

EXECUTIVE SUMMARY

This review was conducted to evaluate the compliance of Lakeview NeuroRehabilitation Center (LNC) with the provisions of NH RSA 151 and He-P 807, at a minimum, in each of the following areas:

- Policy, practice and programming at LNC.
- Safety, security and treatment standards for the care of residents at LNC.
- Safety, security and workplace safety for staff and visitors at LNC.
- All other regulatory and licensing standards and issues governing LNC.

A team of DHHS personnel from the Health Facilities Bureau and an external Quality Management Consultant reviewed numerous documentation sources, interviewed residents, staff and family members and spent five days on-site observing operations.

The questions addressed in the review were:

How does the current operation of LNC comply or not comply with the requirements set forth in NH RSA 151 and He-P 807?

Do the current practices, policies and resources at LNC provide appropriate assessment, treatment planning, case management, discharge planning and related services for residents consistent with regulations and “best practices?”

Does LNC have in place appropriate procedures and policies to effectively ensure the safety of residents, staff and visitors?

The Review Team finds that chronic and acute staffing deficits combined with acuity of admissions as well as deficiencies in training, communication, crisis management, program oversight and lack of a robust quality improvement function has caused a confluence of circumstances leading to unintended, potentially problematic incidents and “bad outcomes” for program residents.

The following recommendations resulted from the review:

- The organization needs to increase its recruitment efforts, including salaries that are above market, to attract and retain qualified and competent direct care staff to this somewhat isolated, rural location. Semi-annual re-administration of a Staff Satisfaction Survey may yield insights into the effect of staffing enhancements on morale and retention. The organization needs to more comprehensively analyze crisis management training and response to events to identify problem areas and inform the development of alternative strategies.
- The program needs to immediately implement a policy that levels of supervision are never to be lowered based on lack of sufficient staffing. Mechanisms need to be developed to clearly articulate and communicate levels of supervision across shifts and between program components and treatment venues.
- The organization’s staffing levels need to make accommodation for a trained dedicated Response Team to assure that crisis management events do not impact on the required level of supervision of other residents.

- The organization needs to ensure that there is a sufficient staffing resource as part of the determination to admit prospective program participants who have a history that would indicate the need for high levels of supervision. The Director of Human Resources or designee needs to be part of the admission determination.
- Treatment and Behavioral Plans need to be modified in “real time” when there are significant changes in the individual’s condition and behavior. There needs to be a more robust process for Medical Record audits at the point of care. Implementation of an electronic medical record, which the program is committed to, needs to continue to progress.
- The review team feels that enhancements to staff communication is one of the most critical areas for improvement. The Review Team encourages LNC to continue to implement appropriate communication mechanisms to ensure that all staff, especially direct care staff, have access to critical clinical and behavioral/functional information regarding program participants at a frequency that guides day-to-day operations.
- The Review Team encourages LNC to incorporate Environment of Care and Safety issues into its Infection Control Program and to develop mechanisms for Infection Control Program pro-active risk assessment and evaluation.
- The organization needs to develop a comprehensive program of staff training, monitoring, evaluation, data aggregation and analysis regarding the Incident Report system through its Quality Improvement function.
- The organization needs to develop a comprehensive system for the evaluation of medication management issues which utilizes its contracted pharmacy as a primary resource.
- The organization needs to continue to develop its Quality Improvement program. QA/QI staff need to be leaders and role models in the utilization of accepted QI methodologies, such as PDCA, LEAN and Six Sigma. EMR implementation needs to be closely linked to QI methodologies. All key aspects of organizational functions, such as medication management, infection control, safety, security, staff and resident perception of satisfaction and care, human resources, staff competencies, documentation need to be elements of the QA/QI program.
- The Department of Health and Human Services should undertake a review of its regulations for facilities such as Lakeview to determine if they adequately address all areas of patient safety and program quality. Appropriate modifications, including organizational Quality Improvement functions should be addressed.
- The State of New Hampshire should continue to freeze admissions to the facility until such time as a corrective action plan including addressing all recommendations in this report has been approved by DHHS. Further, resumption of admissions shall be commensurate with compliance with the corrective plan as documented by DHHS monitoring reviews.
- The organization shall submit a Plan of Correction as mandated by He-P 807.12 (a) (1) to address all findings/recommendations as identified in this report.

REVIEW OF LAKEVIEW NEUROREHABILITATION CENTER EFFINGHAM, NEW HAMPSHIRE

The purpose of the review was to conduct an evaluation of the Lakeview NeuroRehabilitation Center (LNC). The scope of the review included, but was not limited to, LNC's compliance with the licensing and regulatory requirements for the delivery of clinical and non-clinical services. The review and incorporated complaint investigation was intended to provide an assessment of compliance by LNC with NH RSA 151 and He-P 807, at a minimum, in each of the following areas:

- Policy, practice and programming at LNC.
- Safety, security and treatment standards for the care of residents at LNC.
- Safety, security and workplace safety for staff and visitors at LNC.
- All other regulatory and licensing standards and issues governing LNC.

