Manager or Service Coordinator in other states. This policy (4.24) requires notification to the NYS Justice Center for NY residents, notification for school districts for any children or adolescents, but does not address notifying other states that have placed an individual at Lakeview. This policy lacks in transparency in its notification protocol.

The POC does not detail the purpose of sharing aggregate data with three different groups on a weekly then monthly basis. It is not apparent that Lakeview has thoroughly analyzed its weaknesses in incident reporting, review and follow up to most efficiently share information and most effectively use the lessons learned from the review of incidents. I am also concerned that the focus on training and retraining is on MANDT throughout many sections of the POC. This demonstrates a lack of understanding of the various aspects of training that staff will need. Incident reviews should lead the leadership to determine what clinical and programmatic areas of training are needed. Topics may include risk assessments and risk prevention training, positive behavioral intervention techniques, recognizing signs of abuse, etc.

This area of the plan and others bring issues to the attention of leadership, the Risk Management Committee, and the Operations Committee. The POC does not address the role that each of these groups has in reviewing this or other data that will be shared with them. This needs to be decided and clearly communicated to all committee members. Otherwise there will be a lack of clarity, potential for working at cross-purposes or leaving some responsibilities undone.

It places significant responsibility on the QA Department for data analysis, report preparation, communication and training. I question if the administration of Lakeview has analyzed the workload, timeframes and staffing resources to determine if all of the activities proposed in this POC can be accomplished. The QA Department has two QA staff positions of which one is vacant. The implementation of this plan is also contingent on having the EHR in place but no timeframe is provided.

## E. Acuity Level of Participants

DHHS requires Lakeview to ensure sufficient staffing as part of the process to determine if it can admit prospective program participants who require high levels of supervision. DHHS directs that the Director of Human Resources or designee participate in the admission process.

Lakeview took steps in December 2014 to review the acuity levels for all of its participants. It determined that six individuals had high acuity levels that were difficult to consistently meet. Lakeview is working with their funders to find alternative placements. One individual was placed at Crotched Mountain in 2014. Dr. Trudel reported on discharges that occurred from January – March 2015. A total of eleven individual have been discharged, five of whom were placed by New Hampshire. Two from NH were transferred to Florida. One went to Neuro International and the other individual went to the Florida Institute for Neuro-Rehabilitation (FINR) and the other three were transitioned to community settings. New York has transitioned three individuals. The remaining three individuals were from Maine, Massachusetts and Virginia.

Lakeview will submit monthly discharge reports to HHS until further notice. A HR staff will participate in the admission review process, which will also assist the HR department to target its recruitment efforts. Lakeview is using a more comprehensive risk assessment process to review individuals who are referred. Staff will be trained to use the new assessment tools by March 1, 2015.

**Findings, Analysis and Concerns:** It is a reasonable approach to assess the needs of individuals to determine how many participants can be successfully served and kept safe with the number of staff that are available. It is unfortunate that not all individuals are not being supported to transition to a community program in their home state. New Hampshire has directed each of its Area Agencies to plan community transitions for the individuals from NH that have been placed at Lakeview. The lack of suitable community alternatives is evidenced by the choices of FINR and Crotched Mountain as the placement alternatives. The lack of community alternatives in New

Hampshire and other states is why Lakeview continues to serve individuals for extended periods of time and to receive active referrals.

I interviewed the guardian of the gentleman who was placed at FINR who Lakeview reported as having significant medical issues. This man had an incident in late January at Lakeview because he was refusing to take his medications including those that control his seizures. He had a grand mal seizure lasting several minutes. He was hospitalized and required tube feeding. Lakeview told the guardian he could not return to Lakeview. The guardian worked with the hospital discharge planner and the insurance company to find another placement. She did not receive any assistance from Lakeview or the Area Agency. She could not find a program in New Hampshire. She spends part of the year in Florida and was pleased to have the FINR program accept him after failing to find any appropriate community setting to meet his needs.

I was provided the list of individuals residing at Lakeview in December. At that time there were 20 individuals placed from NH of whom six had resided at LNC for more than two years. Maine had ten residents of whom nine resided there for over three years. Maine has an initiative to return its citizens placed out of state to Maine. New York had six individuals at the campus, one of which was there over six years and the others placed within the last 12-14 months. Pennsylvania and Connecticut are other states with a number of people at LNC. PA has eight current placements, two of which have lived there over 12 years. Connecticut has only used Lakeview within the past two years. They fund six individuals at LNC.

I do not have concerns about Lakeview's plan to reduce its census and refocus on improving its staffing ratios to better support its existing residents. As long as positive alternatives are not developed in New Hampshire and the other states that refer individuals to Lakeview, individuals placed at Lakeview will have protracted placements and will not experience opportunities for community living and participation.

#### **F. Assessment, Treatment Planning and Documentation**

DHHS requires Lakeview to assure that treatment and behavioral plans are modified in "real time" when there are significant changes in the individual's condition and behavior.

Lakeview recognizes its lack of effective communication between DSP staff and the clinicians. I found strong evidence of this problem from my record review and my interviews at Lakeview. The administration has already reassigned clinical staff to work 3-11 weekdays and on weekends. Durante Advantage Training is observing staff-participant interaction and determining how information is exchanged between clinicians and DSPs. Lakeview is proposing a new clinical model to extend the programming day and sets clinical goals. A new bio-psychosocial assessment is planned for use to help plan for community living. Lakeview suggest three types of placement:

Track 1: 45-60 day short term stabilization and treatment planning

Track 2: up to 180 days for stabilization through medication trials, behavioral interventions, and habilitative strategies

Track 3: more than 180 days for individuals who are lacking an alternative permanent community placement

Lakeview envisions working with the sending community agency to provide necessary behavioral and clinical supports in the community to address the existing gaps for the individual and assist the community partners to build the community capacity. Lakeview will also offer emergency response to insure individuals do not have to return to the facility.

Lakeview includes a clinical model for service delivery and plans to institute a person-centered planning process. Staff will be trained in the new assessment tool and the clinical model. QAPI will randomly sample treatment plans and behavior plans.

**Findings, Analysis and Concerns:** This area is at the heart of the systemic weakness for Lakeview. I found little active programming in the residential settings during my tour of the campus. The five records I reviewed supported this finding. There is a lack of meaningful engagement for individuals and scant use of natural learning opportunities. Plans focus on behavioral treatment rather than on assisting the person to both modify his or her behaviors while building skills that will increase independence and provide the basis for successful community living. Individuals do not get to do meal planning, shopping or meal preparation even though there is a working kitchen in

each cabin. Instead they are encouraged to eat in the dining hall. There is a central laundry so few are taught this basic skill for community living. There is no assessment of community living skill needs or strengths and little opportunity to interact in the local communities with the occasional exception of fast food dining. There is little discussion or planning for individuals vocational or volunteer pursuits. I visited cabins during the day and one in the evening. Mostly I found individuals sitting or lying around not engaged in any activity or social interaction with the exception of watching television. This is particularly disheartening for the individuals who have lived at Lakeview for many years.

Lakeview has included a graphic representation of its new clinical model. It lists clinical goals which is a general list including enhanced communication, improved problem solving, enhanced mobility, improved social skills, effective cooperation, enhances self-care, self-soothing skills, improved academic skills and development of cooking skills. Treatment strategies include a number of program groups, PT, OT, and ST, ADLs and sports programs. This is not a complete list of skill areas that any one participant may need to develop for community living and it fails totally to address employment skill building. There is no reference to any individualization of programming or how Lakeview is going to engage in person-centered planning. The individual team is not described and the important role of the case manager to coordinate planning and facilitate service delivery is not addressed. There also is no articulation of how the individual, family and external Service Coordinator is involved in person-centered planning.

Lakeview plans to train all staff on this new assessment tool and clinical model by March 2015. The model is not adequately thought out or described. Training will need to be extensive and delivered by individuals who understand and have experience with person centered planning and habilitative service delivery. Lakeview has not demonstrated that it has the staff expertise in either of these important topic areas. It is also concerning that the behavior plan and treatment plan continue to be referenced as separate plans. This is further evidence that the administration of Lakeview does not understand habilitative programming or the interdisciplinary or transdisciplinary

models of service delivery, both of which ensure the integration of all services the individual receives.

Changing the organization to one that engages in person centered planning and meaningful habilitative programming requires a shift in the organizational culture for managers, clinicians, educators and direct support staff. Working in a transdisciplinary model requires significant changes in the behaviors and interactions of clinical staff and a focus on training, mentoring and supervising DSPs who will have the majority of responsibility to carry out new programming. This will not be accomplished quickly or without a significant allocation of resources, thoughtful planning, clear and ongoing communication, extensive training and ongoing mentoring. There will not be implementation of a new model within a month or two of developing the POC.

The change in the work schedules of the behaviorists and managers is an excellent first step to improve evening and weekend programming and interaction between participants and staff. The plan to more regularly review the implementation of behavior programs and make changes if a strategy is not working is also a positive step. However there does not appear to be a clear reason or explanation of the change of schedule for the behaviorists. Are the behaviorists responsible to observe the implementation of behavior interventions, take data for review by the team, train staff, and/or intervene to help manage behavior? It is important that the administration clearly articulate the role to both the behaviorists and to the residential staff so all understand the rationale for the change.

