



# **DISABILITY RIGHTS CENTER - NH**

## **Report of an Investigation into the Circumstances Leading to the Death of J.D., a Resident of Lakeview Neurorehabilitation Center**

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**The Disability Rights Center – NH is the designated federal protection and  
advocacy system for New Hampshire and is a member of the National  
Disability Rights Network**



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## **Executive Summary**

On [REDACTED] 2012, “J.D.”<sup>1</sup>, a twenty-two (22) year old young man with a known history of depression and developmental disabilities as well as a seizure disorder, died in his residence at Lakeview Neurorehabilitation Center in Effingham, New Hampshire (“Lakeview”). He had been at Lakeview for only seventy-two (72) days at the time of his death.<sup>2</sup>

Shortly after J.D.’s death, the Disability Rights Center - NH (“DRC”), New Hampshire’s designated protection and advocacy system, received reports alleging that Lakeview’s actions or inactions with respect to J.D.’s treatment and supervision may have caused, or led to, J.D.’s premature death. In particular, DRC received reports alleging that during his brief time at Lakeview, J.D.’s physical and mental health sharply declined and that Lakeview failed to provide appropriate medical care and behavioral interventions to address J.D.’s healthcare needs. Further, DRC received reports alleging that Lakeview failed to inform J.D.’s legal guardian, family members, the Area Agency that funded his placement, or community residential services providers of the extent of J.D.’s declining physical and behavioral health; Lakeview thereby deprived these individuals of the information necessary to consider options to address these concerns, including possibly terminating his placement at Lakeview and moving him to a different setting.

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<sup>1</sup> “J.D.” is a pseudonym assigned to protect this individual’s privacy. In addition to using a pseudonym, DRC has redacted information, such as dates, which could lead to J.D.’s identity. In some instances in which confidential information has been removed, DRC has added clarifying information, in brackets, to provide contextual information for the reader. An un-redacted version of this report, including J.D.’s identity, has been provided to individuals and officials who have the authority to obtain this information, e.g. Lakeview Neurorehabilitation Center, the NH Department of Health and Human Services.

<sup>2</sup> Prior to his admission to Lakeview, J.D. had lived successfully with a caregiver in his home community for approximately 2 years. Unfortunately, J.D. was required to move to a new provider in a different community. He did not adjust well to his new surroundings. J.D.’s residential provider raised concerns about his safety which resulted in his involuntary admission to New Hampshire Hospital and then his placement at Lakeview for a short term basis until an appropriate community-based residential placement could be arranged.

Pursuant to its federal authority, DRC conducted an investigation of the circumstances surrounding J.D.'s death to determine whether Lakeview's actions or inactions constituted abuse or neglect and/or contributed to, or caused, his death. DRC's investigation focused on the care and treatment J.D. received at Lakeview including medical, mental health, crisis intervention services, general supervision and residential care. DRC reviewed Lakeview's efforts to communicate pertinent information regarding J.D.'s health status with, and seek input from, J.D.'s legal guardian and other individuals involved with his treatment in his home community. DRC reviewed J.D.'s records maintained by Lakeview as well as relevant policies and procedures in effect at Lakeview. DRC interviewed Lakeview residents who had lived with J.D., staff members who worked with J.D., his legal guardian, and other individuals involved with his care and treatment. In addition, DRC reviewed reports regarding J.D.'s autopsy which were completed by the New Hampshire Office of the Chief Medical Examiner.<sup>3</sup> DRC reviewed a report concerning J.D.'s treatment while at Lakeview authored by Dr. Carl Cooley, Chief Medical Director at Crotched Mountain Foundation, an expert retained by DRC to assist with this investigation. DRC provided a draft investigation report to Lakeview for its review and response prior to issuing this report. DRC reviewed Lakeview's response, which was provided by its attorney, obtained additional consultation from Dr. Carl Cooley regarding Lakeview's response and reviewed a supplemental report authored by Dr. Cooley pertaining to Lakeview's response to the draft investigation report.

After carefully reviewing the above-referenced information, the DRC concluded that Lakeview's actions and inactions including, but not limited to, the conduct of various administrators, consultants, and staff members with regard to J.D.'s treatment constituted neglect

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<sup>3</sup> Due to Confidentiality Requirements, the Chief Medical Examiner's Report is not included with this Report. In addition, in accordance with the Chief Medical Examiner's instructions, information contained in the Chief Medical Examiner's Reports, other than cause and manner of death, have been redacted.



as defined by relevant New Hampshire and Federal laws. Further, DRC determined that the deficiencies DRC uncovered likely led to J.D.'s untimely death.

DRC's most significant findings include the conclusion that Lakeview inadequately responded to clear warning signs of a serious health condition, in particular: J.D.'s refusal to eat and loss of nearly 50 pounds in only ten (10) weeks, a refusal to take prescribed medications as directed by a physician and his guardian, two hospitalizations for prolonged seizures, expressed suicidal ideation, and a lack of participation and engagement in nearly all activities. Further, Lakeview failed to adequately track, and assess the impact of, J.D.'s weight loss, ensure staff complied with J.D.'s supervision requirements, and failed to secure medically-indicated lab work in a timely manner. While under Lakeview's supervision and care, J.D.'s overall health declined to the point where he was in a metabolic state of starvation and his medication levels had likely dropped well below therapeutic levels. Despite this, in his final days and hours, J.D.'s physical and mental health status did not appear to be of much concern to many of Lakeview's staff members, including medical and clinical staff.

The morning he died, direct support staff noted that J.D. was naked and lying on the floor in a pool of urine. An overnight staff member who reportedly observed J.D.'s condition at approximately 5:00 a.m. suspected he had experienced a seizure. Yet, instead of contacting health services, or attending to J.D.'s physical condition, this staff member, and subsequent staff on duty, left him and attended to other residents. Several hours after staff first noted J.D.'s condition, another direct support staff member noted J.D. was "nonresponsive." Rather than assess whether J.D. was conscious or call for assistance, he simply left J.D. alone and tended to other residents. It was not until more than four hours after J.D. was observed lying on the floor that one of Lakeview's nurses, who had come to deliver medications, noticed that J.D. was not

breathing, called for help and began administering C.P.R. J.D. was likely deceased at that point, but was not pronounced dead until his arrival at Huggins Hospital, at approximately 10:30 a.m.

Additional findings include failure to provide timely evaluations or develop an individual service plan, and failure to conduct a functional behavior assessment or modify J.D.'s behavior plan to address continuing resistance to food and medication intake. Further, Lakeview failed to ensure sufficient staffing levels to provide J.D. with the level of supervision ordered by Lakeview's psychologist. Lakeview failed to provide timely, and full, information regarding J.D.'s declining health status to J.D.'s guardian, the Area Agency that served him or community-based residential care providers who had expressed concern for his well-being. Finally, DRC found that Lakeview's system of care lacks the necessary level of interdisciplinary communication and coordination to meet the treatment needs of residents with complex emotional, behavioral, and medical needs, such as J.D.

Individuals with disabilities, including those with long-term care needs, are legally entitled to receive services in the most integrated setting appropriate to their needs.<sup>4</sup> The "most integrated setting" is one that enables individuals with disabilities to interact with nondisabled peers to the fullest extent possible.<sup>5</sup> This is generally accomplished through serving individuals in their home communities with necessary supports and services.<sup>6</sup> Unfortunately, while J.D.'s placement at Lakeview may have been precipitated by behavioral challenges he presented in the community, it appears that the decision to move J.D. from his community residence to New Hampshire Hospital and finally to Lakeview was driven less by J.D.'s needs than by the lack of alternative appropriate community-based options. The circumstances surrounding J.D.'s death

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<sup>4</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999)

<sup>5</sup> 28 C.F.R. pt. 35 app. A (2010)

<sup>6</sup> See e.g. R.S.A. 171-A:1. ("The policy of this state is that persons with developmental disabilities and their families be provided services that emphasize community living.")

serve to reinforce the critical importance for New Hampshire to develop the community-based capacity to meet the needs of individuals, such as J.D., who, from time to time, require enhanced services to live safely in their home communities.

In the interim, and to the extent that individuals continue to receive residential services at Lakeview, DRC offers recommendations to improve the safety, treatment, and well-being of Lakeview's residents and to prevent the type of tragic outcome J.D. suffered in the future. A summary of DRC's recommendations follows.

1. Lakeview should ensure there is appropriate coordination among the three domains of medical care provided at its facility (i.e., medical, neurologic, and psychological/psychiatric) as well as a good communication between direct care staff and clinical professionals. Further, Lakeview should ensure that any time one of its medical or clinical professionals examines or evaluates a resident's healthcare needs, that the examining/evaluating healthcare professional receives sufficient information from the individual, his or her guardian, direct support staff, and other medical/clinical professionals to secure a full picture of the resident's health status to complete a History of Present Illness. Finally, Lakeview's medical and clinical providers should take all steps necessary to ensure their treatment recommendations are provided in a timely manner to residents and adhered to by all staff members charged with implementing these recommendations.

2. When presented with a situation, such as J.D.'s, in which a resident's behaviors and health status are rapidly deteriorating, Lakeview should immediately convene a multi-disciplinary team meeting to consider amendments to the individual's treatment plan or, if medically indicated, to determine whether the resident requires a higher level of care than is available at Lakeview.