REVIEW TEAM

The Review Team consisted of:

Michael E. Fleming, MBA, RN, Bureau Chief Health Facilities Administration

Darlene Laro, BA, Surveyor

Brenda Bailey, BA Psychology, Surveyor

Al Swanson, BA, Surveyor

Jane Kendall, RN, Surveyor (Part of on-site team for 3 days)

Joseph W. Romeo, Life Safety Inspector I and Fire Inspector II

Dr. Ben Lewis, Ed.D, External Quality Management Consultant

Sources and type of information for the review included:

- All relevant regulatory and licensing standards, including but not limited to, RSA 151 and He-P 807.
- Records of LNC and other administrative or medical records for LNC Residents.
- Input from and/or observations of the following:
 - LNC staff.
 - LNC programs, including Health Services, Occupational Therapy, Recreational Therapy, Education.
 - Department of Health and Human Services staff.
 - Parents, guardians and caregivers of current and former LNC Residents.
 - Advocates for current and former LNC Residents.
 - Life Safety and Environment of Care tours of all LNC buildings.
 - Various Area Agency staff, as necessary.
 - Other involved stakeholders, as needed.

- Previous reviews, investigations and materials regarding LNC.
- Statutes and regulations governing and applicable to LNC.
- Minutes, notes and/or attendance records for LNC staff.
- Incident Reports, staff and resident grievances and complaint documents.
- Credentialing files for Licensed Practitioners as well as personnel files for a randomly selected group of facility personnel.
- Other source documents, as the team deemed appropriate.

Specifically, the following documents were requested from and provided by LNC:

1. REPORTS OF LAST 2 CYCLES OF JOINT COMMISSION SURVEYS AND ANY/ALL PLANS OF CORRECTION AND MEASURES OF SUCCESS
2. REPORTS OF LAST 2 CYCLES OF CARF SURVEYS AND ANY/ALL PLANS OF CORRECTION AND MEASURES OF SUCCESS
3. SCHEDULED VS ACTUAL STAFFING ALL SHIFTS PAST 12 MONTHS
4. CREDENTIALING FILES- ALL LICENSED INDEPENDENT PRACTITIONERS
5. COMPETENCIES REQUIRED FOR ALL DIRECT CARE STAFF
6. INCIDENT REPORTS –PAST 4 MONTHS
7. POLICY REGARDING ROOT CAUSE ANALYSIS (RCA)
8. LIST OF PATIENTS-RCA/MORBIDITY/MORTALITY REVIEWS- PAST 2 YEARS
9. STATE LICENSING REVIEWS- PAST 5 YEARS
10. ANY/ALL REPORTS OF SITE VISITS BY THIRD-PARTY PAYORS
11. COPY OF ANNUAL REPORTS OF OPERATIONS
12. AGENDAS OF QUALITY IMPROVEMENT COMMITTEE- PAST 2 YEARS
13. MINUTES OF BOARD OF DIRECTORS- PAST 2 YEARS
14. STAFF, PATIENT AND FAMILY GRIEVANCES-PAST 2 YEARS
15. POLICY REGARDING NUTRITIONAL SCREENING/ASSESSMENT/NUTRITIONAL SERVICES
16. FTE PHYSICIAN/NURSE PRACTITIONERS (SCHEDULED VS ACTUAL)
17. CRITERIA FOR PATIENT DISCHARGE
18. SAMPLE OF STAFF PERSONNEL RECORDS/TRAINING RECORDS
19. SAFETY PLAN AND PLAN EVALUATION
20. SECURITY PLAN AND PLAN EVALUATION
21. QA/QI PROCESSES AND PROCEDURES
22. ANY/ALL PHARMACY POLICIES/PROCEDURES, MEDICATION MANAGEMENT P&Ps and ERROR REPORTS (PAST 12 MONTHS)
23. ANY/ALL EVALUATION OF PHARMACY PROCESSES
24. JOB DESCRIPTIONS-ALL LICENSED PRACTITIONERS
25. ANY/ALL DEFICIENCIES IN ENVIRONMENT OF CARE/LIFE SAFETY CODE BY LOCAL/STATE/ACCREDITING BODIES-PAST 5 YEARS
26. RESTRAINT POLICY/PROCEDURES
27. ALL INCIDENTS OF RESTRAINT-PAST 12 MONTHS (BASED ON FACILITY DEFINITION OF RESTRAINT)
28. POLICY REGARDING INVOLVEMENT OF FAMILIES/GUARDIANS IN TREATMENT
29. CONTENT OF STAFF ORIENTATION