I do support Lakeview's plan to have three tracks for admission and focus on short-term stays that help stabilize individual's behaviors and review their use and need of medication, if New Hampshire decides to maintain LNC as a licensed facility either for the short or long term. Lakeview's plan to work fairly immediately with its referring entities to plan for eventual discharge and to offer its expertise to address gaps in community programming is worth consideration. Lakeview's strength is that is able to maintain individuals who exhibit dangerous behaviors that are a threat to themselves or others. Families who are positive about their children's experiences at the campus find great relief and

support to finally stop worrying daily about the potential for their children to be abruptly discharged from yet one more program.

Lakeview is able to maintain individuals in part because of the behavioral programming but in large part because of the setting. Individuals are not contained in homes or program areas but have much greater freedom to traverse the acreage in relative safety than they would in a typical community setting. Community agencies will need to determine if Lakeview has the expertise they lack and need to effectively transition someone to a community residential setting.

Lakeview should only be considered a short term residential placement focusing on stabilizing individuals' behaviors, teaching them new behavioral strategies and coping skills and preparing them to be able to transition to a community setting and begin learning community living skills or utilizing skills that were weakened by challenging behaviors.

#### **G. Medical Records**

DHHS requires the organization to have a more robust process for medical record audits and to utilize an Electronic Health Record (EHR). Lakeview's commitment to have the EHR by the second quarter of the year is valuable in addressing this issue. Records will be audited regularly and the results used for quality improvement.

**Findings, Analysis and Concerns:** This was not an area that I undertook in my review. The approach to address this deficiency appears to be solid. There is a staff position in the QA Department devoted to Medical Records. Lakeview appears to have sufficient resource in this area to implement the POC in the time period proposed.

#### **H. Communication**

DHHS expects Lakeview to assure the safety of participants and staff. The organization needs to make critical behavioral and clinical information available to DSPs and other staff. Lakeview is making all supervisory and clinical staff available to debrief at change of shift. All staff members also have computer access for agency email and to access the EHR when it is available. Lakeview started house meetings in January to include staff and participants. Long-term solutions address

general communication with DSPs, training on the use of information in the behavioral plan and greater interaction between DSP and clinicians. Greater focus is being placed on sharing the plan with all involved staff and to communicate the goals of the plan.

**Findings, Analysis and Concerns:** The strategies in the POC should address the needs of the DSPs to have more timely information about critical behavioral and clinical issues. It would enhance the organization's ability to achieve this goal if it clearly sets an expectation that any incidents and changes in health or behaviors are reviewed at the change of shift debriefing.

The POC and the DHHS survey finding focuses on this one aspect of communication. My review has led me to have other concerns about communication. I did not find examples of effective communication to all staff when first conducting my interviews. I think the all- staff meetings; efforts to provide written updates and the presence of administrators on evenings and weekends will help in this regard. Lakeview needs to develop a consistent and well -articulated message about its mission, philosophy and direction to set a context for staff to understand and embrace the changes that are being made. Staff must also have the chance to express concerns, share ideas and believe they are being taken seriously. Lakeview's indication in other parts of the POC that they will listen to staff and respond to concerns is positive as long as it is consistently implemented.

Lakeview's communication with its participants, families, funders and external service coordinators is uneven. Some families report positively about the organization's efforts to communicate and others report it is not timely or thorough. Families generally find the monthly planning meeting for each individual cursory and not scheduled at the convenience of the individual or family to participate. (A full summary of family concerns is in Section III.)

I spoke with two states that refer individuals to Lakeview. One reports positive interaction and communication and the other reports untimely reporting and a lack of responsiveness.

There is no participant advisory or family advisory committee. Lakeview would benefit from creating advisory councils for the purpose of sharing information and seeking input as to both satisfaction and how to improve the quality of services.

### **Medication Management and Health Services**

DHHS is requiring the organization to do a medication analysis on medication errors or adverse events. DHHS expects medication errors and adverse medication events to be reported within 24 hours. DHHS expects Lakeview will develop a comprehensive system to evaluate its medication management issues that utilizes its contracted pharmacy as a primary resource. It must assure it is following providers' orders. Lakeview has a plan and has already initiated an audit completed by the Director of Nursing to establish a baseline. The Director of Nursing will continue these audits and the QAPI sub-committee will be involved in observing medication pours quarterly. Training will be provided as needed. Policies that follow state and federal regulation are in place and reflect the expertise of the consulting pharmacy.

**Findings, Analysis and Concerns:** I interviewed the Director of Nursing when I was on campus. She has worked at Lakeview for three years and has revamped the nursing department. She has intensified training, adjusted schedules, strengthened medication administration, streamlined documentation and established quarterly markers for areas of concern including medication errors. She has addressed nursing on call and requires nurses to attend the staffing meetings and participate in goal planning. She brought in an outside consultant to review changes in staffing, training and protocols. The nurse consultant's report was very positive about the changes the Director made.

I do not disagree with the POC developed by Lakeview but do not find that there are sufficient staffing resources in QA for the QA Director or staff to be engaged in observations of medication passes. The Director of Nursing should be held responsible for these audits and to present her findings and recommendations for any corrective action to the QAPI committee. She should establish performance objectives using the baseline information she now has. The QAPI committee can review these action strategies and determine if they are sufficient.

The POC does not include any information about the number of medication errors found in the baseline audit or the reasons for the medication errors. It does not set a performance expectation or indicate the targeted training that will be needed based on the initial audit performed in January.

#### **I. Life Safety and Environmental Issues**

The Licensing Team that visited the facility in November 2014 did not address life safety issues. That inspection was to review clinical and program issues. DDHS shared the summary of its Life Safety Inspections from 2011, 2013 and 2014. There was no report from 2012 so I do not know if an inspection occurred that year.

Site visits by Licensing from 2011, 2013 and 2014 show repeat citations under He-P 807.24(a) Emergency and fire Safety for years 2007, 2008, 2009, 2010, 2011 and 2013. Repeat citations range from simple fixes (replacement of door latches) to highly dangerous situations, i.e. sprinkler system issues, broken doors and cracks that would allow superheated gasses into bedrooms in the event of a fire, exposed wires, open junction boxes, etc. Lakeview demonstrated an inability to make all necessary corrections on a timely basis and develop a preventive maintenance approach to ensure life safety concerns did not re-occur. Some of these citations point to concerns that put residents at safety risk.

Licensing did not share the report of its 8/17/2011 inspection with Lakeview until 1/8/13. David Armstrong sent the POC to Licensing on 1/25/13. Lakeview had addressed many of the citations on its own in 2012 but a number of the citations were not corrected until the report was received in January 2013. These included a number of areas where wires were exposed and lacked box covers and areas that were padlocked that could block egress in the case of a fire or other emergency. Inadequate sprinkler system coverage was not addressed in some areas until 1/13. Licensing contributed to a lack of physical safety when it did not submit its citation report to Lakeview for 17 months.

I was able to tour most of the program areas and many of the cabins when I visited the campus in December 2014. I was struck by the lack of cleanliness. Bathrooms were not well cleaned and residents did not seem to be expected to keep their own rooms neat. Living rooms were very stark and were not homelike or inviting. All areas were very sterile with little personalization or decoration. Lakeview staff cites that it is very difficult to create or maintain a home environment because of the impact of individual's behaviors on their living space. I have found numerous providers in community programs who are able to address the challenges presented by the individuals they serve and offer inviting homes in which these individuals live. It takes some creativity on the part of an organization to research durable but attractive furniture, wall coverings and decorations and to train staff to maintain these settings as homes. It is very possible to create an inviting environment that individuals enjoy living in if an organization places a value on creating a welcoming home setting. It also provides an opportunity for individuals to learn how to care for their home and to take pride in it. I saw minimal attention to this aspect of residential services at Lakeview.

## **J. Quality Assurance and Performance Improvement**

The state had four findings in this area:

1. The organization needs to continue to develop its QAPI program using nationally recognized QAPI methodologies.
2. All aspects of its organizational functions need to be identified elements of the QAPI program to ensure a cultural shift to a QAPI process.
3. The organization needs to develop a comprehensive program of staff training, monitoring, evaluation data aggregation and analysis regarding the incident reporting system through its QAPI function, and implement Root Cause Analysis for significant incidents to develop a deeper understanding of inter-related systems.
4. The organization needs to assure that the EHR implementation will be closely linked to QAPI methodologies.

**Findings, Analysis and Concerns:** Lakeview's response does not display meaningful understanding of how to establish an effective QAPI

process. It includes a lot of verbiage about QAPI including root cause analysis and the need to involve stakeholders. It speaks about having the right data rather than “data that merely adds to the noise.” It indicates leaders should establish priorities and benchmarks for performance improvement. It refers to data driven decision- making and reprioritizing performance improvement activities. It gives one example of the QAPI process for incidents and suggests all staff will be trained in the QAPI process by March 30, 2015. By June 30, 2015 the QAPI system will be fully operational.

It does not clearly articulate a full understanding of establishing a Quality Assurance and Program Improvement that embodies best practices. No benchmarks or performance measures and performance expectations are set. Lakeview reports it is still collecting data for most areas but does not share or use the existing data to set performance expectations for any area in which correction is needed. It places significant responsibilities on the QA Department with a staff of 1 and a vacancy to be filled, and on the QAPI committee. There is no analysis of whether there are sufficient resources to successfully implement these new initiatives and responsibilities. The actual role and responsibilities of the QAPI are not clearly described. I find that the responsibilities of the actual managers to analyze data, make recommendations and implement them are missing, although may be intended.