3. Lakeview should amend its Family Notification Policy to require that its case manager have weekly contact with residents' legally-responsible parent(s) or guardian(s) and provide timely information regarding accidents, injuries, illnesses, or "unusual incidents" in accordance with this policy. Lakeview's policies should be amended to specifically define and/or enumerate a non-exhaustive list of the types of incidents considered to be "unusual" and, therefore, must be reported to the parent/legal guardian. In addition to notifying the parent/legal guardian of accidents, injuries, illnesses, and incidents with police or public involvement, this policy should require timely communication with the parent/legal guardian to inform them about medication, food and/or program participation refusals, changes in medications, changes in supervision levels, and any recommended changes in treatment or behavior plans.

4. Lakeview should take all steps necessary to ensure that case management staff members timely obtain relevant information regarding the clients for whom they are responsible. Further, Lakeview should take all steps necessary to ensure that case management staff members provide relevant information to residents' parents and legal guardians on a timely basis.

5. Lakeview should timely convene a meeting of responsible parties, including the guardian and funders (e.g., area agency) to identify alternative providers, plan for, and effectuate, the individual's transfer to an alternative setting when, as in J.D.'s circumstances, an individual's health and safety are threatened by his or her deteriorating condition and Lakeview is unable, for any reason, to timely correct or ameliorate the condition.

6. Lakeview should immediately address and resolve communication deficiencies between and among professional and direct care staff to ensure that all staff members who have contact with residents are aware of, and comply with, each resident's current level of supervision.

7. Lakeview must maintain sufficient staffing levels in each of its residences to meet the supervision needs of each of Lakeview's residents; i.e., there should be sufficient staff available to meet the supervision levels ordered by Lakeview's clinical staff and/or residents' treatment teams at all times. No staff member should ever be left alone in living quarters with more than one resident.

8. Lakeview should amend its emergency response protocol to clearly define what constitutes a "medical emergency," by including examples such as: seizures, allergic reactions, choking, serious injuries, loss of consciousness, respiratory arrest, and cardiac arrest. Further, Lakeview should train, and test to verify understanding, each and every direct care staff member on its emergency response protocols including, but not limited to, the steps staff should take in the event that a resident has experienced a medical emergency including whenever a resident appears "unresponsive." Finally, Lakeview should provide its direct care staff with periodic training to reinforce and refresh their understanding of Lakeview's emergency response protocols.

## **I. Introduction**

On [REDACTED], 2012, J.D., a twenty-two (22) year old young man and resident of Lakeview Neurorehabilitation Center in Effingham, NH ("Lakeview") died in his residence. Shortly thereafter, the Disability Rights Center - NH ("DRC") received reports alleging that J.D.'s death may have been the result of Lakeview's actions or inactions.

According to reports received by DRC, during the seventy-two (72) days he resided at Lakeview, J.D. was severely depressed. He repeatedly and consistently requested to leave Lakeview and return to his home town. J.D. regularly refused his medications and food. In addition he refused to attend to his personal hygiene needs. J.D. had a seizure disorder and had been under the care of a neurologist prior to his admission to Lakeview. He had been prescribed anti-convulsant medications which, prior to [REDACTED] 2012 [J.D.'s second month at Lakeview], kept his seizures under good control for an extended period of time. During his time at Lakeview, J.D. lost a significant amount of weight (nearly 50 pounds). Reports alleged that Lakeview personnel failed to recognize the severity of J.D.'s conditions and failed to provide appropriate medical and/or behavioral interventions to address J.D.'s physical, emotional, and behavioral issues. Reports alleged that deficient attention to, and care for, J.D.'s conditions directly or indirectly resulted in his premature death. Further, DRC received reports that Lakeview personnel failed to inform J.D.'s guardian, family members, community residential services providers, or the Area Agency that arranged funding for his placement of the extent of J.D.'s medical issues and behavioral challenges that developed during his time at Lakeview. As a result, neither J.D.'s guardian nor other members of his treatment team who were not employed by Lakeview were aware of J.D.'s ongoing refusal to take medications or his near complete refusal to eat during the month preceding his death.

Pursuant to DRC's authority as New Hampshire's designated protection and advocacy system ("P&A") for individuals with disabilities,<sup>7</sup> DRC conducted an investigation of the circumstances surrounding J.D.'s death to determine whether Lakeview's actions or inactions constituted abuse or neglect and/or contributed to or caused his death. DRC's investigation focused on the care and treatment J.D. received at Lakeview including medical, mental health, crisis intervention services, general supervision and residential care. In addition, DRC reviewed Lakeview's efforts to communicate with, and seek input from, J.D.'s guardian and other individuals involved with J.D.'s treatment and life in his home community.

A summary of the evidence DRC reviewed, governing laws, and DRC's findings, and recommendations are set forth below.

## **II. Summary of DRC's Investigation and Methodology**

DRC reviewed J.D.'s medical, behavioral and other records maintained by Lakeview and interviewed Lakeview administrators, medical providers and staff members involved in J.D.'s care. DRC requested, but was denied access to, Lakeview's internal death investigation report. DRC interviewed J.D.'s guardian, Area Agency ("AA") case manager, staff from Living Innovations, the vendor agency retained by the AA to provide J.D. with community based residential services, an individual who served J.D. before his case was transferred to adult services, and several members of J.D.'s family.

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<sup>7</sup> DRC is authorized by federal statute to "investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred." See 42 U.S.C. § 10805(a)(1)(A). The DRC is a statewide organization that is independent from state government or service providers. As New Hampshire's Protection and Advocacy System, the DRC carries out five protection and advocacy programs including Protection and Advocacy for Individuals with Mental Illness (PAIMI). The Protection and Advocacy for Mentally Ill Individuals Act of 1986 provides for the PAIMI program which is funded and overseen by The Center for Mental Health Services (CMHS) within the U.S. Department of Health and Human Services. See 42 U.S.C. § 10801 et seq. DRC is also funded by the New Hampshire Bar Foundation and the Endowment for Health.

DRC conducted three (3) site visits at Lakeview and interviewed two (2) Lakeview residents<sup>8</sup> and fourteen (14) staff members. DRC interviewed Lakeview residents who were staying at [REDACTED], the cabin in which J.D. was residing at the time of his death, on [REDACTED], approximately ten days after his death. DRC conducted additional site visits and staff interviews at Lakeview on [REDACTED] and [REDACTED] [34 and 45 days after J.D.'s death]. DRC interviewed each of the direct care staff who worked at [REDACTED] [J.D.'s cabin] during the relevant time-frame. In addition, DRC interviewed Lakeview medical, managerial, and professional staff, including Lakeview's Primary Care Medical Director, Director of Quality Assurance, Psychiatric Nurse Practitioner, nurses, case manager, psychologists, and program directors. Each staff member and resident was interviewed separately. Although DRC interviewed nearly every staff member who had contact with J.D. during the weekend he died, Rachel Emond, the LPN who administered CPR to J.D. the morning of his death, declined DRC's request for an interview. In addition, DRC was not able to interview the Lakeview employee who served as J.D.'s case manager the first month he was at the facility as she had left Lakeview's employ approximately one month before J.D.'s death.

DRC conducted telephone interviews with various individuals who worked with J.D. in the community or were involved in his personal life including J.D.'s legal guardian, the case manager from his Area Agency (AA), and service providers from Living Innovations, the vendor agency retained by the AA to develop a residential placement in his home community. In addition, DRC conducted in-person interviews with J.D.'s grandmother, one of J.D.'s relatives who had consistent contact with J.D., and an individual who provided direct care services to J.D. before he turned twenty-one (21), at a prior residential placement.

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<sup>8</sup> DRC attempted to interview all residents of J.D.'s cabin but of the four residents available to be interviewed, only two were willing and able to communicate their recollections with DRC's investigators.



The DRC reviewed numerous records and documents regarding J.D.'s medical and emotional issues, behavioral challenges, suspected cause of death as well as policies and procedures in effect during his stay at Lakeview including:

A. The following documents provided by Lakeview:

- 1) Lakeview Policies and Procedures including, but not limited to, policies regarding: (a) procedures Lakeview staff should utilize to communicate information pertaining to residents' challenges, needs, and concerns among the various staff members/disciplines (e.g. medical, direct care, nursing); (b) procedures for communicating information pertaining to residents' progress, incidents, and concerns to residents' guardians; (c) procedures related to monitoring residents and responses to behavior, health, and critical incidents; and (d) patient and/or campus safety. DRC requested, but was denied access to, Lakeview's internal investigation report.
- 2) J.D.'s medical records created by Lakeview.
- 3) J.D.'s medical records created by Huggins Hospital as a result of hospitalizations while J.D. resided at Lakeview, including the date of his death.
- 4) J.D.'s medical records created by New Hampshire Hospital pertaining to his admission and stay at NHH from June 28, 2012 through July 13, 2012. N.B. All of these records were in Lakeview's possession prior to J.D.'s admission to Lakeview.
- 5) Incident reports, Food Tracking logs, and Cabin Logs.
- 6) Letter from Lakeview's Attorney, dated February 3, 2014, provided in response to a draft investigation report DRC provided to Lakeview on or about January 6, 2014.
- 7) Spreadsheet authored by Lakeview's Director of Quality Assurance/Quality Improvement, provided by Lakeview in response to DRC's request for information clarifying representations in Lakeview's February 3, 2014 letter.