30. CONTENT/FREQUENCY OF STAFF TRAINING (P&P)
31. STAFF PERFORMANCE APPRAISALS/STAFF DEVELOPMENT PLANS
32. DOCUMENTATION OF INITIATIVES TO RECRUIT/RETAIN STAFF
33. STAFF TURNOVER PAST 2 YEARS
34. CURRENT STAFF VACANCIES (BY JOB CLASSIFICATION); HISTORY OF VACANCIES
35. PATIENT/STAFF/FAMILY/REFERRERS SATISFACTION SURVEYS-PAST 2 YEARS
36. CLIENT'S RIGHTS POLICY NOTIFICATION-PAST 2 YEARS
37. CRISIS INTERVENTION METHODOLOGY, STAFF INITIAL TRAINING, CERTIFICATION, ON-GOING EVALUATION AND RE-TRAINING
38. ORGANIZATIONAL CHART
39. INFECTION CONTROL P&P
40. ANY MOCK SURVEY RESULTS
41. ANY/ALL OSHA REPORTS-PAST 5 YEARS
42. WORKER'S COMP CLAIMS- PAST 3 YEARS
43. ANY/ALL PENDING COURT SUITS/ACTIONS
44. ADMISSION PACKET
45. LIST OF ALL CONTRACTED SERVICES
46. OTHER DOCUMENTS AS REQUESTED DURING SITE VISIT

QUESTIONS TO BE ADDRESSED BY THE REVIEW

How does the current operation of LNC comply or not comply with the requirements set forth in NH RSA 151 and He-P 807?

Do the current practices, policies and resources at LNC provide appropriate assessment, treatment planning, case management, discharge planning and related services for residents consistent with regulations and "best practices?"

Does LNC have in place appropriate procedures and policies to effectively ensure the safety of residents, staff and visitors?

REVIEW PROCESS

Many documents were requested to be provided prior to on-site observations and activities and were reviewed before the on-site portion.

All additional requested documents were provided on-site and reviewed by the team

Eighteen Medical Records were reviewed in total or with a specific focus.

The Team spent five (5) days on-site observing operations and conducting interviews with the following:

Chief Operating Officer

Clinical Director

Administrator

Assistant Administrator
Case Managers
Director of Nursing/Assistant Director of Nursing
Recreation Therapy, Education and Occupational Therapy staff
Direct Care Staff
Two Former Staff Members
Safety and Facility Management Director
Family members/guardians of program participants
MANDT System Trainers (Crisis Intervention/Restraint methodology)
The lunch meal was taken with program participants and staff for each of the four days.
Kitchen Staff and operations were observed.
Participants of the program, as appropriate. (performed, in part, by observation of program participants as they interacted in a variety of settings with other participants, facility staff and/or Review Team members.).
The team was able to observe several examples of the implementation of MANDT methodology in actual settings, several successful de-escalations and the use of a restraint.

REVIEW FINDINGS

STAFFING

Lakeview has experienced numerous chronic and acute issues regarding staffing in most job categories, but, specifically, has experienced persistent staffing deficits related to Direct Care staff. Interviews with the Director of Human Resources reflect that salaries “are not competitive”; “local McDonalds and Walmart pay more; seasonal jobs (summer tourism/skiing) draw staff away.”

Nurses’ salaries have been increased to a competitive level which has increased recruitment and retention, but in the direct care category entry-level salaries are still a problem that impacts recruitment, retention and safety. The HR Director reported that shift differentials “would help, but they have not yet been implemented.” One of the sequelae insufficient staffing levels is on retention. The turnover rate for direct care staff is approximately 29%. While some of this attrition is during initial orientation, it still results in numerous on-going vacancies. Data provided by the organization reflect that for calendar 2014, “15 professional Clinical Staff, 5 Health and Safety Officers, 3 Nurses and 60 Direct Care staff have left Lakeview employment.” Currently there are 25 vacancies in the Direct Care Staff cadre. In addition, approximately 2500 hours of “lost” employee time, annually, is a function of staff injuries.

While the schedule for new employee Orientation appears appropriate, some content is not geared to the educational level of many new employees. On a Staff Satisfaction Survey administered in March, 2014, one in five employees felt that orientation to their job was “not satisfactory.” Some employees have indicated that they “are not prepared to handle some clients” and expressed not knowing enough about the clients to provide them with the supervision they need. Over one in three Direct Care staff felt that they “did not have the support and resources to provide quality care.”

