DISABILITY RIGHTS CENTER-NH

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March 26, 2015

Via Electronic Mail Only
Marilee Nihan, Deputy Commissioner
Mary Castelli, Esq.
State of New Hampshire
Department of Health and Human Services

RE: Lakeview Neurorehabilitation Center
Corrective Action Plan/Continuing Concerns

Dear Ms. Nihan and Attorney Castelli:

We are writing to bring your attention to DRC's concerns regarding Lakeview's corrective action plan that was recently approved by the Department of Health and Human Services (DHHS).

The Disability Rights Center (DRC) and DHHS Review Team identified numerous, serious and chronic deficiencies in Lakeview's staffing and programs which violate New Hampshire's licensing rules and compromise the health, safety and welfare of Lakeview's residents. Many of the concerns our organizations identified and published in reports issued in September and December of 2014 echo the New York Justice Department's findings in its January 2014 report as well as in the citation of workplace hazards issued by the Department of Labor Occupational Safety and Health Administration (OSHA) in May 2013 and DRC's 2011 report concerning the alleged excessive use of force against L.B. Throughout this time period, Lakeview's administrators have represented to DRC, and perhaps your office as well, that they were making improvements to address deficiencies including, but not limited to: addressing understaffing; ending the practice of relying on staff assigned to provide 1:1 supervision to a particular resident to also supervise additional residents; ensuring that its personnel are properly trained to report abuse or neglect of residents; improving restraint training and practices; implementing an electronic records system to facilitate better, timely communication among Lakeview's professional and direct care staff. Yet, despite its representations, Lakeview has yet to implement any of these promised improvements.

In the meantime, vulnerable individuals are continuing to be subjected to substandard, and in some instances, dangerous conditions. A recent incident, published on the DHHS Bureau of Licensing and Certification website provides a case in point. According to a licensing complaint report dated February 19, 2015, during a January 7, 2015 monitoring visit, two DHHS employees witnessed a Lakeview employee physically restrain a 16-year-old boy in his bed. The employee bounced up and down on the resident and, when the resident stopped resisting, the employee punched the resident in the face. The fact that this type of violence occurred as DHHS staff was there on a routine monitoring visit speaks volumes. It indicates that, despite DHHS's efforts to

provide substantial oversight and monitoring of this facility, Lakeview continues to abuse its residents.

The time for Lakeview to take and maintain corrective action began years ago, and at the very latest, when DHHS stepped up its on-site monitoring efforts in response to the reports DRC issued in September 2014. Yet, abuse and neglect of Lakeview's residents has continued, demonstrating Lakeview's inability to ensure and maintain the health, safety and well-being of its residents, let alone to bring itself into compliance with each and every one of the licensing rule violations identified by the DHHS review team.

In addition to the report described above, the licensing website lists additional violations illustrating Lakeview's continued inability to satisfactorily address chronic staffing and communication deficiencies. On October 20, 2014, following the elopement of two residents assigned 1:1 staff in August and September 2014, the Licensing Bureau cited Lakeview for failure to provide necessary levels of supervision.[1] In a plan of correction dated October 30, 2014, Lakeview represented that it had implemented a level of supervision checklist in which staff are required to confirm that residents' level of supervision is being followed and "staff members assigned one-to-one program participants who demonstrate high elopement risk cannot drop this level of supervision to attend to other issues." Lakeview also represented that its "Operation Team members . . . now participate in daily unannounced Quality Assurance walk-throughs . . . Responsibilities include ensuring that the on-duty staff members are aware . . . of the level of supervision for those in their charge and that the documentation related to their supervision is current and accurate." Despite these representations, subsequent licensing complaint investigation reports indicate Lakeview's continuing failure to to provide ordered levels of supervision. For example, Licensing determined that on or about December 29, 2014, a Lakeview resident who was assigned 1:1 supervision was able to jump out of the shower and run naked into the woods and under a 6-foot fence. The resident remained at large for 45 minutes before located by staff. DHHS's Licensing Bureau found Lakeview not in compliance with RSA 151 and He-P 807 for failure to provide necessary supervision, failure to provide safety services to minimize likelihood of accident or injury, failure to employ qualified staff to meet the needs of clients at all times, and failure to have an adequate security system in place to prevent elopement by clients at risk.[2] A Licensing complaint investigation report dated January 22, 2015 cites Lakeview for again failure to provide adequate supervision, finding that approximately 2 months after adopting the above-referenced corrective action plan, a client eloped from his residence and was found walking off the grounds, on Highwatch Road. The client's supervision level was visual checks every 15 minutes while sleeping. However, this arrangement was not sufficient as the client was able to wake up, dress, and walk outside, down the driveway and onto Highwatch Road without any staff member noticing. In addition, the Licensing report states that Lakeview staff indicated that it was not possible to provide all residents with their required levels of supervision with the number of staff assigned to the residence at issue.