B. NH Office of the Chief Medical Examiner's Autopsy Report dated December 27, 2012 and Addendum Report dated February 11, 2013. NMS Labs Supplemental Report issued to the NH Chief Medical Examiner dated October 18, 2013.<sup>9</sup>

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<sup>9</sup> Note. Information from these reports has been redacted, and the reports themselves omitted, from this public report in accordance with instructions from New Hampshire's Chief Medical Examiner.

- C. Primary and Supplemental Reports authored by Dr. Carl Cooley, Chief Medical Director at Crotched Mountain Rehabilitation Center, expert retained by the DRC to assist with this investigation.

### **III. Governing Laws – Definitions of Neglect**

The definitions of “neglect” provided in the following statutes and regulations are applicable to, and provided the standards and an analytic framework for, this investigation and conclusions reached by the DRC.

A. New Hampshire’s Adult Protection Act, RSA 161-F:42, *et seq.*, was enacted to “provide protection for incapacitated adults who are abused, neglected or exploited.” The Act defines the terms “abuse” and “neglect” and provides for mandatory reporting of suspected abuse of an incapacitated person by “any person, including but not limited to . . . health care professionals, social workers . . . suspecting or believing in good faith that any adult who is or is suspected to be incapacitated has been subjected to abuse, neglect, self-neglect.” RSA 161-F:46. Knowing failure to make a report of suspected abuse is a misdemeanor. RSA 161-F:50.

The Adult Protection Act defines “neglect” as “an act or omission which results or could result in the deprivation of essential services or supports necessary to maintain the minimum mental, emotional or physical health and safety of an incapacitated adult.” RSA 161-F:43, III. “Self-neglect” is defined as “an act or omission by an incapacitated adult which results or could result in the deprivation of essential services or supports necessary to maintain his or her minimum mental, emotional or physical health and safety.” RSA 161-F:43, VI,8.

B. PAIMI Regulations. Federal regulations applicable to protection and advocacy for individuals with mental illness (PAIMI) define “neglect” as “a negligent act or omission by an individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed

an individual with mental illness at risk of injury or death, and includes, but is not limited to, acts or omissions such as failure to: establish or carry out an appropriate individual program or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care; and the failure to provide a safe environment which also includes failure to maintain adequate numbers of appropriately trained staff.” *Id.* 42 C.F.R. 51.2 (Emphasis added).

#### **IV. Background and Events Preceding J.D.’s Death**

J.D. was twenty-two years old at the time of his death. He had been diagnosed with epilepsy, Asperger’s syndrome, and major depression. He began experiencing grand mal seizures before entering elementary school. However, by the time he reached adulthood, J.D.’s seizures were largely controlled by medication.

Prior to his admission to Lakeview, J.D. had lived successfully with a caregiver in his home community for approximately two years. During that time, J.D. was actively engaged in his community. He held a part-time job and regularly attended church. He made friends easily. In exchange for volunteering at a local gym, he secured a gym membership. A friend he made at the gym taught him to swim, an activity he enjoyed immensely. J.D. liked shopping and frequenting local restaurants, particularly establishments where owners and wait staff knew him.

Unfortunately, his residential provider’s circumstances changed, requiring J.D. to move to another provider’s home in a new community. J.D.’s transition to a new provider and new community did not go well. His residential provider raised concerns about J.D.’s safety which resulted in his involuntary admission to New Hampshire Hospital (NHH) on [REDACTED]. NHH staff determined that the hospital milieu was not appropriate for J.D.. Therefore, a decision was made to place J.D. at Lakeview’s Effingham, New Hampshire facility on a short term basis (not more than 90 days) until an appropriate community-based placement, preferably in or near

the community J.D. that considered his home-town, was located. In addition to providing temporary therapeutic residential treatment, Lakeview was to conduct a battery of evaluations, including psychiatric and behavioral, to develop a comprehensive behavior plan to address safety concerns and to assist his treatment providers to develop a community-based placement to meet his needs.

Lakeview Neurorehabilitation Center's facility in Effingham, New Hampshire, is a residential treatment facility, licensed pursuant to RSA 151 and He-P 807. The Effingham program provides residential services for approximately 80 individuals, most of whom have either an acquired brain injury or neurobehavioral diagnosis. According to information on its website, "Lakeview uses positive behavioral supports to address challenging behaviors that interfere with successful rehabilitation and the return to living in the community. Programs address improving healthy choices, increasing behavioral success, reducing unwanted behaviors, improving self management techniques and developing new skills and strategies that allow an individual to transition to living in the community." <http://lakeviewsystem.com/programs-and-services/neurobehavioral>.

J.D. was admitted to Lakeview on [REDACTED], 2012. Lakeview's Pre-admission Memorandum lists J.D.'s height and weight as 6 feet 4 inches, 269 pounds<sup>10</sup>. Among the various diagnoses listed in this memorandum are Major Depression and a seizure disorder. Further, according to the Pre-admission Memorandum, "Risks to self/others or barriers to discharge" include impaired judgment, self injurious behavior, seizure disorder, and medication non-compliance.

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<sup>10</sup> Note New Hampshire Hospital's Admissions Records provide that J.D. weighed 275.8 pounds as of [REDACTED] [15 days after his admission to New Hampshire Hospital], indicating that he began losing weight during his stay at the hospital.

J.D. did not adjust well to his move to Lakeview. Upon, or shortly after, his arrival to Lakeview, J.D. began refusing meals and snacks. He declined to participate in much of Lakeview's programming and scheduled activities. He frequently refused to attend to his activities of daily living (ADLs). He told staff members that he wanted to go home. Nursing notes indicate that, four days after his arrival at Lakeview, J.D. was bitten repeatedly during an attack by a resident in his cabin. Full mouth indentations were visible on J.D.'s arms and legs as a result of the attack and left J.D. in a "bewildered" state.

Initial Medical Health Assessment. In a report of a medical health assessment conducted on [REDACTED] [5 days after his admission to Lakeview], Dr. Dennis Badman, Lakeview's Primary Care Medical Director, reported that J.D. weighed 262 pounds. This represents a 7 pound drop from his recorded weight upon admission to Lakeview, just five (5) days earlier.

Health Services Initial Report [REDACTED]  
[REDACTED] [regarding J.D.'s first 10 days at Lakeview, but not issued until 10 days after the close of the reporting period]. An initial health services report, completed by J.D.'s primary nurse, indicates that during his first ten (10) days at Lakeview, J.D. had "very little initiative and needs maximum encouragement for hygiene, medication administration and getting out of bed daily."

Neuropsychological Evaluation Report. A neuropsychological evaluation conducted on [REDACTED] and [REDACTED], 2012 [J.D.'s 13<sup>th</sup> and 18<sup>th</sup> days at Lakeview] indicates that J.D. was overweight, but "requires the use of a food tracker because he frequently refuses meals."

According to the Health Services Initial Report, nursing progress notes, J.D.'s medication record and information from direct care staff, besides refusing food, J.D. refused medications, at first occasionally and, towards the end of his time at Lakeview, regularly. He rarely participated

in program activities. He frequently refused to get out of bed. J.D. had difficulty with, or refused to attend to, his activities of daily living (ADLs).

The records Lakeview provided do not include any indication that staff members attempted to contact and report any concerns about J.D.'s adjustment or other issues, including the biting incident, to his guardian. To the contrary, despite the challenges J.D. presented regarding program participation, medication, and meal refusals, on [REDACTED] 2012 [7 days after his arrival], Lakeview mailed a letter and information to his guardian indicating that J.D. tolerated his evaluations well and "is adjusting well to his residential setting."

[REDACTED] [T]wo days after mailing the aforementioned letter to J.D.'s guardian, Lakeview conducted a Nutrition Assessment for J.D. It appears that Lakeview's dietician conducted this assessment without meeting J.D. Contrary to staff reports indicating that J.D. regularly refused meals, this Assessment indicates that J.D.'s appetite was "good." This Assessment lists J.D.'s weight upon admission to Lakeview (269 pounds) as well as the weight provided by New Hampshire Hospital (275.8 pounds). J.D.'s weight was not measured as part of the Nutrition Assessment. The nutritionist determined that J.D. was obese and made several recommendations including "feeding therapy as appropriate with behaviorist to try new foods," and gradual weight loss (1-2 pounds per week) to a goal weight of 205 pounds.

Two weeks later -- on or about [REDACTED], 2012, the nutritionist developed a "Nutrition Protocol" "to provide at least one food which [J.D.] enjoys each meal." According to this document, development of the Nutrition Protocol was due to J.D.'s "food preferences and aversions to certain foods and recent wt [sic] loss of 29.5 pounds." Assuming the reported weight loss is accurate, in less than five weeks since his arrival at Lakeview, J.D. had lost an average of more than six pounds per week. [REDACTED] [Shortly thereafter], Dr. Michael

Mozzoni, Lakeview's Director of Behavioral Services, proposed a Behavior Treatment Plan. This plan was based on data obtained [REDACTED] [during J.D.'s first month at Lakeview]. As indicated above, during this time-frame J.D. had lost a significant amount of weight --- nearly thirty (30) pounds --- and a food tracker was in place because he frequently refused meals. The Behavior Plan targeted cooperation with directions, e.g., getting out of bed, performing activities of daily living, following his schedule and taking medications. Other than directing staff to vigorously praise J.D. for trying new foods, no provisions were included in the behavior plan to address his refusals to eat.