Using data to truly determine an organization’s strengths and weaknesses and using this data to set performance expectations is key to a successful QAPI system. I do not find that Lakeview demonstrates an ability to distinguish which data is critical and necessary to its QAPI efforts and which data elements will merely add to the “noise”.

Another crucial element of a strong QAPI system is consumer/customer satisfaction. Lakeview’s POC includes efforts to reach out to staff, include them in decision making, and listen and respond to their concerns. However, there is no mention of any meaningful engagement of participants, their families, or their funders in determining satisfaction and areas for improvement. It is impossible to have an effective and successful QAPI system without listening and responding to an organization’s customers. Lakeview shows no understanding of

the importance of seeking the input of those it serves and should be most responsible to satisfy.

Lakeview commits to significant training regarding QAPI throughout the Plan of Correction, and on a variety of topics. Training is needed in the new clinical model, incident reporting and analysis, and the various aspects of QAPI including new staff and committee expectations. Lakeview expects to complete the vast majority of this between now and June 2015 with much of it occurring by the end of March. They have not submitted any training outlines, curricula, training schedules, or trainer information. Lakeview is proposing to radically shift its organizational culture and dramatically increase and change staff responsibilities at all levels. I think the timeline they have set is unrealistic and am unconvinced that they have thought through all of the training elements.

I also want to comment on the plan to conduct a Root Cause Analysis for every Level III and IV incident. The state is requiring this and Lakeview is responding. I have participated in RCA training and oversaw staff that conducted these analyses during my tenure as Deputy Commissioner of the Department of Developmental Services in Connecticut. It is normally used for a sentinel event, such as a tragic death or significant abuse; or in response to a series of similar incidents, i.e. serious choking incidents within a residence, that may have underlying and systemic causes greater than the neglectful or abusive action of particular staff. It relies on an investigation being conducted and the subsequent of involved staff, supervisors and relevant stakeholder to conduct a review of the sequence of events that led to the incident; and review relevant protocols, procedures, policies, training and other related agency communications.

The expectation of DHHS that Lakeview will conduct a RCA for every Level III and IV incident seems to be a mis-application of this very valuable process. Each one of these incidents should be thoroughly investigated and the findings shared with relevant staff for the purpose of immediate corrective action and for system improvement. Many of these incidents may be the result of a particular staff's inappropriate action and may show the need for retraining, increased supervision or disciplinary action. The incidents may not be the result of a systems

failure or indicate the need for systems improvement. Conducting a true RCA for each incident will take significant resources and has the potential to dilute the process of discovery and improvement that is inherent to root cause analysis.

I conducted a follow up interview with representatives of the NH Area Agencies on 3/11/14 to discuss these entities' responsibilities to monitor the services their consumers receive from Lakeview. (These monitoring responsibilities are addressed in my second report.) Each Area Agency has only a few individuals served by Lakeview at any one time. Area Agency Directors report that they did not use Lakeview significantly until the last five years. Most of their interactions with Lakeview were around one-three individuals at a time. The Area Agencies began to collaboratively examine data and concerns through the Community Support Network, Inc. (CSNI) in November 2013 and started communicating concerns as a group in January 2014. They summarized these concerns in writing in February 2014 to which Lakeview responded. The concerns included: incident reporting, staff communication within Lakeview and with the Area Agencies; a pattern of not meeting timelines and deliverables; follow up on corrective actions; staff retention; and police involvement. Lakeview provided a correction plan. CSNI began regular visits to Lakeview in April that are made daily since October 2014.

Initially the Area Agencies and CSNI noted improvement on the part of Lakeview. However they are seeing a decrease in Lakeview's ability to respond to and follow up to complaint reports, submitting progress notes monthly as required, and submitting incident reports within 24 hours as required. The quality of incident reports especially for follow up has decreased. Complaints are not responded to timely or thoroughly. The Area Agencies remain concerned about the sufficiency of staff to provide the supervision needed. They note that they see insufficient staffing several times per week. A letter sent dated March 12<sup>th</sup> stating these concerns and requesting a response by April 1, 2014.

I note this information because I think it is evidence of Lakeview's continuing inability to sustain corrective strategies and the improvements it needs to make. Submitting reports and information in a timely manner and responding to complaints are basic expectations. It

is troubling that in this period of intense scrutiny and heightened expectation to perform that Lakeview is unable to adhere to minimal standards, has not improved but rather lessened the quality of its follow up responses and continues to not address the staffing needs of its residents.

### **III. Family Forum and Interviews with Families of Lakeview Participants**

I have had the opportunity to speak to many family members who have children who are currently residing at Lakeview or who have been served there in the past. Lakeview provided a mailing list and I contacted over 60 families and Public Guardians. I invited them to attend a Family Forum I was conducting in January 2014. I also offered to interview any families who could not attend the forum. Following is a summary of the forum and of the telephone interviews I conducted. I also received an email response from one family.

The Family Forum was held on January 21, 2015 from 3 PM to 6 PM in Concord NH at the State Office for DHHS. The forum was attended by eight family members and guardians for individuals who are either presently residing at Lakeview or once resided at Lakeview. A lawyer representing four families also attended. The intent of the forum was to allow for a dialogue about the strengths and weaknesses of treatment provided at Lakeview from perspective and experience of family members. In order to create a structured dialogue an agenda was created that included the following topics:

- STRENGTHS OF THE LAKEVIEW PROGRAM
- COMMUNICATION WITH/FROM LAKEVIEW
- RESPONSIVENESS TO FAMILY CONCERNS
- THE BENEFITS OF LNC FOR YOUR FAMILY MEMBER
- CONCERNS ABOUT THE QUALITY OF CARE AT LAKEVIEW
- RECOMMENDATIONS FOR IMPROVEMENT

During the Overview portion of the agenda there was a review of the Ground Rules, which emphasized the following:

- All information provided during the forum would be confidential
- Information gathered during the forum will be used in conjunction with other sources of information in developing the findings and recommendations but will not identify any family member or guardian
- All opinions about Lakeview will be respected
- Participants of the forum will not challenge other families' opinions or recommendations
- Everyone will be given an opportunity to speak on each topic. Participants were asked to limit their comments to a 3 to 5 minute period in order to give ample time for all and to maintain a conversational environment

This next portion of this section provides a summary of the feedback received from families. The summary is presented in the order the families chose to share their impressions of Lakeview.

#### **A. Concerns about the quality of care at Lakeview**

The group voiced concerns here that had themes, which are directly related to health and safety, abuse and neglect, medical neglect and community experience. The events and incidents families recounted were remarkably similar.

Staff Development was described as extremely poor to non-existent in some cases. Direct care staff were described as poorly trained; neglecting individuals basic needs; neglecting medical and dental needs; inconsistent in the implementation of behavior programs or not implementing at all; admitting to not being trained on behavior programs but placed in coverage; 1:1 coverage rarely in place, punishments being dealt out to individuals who did not listen to directives, i.e. bedding being taken away, birthday celebration being cancelled; examples of extreme weight loss never being reported to the family; low staffing ratios that created a danger to individuals and staff

alike and which is also a contributing factor negatively effecting the ability to provide community experiences.

Behaviorist's credentials in some cases were questioned. Families questioned if some interns were doing the work of a fully qualified and experienced behaviorist without the proper supervision. The high turnover rate for this group was also a point of serious concern and contention. The group pointed out that this department never was fully staffed and attributed the turnover rate to the workload carried by the behaviorists on staff. They also saw this as a major contributing factor to the lack of training, oversight and proper and consistent implementation of behavior programs by the DSPs. They talked about one cabin that went 12 to 18 months without a Behaviorist assigned. In addition they supplied examples of when other family members went without a Behaviorist assigned for periods of time intermittently. Also, it should be noted that a consulting Ph. D. was cited as providing some excellent work but the programs that were developed were never consistently implemented due to staff turnover.

Psychiatric oversight and services was not only a significant concern but was coupled with what the group believed to be a planned effort on this departments' part to willfully withhold and hide information from them. The parents and guardians cited a large number of incidences of overmedication and sedation. Parents and guardians also had no knowledge of when psychiatric med reviews were done, the frequency of these reviews, who was in attendance at the reviews, the format for the reviews and even more troubling to them was that they were never apprised of the result of the med reviews. Equally as troubling was that any request for the results of these reviews were never met. There was also an experience they shared in which an APRN represented himself as an MD in person and used the MD in his signature.

Physical Therapy services were brought into question from the standpoint of being recorded and reported as being delivered but were not delivered on numerous occasions. Evidence of this concern was verbal reports from staff to parents and guardians as well as a witnessed event by a sibling. In this instance the PT became quite flustered when challenged and used HIPPA regulations as the excuse not to have any further conversation.

Physical Plant issues centered around health and safety as well. Families consistently reported extremely filthy conditions in bedrooms as well as bathrooms. Requests to see bedrooms and bathrooms after making complaints, yet assured situation was remedied, were either denied or the parent was only given a few minutes to view the room. Repeated complaints to repair areas that are dangerous and pose high risk to those individuals with even minor ambulation problems have gone ignored and continue to exist.

## **Section B. Communication with/from Lakeview**

Families described communication as inconsistent or lacking with the most troublesome description being as a culture of avoidance with active efforts to conceal information. These communication concerns spanned all departments including the administration. Intra-agency communication and coordination between and among disciplines was described as very poor. Key personnel changes are not communicated in a timely fashion or with a personal touch.