Staff have not been fully oriented to the organization’s crisis intervention program (MANDT System); trainers do not observe the process or review Incident Reports regarding restraints. This

has made for some confusion regarding how restraints are applied and how episodes of restraint are processed.

Other than MANDT training the review team did not see evidence of repeated competency-based demonstration training, nor trainings that were conducted directly as a result of the analysis of actual events. Interview with former staff identified that several trainings including MANDT training scheduled for three hours consisted of “gathering of staff conversation and signing off of attendance sheets” without program content, lasting for a total of five minutes.

These aforementioned analyses could identify areas of opportunity for improvement and additional training would be a reasonable first step in addressing these problem areas.

Notwithstanding that the review team witnessed several crisis situations that were well-handled, more intensive analysis of these events could help to identify effective practices which could be built upon.

Many of these staffing and training issues have implications for staff morale. One indicator of morale is that the Staff Satisfaction Survey was responded to by only 25% of employees. Of the 118 respondents, between 33%-50% provided negative responses to questions related to “feeling valued”, having “high morale”, “and “experiencing consistent communication.”

The organization has developed a number of employee benefits, tuition reimbursement, etc, but these seem not to have substantially enhanced retention. Review of reports from the organization indicates that use of overtime is substantial. Consistent utilization of overtime as a resolution of staffing deficits can result in “burnout” or limited effectiveness. The Human Resources Director reports that shifts “run a couple of people short every shift.” As a response to these circumstances, the level of supervision of certain residents may be “dropped” a level, which may be contrary to their Behavior Plan and may compromise their safety and safety in the immediate environment. In addition it was reported by former employees that this practice happened “virtually every shift.”

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.14 (c) Duties and Responsibilities of the Licensee.

(2) Emergency response and crisis intervention;

He-P 807.18 (a) Personnel.

(a) The licensee shall ensure that sufficient numbers of qualified personnel are present in the RTRF to meet the needs of clients at all times.

RECOMMENDATION

The organization needs to increase its recruitment efforts, including salaries that are above market, to attract and retain qualified and competent direct care staff to this isolated, rural location. Semi-annual re-administration of a Staff Satisfaction Survey may yield insights into the effect of staffing increases on morale and retention. The organization needs to comprehensively analyze crisis management training and response to events to identify problem areas and inform the development of alternative strategies.

LEVEL OF SUPERVISION (LOS)

Based on assessed need, the program determines the level of supervision needed including the frequency of visual contact (Constant, every 15 minutes, every 60 minutes) in various settings, i.e. school, general campus, housing and community. Maintenance of these levels of supervision is paramount to providing a safe and secure environment for all participants and staff.

Documentation did not clearly reflect the level of supervision required/provided at any given time, which makes tracking and monitoring the appropriate application of level of supervision problematic. It was difficult to confirm level of supervision during times of incidents and during crisis management. Interviews with direct care staff reflected concerns regarding how level of supervision is communicated between shifts and/or program components. Some staff reported not being sure what the required level of supervision was at any given time. The incident reports were frequently not clear as to the level of supervision was at the time of the incident; documentation of what the level of supervision was supposed to be provided was usually clear but not the level of supervision at the time of the incident, which created discrepancies in the documentation. Interviews with several members of administrative and direct care staff indicated that when staffing was insufficient to meet the required level of supervision, “calls would be placed and decisions made to lower the level of supervision to meet available staffing levels.”

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding:

c. Personnel safety.

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(8) Personal supervision of clients when required to offset deficits that may pose a risk to self or others if the client is not supervised.

He-P 807.18 Personnel.

(a) The licensee shall ensure that sufficient numbers of qualified personnel are present in the RTRF to meet the needs of clients at all times.

RECOMMENDATION

The program needs to immediately implement a policy that levels of supervision are never to be lowered based on lack of sufficient staffing. Mechanisms need to be developed to clearly articulate and communicate levels of supervision across shifts and between program components and treatment venues.

CRISIS MANAGEMENT

Crisis management is a major focus when dealing with the LNC population. Incident Reports reflected that the ability of staff to effectively manage crises, and, at the same time, provide required levels of supervision was very difficult, if not impossible in some situations. Due to findings of a previous regulatory investigation, the facility initiated a Response Team to respond to, assist and provide support in crisis management situations. Interviews during the survey process indicated that while the Response Team concept received some positive feedback there were also staff concerns about the frequency of its use and the availability of staff to respond. Response Team members cannot also be assigned as a one-on-one for individuals requiring that level of supervision. Some staff interviewed indicated that, on occasion, staff assigned to one-to-one coverage are “pulled” to address a crisis management situation. The organization was not able to provide documentation that the implementation of a Response Team was appropriately monitored, analyzed and evaluated to assure its effectiveness.