A Health Services Monthly Report for [REDACTED] [the 28 day period beginning after J.D.'s initial 10 days at Lakeview], dated [REDACTED] [24 days after the close of the reporting period], states, "during this period, J.D. has continued to eat minimally. The dietician did formulate a plan of foods to be made available at each meal/snack time as an alternative. This has not seemed to have had an impact on his dietary intake." (Emphasis added.) In other words, the dietician's efforts to encourage J.D. to increase his food intake were not successful.

Incident reports, nursing progress notes, and medication administration logs indicate that J.D. regularly eloped from the cabin and refused medications including, on at least several occasions, his anti-seizure medications. DRC received conflicting reports regarding the extent of J.D.'s fluid intake. However, it appears that J.D. did drink some water. Despite his continued refusal to eat, Lakeview did not monitor J.D.'s weight. Nor did Lakeview inform J.D.'s guardian of his refusals to eat, medication refusals, or ongoing concerns regarding his failure to participate in program activities and behavior incidents.

During the evening of [REDACTED] -- three and a half (3 ½) weeks after arriving at Lakeview, J.D. experienced a grand mal seizure, resulting in his hospitalization at Huggins Hospital. This was the first time J.D. had a seizure since a medication adjustment [REDACTED] [approximately 4 months earlier]. Lakeview did not inform J.D.'s guardian of the seizure resulting in his [REDACTED] 2012 hospitalization until [REDACTED], 2012 -- thirteen (13) days after he was hospitalized -- during a scheduled treatment team meeting. J.D. experienced a second grand mal seizure, requiring his hospitalization, on [REDACTED] [2 weeks after his first seizure, which was the day after the treatment team meeting]. There is no indication in the records DRC reviewed that Lakeview ever informed J.D.'s guardian of his second grand mal seizure and resulting hospitalization.

A team meeting, including representatives of Lakeview's clinical staff, J.D.'s guardian, and community residential providers, was held at Lakeview [REDACTED] [29 days after his admission]. According to the minutes from this meeting, J.D. had unauthorized absences, spit, and was very slow. Lakeview staff described J.D. as having "effort issues," and "no motivation," and reported that "getting out of bed is very challenging." The only mention of J.D.'s food refusals is a statement that he is "fussy about foods." There was no mention of his recent weight loss or implementation of nutrition protocols.

Lakeview's Director of Behavioral Services, Dr. Michael Mozzoni, reported that he was not aware of the extent of J.D.'s food refusals until [REDACTED] [approximately 7 weeks after his admission to Lakeview] when the Director of Nursing told him that eating had "suddenly" become an issue for J.D. Dr. Mozzoni recalled that, at that time, the Director of Nursing asked whether there were any behavioral strategies that could be implemented to get J.D. to eat.



Dr. Mozzoni told DRC's investigators that, although the Director of Nursing told him J.D. had lost weight, he was not aware of how much weight J.D. had lost. Furthermore, Dr. Mozzoni reported he was not very concerned that J.D. had lost weight because J.D. "was a big boy and could stand to lose some weight," or words to that effect.

Dr. Mozzoni did not conduct or order a functional behavioral assessment to determine why J.D. was not eating or to collect data regarding the extent of his refusal to eat. Nor does it appear that Dr. Mozzoni made any effort to communicate, or collaborate, with Lakeview's medical team regarding J.D.'s refusal to eat. He did, however, recall that the behavior analyst who worked with J.D. in his residence developed strategies to address this issue including taking J.D. to McDonalds and/or offering preferred foods if J.D. was out of bed by 10 a.m. Dr. Mozzoni told DRC's investigators that these strategies were somewhat successful at first. However, he recalled that at some point, J.D. would be excited to earn a trip to McDonalds, but would not eat the food.

Dr. Mozzoni recommended that staff place cans of Ensure® in J.D.'s room so he could get some nutrition without eating in front of others, but he recalled that this strategy was not successful. Dr. Mozzoni did not recommend any alternative behavior strategies or interventions to address J.D.'s refusal to eat. Nor did Dr. Mozzoni consider counseling a viable intervention. In an email to one of J.D.'s community residential providers, he stated, "I find it hard to believe J.D. could benefit from counseling giving [sic] his cognitive level and the fact that his mom died when he was ■[very young]. I just don't think he has the ability to process at a deeper level. I think his depression is a result of our projections vs. his sense of loss."

Finally, Dr. Mozzoni told DRC's investigators that he heard from staff that J.D. would bang his head and say he wanted to die. However, in Dr. Mozzoni's opinion, J.D. lacked the

intellectual capacity to formulate a plan to end his life. Dr. Mozzoni did not share this information with Lakeview's medical staff.

During the last month of his life, J.D. virtually stopped eating and regularly refused his medications. Direct care staff reported their concerns about J.D.'s refusals to eat to Lakeview's health service's office. A memo dated [REDACTED] [4 days before J.D.'s death] from a Lakeview nutritionist to J.D.'s residential supervisor states that beginning [REDACTED] [9 days before his death], J.D. had refused all food, fluid, and medications. The nutritionist instructed J.D.'s residential supervisor to ask staff to institute a food tracker and record all food and fluid J.D. consumed.<sup>11</sup> Further, the nutritionist issued the following instructions: "ask client what foods he would agree to consume and have staff requisition foods from the kitchen or if need be, have staff with appropriate approval . . . leave the campus and purchase food . . . foods high in calorie are preferred and candy bars and McDonald type fast foods are allowed in an effort to get calories PO for the client, ask staff to provide client with fluids at the bedside as appropriate . . . and at all times throughout the day to increase fluid intake." Finally, the nutritionist characterized J.D.'s issues with food as an "eating disorder." Lakeview did not share this information with J.D.'s guardian or the other individuals charged with developing an appropriate community based placement for J.D.

On [REDACTED] [6 days before he died] Lakeview's occupational therapist referred J.D. to Lakeview's psychologist for an evaluation after hearing J.D. make suicidal statements. Dr. Stephanie Griffin, PhD, met with J.D. that day. Dr. Griffin's report indicates that, in addition to making suicidal statements, J.D. had several unauthorized absences that day, including one in which he sat in the middle of a Lakeview road for a long period of time. She

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<sup>11</sup> N.B. According to Lakeview's records and staff interviews, a food tracker was put in place as early as [REDACTED] [2 weeks after J.D.'s admission to Lakeview]. J.D.'s need for a food tracker is referenced in the Psychologist's Neuropsychological Evaluation Report which was based on assessments conducted on [REDACTED], 2012.

also received a report that J.D. “had not been eating regularly, at least since he moved to [REDACTED] Cabin] (and possibly before that).”

Dr. Griffin’s report describes J.D. as “somewhat agitated” and indicates that J.D. reported he was “sad . . . and has thoughts about dying and that he would ‘shoot myself with a gun’ if he could.” J.D. reported a history of self-injury and demonstrated how he had injured himself in the past by banging his forehead very hard with his fist until Dr. Griffin cued him to stop. Dr. Griffin’s report notes that J.D. did not have access to a gun nor appear capable of formulating a plan to injure himself, but that “he may be at risk for impulsive self-injury.”

Given his level of agitation, Dr. Griffin increased J.D.’s level of supervision to a 5 minute check. Dr. Griffin’s report indicates that she shared her findings and recommendations, including the supervision level change, with J.D.’s clinical team and program manager at his cabin. It appears that Dr. Griffin did not share her findings and recommended change in J.D.’s supervision level with J.D.’s case manager – the staff member responsible for keeping J.D.’s guardian informed about his status and progress according to Lakeview’s communication policy.

Nursing notes [REDACTED] [entered 4 days before his death] indicate that J.D. had refused his morning medications and was diaphoretic (sweating profusely). Further, these notes indicate that staff reported J.D. was not eating and was possibly dehydrated. Staff members also reported that J.D. had refused McDonalds and scrambled eggs, two foods for which he had a very high preference in the past. Nursing progress notes dated later the same day state that J.D. took his medications with difficulty with approximately 120 cc water (about 4 fluid ounces). In addition, these notes indicate that J.D.’s speech was slurred and barely intelligible; he was experiencing hand tremors, and he “appears to be moving in slow motion.”

Dr. Dennis Badman, Lakeview's Primary Care Medical Director, examined J.D. that day. It appears from Dr. Badman's medical note, that J.D. was weighed and measured 222 pounds. This represents a forty-seven (47) pound drop from his weight upon admission to Lakeview – just sixty-eight (68) days earlier. Neither Dr. Badman's notes nor statements made during his interview with DRC's investigators reflect any knowledge of J.D.'s recent suicidal statements or increased level of supervision. Dr. Badman did not draw any connection between J.D.'s refusal to eat and his diagnosis of major depression. Rather, in his medical note concerning his [REDACTED] [date omitted] examination, he reported that J.D. "has been on something of a fasting protest for the past several days due to reported multiple dissatisfactions which the behavioral staff are [sic] currently working on."

Dr. Badman ordered the following lab tests: Complete Blood Count with Differential (CBC with diff), Comprehensive Metabolic Panel (CMP) Prothrombin Time and Partial Thromboplastin Time (PT and PTT) and Urinalysis (UA). In addition, Dr. Badman ordered that staff continue to provide fluids and work with Lakeview's behavioral staff "for stabilization." Dr. Badman did not request a check on J.D.'s valproic acid level, J.D.'s primary anticonvulsant medication. Dr. Badman obtained a urinalysis using a urine dipstick. The results of this test indicated that J.D.'s ketones were "large." According to Dr. Cooley, DRC's consulting physician, the presence of large ketones in J.D.'s urine indicates that he was in a metabolic state of starvation.