A Licensing report dated January 12, 2015 indicates that, DHHS's Bureau of Licensing and Certification determined Lakeview was noncompliant with RSA 151 and He-P 807 because it

[1] The report indicates that the client who eloped on August 24th was missing overnight. The client who eloped on September 19th was missing for almost 7 hours.
[2] Complaint Investigation Report, Visit Date 12/30/2014.

failed to administer medication in accordance with the orders of a licensed practitioner. DHHS's inspection revealed that Lakeview failed to provide a client with a prescribed medication from December 1, 2014 through December 19, 2014 because "a nurse did not transcribe the medication." Lakeview's staff did not notice this error until December 19, 2014 and did not resume delivery of the client's prescribed medication until December 20, 2014.

The NH Department of Education's ("DOE") recent reports of its special on-site monitoring activities provide further evidence of Lakeview's inability to comply with relevant laws and rules in place to ensure individuals with disabilities receive appropriate treatment and are free from abuse and neglect. The DOE has identified numerous, serious violations of state and federal laws pertaining to the education of children with disabilities through its monitoring efforts at Lakeview. In a letter to Lakeview dated March 11, 2015 DOE states, "the Lakeview School has shown . . . a consistent pattern in the severity, length and repetitive nature of the findings of noncompliance." (See attached letter dated March 11, 2015, p. 1). For example, during an unannounced visit on February 26, 2015, Lakeview's teachers could not account for their students' whereabouts. DOE monitors witnessed the failure of Lakeview's "first responders" to arrive at the location to which they were called and, once they did arrive at the correct location, the failure to attend to an injured staff member. DOE staff also observed evidence of Lakeview's continuing failure to provide its clients with their assigned levels of supervision. During the February 26 monitoring visit, DOE staff observed Lakeview's failure to provide 1:1 staffing to one student and one student with a teacher acting as 1:1 staff, begging the question – how was teacher going to serve as a student's 1:1 and provide any meaningful education services to the other students?

DOE staff found serious and unlawful deficits in Lakeview's communications with parents. In particular, contrary to the requirements of RSA 126-U:7, New Hampshire's law limiting the use of restraint on children, Lakeview failed to provide evidence of written notification to parents of the use of restraint upon a student. In addition, DOE staff observed, "Lakeview School staff did not appear to know where they needed to be or with whom they were working." (March 11, 2015 letter, p. 11).

Even more troubling, DOE's observations reveal fundamental dishonesty among Lakeview's staff and administrators. For example, Lakeview's Chief Operating Officer represented to the NHDOE that in January 2015 Lakeview had adopted numerous policies and procedures in response to deficiencies identified by the DOE. Yet, during its February 26, 2015 visit, upon questioning by the DOE, Lakeview's school administrator was unaware of any newly adopted policies and procedures. In November 2014, the DOE ordered Lakeview to immediately shut down an unapproved Life Skills Program. During the February 26, 2015 monitoring visit, DOE's monitoring staff overheard the Director of Lakeview's School instructing her staff "not to call the white modular building (where the Life Skills program had been conducted) the Life Skills Program." The Director then told the DOE monitoring team that "two students were removed from the brown building to be put into the white modular building." Lakeview School's personnel roster includes a list of ten consultants. Yet when DOE's monitors inquired further, they learned that Lakeview only had signed contracts with 4 consultants and, of those, only 2 have provided any consultation to school staff. (March 11, 2015 letter, p. 12) Finally, the

Director of Education told DOE's monitors that Lakeview School recently added a daily social skills course, but the monitoring team "saw no evidence of this course"