Case Management, which is a cornerstone of coordination in any system, was depicted as an extremely poor service fraught with problems. Overall quality and effectiveness for this department was rated between a 1 and 2 on a scale of 1 to 10. The basis for service delivery for individuals is their Individual Plan (IP). The IP's were described as very poorly done if at all and when done were plagued with very poor recordkeeping and information from other departments consistently missing. Families did not feel most Case Managers were totally prepared for meetings. The materials families needed to review for monthly meetings were not sent on time. Monthly meetings were conducted unprofessionally and rarely started on time. Families were not offered convenient times for the monthly calls. When the family requested convenient times they were denied. Key personnel from Lakeview were rarely in attendance, many cases cited where parent/guardian either were not invited or never informed of meeting date and time and many examples cited were a Lakeview staff member was rude or dismissive, i.e., "We only have 30 minutes and 20 minutes is allocated to our presentation". Families reported the questions they asked were often ignored.

Case Management is also victimized with high turnover and difficulty attracting candidates to fill vacancies. Again turnover attributed to poor ratios resulting in work overload. A case manager left in October and the departure was not shared timely. Lakeview then assured the families/guardians affected that the Director of QA, in addition to his QA responsibilities, would cover the vacancy. This resulted in case management duties not being met.

In reference to Incident Reports, case managers failed to communicate at all or in a timely fashion, refused to mail copies of the reports, said they emailed but many times it was never received by parent/guardian, or could not be opened and the request to help them open the attachment was met with responses of, "must be your system", there is nothing I can do to help you" or "let me send it again". Many parent/guardians still did not receive incident reports after numerous requests. Families interpret this as an active effort to conceal information about abusive and/or neglectful situations.

Some of the families pointed out that they were acting as case managers in the transition process for upcoming moves out of Lakeview. They detailed all the coordination work they were doing with the receiving agency, attempting to communicate with Lakeview staff in reference to the coordination of paperwork required for the upcoming move, how they were left to find contact information for the receiving agency, and how Lakeview staff did not show up for transition meetings. Some of the families who discussed this were from NH that brings into question the involvement of the Area Agency Service Coordinator.

The Medical Director was described as stonewalling requests for information, refusing to speak to some parents/guardians and being curt and condescending to others. Medical appointments, medical reviews and the results of appointments are not being communicated to most families at the forum. Many medical and health issues appear to be neglected without accountability assigned. An extremely troubling event supporting these claims was in the area of Podiatry. An individual was injured and a prescription was written for a special boot. It took Lakeview 12 to 18 months to accomplish the task of completing the needed appointments and acquiring the boot. The terrible result of this

neglectful occurrence is that the person was ambulatory prior to the injury and now has very limited mobility.

### **C. Responsiveness to family concerns**

Lakeview's responsiveness is in great part addressed under Communication. This area may touch upon some of the above but it will generally be focused on the concerns with Community Experience and Lakeview's non- responsiveness to concerns voiced by families.

Again it was unanimous among the group that Community Experience was non-existent in not only all of the IP's of those represented at this forum but appeared to not be meaningfully available for the entire population living at Lakeview. Requests to case managers and Behaviorists to have community experience built into the IP were either ignored or when put into the IP not implemented. Families reported that trips to Dunkin Donut were the preeminent idea for community experience. Staffing shortages was the defacto reason given time and time again for Lakeview not implementing community experience opportunities. No reasons were given for the lack of innovativeness. When a family member attempted to provide some type of community experience they were at times hampered by poor coordination efforts by Lakeview staff; a refusal to let the individual leave the campus when the parent/guardian showed up for the prearranged visit with no good reason being given; and failure by Lakeview staff to contact a parent/guardian to tell them individual would not be able to leave the campus. Complaints to administration surrounding these events resulted in no positive response.

Some families repeatedly requested to observe activities in the Young Adult room were continually denied with no reason being given, repeated requests for some privacy during phone calls were also denied. Another particularly troubling event disclosed is the repeated request to develop a behavior program to assist an individual who has great difficulty transitioning from phone calls and visits. The individual in question typically becomes quite aggressive toward self and others at the end of phone calls and visits with family members. The requests have been made repeatedly at monthly meetings as well as via calls to the behaviorist. To the date of the forum no program was yet developed

and the individual continues to have difficulty in the transition process putting themselves and staff at significant risk of injury.

#### **D. Benefits of Lakeview for your family member**

Only one family stepped forward with a positive comment. They described their family member as experiencing years of multiple psychiatric hospitalizations, placements and receiving a wide variety of psychiatric medications with inconsistent and widely varying dosages. All of the mentioned experiences left this family member suffering from extreme lethargy and a variety of side effects from the multiple medications and side effects from these medications. Lakeview was very successful in significantly reducing the number of psychiatric medications and accompanying dosages of these medications. They also described the coordination between and among psychiatry, nursing and behaviorists as exceptional and the communication with the family, on this issue, as also exceptional. Unfortunately this family could not give another example of a positive occurrence with Lakeview.

#### **Section E. Strengths of Lakeview**

It is noteworthy that the first comment made was made simultaneously by a number of people and it was "nice view". When asked to list more strengths the request was following by a significant period of silence from all in attendance. Eventually the following was cited and it is the order families responded:

- Dave Armstrong was always available to us. He took our calls and followed through as promised with return calls and information.
- Elaine was always doing more assisting with ADL's
- Carolyn is the first person you meet and she creates a great first impression
- Monty Three has consistent weekend staff
- Nurse Kate is an exceptional caregiver, keeps accurate and up to date records. Her communication with parents/guardians is timely and thorough and she appears to provide the same level of communication internally

- One behaviorist (no longer employed and resigned due to workload) always went above and beyond.

## **F. Recommendations for Improvement**

The families did not make any recommendations for improvement. Only two participants commented in response to this question. There comments were:

1. Close the doors.
2. The place is a spider web of issues.

## **H. Family Interviews**

I conducted telephone interviews with 6 families and one Public Guardian, and a face-to-face meeting with another family. I received a written summary from one family. There is a greater range of opinion and satisfaction among this group.

Family 1: One parent was just transitioning her son after 15 years at Lakeview, with other unsuccessful community trials and returns during that time. She reported it was a wonderful experience for the whole family. LNC staff were very supportive during his father's extensive illness. They visited often and were positive about the communication with staff. LNC was successful in addressing his behaviors. As a result he is more accepted by the children in his family who now want to spend time with him. She thought highly of the medical and psychology staff and felt the DSPs were well trained. LNC was actively involved in planning this community transition for him.

Family 2: I interviewed a mother and personal advocate who was originally her conservator but is no longer serving in that capacity of a young adult who is currently at LNC. They are deeply concerned with her care and the lack of services for her. She has a medical condition that they report is not being thoroughly evaluated or treated. The advocate had to replace her broken glasses because Lakeview did not after she was without them for four months. (She does not have Medicaid coverage in NH and comes back to her home state for any tests and medical appointments.) They complained about the competency of

weekend staff and the lack of any meaningful activities on the weekend. LNC has removed her phone after she called her mother about an incident and her mother called the police. They believe she should have counseling for a past sexual assault and are concerned she is not receiving it. Communication between LNC and the family is poor.

Family 3: The daughter of this family has been at LNC for 12 years. Her family visits every other weekend and talks to her daughter daily. They don't get to meet other families and have asked LNC to establish family meetings or support groups. LNC has not responded. Her daughter receives 1:1 supervision. She participates in the monthly calls and finds them generally useful but also relies on her daughter's reporting to her. She was completely satisfied for the first 5 years of the placement at LNC. She reports it then went downhill because of staff turnover, especially in the last year. Her daughter's behavior regresses because of staff inconsistency. She wants the administration to take action to improve this. She reports it has been spiraling down quickly during the past six months. She is sending numerous emails and not getting adequate responses to her concerns and questions. However notes they make some effort to change what she doesn't like. She thinks they struggle with the 3-11 weekday shift. There is no staff consistency and good staff have left or been transferred. She wants to see better-trained staff so she can stop worrying about her daughter and wants more staff consistency so her daughter can be part of the community. Overall she likes LNC and has not found another suitable place for her daughter that can meet her needs and keep her safe.

Family 4: This family transferred their daughter as a result of substantiated allegations of abuse and neglect, dissatisfaction with the services LNC provided, concern with LNC's communication and their poor interactions with the family. The cabin environment was unclean, unsanitary and devoid of appropriate furnishings. Programming was inadequate or inconsistently offered. Her daughter was left alone in her room instead of being offered the activities and interventions that were part of her plan. There was serious communication breakdown between LNC and the family. The family did not feel respectfully treated or supported to interact with their daughter when they visited. This family lives out of state. They have brought numerous concerns to the

attention of DHHS in terms of life safety, licensing, protective service and human rights, which they report are not addressed.

Family 5: A mother wrote to me who has had her son at LNC since 2009. She was positive about his placement reporting it is the first successful placement he has ever experienced.