Dr. Badman did not order any immediate follow-up testing, or behavioral or medical interventions to address J.D.'s ongoing refusal to eat or documented medication refusals. He called for repeating the lab tests that had been conducted [REDACTED] [on the date he examined J.D.], including a urinalysis, but did not specify any particular date by which these

tests should be repeated. Also, Dr. Badman recommended that staff “continue to provide fluids as tolerated and work with behavioral staff for stabilization.”

During an interview with DRC’s investigators, Dr. Badman stated he was not alarmed by J.D.’s lab results, including the large ketones. He did not feel any sense of urgency regarding the follow up tests he had recommended and seemed to endorse waiting approximately one month before conducting any further testing. An additional note on the Physician’s Order Sheet dated [REDACTED] [one day after J.D.’s appointment with Dr. Badman], and written by the Physician’s Assistant, indicates an order for Chocolate Flavored Ensure® “per dietary and med director notes.”

Francis Berks, NPP, conducted an Initial Psychiatric Evaluation on [REDACTED] – more than two months after J.D.’s admission to Lakeview. Mr. Berks’ report of this encounter describes J.D. as “frequently uncooperative when task demands are placed on him” and states, “Things have been getting worse for the last couple of weeks.” However, it appears that Mr. Berks did not have the full picture regarding just how bad things had gotten for J.D.. Mr. Berks’ report indicates that, “for several days he has been refusing to eat.” Mr. Berks did not, however, measure J.D.’s weight or check the records for the weight that was recorded by Dr. Badman one day earlier. Had he done so, he would have determined that J.D.’s refusal to eat had resulted in his losing nearly fifty pounds in two months. Rather, Mr. Berks’ report states J.D. weighed 269 pounds, the amount listed in the Preadmission Memorandum.

Mr. Berks determined, “there is clearly an agenda to J.D.’s behaviors.” In response to DRC’s investigators’ questions regarding what he meant by this remark, Mr. Berks explained that J.D. figured out that he could control staff members by refusing to eat. In Mr. Berks’ opinion, this presented a “worst case scenario” situation because once a person realizes his

behavior can control others, there is not much staff members can do to address the client's behavior. Mr. Berks acknowledged that a facility cannot let a person refuse to eat "forever." According to Mr. Berks, at some point a resident who refuses to eat would need to go to the hospital. Mr. Berks stated that in the case of a resident's refusal to eat, the appropriate course of action would be to monitor the resident daily and make sure to order ongoing lab work. Mr. Berks reported that Dr. Badman was monitoring J.D. and had determined J.D. was neither starving to death nor dehydrated.

Nursing progress notes dated [REDACTED] [3 days before his death] indicate that J.D. refused his morning and evening medications, including valproic acid, his primary anti-seizure medication, and that, at about 9 pm, staff reported J.D. had purposely injured the back of his head. He requested his medications and Tylenol. Nursing notes indicated that he was provided, but then refused, medications.

A Health Services Monthly Report for reporting period [REDACTED] [REDACTED] [ending 3 days prior to his death] provides, "J.D. continues to eat little despite having a dietary plan on [sic] place." The health services plan includes monitoring for seizure activity, bowel activity, and food intake. Despite J.D.'s continuing refusals to eat, other than his admissions physical and [REDACTED] [recent] appointment with Dr. Badman, Lakeview's medical staff did not check J.D.'s weight.

Lakeview Staff did not make any attempt to notify J.D.'s guardian of the extent of J.D.'s food refusals until [REDACTED] three (3) days before his death. And, even then, Lakeview personnel failed to communicate the severity of J.D.'s situation including how much weight he had lost or the results of the tests Dr. Badman ordered.<sup>12</sup> On that day, J.D.'s

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<sup>12</sup> In particular, and as noted previously, J.D.'s urine dipstick test revealed that he had large ketones in his urine which, according to Dr. Cooley, indicated he was in a metabolic state of starvation.

case manager contacted his guardian and informed her that J.D. was not eating well. The guardian informed DRC's investigators that the case manager did not convey any sense of urgency during this telephone call. Nor did the case manager say anything that would lead the guardian to believe that J.D.'s nutritional needs were not being met. Finally, the case manager did not provide any information to the guardian regarding J.D.'s medication refusals, incidents reported by staff members or second hospitalization.

Although he did not communicate with J.D.'s guardian, Dr. Mozzoni provided some information regarding J.D.'s status to Living Innovations, the vendor retained to provide J.D.'s community-based residential program. On [REDACTED] [3 days before J.D. died], Dr. Mozzoni sent an email to Kinga Kardasinska, the Community Living Coordinator at Living Innovations, in which he stated that J.D. "has not been eating but will drink water." Further, in his email, Dr. Mozzoni informed Ms. Kardasinska that they had "placed some preferred foods and nutrition drinks in his room that he can eat without letting on that he is eating." Dr. Mozzoni did not convey any sense of alarm regarding J.D.'s refusal to eat. Dr. Mozzoni reported that J.D. was losing weight, "which is not a bad thing and he is drinking water regularly, which is a good thing." That same day, Ms. Kardasinska sent an email to Dr. Mozzoni inquiring whether J.D.'s nutritional needs were being met. Dr. Mozzoni did not respond to this inquiry.

Neither Dr. Mozzoni nor the case manager provided any information to the guardian regarding J.D.'s medication refusals. Nor did these individuals provide any information to the guardian, Living Innovations or other interested parties outside Lakeview regarding the suicidal statements he had made or the changed level of supervision. Neither J.D.'s records nor information DRC obtained through interviews demonstrates that Lakeview Staff made any effort to solicit information and/or suggestions from J.D.'s guardian or other community-based

caregivers regarding possible strategies to address J.D.'s refusals to eat or consistently comply with his medication regimen.

Staff continued to offer preferred foods to J.D.. In addition, staff members offered J.D. chocolate-flavored Ensure®. However, J.D. refused to eat anything. Incident and staff reports indicate that on [REDACTED] [3 days before his death] J.D. threw an unopened can of Ensure® out of his room. Several staff members told DRC investigators that they expressed continuing concerns to supervisors, including worries that he was starving and/or suffering from dehydration, but were told that health services did blood work and that J.D.'s numbers were okay.

During his last few days at Lakeview, staff members reported several incidents in which J.D. had lost his balance and/or fell to the ground. Carol Rivard, the Lakeview employee who transported J.D. to his appointment with Dr. Badman on [REDACTED], reported that J.D. was "unstable on his feet." Nicole Hanna, a direct support worker, filed an incident report indicating that, on [REDACTED] [3 days before his death] at approximately 8:30 p.m., J.D. left the cabin, dropped to the ground and hit the back of his head. Josh Campbell, a week-end supervisor, reported that, on [REDACTED] [the same date as the prior incident], J.D. had collapsed, had bruising on his arms and was refusing to eat. Haley Knopp, a direct support staff member, filed an incident report indicating that, on [REDACTED] [the same date] at approximately 3:30 p.m., she observed "J.D. was walking towards four-corners then stopped with a blank look on his face, stumbled, then took five steps backward and fell on his back. He appeared to be dizzy and did not stand back up." Alex Adinolfi, one of the direct care workers in J.D.'s cabin, reported two incidents during the evening [REDACTED] [before J.D. died]



– one that occurred at 5:30 p.m. and a second at 6:15 p.m. Both incidents involved J.D. losing his balance and falling to the ground.

**V. [REDACTED] – Date of J.D.’s Death**

Overnight staff member Dwayne McNeil reported that J.D. was up frequently during the evening [REDACTED] [prior to the day he died] and early morning hours of the [REDACTED] [date he died]. Mr. McNeil told DRC’s investigators that J.D. was checked every 15 minutes until approximately 5:00 a.m. when his co-direct support staff member left the cabin to take care of an issue in another cabin, leaving him alone to monitor all of the cabin’s residents. Mr. McNeil remained the sole staff member in the cabin until approximately 7:00 a.m. when the first shift staff arrived. Mr. McNeil told DRC’s investigators that, at approximately 5:00 a.m., he checked on J.D. and noted that he was naked and lying on the floor in his bedroom. In addition, Mr. McNeil recalled that J.D. had wet himself. Mr. McNeil did not attempt to clean J.D. or assist him back to bed. Mr. McNeil recalled that he saw J.D. again at about 7:40 a.m., that J.D. was still lying on the floor, and that he appeared very lethargic.<sup>13</sup> Mr. McNeil stated he assumed J.D. had had a seizure, but he was not sure. He told DRC’s investigators that he reported his suspicion to the first shift staff members during staff-changeover. However, since he had not actually witnessed the seizure, Mr. McNeil did not call for any medication to be administered. Nor did he contact Health Services to report J.D.’s condition or his suspicion that J.D. had experienced a seizure.

Generally weekend staff shift changes occur between 7 and 7:30 in the morning. On [REDACTED] [the morning of J.D.’s death], during that time-frame, two direct support staff members, Alex Adinolfi and his supervisor Kyle Johnston, reported for work at J.D.’s cabin.

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<sup>13</sup> It should be noted that Nicholas Cio, Lakeview’s Quality Assurance Director, reported that Mr. McNeil had informed him that J.D. had gotten out of bed at approximately 5:00 a.m. and that Mr. McNeil had last checked J.D. at 5:30 a.m.