Lakeview has failed to timely correct issues of noncompliance as ordered by the DOE. For example, in November 2014, the DOE ordered Lakeview to "immediately develop written policies and procedures for reporting suspected abuse and neglect to DCYF and BEAS," and provide evidence that this deficiency was corrected by January 24, 2015. As of March 11, 2015, Lakeview School had failed to correct this noncompliance. The policies and procedures it represents as approved by the board on January 27, 2015 to address this issue "make no mention of reporting instances of abuse to the BEAS and state that reporting must be done no later than the next working day to DCYF. This timeframe is contrary to New Hampshire law which requires the oral reporting of abuse or neglect "immediately." RSA 169-C:30. In fact, each time the NH DOE returned to Lakeview to review whether it had corrected the noncompliance identified in prior visits, it found additional noncompliance. According to the DOE letter dated March 11, 2015, Lakeview has only corrected 3 of the more than 30 findings of noncompliance identified by the DOE.

Given the scope, severity and continuing nature of the deficiencies cited by DRC, DHHS, the NHDOE and other government entities, at the very least, DHHS should not permit vulnerable individuals with disabilities to continue residing at Lakeview, placing their lives and well-being at risk, while Lakeview attempts to correct the deficiencies and begins to operate a program that fully complies with relevant health, safety and clinical standards. It is therefore, DRC's position that, pending satisfactory demonstration of its capacity to offer and maintain a program that corrects each and every one of the deficiencies cited by DHHS, Lakeview's license should be revoked or, at the very least, suspended. Should Lakeview make, and demonstrate capacity to maintain, the improvements recommended by DHHS's licensing team as well as all recommended improvements recommended by the independent evaluator DHHS retained, it could apply for a new or renewed license.

DHHS should not license a facility unless it demonstrates present capacity to comply with all relevant rules and regulations. Lakeview has not remedied the deficiencies cited by DHHS nor has it implemented DHHS' recommended action steps to address those deficiencies. Lakeview's acceptance of those findings and the "seriousness" of those findings is clear acknowledgement that it does not have the capacity to ensure compliance with all relevant rules at this time. Even if Lakeview's Plan of Correction ("POC") leads to compliance, it will take many months, or possibly years, to successfully implement and maintain compliance. The individuals who currently reside at Lakeview should not be "guinea pigs" while Lakeview works towards eventually operating a program that complies with New Hampshire's licensing statute and regulations pertaining to the health, safety, welfare and provision of meaningful rehabilitative care.

We also question DHHS's decision to approve Lakeview's POC before receiving a final report from Kathryn Dupree, the independent evaluator retained by DHHS who, in addition to assessing the Department's monitoring and oversight of this facility, is charged with conducting an independent "review of the facility to determine whether it has the infrastructure to provide the necessary supports and services to its residents." (November 18, 2014 letter DHHS submitted

to the Governor and Council requesting approval of sole source agreement with Kathryn Dupree.) According to DHHS's request, Ms. Dupree was expected to "review and utilize the findings of a current licensing/complaint review of the facility to complement her review." (November 18, 2014 Letter, p. 2). Rather than "complementing her review," DHHS's acceptance of Lakeview's POC undermines the authority and import of Ms. Dupree's review and is inconsistent with the contract approved by the governor and council.

Besides the aforementioned concerns, DRC strongly doubts Lakeview has the capacity to resolve chronic and persistent staffing, communication and program deficits and satisfactorily correct the deficiencies identified by our respective organizations due to its demonstrated inability to make previously promised improvements as well as to factors outside Lakeview's control Even if that capacity did exist, we do not believe the provisions of the plan are designed to meet licensing standards and address the findings of the licensing team.

Although not an exhaustive list, DRC has identified the following serious concerns with the POC:

1. Quality Assurance/Performance Improvement.

DHHS's review team determined that Lakeview "needs to continue to develop its Quality Improvement Performance Improvement (QAPI) program," including utilizing accepted QI methodologies such as PDCA, LEAN and Six Sigma. DHHS Review Team Report, p. 13. The Plan of Correction does not specify what accepted methodologies Lakeview will use to analyze the data it collects, design and implement action plans. In addition, it should be noted that Lakeview's promise to implement a quality assurance program is not new. Lakeview had a designated director of Quality Assurance/Quality Improvement on staff, and represented it maintained a QAPI program at least as early as May 2010. Several years ago, as part of its response to DRC's efforts to follow-up on findings and recommendations published in the 2011 investigation of alleged use of force against L.B., Lakeview assured DRC it had implemented a continuous improvement quality assurance program. A key component of Lakeview's plan to improve its QAPI efforts was a transition to electronic medical records. Lakeview has yet to make this transition (though it is again representing a commitment to implement a system to maintain health records electronically.) Furthermore, the continuing documented incidents of abuse, neglect and sub-par treatment provided to its residents indicate Lakeview's inability to effectuate and sustain any meaningful effort at quality assurance and program improvement.