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding:

c. Personnel safety.

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(8) Personal supervision of clients when required to offset deficits that may pose a risk to self or others if the client is not supervised.

He-P 807.18 Personnel.

(a) The licensee shall ensure that sufficient numbers of qualified personnel are present in the RTRF to meet the needs of clients at all times.

RECOMMENDATION

The organization’s staffing levels need to make accommodation for a dedicated Response Team to assure that crisis management events do not impact on the required level of supervision of other residents.

ACUITY LEVEL OF PARTICIPANTS

The acuity of clients is also a factor compounding staffing concerns. A recent study on campus indicated that the Program has high percentages of physical aggression, assault, elopements and other behavioral issues. These are reflected in over 500 Incident Reports per month. Currently data in the Reports do not comprehensively describe the event and are not systematically aggregated to determine individual, group, or cabin trends which may serve to modify Behavioral Plans or programming. The staffing deficit is heightened when there is more than one

occurrence of an event requiring intervention at a time. The organization has determined that dealing with this higher acuity population is stretching its ability to provide appropriate levels of supervision, but has not yet taken effective steps to address this problem. The Human Resources Director, who is acutely aware of staffing and coverage needs, is currently not part of the Pre-Admission processes and therefore some issues related to staff capacity to address behavioral management issues might not be part of the decision to admit or not.

Concerns about violence rose to the level of a complaint to OSHA. A Settlement Agreement reached with OSHA has resulted in the development of a Workplace Violence Prevention Program which is in the process of being implemented. Another OSHA complaint has recently been filed.

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.18 Personnel.

(a) The licensee shall ensure that sufficient numbers of qualified personnel are present in the RTRF to meet the needs of clients at all times.

RECOMMENDATION

The organization needs to ensure that there is a sufficient staffing resource as part of the determination to admit prospective program participants who have a history that would indicate the need for high levels of supervision. The Director of Human Resources or designee needs to be part of the admission determination. The Workplace Violence Prevention Program needs to be fully implemented and evaluated.

ASSESSMENT, TREATMENT PLANNING AND DOCUMENTATION

Overall, documentation in the Clinical Record is adequate, although there were a number of instances where an initial assessment of a domain (ex. fall risk) or re-assessment of a domain (ex. suicide risk) were not documented. The organization's Suicide Risk Assessment is currently incomplete in that it does not address "protective" factors. Of critical importance, Treatment Plan documentation did not reflect any modification of Treatment Plans, in "real time", based on a change in the participants' behavioral picture. There was also no documentation of a clinical justification for appropriate modifications not being made. Furthermore, there is no documentation, in the form of signatures, as to who participated in the development of the Plan. The list of staff/departments appended to the Plan misrepresents individuals who potentially could contribute to Plan formulation but were not necessarily physically present. In addition, it was also noted that authentication of entries and the dating and timing of entries as required by organizational policy were inconsistently documented.

The Review Team found that deficits in modification of Behavior Plans, based on changes in participant behaviors/condition impairs communication among providers and may lead to problematic treatment outcomes.

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807. 19 Client Records.

(a) The licensee shall maintain a legible, current and accurate record for each client based on services provided at the RTRF.

RECOMMENDATION

Treatment and Behavioral Plans need to be modified in “real time” when there are significant changes in the individual’s condition and behavior. There needs to be a more robust process for Medical Record audits at the point of care. Implementation of an electronic medical record, which the program is committed to, needs to continue to progress.

COMMUNICATION

Staff report that Lakeview Departments i.e. Occupational Therapy, Recreational Therapy, Nursing, Medical, Clinical, etc. have historically operated within “silos” for the most part and communication among clinical disciplines does not always flow smoothly. Forty-one percent (41%) of respondents in the 2014 Staff Satisfaction Survey felt that ‘facility communication networks were not adequate to keep staff up-to-date’ and 50% felt that “communication between Departments was inadequate.”

Some staff interviewed also commented that “charts were difficult to access” in that some parts were kept in Health Services and notes from various disciplines were not entered in the chart in “real time.” Residential Communication Books were not easily accessible nor did comments in them tie into the participant’s Behavioral Plan. Other significant examples of lapses in communication were related to:

- Changes in the level of supervision needed for participants on a shift-to-shift basis.
- Communication between and among program components, i.e. residential, school, health services, etc.
- Incident report data collection.
- Medication error analysis.
- On-going implementation, monitoring, evaluation and improvement of MANDT interventions.

Case Managers assist in the communication process, but this takes them away from a critical Case Management role, namely discharge planning and transitioning of individuals to home or other less restrictive environments.

Recently the organization has developed a number of promising initiatives to increase and enhance communication, but their effectiveness has not yet been evaluated.