Although J.D. had been placed on a 5 minute watch, none of the direct care staff members DRC interviewed was aware of J.D.'s change in supervision level. Mr. Adinolfi and Mr. Johnson told DRC staff that J.D. was on a 15 minute watch. Mr. Johnston told DRC's investigators that overnight staff informed him and Mr. Adinolfi that J.D. had urinated on the floor. Mr. Johnston reported that he checked J.D. every 15 minutes from the time he arrived at the cabin. He recalled that J.D. was lying on the floor and that his arms looked bruised. Neither Mr. Johnston nor Mr. Adinolfi attempted to clean J.D. or assist him back to bed. Records and staff interviews indicate that at approximately 8:00 a.m., Mr. Johnston left the cabin to meet with his supervisor to complete a report for an injury he had sustained the day before. This left direct support staff member Alex Adinolfi alone with 8 or 9 residents.<sup>14</sup> According to Mr. Johnston's recollection, J.D. was responsive when he left the cabin.

Mr. Adinolfi remained the sole staff member in the cabin until approximately 9:00 a.m., when the nurse arrived to deliver medications. According to staff interviews, residents typically wake up and begin their morning hygiene routines between 8:00 and 9:00 a.m. Mr. Adinolfi told DRC investigators that, at approximately 8:00 a.m., he checked on J.D. and observed that he was naked and lying on the floor of his room in a pool of urine. According to Mr. Adinolfi, J.D. was "responsive." Mr. Adinolfi told DRC's investigators that he verbally cued J.D. to get up for breakfast and that J.D. slowly replied, "No."

Mr. Adinolfi reported that he went to check on the other clients and then returned to check on J.D.. There is some discrepancy in the records and reports regarding how frequently Mr. Adinolfi checked on J.D.. However, according to statements Mr. Adinolfi provided to DRC's investigators, at some point before 9:00 a.m. when the nurse arrived at the cabin to

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<sup>14</sup> Mr. Adinolfi did not recall the exact number of residents in the cabin at that time, but reported there were at least 8 residents, and possibly, 9.

administer medications, he noted that J.D. was not responsive. As Mr. Adinolfi described J.D.'s status at that moment, J.D. did not say anything and was not moving. Rather than attempt to arouse J.D. or call for assistance, Mr. Adinolfi left J.D. alone while he checked on other clients.

Rachel Emond, one of Lakeview's nurses, arrived at J.D.'s cabin to deliver medications at approximately 9:00 a.m. on [REDACTED] 2012. Because J.D. had a history of refusing medications, the nurse generally administered medications to the other residents before attempting to deliver medications to J.D.. Ms. Emond denied DRC investigators' request for an interview. However, Ms. Emond's nursing progress notes indicate that she went to J.D.'s room to deliver his medications at 9:10 a.m. and observed that J.D. was "on the floor laying on his stomach." Further, Ms. Emond's notes indicate that J.D. did not respond to verbal cues. She shook his shoulder, but he was still unresponsive. Ms. Emond checked J.D. for radial and carotid pulse, but did not find a pulse. She turned his face upward and noted his lips were blue, his face was cold and he was not breathing. Incident reports and staff interviews indicate that Ms. Emond ran downstairs and informed staff that J.D. was not breathing and to call 911. She started CPR and continued until emergency medical services arrived. J.D. was transported, via ambulance, to Huggins Hospital in Wolfeboro where he was pronounced dead upon arrival.

**VI. State of New Hampshire – Office of the Chief Medical Examiner – Autopsy Report**  
**[Note. This Section has been redacted in accordance with instructions of the Chief Medical Examiner.]**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The medical examiner determined that J.D.'s death was caused by a chronic seizure disorder [REDACTED]

[REDACTED]

[REDACTED]

## **VII. Dr. W. Carl Cooley's Findings**

The DRC retained Dr. W. Carl Cooley, Chief Medical Officer for the Crotched Mountain Foundation, to review the records and information DRC's investigators obtained through this investigation and to provide his opinion regarding whether or not Lakeview's actions or inactions may have played a role in J.D.'s death. In addition to reviewing the aforementioned information, Dr. Cooley reviewed the OCME's report regarding J.D.'s autopsy, as well as the OCME's Addendum Report and Supplemental Report, and interviewed Dr. Thomas Andrew, NH's Chief Medical Examiner regarding his findings. Finally, Dr. Cooley reviewed Lakeview's

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<sup>15</sup> The usual therapeutic range for valproic acid is 50 to 100 mcg/mL. However, it should be noted that lab work following J.D.'s [REDACTED] and [REDACTED] seizures indicates that he had breakthrough seizures despite valproic acid levels of 60 mcg/mL and 110 mcg/mL, respectively. *See also*, Dr. Cooley's Report, Appendix D, p. 5, [REDACTED]  
[reference to information in OCME report has been redacted per Chief Medical Examiner's instructions].

response to a draft report DRC provided to Lakeview on or about January 6, 2014. Dr. Cooley's findings are set out in two reports; a primary report dated December 31, 2013 and a supplemental report dated February 20, 2014, attached hereto as Appendices D and E respectively.

A summary of Dr. Cooley's findings follows [Note portions of Dr. Cooley's report have been redacted in accordance with instructions from the OCME]:

1. Dr. Badman, who conducted a physical examination upon J.D.'s admission to Lakeview, did not mention any specific diagnosis except "neurodevelopmental and behavioral issues." J.D.'s neuropsychological assessment, conducted by Tracey Shannon and Dr. Stephanie Griffin, summarized J.D.'s past history and current test results. Their diagnoses included cognitive disorder NOS, autistic disorder, moderate "mental retardation," epilepsy and "problems related to the social environment and problems with primary support group." Neither assessment mentioned "major depression." Other than suggesting continuation of the medications J.D. used upon his admission, neither of the above reports mentioned the need for any treatment plan for depression or obesity. Dr. Cooley's Report, p. 2.

2. "During August and September 2012, staff notes indicate that [J.D.] became increasingly resistant to any food intake even when offered preferred foods and special treats." Records Lakeview provided to DRC's investigators shortly following J.D.'s death indicate that, despite his refusals to eat, Lakeview personnel weighed J.D. on only two occasions – the date he received his admission physical and 4 days prior to his death, as part of a medical consultation with Dr. Badman. Dr. Cooley's Report, p. 3.<sup>16</sup>

3. Prior to his admission to Lakeview, and until the month of August, 2012, J.D.'s "seizures had been in good control for an extended period of time." Dr. Cooley's Report, p. 2.

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<sup>16</sup> Note, on February 20, 2014 Lakeview, through its attorney, provided DRC with a spreadsheet listing services provided to J.D. while he resided at Lakeview. It lists a third date, not included in the medical records it provided in response to DRC's initial records request, that J.D. was weighed by Lakeview's staff (August 9, 2012).

4. Initial Toxicology reports revealed [REDACTED]

[REDACTED] At his prescribed dose . . . his blood level should have been in the 50-100 mcg/ml range.” Dr. Cooley’s report, p. 5.

5. Dr. Cooley found that [REDACTED] would have left (J.D.) vulnerable to seizure activity . . . [and] would also suggest a failure on the part of Lakeview nursing staff to ensure that Mr. D. received all of his prescribed medication.” *Id.* at p. 6.

6. Postmortem laboratory findings include [REDACTED] consistent with ketoacidosis associated with either an uncontrolled diabetic condition or with significant and prolonged fasting – in either case constituting a potential medical emergency.” (Dr. Cooley’s report, p. 6).

7. As there was no evidence that J.D. had diabetes, Dr. Cooley concluded that J.D.’s ketoacidosis “was due to extreme fasting.” *Id.*

8. Dr. Cooley concluded, although the exact cause of J.D.’s death is uncertain, “it seems likely that his long-standing refusal to eat and frequent refusal of his medications may have led to increased seizure activity as evidenced by the two emergency room visits in [REDACTED] [J.D.’s second month at Lakeview] after a long history of good seizure control.” *Id.* at p.4.

9. Although staff members could not force J.D. to eat or take his medications, Dr. Cooley found, “available records suggest no recognition of the seriousness of J.D.’s condition as

a result of these refusals or the development of any plan for intervention beyond a few behavioral management suggestions.” *Id.*

10. Dr. Cooley determined that, as described by Dr. Badman, “the major domains of health care at Lakeview (medical, psychiatric, and neurologic) are compartmentalized with little exchange of information, discussion, or interaction among the doctors responsible for each of these disciplines. This lack of coordination may have led to a failure to recognize a connection between J.D.’s diagnosis . . . of major depression and a pattern of behavior that reflected a somatic symptom of that diagnosis if not an active attempt to end his life. In addition, the lack of coordination of the neurologic management of his seizure disorder with the fact of his frequent medication refusal (and the undetectable level of one of his seizure medications on his autopsy) did not seem to identify the seriousness of this situation or result in an aggressive or coordinated plan of action.” *Id.* at pp. 4-5.

11. Dr. Cooley noted, “in his final hours, J.D.’s status did not seem to be the subject of a high level of concern by his direct care staff in spite of the recent institution of ‘5-minute checks’ due to concerns about suicidality by his psychologist.” *Id.* at p. 5.