Family 6: One family has had their son placed in NH for four years of which the last 2½ years has been at LNC. They live in a distant state. He is a student at LNC. The family reports it is the first school to be able to academically engage him since he was in the 5<sup>th</sup> grade; he is now 18. He attends school regularly, has become a reader and is offered online courses. They feel he is safe and wish they had discovered LNC earlier. They talk to him most evenings and see him several times each year. He is able to come home and they travel to NH. They cannot say enough positive things about Dr. Lewis. They participate in the monthly calls. Their one concern is about the staff turnover. They have experienced changes in case managers but their son has had a consistent behaviorist. They believe the psychiatrist has been instrumental in titrating their son from high levels of medication. The nurses call regularly with any medication changes or health concerns. Some other disciplines do not communicate as effectively. They feel the behavioral approach is successful and consistent and teaches social ramifications of behaviors. This is currently the least restrictive setting for their son. They hope to transition him back to their community but will need to design something unique and probably have him at home with supports because there are no appropriate programs in their state.

Public Guardian: The Public Guardian has been the guardian for three individuals who lived or live at LNC. One woman is now living in a community program in NH but lived at LNC starting in 2013 when she turned 21. She had to leave her school program and there was no response to the Area Agency RFP to serve her in a community setting. LNC did stabilize her behavior and kept her engaged in activities. Her transition to the community was well planned and supported by LNC.

Another woman is still there who she feels doesn't need LNC but was supposed to be there for 6-12 months while the Area Agency develops a program for her. She has been there three years. A program is now

under development. LNC stabilized her behaviors and got her off some medications but she has been left there too long. She was assisted to visit her family, has a job in the campus kitchen and had a good case manager who has since left LNC. LNC tried to transition her to one of their community programs but it was disastrous.

The third woman has very dangerous behaviors. She is also at Lakeview because no community providers responded to an RFP to serve her. She was to be there for a short time but was admitted in 2012 and remains. She needs DBT but no staff are trained to provide this therapy to her.

Her overall impression is that individuals are kept safe at LNC but there is a lack of individualized programming. The staff turnover is problematic for the individuals served at LNC. She thinks newly hired staff do not understand what they are getting into with this population. They need to help staff develop safe coping skills and this is not occurring. There is very little community engagement because of staff shortages and lack of transportation.

Family 7: This family lives out of state and is privately funding their son for what they hope will be one year. Their experience has been "pretty good." Their son is safe. For the first time they do not worry he will be kicked out of a residential program. They think programming could be more individualized and meaningful and think he should have consequences for not attending. He has a job on campus but is not required to go. There is good communication and it is timely although they don't always have the details of incidents. They are very complimentary of their case manager. They visited in December and thought staff were very transparent. They take input and recommendations from the family. They find LNC good at behavioral programs. They wish he were more physically active. Their recommendations for improvement are: improve the physical plant in terms of cleanliness and personalization, offer more engaging activities and intervene when individuals refuse to participate in programs.

Family 8: This family recently experienced a tragic experience. Their brother has been at LNC for several years and previously suffered from exposure from eloping once each winter over the past two years. Someone snowplowing the road during the most recent occurrence

found him. He also attacked a staff person who came in his room at night startling him when he lived at a Lakeview community program. LNC called the police who pepper sprayed him. He was then moved to Effingham.

In late January he was refusing to take his medications including his seizure medications. His sister is available at any hour to help convince him to do what is best for him but wasn't called. He suffered a grand mal seizure and was hospitalized where he was placed on tube feeding. LNC refused to have him return to the campus stating they could not serve him any longer. The family sought and arranged for an alternative placement with assistance from the hospital and their insurance company. Lakeview or the Area Agency did not help them to find an alternative. In general she thought staff needed more training, especially the weekend staff.

#### **Section IV: Review of Other State's Experiences with Lakeview and External Reviews of Lakeview**

Many states use LNC due to a lack of adequate community based or facility programs for individuals with traumatic brain injury, neuro-psychiatric challenges who may also exhibit dangerous behaviors that impact their own safety or the safety of others. I felt it was important to interview some of these stakeholders and review analyses they had completed of services at LNC. I reviewed the summaries of a number of investigations completed by the New York State Justice Center, interviewed NYS JC staff, read reviews completed by two managed health care companies in Pennsylvania who fund individuals at Lakeview, interviewed staff at the Connecticut Department of Mental Health and Addiction Services (DMHAS), and reviewed recent annual accreditation reports. These are summarized in this section to provide a more thorough of the perceptions, findings and concerns regarding service provision at LNC. I summarize the investigations I reviewed from the NYS Justice Center because they demonstrate a pattern of an inability to maintain corrective action. I requested similar information from DHHS but did not receive it in time to include it in my report.

## **Section A New York State**

I was able to interview Randal Holloway who is the Unit Manager, Out of State Placement Oversight, New York Justice Center for the Protection of People with Special Needs. He has made several visits to LNC since October 2013. Lakeview's administration has not been particularly receptive or responsive to the findings and concerns of the Justice Center. Lakeview to date has not demonstrated an effective response to the indication of systemic failings in the areas of staff supervision, staff training and incident reporting. The Justice Center finds that the core problem is that there is not an effective treatment approach. Individual plans are not designed with measurable goals that can be evaluated. The staff do not track the progress of proactive behavioral strategies. Mr. Holloway finds that Lakeview backs off on the provision of active programming in an effort to reduce aggression, outbursts, and potential injuries to staff. He questions the viability of the MANDT training in light of Lakeview's decision to significantly curtail the use of physical restraint. Lakeview serves individuals with significant behavioral challenges who can become physically aggressive towards others. It is questionable if individuals can be kept safe using only MANDT approved techniques. The policy to no longer rely on physical restraint is laudable. However, the consequences of this change in managing behavior must be examined and analyzed. It appears to be coupled with a "hands off" approach including staff directed to run from individuals who are confronting them and an increase in elopements. The Justice Center (JC) does not find the MANDT training alone is suitable to manage and improve the behaviors of the NYS residents who are served at Lakeview. Staff are left at risk and cannot safely contain individuals who are having a behavioral episode. Staff report to the JC investigator that they are frightened. This leads to an unsafe and insecure environment for the residents.

The NYS JC reports that there is insufficient staffing to prevent aggression between residents and toward staff. They have found evidence of severe understaffing especially on weekends and evenings. These times of the day and week can be of particular concern because individuals are not necessarily engaged in active programming or have a

range of activities to choose to participate in for structured leisure. When so many individuals require individual supervision or to always be under visual supervision it is difficult for staff to respond to assist other staff who need help due to an individual's escalating behavior.

There is no preparation for community living or community integration.

NYS Justice Center finds there is significant turnover among psychology and psychiatric staff.

NYS JC did recommend an outside group, Labor Relations Alternative, to LNC to conduct investigatory training. LNC followed up and engaged the group to train their staff. Recently LNC conducted a Root Cause Analysis after a NY resident eloped while being individually supervised. While Mr. Holloway was pleased this was done he was concerned the results and recommendations were not shared since the QA Director believed they were protected under quality assurance protocol. He does not find that Lakeview has effective plans for quality improvement. His assessment is that the program's prospects for sustained improvement are bleak. There have been seven investigations since 2013. Lakeview has not developed acceptable Corrective Action Plans (CAP) and did not respond at all to three requests for corrective action. Two CAPs were due on 1/30. LNC asked for a two -week extension that the Justice Center granted. New York had only three individuals at Lakeview who are in the school or Young Adult Program as of January 2015.

The most recent report issued by the NYS Justice Center is dated March 9, 2015 and is regarding an incident that was reported on October 14, 2014. Two residents who were to receive individual supervision were assigned to the same staff person who was called away to respond to a crisis. The two were found with one of them naked. LNC found no reason to conduct a formal investigation and orally reprimanded the staff involved in providing supervision. It was reported by the Justice Center that one of the individual had pending criminal charges for sexual assault that did not seem to be known to program staff at Lakeview.

The Justice Center did not find that action to be warranted because the staff followed all policies. The Justice Center found that "drops in

supervision due to staffing shortages are a recurrent problem at Lakeview that the JC has identified in multiple prior investigations. Lakeview has yet to demonstrate or provide meaningful assurances that assigned staffing levels will be reliably maintained and that crises staffing levels will be sufficient to permit adequate staff responses to elopements and aggressive episodes without dangerous lapses in the required supervision of other service recipients. Conditions at a facility which exposes service recipients to harm or risk of harm where staff culpability is mitigated by systemic problems such as inadequate management, staffing, training, or supervision, are defined as abuse in NYS Law.” The JC found that Lakeview’s supervision policy, inadequate staffing, and unreasonable staff assignments were causal to this incident.

This incident occurred in the month following the Disability Rights Center of NH report and findings related to a death. Lakeview did not take any assertive action to thoroughly review this critical incident at a time when the program was under increased scrutiny and monitoring. This does not demonstrate an understanding of the administration of Lakeview of its responsibilities to insure the safety of all of its residents and to quickly respond to critical incidents by determining the underlying systemic causes.

In the following pages I summarize some of the other investigations that have been completed by the NYS Justice Center to portray the pattern of concerns and Lakeview’s responses.