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding:

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(8) Personal supervision of clients when required to offset deficits that may pose a risk to self or others if the client is not supervised.

He-P 807.17 Medication Services.

(ap) The licensee shall develop and implement a system for reporting any observed adverse reactions to medication and side effects, or medication errors such as incorrect medications, within 24 hours of the adverse reaction or medication error.

RECOMMENDATION

The review team feels that additional enhancements to staff communication are one of the most critical areas for improvement of patient and staff safety. The Review Team encourages LNC to continue to implement appropriate communication mechanisms to ensure that all staff, especially direct care staff, have access to critical clinical and behavioral/functional information regarding program participants at a frequency that can guide day-to-day operations.

INFECTION SURVEILLANCE, PREVENTION AND CONTROL

The organization has written Infection Control Plan. However, there is no documentation that there has been an evaluation of the effectiveness of the Plan. Plan implementation tracks and trends some infections and does reflect that LNC has a low incidence of infections. However, the IC Plan does not sufficiently addresses components such as, surveillance, data collection, orientation, education and understanding of the unique infection control challenges that exist when caring for this population. An example of this lack of understanding is reflected in the inadequate review of incident reports that highlight several infection control challenges, viewed more as behavioral issues than infection control concerns. The Plan does not adequately address the intersection of infection control and environment of care concerns. On the tour of residential buildings there were a number of observations of potential vectors of cross-contamination, for example, clean laundry stored with “dirty” mops.

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.21 Infection Control.

(a) The RTRF shall develop and implement an infection control program that educates and provides procedures for the prevention, control, and investigation of infectious and communicable diseases.

He-P 807.21 Infection Control.

(b) The infection control program shall include written procedures for:

(6) Maintenance of a sanitary physical environment.

RECOMMENDATION

LNC needs to incorporate Environment of Care and Safety issues into its Infection Control Program and to develop mechanisms for Infection Control Program pro-active risk assessment

and evaluation. The plan needs to address surveillance, data collection and analysis, and education.

INCIDENT REPORTING

The facility has a well-developed system of incident reporting. The facility documents hundreds of incident reports over very short periods of time. Incident Reports are categorized as Level II, III and IV. Reports accurately document dates, times, content and level of incident. However, a review of Incident Reports identified that there were many inconsistencies in Incident Report documentation i.e. Reports not filled out in entirety and data in numerous required fields omitted. Of concern is that there was no documentation of a robust review and analysis of the content of the Incident Reports. The team recognizes the vast source of data that could be available in these reports if they were filled out completely and consistently. Such a review could yield important insights into the who, when, where, level of supervision, staffing sufficiency, etc. that could inform improvements in program operations. During an interview session with the Quality Committee it was reported that the facility has begun looking at the Incident Report as an integral part of their Quality Improvement Program.

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding:

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding:

c. Personnel safety.

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(2) Emergency response and crisis intervention;

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(8) Personal supervision of clients when required to offset deficits that may pose a risk to self or others if the client is not supervised.

RECOMMENDATION

The organization needs to develop a comprehensive program of staff training, monitoring, evaluation, data aggregation and analysis regarding the Incident Report system through its Quality Improvement function.

MEDICATION MANAGEMENT

The medication records of 18 participants were reviewed, including some at The Meadows. During this review it was noted that recently a pharmacy company (Omnicare) had been contracted to take over pharmacy services at LNC. Interviews with administrative staff reflected that this was a result of some significant pharmacy issues that had been uncovered, including the prosecution of the organization's Pharmacist for illegal possession of controlled substances. During the review it was determined that a relatively new Director of Nursing was taking a much more direct and hands-on approach to medication administration practices. However, review of medication administration records found several instances of failure to follow physician orders. In one case, medications were not given due to "lack of availability" with no documentation for several days that the physician was notified. In another instance medication was given twice during a 3 hour period when the order was for this medication to be given once a day. The review also identified instances when medications were supposed to be given concurrently with other medications for "extreme" agitation, but the documentation does not support that this occurred at all times. In addition, there was a lack of appropriate documentation in several of the records reviewed, i.e. medications not administered, medication unavailable, lack of explanation regarding physician notification and discrepancies between the information on the Medication Administration Record (MAR).

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.17 Medication Services.

(a) All medications and treatments shall be administered in accordance with the orders of the licensed practitioner, except as allowed in (b) below.

RECOMMENDATION

The organization needs to develop a comprehensive system for the evaluation of medication management issues which utilizes its contracted pharmacy as a primary resource.