12. Regarding the staffing level at J.D.’s residence the morning of his death, Dr. Cooley found, “given the medical and behavioral complexity of some of the patients at Lakeview, leaving a residence for a group of patients attended by only one staff member especially with one patient on an every 5-minute suicide watch does not constitute safe practice.” *Id.*

13. Even without being able to make a definitive finding on the exact cause of J.D.’s death, Dr. Cooley determined that, “J.D. appears to have suffered from a systemic lack of coordination among members of his health care team, a lack of sufficient concern about his

nutritional status to even weigh him regularly or regard it as a serious medical problem and determine plans of action, a failure to continue to monitor and adjust the treatment of major depression in the face of serious symptoms, and uncertain responsibility for assessment and intervention in the face of an unresponsive patient.” *Id.*

14. Finally, Dr. Cooley found, “communication with his responsible guardian regarding these problems seems to have been limited, inexplicit, and at other times absent.” *Id.*

### **VIII. DRC Findings and Conclusions.**

For the reasons listed below, DRC has determined that there is sufficient evidence to find that Lakeview’s actions and inactions including, but not limited to, the conduct of various administrators, consultants, and staff members with regard to J.D.’s treatment at Lakeview constituted NEGLECT as defined by RSA 161-F:43, III and 42 C.F.R. 51.2. Further, DRC has determined that the deficiencies listed below likely led to J.D.’s untimely death.

A. Lakeview failed to adequately address and attend to J.D.’s emotional challenges and behavioral needs.

According to medical records from prior treatment providers, which were in Lakeview’s possession, J.D. was diagnosed with major depression. In addition, as reflected in his preadmission memorandum, J.D. had a “history of ongoing challenging behaviors that include self injury, placing himself and others at risk, elopement and aggression towards people and objects . . . [and] requires 24 hours supervision due to his safety and impulsivity.” He was referred to Lakeview for, among other services, a neuropsychological evaluation, psychiatric services, medication management, and a comprehensive behavior plan. Yet, despite J.D.’s psychiatric diagnosis, repeated requests to leave Lakeview, expressed desire to end his life, medication and food refusals resulting in significant weight loss, Lakeview failed to adequately address his emotional and behavioral needs. In particular:



**1. Lakeview failed to complete initial evaluations in a timely manner and failed to develop an Individual Service Plan.**

J.D.'s initial treatment plan provided for completion of a battery of assessments, including psychiatric assessments, within 10 days of his admission to Lakeview. However, J.D. did not receive a psychiatric assessment from an ARNP until [REDACTED] -- 69 days after arriving at the facility. Furthermore, it appears that, contrary to Lakeview's Policy requiring the development of an Individualized Service Plan (ISP) for each of its residents which is then formally reviewed by the treatment team twice per month and adjusted as treatment needs change (Policy No. 2.03), Lakeview failed to develop an ISP for J.D. beyond the initial 10 day ISP to secure evaluations.

**2. Lakeview minimized the signs and symptoms of depression J.D. exhibited, resulting in an inadequate response to J.D.'s declining emotional and physical health.**

Lakeview's clinical staff minimized the feelings J.D. expressed regarding how sad he was about being at Lakeview. Professional staff did not connect his refusal to eat or take medications with his diagnosis of major depression. Clinical staff members also expressed doubts regarding J.D.'s ability to benefit from psychological or psychiatric services. However, records from a prior placement indicate that J.D. responded well to having staff listen to his concerns. Further, an email from a Living Innovations staff member to Lakeview's Director of Behavioral Services indicates that J.D. had received some benefit from therapy he received while living in his home community. The negative attitudes some Lakeview clinicians expressed regarding J.D.'s ability to benefit from psychological or psychiatric services suggests a lack of skill, knowledge, or sensitivity regarding the emotional needs of individuals with developmental disabilities.

**3. Lakeview failed to develop an adequate behavior plan or alternative strategies to address J.D.'s behavior challenges, particularly those concerning food intake and medication compliance.**

Lakeview's records and results from staff interviews indicate that staff members were well aware J.D. was not eating; not regularly taking his medications; was depressed; and had expressed suicidal thoughts. Further, Lakeview's direct care staff repeatedly voiced their concerns regarding J.D.'s refusal to eat to Lakeview's professional and clinical staff. Yet, Lakeview's response to the concerns voiced by direct support staff was inadequate and ineffective.

Lakeview developed a Behavior Treatment Plan approximately one month after J.D. arrived at the facility. In the Behavior Treatment Plan, J.D. is described as having a "history of non-compliance with his medication" and mentions that he is a "picky eater." Rather than focus on the two behaviors which posed the greatest danger to J.D.'s health – lack of compliance with his medication regimen and refusal to eat – the Behavior Treatment Plan's focus was on aggressive and disruptive behaviors, elopement and noncompliance with instructions.

Lakeview staff attempted the following strategies to address J.D.'s food refusals: offering trips to McDonalds for positive behaviors, tracking food and liquid intake, developing a set of nutrition protocols, and providing him with Ensure®. However, when it became apparent that none of these strategies were successful, no efforts were made to identify alternative means to address J.D.'s refusal to eat. Further, Lakeview failed to conduct a Functional Behavior Assessment (FBA) to determine why J.D. was not eating or taking his medications. Nor did Lakeview revise J.D.'s behavior plan when it became apparent that the Behavior Treatment Plan was not working.

**4. Lakeview failed to inform direct care staff of, or implement, the change in J.D.'s supervision level ordered by its Psychologist.**

When he was referred to Dr. Stephanie Griffin, Lakeview's Psychologist, for making suicidal statements, Dr. Griffin noted concerns about J.D.'s safety. She determined J.D. was at

risk for impulsive self-injurious behavior and changed J.D.'s supervision level from checks every 15 minutes to 5-minute checks. Yet, Dr. Griffin's level of supervision order was never implemented.

In general, direct care staff members DRC interviewed were either not aware that J.D. had any particular level of supervision or recalled that he required 15 minute, rather than 5 minute, safety checks. None of the direct support staff DRC interviewed, including all staff members who worked in J.D.'s cabin, were aware that, as of [REDACTED] 2012 [6 days before his death], J.D.'s level of supervision had been changed from a 15 minute to 5 minute watch. Furthermore, even if staff was aware that J.D.'s level of supervision had been changed to a 5 minute watch, this order would have been extremely difficult, if not impossible, to effectuate the morning of J.D.'s death as there was only one staff member in the cabin between 5:00 a.m. and 7:00 a.m. and approximately 8:00 a.m. and 9:00 a.m., when the nurse arrived to deliver medications. Had he received the ordered level of supervision, it is possible that J.D.'s declining health status – from lethargic and lying in a pool of urine to becoming “unresponsive” – would have been noted, and attended to, more quickly.

- B. Lakeview's professional staff failed to recognize the severity of, or provide an appropriate coordinated plan of care to treat, J.D.'s medical condition or his emotional/ behavioral challenges.

From the time he entered Lakeview until he died – seventy-two (72) days later, J.D.'s experienced a stark decline in his physical and mental status. The records indicate that J.D. began refusing medications and meals during his first ten (10) days at the facility. Further, Lakeview's records indicate that J.D.'s food and medication refusals escalated during his time at Lakeview to the point that he reportedly refused all food, nearly all liquids and regularly refused his medications. J.D. suffered two grand mal seizures within two weeks of each other, after a

relatively lengthy period of being seizure-free prior to his admission to Lakeview. Towards the end of his life J.D.'s speech slowed. There are multiple reports from staff members describing him as unsteady on his feet and falling down. J.D. made statements indicating he wanted to commit suicide. Yet, neither medical nor clinical staff members seemed to feel any sense of urgency regarding J.D.'s well-being. Representatives of the three treatment domains at Lakeview – medical, neurologic, and psychiatric— were not aware of the extent of J.D.'s decline in areas outside of their specific clinical purview. As a result, the healthcare providers in these various disciplines failed to make adequate efforts to ensure coordination of care or to consider whether J.D.'s decline in each of these areas pointed to a need for a greater degree of intervention and/or possibly a move to another placement that would have been better equipped to deal with J.D.'s health care needs and emotional/behavioral challenges.

**1. Lakeview's medical staff failed to take the most basic action --- regularly weighing J.D. -- to assess the impact of J.D.'s refusals to eat.**

Lakeview's medical staff made minimal effort to address J.D.'s refusal to eat or to assess the impact this had on his overall health. Records from New Hampshire Hospital (NHH) and Lakeview's initial health services examination reveal that J.D. had begun losing weight from the time he was admitted to NHH. Lakeview's records indicate that staff members ranging from direct support staff to nursing staff to professional staff were aware that, upon his arrival to Lakeview, J.D. often refused meals and eventually refused virtually all meals and snacks. According to information DRC obtained during an interview of Dr. Cooley, DRC's consulting expert on this investigation, Lakeview's medical team should have made a plan to address J.D.'s refusals to eat early in the summer, including weighing him weekly. However, despite

widespread knowledge of J.D.'s refusal to eat, medical staff took J.D.'s weight on only three occasions<sup>17</sup>

**2. Efforts on the part of Lakeview's clinical staff to develop behavioral or other interventions to address J.D.'s refusal to eat were inadequate.**

Lakeview's Nutritionist and Director of Behavioral Services and Training instructed direct care staff to attempt a few approaches to increase J.D.'s food intake -- implementation of a food tracker and nutrition protocols, offering trips to McDonald's and providing him with Ensure®. As noted earlier, however, none of these approaches were based on assessments, such as a functional behavior analysis, which would have required Lakeview's staff to determine why J.D. was not eating. Further, none of the strategies Lakeview employed were effective. Despite the dietician's recommended use of a food tracker, it appears from the records that staff did not complete the food tracker forms consistently. Based on interviews with staff, information provided in the dietician's notes and the data recorded on the food tracking sheets, it is not clear who had overall responsibility for reviewing J.D.'s food and liquid intake, or how frequently these documents should be reviewed. Finally, Lakeview's professional/clinical staff did not make any adjustments to these approaches or develop new interventions when it was clear that implementation of these strategies did not result in any increased food intake. Rather, J.D.'s refusals to eat intensified to the point that he did not ingest any food at all.