1. 12/30/14 letter from Randal Holloway, Unit Manager, Out of State Placements Unit, NYS Justice Center Summarizes 3 allegations of abuse or neglect involving a participant that occurred between August 20, 2013 and October 4, 2013. The Bureau of Elderly and Adult Services (BEAS) also investigated these allegations. Neither the NYS JC nor BEAS found the allegations of neglect substantiated. However NYS Justice Center did determine the following:

- a. Staff training was not sufficient to ensure the individual’s aggressive behavior was effectively managed without placing staff at risk of injury or the participant at risk of bruising and abrasions;

- b. The behavioral treatment plan in place at the time did not require staff to provide adequate supervision to ensure her safety;
- c. The supervision policy allowed the staff to leave his 1:1 assignment to assist with a crisis involving another individual whose supervision level may have been reduced without the knowledge or approval of the placing agency;
- d. Understaffing and deficient supervision leave individuals at risk
- e. Lakeview's failure to report these allegations to the NYS Justice Center in a timely manner constitutes obstruction of reportable incidents;
- f. New Hampshire oversight of Lakeview is not sufficient to ensure the safety of the residents. The deficiencies noted by the NYS Justice Center regarding staffing, supervision and training were not noted in the BEAS report. These incidents were not investigated by BDS because they did not involve residents of NH.

Five recommendations were made including: modification and enhancement of staff training to safely and effectively intervene when individuals are being aggressive noting what floor holds are authorized using MANDT training; review and revise supervision levels for individuals to meet their safety needs; require approval of placing agencies to reduce levels of supervision; improve staff training to address staffs' responsibilities to report incidents; and develop adequate quality assurance and improvement mechanisms, ensuring timely implementation of corrective actions at Lakeview in the absence of investigative oversight by New Hampshire. Lakeview is to respond by January 31, 2015.

2. NYS JC summary of its investigation of an allegation of an incident occurring 3/4/14 involving a participant. The JC found neglect due to inconsistencies between the behavior plan and staff practices. The NYS JC recommended female staff be assigned as stipulated in her behavioral plan and that all staffing assignments for NYS residents be reviewed to ensure consistency with the behavioral plans. The response form Lakeview was due on December 31, 2014.

3. A letter from NYS JC dated January 21, 2014 summarized the results of a visit made in October 2103 to review services, safety and supervision. Lakeview policies and practices were appropriate to

ensure preservation of residents' civil rights and provision of basic living needs. However, the safety of NY residents was not consistently or reliably maintained due to staff inadequacies, supervision policies, behavior management practices, and incident management practices. Staffing shortages led to reductions in supervision levels for individuals who needed individual supervision. These shortages contributed to incidents of aggression to self, others and staff, and to elopement. Staff reported difficulty effectively supervising individuals and sometimes being targeted by individual residents.

Recommendations were made to assure sufficient staffing, training to assist staff to respond to crisis with an understanding that multiple crises may occur at one time, improved incident reporting, and improved investigation of incidents. NYS JC did not find evidence of comprehensive investigative reports with relevant findings or recommendations for appropriate corrective actions. The NYS JC recommends this occur even though it notes the NH law does not require the facility to investigate allegations of abuse or neglect. It further recommends that Lakeview take action to insure staff reporting of incidents. The NYS JC had concerns about the programming offered in the Young Adult Program in terms of the adequacy of habilitation and vocational programs. It requires a plan of correction in this area. Recommendations were made regarding the accountability of staff given 1:1 supervisory assignments. Policies and procedures were noted lacking in terms of documentation and transfer among staff of this responsibility. In terms of the physical plant, bedrooms lacked personalized touches, furniture was in disrepair, and there was not sufficient furniture in all cabins. Recommendations were made to address these areas and to check fire extinguishers.

4. The NYS JC investigated an allegation involving a participant reported on 2/24/14. Staff visited the facility March 18-19, 2014. The allegation was not substantiated but it was noted that her revised behavioral plan should have been implemented awaiting her guardian's approval while making reasonable efforts to obtain approval.

5. The NYS JC investigated an allegation made on 9/19/14 of abuse or neglect related to providing 1:1 supervision for a participant. Neglect was substantiated. Lakeview had also failed to report the incident in a

timely fashion. The recommendations noted that NYS JC and NYSED had made numerous attempts to correct the reporting recommendations for staff training. NYS JC views the lack of follow through as an intentional disregard of these requirements on the part of Lakeview's leadership. A response and corrective action plan is expected.

6. The NYS JC completed a review of an investigation completed by New Hampshire Department of Health and Human Services, (BEAS) into an allegation of abuse or neglect at Lakeview Neuro-Rehabilitation Center that allegedly occurred on July 15, 2014 involving a NYS resident. The correspondence to Lakeview regarding this investigation was on November 3, 2014. The NYS JC also notified John Martin, Manager, Bureau of Licensing and Certification, NH DHHS. The Justice Center concurred with BEAS that the individual was abused. The BEAS investigation also uncovered credible evidence that the staff person regularly failed to implement the individual's treatment program and improperly allowed her to isolate herself in her bedroom. A behavioral intern who allegedly reported it observed him doing this on more than one occasion. No staff intervened to keep her from being isolated in her room. Lakeview has no record the concern was reported.

The NYS JC reported that BEAS did not inform Lakeview of the information concerning the observation and report by the behavioral intern. The incident was not promptly reported to the NYS Justice Center. BEAS was notified two days after the incident and the Justice Center was not notified by anyone at Lakeview. The Justice Center made two recommendations. One was that Lakeview assess and revise as warranted the facility training programs for all staff related to incident reporting and treatment provision. The second was for Lakeview to develop a substantive plan of correction detailing how the administrative practices will be improved to ensure adequate oversight of care, thorough investigations of reported incidents and review by the governing body.

The NYS JC report includes information that the BEAS report did not include findings about the training, supervision and incident reporting deficiencies it surfaced during the course of the investigation. The Justice Center is requiring Lakeview to improve its protective oversight and internal quality improvement "in order to accommodate the

insufficiencies in New Hampshire oversight of the care of New Yorkers placed at the facility.”

## **B. Connecticut**

I was able to interview Nikki Richer Director, Young Adult Program, CT DMHAS and Daniel Brockett, Clinical Director; CT DMHAS. DMHAS has placed 6 individuals at LNC over the past 15 months. The individuals have been there from 5 – 15 months. CT DMHAS did not refer to LNC prior to 2013. They refer individuals who have severe developmental disabilities and neuro-psychiatric or neuro-behavioral diagnoses. Ms. Richer and Dr. Brockett find the campus setting that allows for freedom of movement and LNC’s neurologically informed care with a behavioral component to be suitable for some of the individuals served in the young Adult Program operated by CT DMHAS.

DMHAS provides oversight for the individuals it sends to LNC through monthly calls and onsite visits. Staff reviews the individual record and progress notes, meet with the individual and tour the facility during the onsite visits. Ms. Richer has visited the campus 3-4 times over the past 15 months and made a 2 -day visit in October 2014 to follow up after the investigative report was issued by NH Disabilities Rights Center. She reviewed policies and procedures; the behavior plans for CT residents; and toured the campus. DMHAS reports being selective in whom it refers to Lakeview. The agency does not refer individuals with a strong history of violence. Individuals who are referred were not well served in community-based programs. Staff report they are doing well and families are satisfied with their care. I did interview one family from CT who is extremely dissatisfied with the services at Lakeview but a public guardian who is satisfied with her care now represents their family member. DMHAS does not view the program as short term. The Young Adult Program envisions transitioning individuals after three to four years at Lakeview.

Ms. Richer reports that families and service coordinators have monthly contact to discuss the implementation of the individual plan. Two families report seeing positive changes in their children's behaviors and another father reports this is the best his child has ever done. LNC has been very responsive to issues and concerns raised by families and DMHAS finds them to be transparent in discussing and explaining specific services and interventions and the service delivery model.

CT DMHAS is concerned with the problem LNC experiences in retaining staff. The DMHAS Young Adult Program wants seasoned regular staff to provide behavioral therapy rather than student interns so that the individual has greater consistency.

Dr. Brockett reviewed the DRC report. He believes LNC is addressing its communication inadequacies between the residential, clinical and medical staff. He reports indications that the administration is addressing staff training and the gaps in supervision. He has found the administration open to the feedback from CT DMHAS.

Ms. Richer is concerned about the timeliness and consistency of documentation and staff retention. She reports LNC is aware of these issues but she does not see measurable improvements yet. She believes they will resolve the issue of adequate staff and supervision. Dr. Brockett is pleased they are adopting a Quality Assurance model and is generally satisfied with LNC's work. Both Ms. Richer and Dr. Brockett are concerned about LNC sustaining its corrective actions and improvements. They are also concerned that LNC sold the majority of its community residential program in NH. CT DMAS was interested in using Lakeview to provide a continuum of care for CT residents as their behaviors were stabilized and they were ready to transition to the community.

CT DMHAS started to use Lakeview after LNC changed its focus to non-restraint to address aggressive, self-abusive and violent behaviors. The DMHAS staff do acknowledge this has led to greater property destruction and it may have been done without sufficient introduction and training of staff and communication with local community health and safety responders.

CT DMHAS contracts with Lakeview and uses state funding to support the individual it places at Lakeview. It does not consider it a HCBS waiver program nor does it use waiver funding. The Young Adult Program of DMHAS has made one referral since Governor Hassan has frozen admissions to LNC from New Hampshire. CT DMHAS plans to continue to make referrals of individuals it thinks can be appropriately served by Lakeview.

### **C. Pennsylvania Review of Services at Lakeview**

Pennsylvania has eight individuals placed at Lakeview as of December 2014. Two of the managed care organizations that coordinate care for Pennsylvania conducted onsite reviews after Governor Hassan imposed a hold on admissions to Lakeview. Magellan Behavioral Health and Community Care Behavioral Health Organization conducted the onsite reviews. Based on the meetings with staff, record review, interviews with Magellan members, a campus tour and observations of staff/resident interactions Magellan does not determine there were any immediate safety concerns that would necessitate transferring the three individuals Magellan has placed at Lakeview.