2. Staffing Deficits.

In the December 2014 report of its review of Lakeview, the DHHS Review team determined that "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." (DHHS Review Team Report, p 4). Lakeview's Director of Human Resources reported that Lakeview's salaries are not competitive, that local McDonalds and Wal-Mart pay more and that seasonal jobs draw staff away. *Id.* DHHS's recommendations provide that Lakeview "needs to increase its recruitment efforts, including salaries that are above market, to attract and retain qualified and competent direct care staff." *Id.* at p.5.

a. Compensation for Direct Support Staff.

The POC does not provide for salaries commensurate with DHHS' recommendations. It appears that Lakeview did not conduct a market analysis to determine whether the proposed salary increases are, in accordance with DHHS' recommendations of, "above market" rates to attract and retain qualified and competent direct care staff. Rather than raise salaries to above-market rates, the POC calls for raising starting salaries for rehabilitation specialists and education aides from $10 to 10.50 per hour, a mere .50/hour increase. Neither this modest increase nor the increased differentials for 2nd and 3rd shift bring the salary levels sufficiently above market rates to attract sufficient numbers of qualified workers for those shifts. A readily available source for information on pay rates for comparable positions is the State of New Hampshire's Administrative Services Department. According to information published in this department's website, the salary range for a Mental Health Worker I, a position comparable to Lakeview's "rehabilitation specialist," is from $12.91 to $16.81 per hour. On top of that, individuals employed by the State of New Hampshire also receive generous health insurance, vacation and retirement benefits. Lakeview represents that it will tie "additional milestone bonus opportunities" to completion of "a comprehensive staff training development plan," but does not provide any specific information about the actual compensation staff may expect.

Although the POC calls for Lakeview to "over-recruit a pool of quality staff," (POC p. 14) the POC does not provide any substantial, ongoing activities to attract and maintain a sufficient pool of qualified direct care workers. The POC touts a one-time referral and sign on bonus for January 2015 to increase the pool of potential hires, but does not provide any descriptions of efforts to ensure that the individuals hired are qualified for the type of work required. Nor is there any evidence of a plan to ensure that the newly hired individuals remain at Lakeview for any period of time. We can envision a situation in which someone without a lot of schooling would be attracted to the sign-in bonus, start working at Lakeview, collect the bonus and then leave shortly thereafter for a higher paying, less stressful position.

Lakeview's POC recognizes that, given the limited population in the immediate area, it is necessary to recruit staff from a broader geographic region. To support this effort, the POC states that Lakeview will provide transitional housing options for applicants who may be willing to relocate. We doubt that many individuals would choose to uproot their lives to move to Effingham, NH for a job that pays only 10.50 per hour to start. In short, we question Lakeview's assumption that a one-time hiring bonus for one month and small hourly pay increases will have any meaningful impact on Lakeview's ability to recruit and retain a sufficient number of qualified staff members to meet the treatment needs of the 88 individuals it is licensed to serve.

b. All-Staff Town Meetings.

DHHS identified a need to administer a staff satisfaction survey on a semi-annual basis to generate data for Lakeview to "gain insights into the effect of staffing increases on morale and retention." (DHHS Review Team Report, p. 5). Lakeview's POC includes instituting monthly "all-staff town meetings" to increase communication with staff, including listening to staff ideas for improvements. Again, this is nothing new. During a meeting held with DRC staff in 2012, Lakeview represented that it used such "town meetings." Yet incidents of client abuse, neglect

and substandard care have continued. It is DRC's impression that issues with staff morale and retention have less to do with providing public opportunities for staff to express their opinions than Lakeview administration and clinical staff's failure to listen to and respond to critical concerns related to clients and client treatment raised by direct care staff. For example, during DRC's investigation of JD's death, several staff members attempted to communicate concerns about JD's declining health to professional and supervisory staff. The problem was that Lakeview's administrative and clinical staff failed to respond effectively to their concerns.

c. Compliance with prescribed levels of supervision.