QUALITY MANAGEMENT

One of the organization's critical areas for improvement and growth is their Quality Assessment/QAPI program. Quality Assessment/Quality Improvement (QAPI) is the cornerstone for the effective management of day-to-day activities, practices and outcomes experienced by any given facility. LNC leadership has recognized this and has identified and initiated several QA initiatives. The facility gathers data in several areas. This data collection should be expanded to all areas and then a definitive plan and methodology articulated aggregate, analyze and disseminate data to improve operation, programs and care. However, given the population served and the potential for "bad outcomes" LNC needs to significantly increase their efforts in creating, implementing, analyzing and evaluating all aspects of safety

and quality at the facility. It appears that QA/PI functions are primarily located in the higher administrative and clinical tier of the organization. Staff at all levels need to be involved for improvements to be “owned” by all LNC staff, including health services, physicians, pharmacy, housekeeping, maintenance, direct care, education, etc.

Feedback during the survey indicated that medication error information, for example, was passed on to the Director of Nurses, but after that, no one was aware of the outcomes. The analysis of crisis occurrences, incident reports and other data can spotlight where documentation, communication or practice standards have lapsed and can inform corrective action.

While the facility has an appropriate QI Plan, the scope needs to be widened and implementation accelerated. The analysis of incident reports and the addition of electronic medical records, both of which are in the early stages of implementation are two examples of this; data collected from use of the EMR can assist in the process of improving any potential issues experience in medication administration. This will provide enhanced ability to improve care in all program settings. The continued development of a robust QA/PI program utilizing all data collection and data content will allow the facility to employ in depth root cause analysis leading to internal corrective action plans.

The findings outlined in this section demonstrate non-compliance with He-P 807 at:

He-P 807.14 Duties and Responsibilities of the Licensee.

(c) The licensee shall provide the following core services:

(1) Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding:

This rule (807.14 (c) (1)) covers the overall safety and protection with appropriate oversight to all participants. In relation to any deficits identified in the Quality Management section of this report those deficits will be causal factors in non-compliance with all other rules cited in this report.

RECOMMENDATION

The organization needs to continue to develop its Quality Improvement program. QA/QI staff need to be leaders and role models in the utilization of accepted QI methodologies, such as PDCA, LEAN and Six Sigma. EMR implementation needs to be closely linked to QI methodologies. All key aspects of organizational functions, such as medication management, infection control, safety, security, staff and resident perception of satisfaction and care, human resources, staff competencies, documentation need to be elements of the QA/QI program.

SUMMARY OF INTERVIEWS WITH PARENTS

The Survey selected 10 sampled residents for family/guardian Interviews with regard to LNC’s services, however only seven were available and interviewed via telephone. Most of the families interviewed reported that their family member had lived or attended another facility prior to coming to Lakeview.

One parent interviewed indicated prior to going to Lakeview their son had lived at home.

However, they report their son has Autism with other diagnoses and his behavior was becoming so aggressive, breaking things including windows during transport on the Bus to school, that they refused to transport him. This parent initially said he wanted to keep his son at home or located closer to home. However, parent reported that after visiting LNC, LNC kept in contact because they felt they could help. Parent stated that LNC is the only place which would accept him. Currently they keep in contact daily via phone and the parent reports participating in sons programs and reports the facility listens to suggestions provided. This family further reports that Lakeview is working on an active transition plan to another facility closer to allow him to live at home and be transported to the school site.

Another parent interviewed stated that before coming to LNC their son was having extreme self-injurious behavior and extreme physical aggression and was in restraint a lot of the time. They report at LNC their son's physical aggression has significantly decreased. Parent stated LNC is much less invasive and less punitive. At the school and residence program their son has 2-to-1 staffing for him and they are working on expanding their son's communication skills. Parent further stated that no one or place has been able to do more for their son in such a short period of time.

Additional parent(s) interviewed report the school program is "second to none", that their child has progressed well and is being transitioned up to the next level. They report participating in meetings via phone, discussing current progress, medical, education and social concerns and reports that Lakeview works to understand and include the parent recommendations. They did report some concerns stating that they did request to have one-to-one staff level of supervision in the group home and have insisted that he have a single bedroom, stating further that an incident had occurred in which something was thrown by a peer and their child's teeth were broken and they still don't really know what or how the incident occurred. They insist on having a one-to-one and no roommate at the residence.

One concern expressed was the high staff turnover in particular at the residences; parent seems to feel this is likely related to not having requirements for professional credentials in residential staff, and not having the same level of pay or salary.

One family interviewed was not satisfied or positive about the LNC program. Stated her child was supposed to have speech therapy and occupational therapy and asked for pragmatic language and says that did not happen. The parent also reports that evening social skills groups were supposed to be happening but were not being provided.