Community Care BHO had placed six individual at Lakeview. Its staff conducted an onsite review in October 2014. Community Care conducted a review similar to that conducted by Magellan representatives. As a result of this visit Community Care noted deficiencies related to incident reporting, documentation, life safety requirements, trauma assessment, substance abuse screening, MISA screening, treatment planning, treatment goal setting, communication with families, and community participation. Community Care required a correction plan by December 4, 2014.

### **D. External Quality Reviews**

CARF completed an inspection in August 2014 and issued a one-year accreditation to Lakeview. CARF offers a three-year accreditation to agencies whose performance merits a sustained accreditation level. Strengths were noted in the areas of nursing and clinical skills, reduction of staff turnover, outreach to emergency responders and

police personnel, and developing expertise in treating brain injury, among others. Areas of improvement include but are not limited to: consistent application of standards and implementation of policies and procedures, including maintaining a health and safe environment for staff and residents, testing emergency procedures, addressing prevention and timely debriefing of critical incidents, demonstrating crisis intervention procedures, and consistently providing an adequate level of staffing. It was also noted that Lakeview should develop specific admission and discharge criteria and a vision of this program's role within a continuum of care.

The Joint Commission surveyed Lakeview in July 2014. The Joint Commission sent a letter to Lakeview dated December 15, 2014 that extended Lakeview's accreditation based on a 2011 survey and pending the completion of the findings of the review conducted in July 2014. However the majority of findings were either at the level of Partial or Insufficient Compliance in the attached interim report.

### **Section V. Lakeview Compliance with CMS Definition of Community Living**

The Deputy Commissioner of DHHS asked that I include a review of the key components/provisions of CMS Rules specific to the Home and Community-Based Services (HCBS) Waiver and to analyze whether Lakeview will comply with the new waiver requirements for community living. The Area Agencies use HCBS waiver funding to support NH residents who are placed at Lakeview. All states are required to analyze the programs that are part of their HCBS waiver and develop a five-year plan to bring all of these settings into compliance with the new definitions of community living.

#### **A. Final Rule 1915(i):**

CMS' definition of home and community-based waiver settings has been evolving over a number of years which has been based on the states' experiences and extensive public feedback concerning the best possible way to determine the difference between institutional and community-based settings. In addition, this final rule also establishes a set of person

centered planning requirements for HCBS participants under 1915(c) and 1915(i). CMS has moved away from defining home and community based settings by, “what they are not,” and more toward defining them via the quality of participants’ experiences. Thus, the final rule sets a more outcome-oriented definition of home and community based settings, rather than one that is based on a setting’s location, geography or physical characteristics. The changes related to clarification will effectuate the laws’ intention to provide alternatives to services provided in institutions and maximize the opportunities for waiver participants to have access to community living and receiving services in the most integrated of settings.

The person centered planning component specifies that service planning for all participants in HCBS programs must be accomplished via the person centered planning process. The process/plan must address health and long-term services and support needs that incorporate individual preferences and goals. This process must be directed by the individual and may include a representative freely chosen by the individual and any others chosen by the individual that they would like to contribute to the process. The minimum requirements developed in this process are:

- A person centered plan with individually defined goals and preferences
- Includes goals and preferences related to community participation
- Employment goals and preferences
- Income and savings
- Health care and wellness
- Education
- Services and supports, paid and unpaid, who provides the supports and if the individual chose to self direct

In assessing whether individuals are receiving services in an institutional setting the guidelines cited below are established by CMS.

**B. Characteristics that are expected to be present in all home and community-based settings and associated traits that individuals in those settings might experience.**

1. The individual selected the setting.

- Was the individual given a choice of available options regarding where to live/receive services?
- Was the individual given opportunities to visit other settings?
- Does the setting reflect the individual's needs and preferences?
- The individual participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services.
  - Does the individual regularly access the community and is s/he able to describe how s/he accesses the community, who assists in facilitating the activity and where s/he goes?
  - Is the individual aware of or does s/he have access to materials to become aware of activities occurring outside of the setting?
  - Does the individual shop, attend religious services, schedule appointments, have lunch with family and friends, etc., in the community, as the individual chooses?
  - Does the individual come and go at any time?
  - Does the individual talk about activities occurring outside of the setting?
- The individual is employed or active in the community outside of the setting.
  - Does the individual work in an integrated community setting?
  - If the individual would like to work, is there activity that ensures the option is pursued?
  - Does the individual participate regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual?

4. The individual has his/her own bedroom or shares a room with a roommate of choice.

- Was the individual given a choice of a roommate?
  - Does the individual talk about his/her roommate(s) in a positive manner?
  - Does the individual express a desire to remain in a room with his/her roommate?
  - Do married couples share or not share a room by choice?
  - Does the individual know how s/he can request a roommate change?
5. The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.
- How is it made clear that the individual is not required to adhere to a set schedule for waking, bathing, eating, exercising, activities, etc.?
  - Does the individual's schedule vary from others in the same setting?
  - Does the individual have access to such things as a television, radio, and leisure activities that interest him/her and can s/he schedule such activities at his/her convenience?
6. The individual controls his/her personal resources.
- Does the individual have a checking or savings account or other means to control his/her funds?
  - Does the individual have access to his/her funds?
  - How is it made clear that the individual is not required to sign over his/her paychecks to the provider?
7. The individual chooses when and what to eat.
- Does the individual have a meal at the time and place of his/her choosing?
  - Can the individual request an alternative meal if desired?
  - Are snacks accessible and available anytime?
  - Does the dining area afford dignity to the diners and are individuals not required to wear bibs or use disposable cutlery, plates and cups?

8. The individual chooses with whom to eat or to eat alone.
  - Is the individual required to sit at an assigned seat in a dining area?
  - Does the individual converse with others during meal times?
  - If the individual desires to eat privately, can s/he do so?
9. Individual choices are incorporated into the services and supports received.
  - Do Staff ask the individual about her/his needs and preferences?
  - Are individuals aware of how to make a service request?
  - Does the individual express satisfaction with the services being received?
  - Are requests for services and supports accommodated as opposed to ignored or denied?
  - Is individual choice facilitated in a manner that leaves the individual feeling empowered to make decisions?
10. The individual chooses from whom they receive services and supports.
  - Can the individual identify other providers who render the services s/he receives?
  - Does the individual express satisfaction with the provider selected or has s/he asked for a meeting to discuss a change?
  - Does the individual know how and to whom to make a request for a new provider?
11. The individual has access to make private telephone calls/text/email at the individual's preference and convenience.
  - Does the individual have a private cell phone, computer or other personal communication device or have access to a telephone or other technology device to use for personal communication in private at any time?

- Is the telephone or other technology device in a location that has space around it to ensure privacy?
- Do individuals' rooms have a telephone jack, WI-FI or ETHERNET jack?

12. Individuals are free from coercion.

- Is information about filing a complaint posted in an obvious location and in an understandable format?
- Is the individual comfortable discussing concerns?
- Does the individual know the person to contact or the process to make an anonymous complaint?
- Can the individual file an anonymous complaint?
- Do the individuals in the setting have different haircut/hairstyle and hair color?

13. The individual, or a person chosen by the individual, has an active role in the development and update of the individual's person-centered plan.

- Is/are the individual/chosen representative(s) aware of how to schedule Person-Centered Planning meetings?
- Can the individual explain the process to develop and update his/her plan?
- Was the individual present during the last planning meeting?
- Did/does the planning meeting occur at a time and place convenient for the individual to attend?

14. The setting does not isolate individuals from individuals not receiving Medicaid HCBS in the broader community.

- Do individuals receiving HCBS live/receive services in a different area of the setting separate from individuals not receiving Medicaid HCBS?
- Is the setting in the community among other private residences, retail businesses?

- Is the community traffic pattern consistent around the setting (e.g. individuals do not cross the street when passing to avoid the setting)?
  - Do individuals on the street greet/acknowledge individuals receiving services when they encounter them?
  - Are visitors present?
  - Are visitors restricted to specified visiting hours?
  - Are visiting hours posted?
  - Is there evidence that visitors have been present at regular frequencies?
  - Are there restricted visitor's meeting areas?
15. State laws, regulations, licensing requirements, or facility protocols or practices do not limit individuals' choices. Do State regulations prohibit individuals' access to food at any time?
- Do State laws require restrictions such as posted visiting hours or schedules?
  - Are individuals prohibited from engaging in legal activities?
  - The setting is an environment that supports individual comfort, independence and preferences.
  - Do individuals have full access to typical facilities in a home such as a kitchen with cooking facilities, dining area, laundry, and comfortable seating in the shared areas?
  - Is informal (written and oral) communication conducted in a language that the individual understands?
  - Is assistance provided in private, as appropriate, when needed?
16. The setting is an environment that supports individual comfort, independence and preferences.
- Do individuals have full access to typical facilities in a home such as a kitchen with cooking facilities, dining area, laundry, and comfortable seating in the shared areas?
  - Is informal (written and oral) communication conducted in a language that the individual understands?

- Is assistance provided in private, as appropriate, when needed?