The DHHS Review team found that Lakeview did not have an effective means of communicating residents' levels of supervision between shifts and/or program components. Some staff reported not knowing residents' levels of supervision ("LOS") at any given time. LOS documentation was lacking in incident reports. In addition, 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" rather than to meet the needs of its clients. DHHS Review Team Report, p. 6.

Lakeview's POC calls for it to achieve sufficient "staffing density" to be able to "overstaff each shift by at least two direct care staff" to compensate for the call-outs they expect each day from direct care staff. (POC, p. 14). Given Lakeview's chronic understaffing, difficulty recruiting and retaining qualified staff, DRC does not find Lakeview's plan to recruit and retain qualified direct care staff to enable overstaffing by March 30, 2015 to be a realistic goal.

The POC provides for review and adjustment of LOS at weekly risk management meetings. DRC has serious concerns regarding this strategy. Under New Hampshire law, LOS must be addressed in the context of the development of the client's Individual Service Agreement, a process which is organized, facilitated and monitored by the individual's service coordinator. He-M 503.01, *et seq.*, He-M 522.01, *et seq.* Any changes to the service agreement must be discussed among, and approved by, the client, guardian, if applicable, and the area agency. *Id.* Besides violating New Hampshire's rules regarding the provision of services to individuals with developmental disabilities and acquired brain injuries, having its risk management team change clients' LOS would likely violate Lakeview's contracts with the placing organizations in New Hampshire as well as other states. As DHHS' own review team found, Lakeview's persistent staffing deficits have resulted in Lakeview lowering required LOS to meet its available staffing levels. DHHS Review Team Report, p. 6. DRC is concerned that staffing levels will not improve to the extent necessary to meet client's supervision needs and, therefore, provide an incentive for Lakeview's risk management team to reduce LOS for expediency and self-interest rather than clinical appropriateness.

The POC calls for "bringing clinical staff and management . . . onto the 3-11 and week-end shifts."(POC, p. 19). Again, this proposal is not new from DRC's perspective. In fact, Lakeview's management informed DRC that it was making this very adjustment during a meeting held in May 2012. Yet, Lakeview has continued to fail to provide its residents with the requisite LOS and to ensure they are free from abuse and neglect.

d. Crisis management.

DHHS's review team determined that Lakeview "needs to comprehensively analyze crisis management training and response to events to identify problem areas and inform the development of alternative strategies." (DHHS Review Team Report, p. 5). Lakeview's POC provides that it needs to "revamp the way in which our crisis intervention training is taught and way that ongoing application of Mandt techniques is supported." (POC, p. 23). One of the improvements Lakeview promises in the POC is to "institute a continuous learning culture, where direct care staff are supervised (in real time) by Mandt trainers in using crisis response techniques" (POC p. 25). To truly provide "real time" supervision of direct care staff by Mandt trainers, Lakeview would need to assure there is a Mandt trainer on site at each and every residence, during each and every shift. Is this what Lakeview is guaranteeing? If so, this should be made clear in the POC and include provisions for documenting that the Mandt trained staff is present on each shift, at each residence and program location.

e. Dedicated response team.

The DHHS review team determined that Lakeview needs to "make accommodation for a dedicated response team to assure that crisis management events do not impact the required level of supervision of other residents." (DHHS Review Team Report, p. 7). A prime factor calling for the need for a response team is that the nature of the population that an institution like Lakeview serves – individuals with complex issues, including challenging behaviors, that cannot be successfully maintained in their home communities with appropriate services and supports. Even with correct levels of trained staff, behavioral incidents may, therefore, occur which require more staff resources than are generally available at a particular housing or program location. A "response team" lends additional staff resources, when and where needed, without necessitating the reduction of staff for other residents. For this reason, response team members should never include individuals who are currently assigned to attend to the needs of clients in a residence or program. Otherwise, individuals who are assigned as 1:1 support or to provide higher levels of support to individuals not in crisis will be forced to take on additional supervision responsibilities that will make it impossible for them to provide their charges with their prescribed levels of supervision.