One of the more serious and frequently stated concerns was that there is not enough staff in the residential programs to maintain the one to one staffing. One parent further stated there was not enough staff, that there were an additional 1-2 children present and not extra staff. Further that this is when a child ran away.

One parent stated that there was not enough communication and that she did receive some reports that her family member was scratching herself, but when she brought her family member home she had hundreds of scratches and was and had been eating glass. The parent reports she did not receive incident reports that reflected the amount of scratches or about eating glass.

One family interviewed stated their concern about their family member who needs 1 to 1 staffing in the residence; however, reports that when the resident goes to sleep there isn't enough one-to-one staff available and the resident gets up and gets into dangerous things that she shouldn't get into. The parent reported she has eloped into the community at night, vandalizes, and the police were called.

Record review was completed which confirmed this resident has eloped at times and confirmed that staff accompanied the resident the entire time working to de-escalate and also confirmed she threw a rock at a camper during this incident which is when the Police were called, however, staff stayed with her so she was supervised until she safely returned home.

Further survey observation of this resident occurred at the vocational skills classroom with vocation staff supervision. This resident presented the vocational project they were working on as a team. The resident stated they started a snack and lunch delivery service, in which they planned snacks, meal menus, made signs, went with staff to post signs, took, prepared and delivered the orders. They also collected the money due.

During one parent interview via phone, the parent reported the resident somehow found or obtained a bottle of nail polish and broke the bottle and ingested the nail polish and the glass and was in surgery having glass removed at the time of the parent interview.

Life Safety Code

Life Safety Code Inspection under NFPA 101 (2009 edition) Visit Dates: 11/13/14 and 11/14/14. Buildings included in survey: Main House, Cambridge, Monterey I, II & III, Americana I & II.

A tour with the Maintenance Director included all 8 buildings that house residents, a review of vendor documentation, maintenance records, and required Fire Drill reports. All fire drills have been conducted (106 times) in addition to multiple false alarms (resident pulls) and all were documented. The Facilities Maintenance Department has a difficult and challenging job of repairing and/or replacing items on an almost daily basis. Some items such as baseboard heater covers (for example) are kicked and damaged regularly. Doors and walls are routinely damaged by challenging residents and repaired in a timely manner. Exit signs and smoke detectors sometimes become the focus of some residents and need constant repair. During the Life Safety tour of the Main Building it was observed that 2 rooms could be lacking some sprinkler coverage, The Main living room, on the first floor and the hallway to the dining room. The rest of the building appears to have appropriate coverage. The main hallway door next to the ILS wing has a damaged frame and needs to be fixed/changed to keep a smoke tight seal on the door. The Cambridge cabin has a crawl space below the 1st floor (Furnace area) with some minor penetrations through the drywall that need to be sealed to prevent the potential passage of smoke. The Monterey I cabin had a burned outlet receptacle in the mechanical room which was replaced during the tour. The 5 remaining cabins had no Life Safety issues observed during the tour.

ADDENDUM

DR. BEN LEWIS, ED.D

QUALITY MANAGEMENT CONSULTANT

ROLE AND FUNCTION OF THE EXTERNAL QUALITY MANAGEMENT CONSULTANT

REVIEW OF LAKEVIEW NEUROREHABILITATION CENTER, EFFINGHAM, NEW HAMPSHIRE

PRE-ON-SITE ACTIVITIES PERFORMED BY EXTERNAL CONSULTANT:

- Met with DHHS Certification Bureau Chief and staff to develop strategy for on-site review
- Developed list of documents and materials required for pre-site and on-site review
- Consultant reviewed all requested materials submitted by Lakeview

ON-SITE ACTIVITIES PERFORMED BY CONSULTANT:

- Consultant met daily with DHHS Bureau Chief to discuss tentative findings, assess progress and plan next day's activities
- Provided consultation to Bureau Chief and Team members regarding review process and findings
- Participated as a Team member in all Review activities
- Co-facilitated all Review Team activities in collaboration with DHHS Bureau Chief
- Reviewed all relevant documents, Medical Records, accreditation reports
- Conducted environment of care tour, with Team
- Conducted interviews with key leadership staff
- Conducted group interviews re Infection Control, Human Resources, Quality Improvement with Team

POST ON-SITE ACTIVITIES PERFORMED BY CONSULTANT:

- Consultant designed and developed structure for Final Report
- Wrote substantial sections of Final Report
- Integrated material from other Team members into Final Report
- Edited numerous drafts of Final Report
- Consultant developed all RECOMMENDATIONS in Final Report for review by Team members

As an external, independent consultant, Dr. Lewis, both participated in and provided consultation to the Review Team in all aspects of the review process and findings. The final product of the review is a comprehensive, integrated report with process and all findings and recommendations endorsed by the Consultant and all Team members.