17. The individual has unrestricted access in the setting.

- Are there gates, Velcro strips, locked doors, or other barriers preventing individuals entrance to or exit from certain areas of the setting?
- Are individuals receiving Medicaid Home and Community-Based services facilitated in accessing amenities such as a pool or gym used by others on-site?
- Is the setting physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting or if they are present are there environmental adaptations such as a stair lift or elevator to ameliorate the obstruction?

18. The physical environment meets the needs of those individuals who require supports.

- For those individuals who need supports to move about the setting as they choose, are supports provided, such as grab bars, seats in the bathroom, ramps for wheel chairs, viable exits for emergencies, etc.?
- Are appliances accessible to individuals (e.g. the washer/dryer are front loading for individuals in wheelchairs)?
- Are tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably?

19. Individuals have full access to the community.

- Do individuals come and go at will?
- Are individuals moving about inside and outside the setting as opposed to sitting by the front door?

- Is there a curfew or other requirement for a scheduled return to the setting?
- Do individuals in the setting have access to public transportation?
- Are there bus stops nearby or are taxis available in the area?
- Is an accessible van available to transport individuals to appointments, shopping, etc.?
- Are bus and other public transportation schedules and telephone numbers posted in a convenient location?
- Is training in the use of public transportation facilitated?
- Where public transportation is limited, are other resources provided for the individual to access the broader community?

20. The individual's right to dignity and privacy is respected.

- Is health information about individuals kept private?
- Are schedules of individuals for PT, OT, medications, restricted diet, etc., posted in a general open area for all to view?
- Are individuals, who need assistance with grooming, groomed, as they desire?
- Are individuals' nails trimmed and clean?

21. Individuals who need assistance to dress are dressed in their own clothes appropriate to the time of day and individual preferences.

- Are individuals wearing bathrobes all day long?
- Are individuals dressed in clothes that fit, are clean, and are appropriate for the time of day, weather, and preferences?

## 22. Staff communicates with individuals in a dignified manner.

- Do individuals greet and chat with staff?
- Do staff converse with individuals in the setting while providing assistance and during the regular course of daily activities?
- Does staff talk to other staff about an individual(s) as if the individual was not present or within earshot of other persons living in the setting?
- Does staff address individuals in the manner in which the person would like to be addressed as opposed to routinely addressing individuals as 'hon' or 'sweetie' ?

### **Conclusion of the implications of the community living definition:**

I have listed all of the indicators a state is to consider to determine if a setting meets the CMS definition of community living. The setting and the service delivery model of Lakeview are antithetical to this definition. Lakeview does not practice person-centered planning although they profess to want to change this. Planning using a person centered approach may be the one area LNC could change but it will take a significant cultural shift for them to place the participant and the family in a leadership position within the team and be responsive to the times they wish to meet and invite who they want to the meetings. LNC will then to implement more personalized and individualized programming as a result. It seems impossible for this and most of the other requirements to be met in this isolated setting serving 60 or more individuals in residences of several people. Individuals would need to be given choice over all aspects of their lives including scheduling, meals, personalization of living space, participation in meaningful community activities, and the opportunity to be engaged in meaningful employment.

**C. Characteristics that are expected to be present in all provider owned or controlled home and community-based settings and associated traits that individuals in those settings might experience.**

1. Modifications of the setting requirements for an individual are supported by an assessed need and justified in the person-centered plan.
  - Does documentation note if positive interventions and supports were used prior to any plan modifications?
  - Are less intrusive methods of meeting the need that were tried initially documented?
  - Does the plan includes a description of the condition that is directly proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews to determine the ongoing necessity of the modification, informed individual consent, and assurance that the intervention will not cause the individual harm?
2. Individuals have privacy in their sleeping space and toileting facility.
  - Is the furniture arranged as individuals prefer and does the arrangement assure privacy and comfort?
  - Can the individual close and lock the bedroom door?
  - Can the individual close and lock the bathroom door?
  - Do staff or other residents always knock and receive permission prior to entering a bedroom or bathroom?
3. The individual has privacy in his/her living space.
  - Are cameras present in the setting?
  - Is the furniture arranged as individuals prefer to assure privacy and comfort?
  - Do staff or other residents always knock and receive permission prior to entering an individual's living space?
  - Does staff only use a key to enter a living area or privacy space under limited circumstances agreed upon with the individual?
4. The individuals have comfortable places for private visits with family and friends.

- Is the furniture arranged to support small group conversations?
5. Individuals furnish and decorate their sleeping and/or living units in the way that suits them.
- Are the individuals' personal items, such as pictures, books, and memorabilia present and arranged as the individual desires?
  - Do the furniture, linens, and other household items reflect the individual's personal choices?
  - Do individuals' living areas reflect their interests and hobbies?
6. There is a legally enforceable agreement for the unit or dwelling where the individual resides.
- Does the individual have a lease or, for settings in which landlord tenant laws do not apply, a written residency agreement?
  - Does the individual know his/her rights regarding housing and when s/he could be required to relocate?
7. Individuals are protected from eviction and afforded appeal rights in the same manner as all persons in the State who are not receiving Medicaid HCBS.
- Do individuals know their rights regarding housing and when they could be required to relocate?
  - Do individuals know how to relocate and request new housing?
  - Does the written agreement include language that provides protections to address eviction processes and appeals comparable to those provided under the jurisdiction of landlord tenant laws?

**Conclusion:** Lakeview does not lend itself to affording individuals privacy; individualized home settings or choice of all furnishings; private communications; or any control over their home in terms of a legal agreement.

In summary, based on the established CMS Rules cited above and the associated guidelines Lakeview would not qualify for participation under the HCBS Wavier. New Hampshire will have five years to

determine another funding source if Lakeview continues to be used by the Area Agencies.

## **Section VI. Summary**

Lakeview continues to be used by many states including New Hampshire because of its ability to serve individuals with brain injury, neuro-psychiatric diagnoses, and who may pose significant threat to themselves or others. States rely on the few programs in the nation such as Lakeview because of the lack of sufficient community based alternatives. Advocacy groups such as the Brain Injury Association of New Hampshire believe that such a program is needed although express concern that Lakeview has not kept its mission precise. During my interview with them they spoke to a concern that I believe many families and referring organizations have if Lakeview is closed. They reported to me that individuals who would normally be referred to Lakeview in NH have gone to nursing homes; acute care hospitals and rehabilitation centers since the Governor imposed the freeze on admissions to Lakeview. The Area Agencies report that some individuals have gone to jail or psychiatric facilities. Families who use Lakeview have concerns that these or juvenile facilities are all that would be available to their children if there was not the option of Lakeview.

I have been asked to determine the quality of services at Lakeview, the organization's ability to make necessary improvements and to sustain corrective actions. Throughout this report I have indicated significant areas of service delivery, supervision and management and quality oversight where I find the organization to lack basic skills. I do not dispute that the organization is making significant effort and committing resources to improve. I do not find that these efforts are taking hold or demonstrating the level of improvement in performance that is needed.

This is evidenced by the recent conclusions of CSNI that decreases in responsiveness and quality improvement are noted and by Lakeview's inability to develop an acceptable Plan of Correction for the NH Department of Education for its operation of a residential school.

Lakeview has had a provisional certificate to operate its school program since late 2014. It cannot admit school age children and youth until it has an acceptable POC. It has been making efforts since December 2014 but has yet to have its POC accepted by the DOE. Lakeview continues to miss its deadlines to submit acceptable POCs to NY.

Lakeview's POC for its residential treatment facility license has been accepted by DHHS. However, I have determined that it is lacking in many basic areas. Its mission and programming approach is not clear, the staffing remains insufficient, its involvement of families is poor and its quality assurance area is significantly under-resourced. It is of significant concern that many families are dissatisfied with the care provided to their children yet feel they often have no other alternatives. I do not believe Lakeview will be able to successfully implement and sustain its POC within a reasonable period of time.

Lakeview cannot be closed quickly if the state of New Hampshire decides on this course of action. A well-planned closure will require the development of alternatives for over 60 individuals and coordination with NH Area Agencies and other states. Individuals living at Lakeview deserve the opportunity to live in community settings. New Hampshire and other states need time and the clinical capacity to appropriately support these individuals in more individualized settings. States' plans to use facilities such as FINR merely serve to ignore the lack of community capacity and continue families' uncertainty about whether their children can have stability and security in the future in a setting that affords them opportunities for community interaction and regular contact with their families.

New Hampshire may decide to maintain Lakeview as a licensed facility until adequate resources are available for the current residents and others who may be referred in the future. If Lakeview remains open I recommend the following:

- New Hampshire continues its own freeze on admissions until substantial improvement is made and sustained for at least six months
- Lakeview becomes a facility that identifies its mission to provide short-term stabilization and assist individuals to improve their

behaviors serving individuals for no more than eighteen months. This period of time gives state the time to develop a community based alternative

- Lakeview continues its new practice of not accepting referrals if it does not have consistent, well trained and sufficient staffing
- Lakeview develops meaningful performance measures and achieves them
- Lakeview commits sufficient resources to its QA department to carryout its critical functions
- Lakeview establishes a participant and family advisory committee to advise on policy
- Lakeview regularly determines participant and family satisfaction and acts upon recommendations for improvement
- NH identifies experts in person-centered planning to train the staff at Lakeview
- NH develops enhanced rules and oversight of the facility. This will be addressed in my second report to the Governor