Lakeview's POC does not appear to recognize this potential. Its POC seems to permit the assignment of generally-assigned staff to the response team. As written, the POC would permit Lakeview to pull a a staff member assigned to the "general milieu" in Monty 1, for example, onto the response team. In doing so, the question is whether there would be sufficient staff remaining in Monty 1 to provide the levels of supervision for the residents in that cabin. What if there are multiple behavioral incidents at the facility at the same time? Will there be sufficient staff to both attend to the treatment needs of the individuals who are not involved in the incidents as well as to provide the enhanced staff needed to attend to the clients with behavioral issues? Finally, DRC questions the skill level and efficacy of Lakeview's response team. A recent letter issued by the DOE details observations of Lakeview's response team in action on February 26, 2015. According to the DOE report, on that date, the response team was called to attend to a behavioral incident at the school. DOE reported that the response team did not even know where the incident occurred, went to the wrong building and had to ask around before team

members finally arrived at the scene of the incident. When they finally arrived at the correct building, responders failed to attend to the staff member who had been injured. (3-11-2015 letter, p. 8).

3. Communication.

Lack of effective clinical documentation and communication between and among Lakeview's clinical professionals and direct care staff was identified by DRC as part of the L.B. investigation report issued in 2011 and, most recently, through the DHHS team's review. (DHHS Review Team Report, p. 9). In its POC, Lakeview expresses its agreement that its staff must have "immediate access to key information related to care, treatment and advancement of our program participants, and that we must utilize multiple mechanisms to ensure that information is shared effectively." POC, p. 43.

a. Conversion to Electronic Medical Records.

One method, recommended by DHHS' review team, to improve communication is to implement electronic medical records. (DHHS Review Team Report, p. 9). This is another strategy, included in the POC that Lakeview has promised, but failed to deliver, for several years. As early as August 2012, Lakeview represented to DRC that it was changing over to an electronic health records system to better enable communication and coordination of resident's care. Nearly three years later, Lakeview has not implemented the changeover to electronic health records.

b. Supervision for direct care staff.

The POC calls for "observation and real time feedback on crisis management and incident reporting as well as "clinical staff and direct care staff working side-by-side during shifts including day, evenings and week-ends" (POC, p. 44). This sounds like a laudable goal. However, the POC does not specifically require scheduling of clinical staff throughout shifts at the residences and program areas. Rather than assure that clinical and direct care staff will actually work side-by side, the POC calls only for leadership staff and trainers to "drop in" during shift time to observe the quality and comprehensive nature of the communication during the shift change. (POC, p. 45). It should also be noted that the 30-minute shift overlap provided in the POC is not new. Lakeview informed DRC that it was instituting the 30-minute shift overlap in August of 2012. Its implementation has not seemed to impact services at Lakeview. For example, in the case of J.D.'s death, an overnight staff member observed J.D. lying on the floor, naked in a pool of urine and suspected he had suffered a seizure. Providing this information to the morning shift staff had no impact as neither the overnight staff nor daytime relief staff took any action to address J.D.'s situation.

To conclude, the POC on its face is inadequate to address the findings made by the licensing team, particularly when considered in light of the long history of persistent and chronic deficits in staffing levels, communicaton, and clinical practices resulting in substandard care and mistreatment of residents and the equally unending series of broken or unimplemented commitments to remediate these conditions and their causes. Even assuming that the POC could

lead to compliance, it would take months, if not years, for the substantial, chronic and persistant deficiencies to be corrected in a manner that would be sustainable over time. Lakeview does not have the present capacity to adequately serve its residents, a reality which is buttressed not only by historical events, but also as evidenced by continuing findings of noncompliance by the DOE and DHHS's Licensing Bureau. Lakeview, therefore, should not be permitted to operate as a licensed residential facility in our state. At the very least, Lakeview should not be permitted to house and treat any residents, regardless of their state of origin, until they are able to satisfactorily demonstrate a present, and sustainable, ability to correct each and every violation of New Hampshire's licensing rules and statute identified by DHHS's review team. The same or similar widespread levels of mistreatment and substandard conditions would not be tolerated for a minute in a community hospital or other generic facility serving the general population and certainly should not be tolerated in a facility that serves individuals with highly significant needs and vulnerabilities.

It is also both premature and inappropriate for DHHS to accept Lakeview's POC before receiving a full report from Kathryn Dupree, the independent evaluator retained to review both Lakeview's capacity and DHHS's oversight of this facility and potential findings she may make in both areas.

Please feel free to contact any of us if you have any questions or would like to discuss the matters set forth in this letter.

Sincerely,

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