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<sup>17</sup> Note. The records Lakeview provided to DRC's investigators shortly after J.D.'s death documented only two instances in which Lakeview personnel took J.D.'s weight -- [REDACTED], as part of the Initial Medical Health Assessment, and [REDACTED], 2012, as part of an appointment with Dr. Badman due to staff concerns about possible dehydration. Although not listed in his medical chart, the Nutrition Protocol dated [REDACTED] [approximately 1 month after J.D.'s admission to Lakeview] indicates that J.D. had lost 29.5 pounds since entering Lakeview. On February 20, 2014, Lakeview emailed a spreadsheet to DRC's investigators listing services provided to J.D.. This spreadsheet indicates that Lakeview's nursing department obtained J.D.'s weight on one additional occasion -- [REDACTED] [approximately 5 weeks after his admission to Lakeview] and that, at that time, he weighed 248 pounds.

**3. Lakeview's Primary Care Doctor failed to adequately respond to serious warning signs regarding J.D.'s health status as a result of his food and medication refusals.**

Dr. Badman, Lakeview's Primary Care Medical Director and only primary care physician on Lakeview's staff, was either not aware or did not recognize the severity of J.D.'s physical and emotional health status. Dr. Badman saw J.D. twice while at Lakeview. J.D.'s first visit with Dr. Badman, on [REDACTED], [5 days after he arrived at Lakeview] was for an admission physical and to gather pre-admission history. Dr. Badman saw J.D. again on [REDACTED] [4 days before his death] in response to a staff referral due to concerns of suspected dehydration. By this time, J.D. was refusing all food and most of his prescribed medications. In addition, J.D.'s level of supervision had been increased to a five-minute watch due to his threats to commit suicide.

During his interview with DRC's investigators, Dr. Badman did not recall any specific issues with J.D. regarding weight loss. He had not reviewed incident reports. Nor did he recall that J.D. had threatened suicide. Despite nursing notes documenting J.D.'s refusals to take his medications, Dr. Badman did not order laboratory testing to check J.D.'s zonisamide or valproic acid levels as part of the examination he conducted on [REDACTED] 2012 [4 days before J.D.'s death]. Nor did Dr. Badman communicate with Dr. Usher, Lakeview's consulting neurologist, to inform him of J.D.'s food and medication refusals and to seek input regarding whether to order lab work to check J.D.'s anti-seizure medication levels or to obtain other recommendations for J.D.'s medical care. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] according to Dr. Cooley, "suggests a period of at least

several days during which he may not have received his prescribed does of this drug” leaving him vulnerable to seizure activity. Dr. Cooley’s Report at pp. 5-6.

Although the results of J.D.’s urine dipstick test indicated that he had “large ketones,” Dr. Badman reported he was not alarmed by this result. Dr. Badman informed DRC’s investigators that he suspected J.D. might have had a bladder infection.<sup>18</sup> He recalled that a food tracker was in place and the dietician was involved. According to Dr. Cooley, because prior testing had indicated that J.D. did not have diabetes, the presence of large ketones in J.D.’s urine indicated that he was in a metabolic state of starvation. This status, according to DRC’s interview with Dr. Cooley, should have been recognized as a serious issue requiring, at the very least, a repeated urine dipstick immediately, to verify the initial result’s accuracy, and a repeat test in the day or two following the initial result. In addition, according to Dr. Cooley, given J.D.’s abnormal lab result, nearly fifty (50) pound weight loss, and expressed suicidal thoughts, an emergency treatment team meeting should have been convened to consider how to address J.D.’s weight loss and large ketones. Instead, as Dr. Cooley observed, Dr. Badman did not convey any sense of urgency regarding J.D.’s health status. Rather than identify the severity of J.D.’s situation and initiate an aggressive or coordinated plan of action, Dr. Badman informed DRC’s investigators that he was comfortable having J.D. wait approximately one month before repeating the urinalysis or ordering any additional lab work, such as testing his valproic acid (anti-convulsant medication) level. Dr. Badman did not recommend any adjustments to J.D.’s treatment plan to address his medication or food refusals. Nor does it appear that he made any effort to communicate his findings or recommendations with the other members of J.D.’s treatment team.

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<sup>18</sup> He did not, however, order an antibiotic or other medication, to treat a bladder infection. Further, according to Dr. Cooley, “there was nothing in the urine dipstick result that would have suggested a urinary tract infection (only minimal white blood cells were present and nitrite test was negative), but even the presence of a urinary tract infection would not have been a cause for a ‘large’ amount of ketones in the urine.” Dr. Cooley’s Supplemental Report, Appendix E, p. 1.

**4. Lakeview's system of care lacks the necessary level of interdisciplinary communication and coordination to meet the treatment needs of residents with complex emotional, behavioral, and medical needs, such as J.D.**

There is little in the way of interdisciplinary communication or coordination of treatment efforts in the various treatment domains (i.e. medical, psychological/psychiatric, and neurologic) at Lakeview. As a result, in J.D.'s case Lakeview failed to develop a coordinated approach to attend to J.D.'s refusals to eat or take the medications that, prior to his admission at Lakeview, had successfully controlled his seizure disorder. According to Dr. Cooley, "this lack of coordination may have led to a failure to recognize a connection between J.D.'s diagnosis (at NH Hospital) of major depression and a pattern of behavior that reflected a somatic symptom of that diagnosis if not an active attempt to end his life. In addition, the lack of coordination of the neurologic management of his seizure disorder with the fact of his frequent medication refusal [redacted] [information in OCME report] did not seem to identify the seriousness of this situation or result in an aggressive or coordinated plan of action." (Dr. Cooley's report, P. 5.)

The medical delivery system at Lakeview, as described by Dr. Badman, is one in which residents' varying needs are dealt with by the three separate types of providers -- the neurologist, psychiatrist/ARNP, and general medical, Dr. Badman's purview. According to Dr. Badman, nursing is responsible for coordinating the three medical disciplines. Nursing accomplishes this by maintaining a universal medical chart for each patient upon which each medical provider

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[redacted] suggests a period of at least several days during which he may not have received his prescribed dose of this drug." The results of the additional postmortem report did not materially change Dr. Cooley's initial findings. See Dr. Cooley's Report, Appendix D, pp 5-6.



records his or her treatment notes. However, the system of coordination and communication described by Dr. Badman failed in J.D.'s case.

Lakeview has adopted various policies and procedures which purport to establish mechanisms by which patient information is communicated among Lakeview's professional and direct care staff. However, these policies are inadequate in design and in implementation. For example Lakeview's policy entitled "Staffing Agendas," Policy No. 5.02.6, includes a stated purpose "to have team meetings to review the progress of the individual and solicit the input of the person served and all stakeholders." This policy requires that monthly staffing meetings include a review of "current data, human growth and development norms . . . changes in the interventions for each objective . . ." and that the clinical team discuss the individual's progress toward his/her goals. Missing from this policy is any requirement that the team review incidents or concerns. This policy also calls for "monthly rounds . . . to address problems that arose during the reporting period and discuss possible interventions." Monthly rounds are to be conducted by either the physician or "scheduled for transdisciplinary team discussion" each month. It appears that coordination of behavior services and medication regimen are reviewed only if the physician conducts rounds. However, during his interview with DRC's investigators, Dr. Badman revealed that he never conducts rounds. According to Dr. Badman, he sees residents on an as needed basis only. Further, none of the records DRC reviewed indicate that a transdisciplinary team discussion was ever held regarding J.D.

Another Lakeview Policy entitled "Health Services Monthly Staffing Summary," Policy No. 6.05, provides, "A Monthly Staffing Summary Report, completed by Health Services, currently provides the clinical team with updated medical information about their client. The primary nurse will participate in a Monthly staffing to address the client's health needs and

delivery of services.” The procedure calls for “individual client health concerns and/or potential health risks” to be addressed. Monthly staffing summary forms are to provide specific information including “present health concerns and/or potential health risks . . . nutritional status, medication/health education updates, current weight – loss or gain.” (Emphasis added.) Further, according to this policy, the monthly staffing report is supposed to be sent to the client’s case manager “for incorporation into the client service record and team information.”

In J.D.’s case, Health Services failed to consistently and fully complete the required staffing reports on a timely basis. Lakeview’s Primary Nurse completed two Health Services Monthly Reports during J.D.’s stay at Lakeview. The first report, for the period [REDACTED] [beginning after J.D.’s initial 10 days at Lakeview], was not completed until [REDACTED] nearly a full month after the end of the reporting period. The second report, for the [REDACTED] [following month], was timely completed on [REDACTED]. Neither report contained the full scope of information required by Policy No. 6.05. For example, neither report included a weight or any reference to J.D.’s medication refusals. The [REDACTED] [second monthly] report makes no mention of J.D.’s appointment with Dr. Badman, threats of suicide or change in level of supervision.

**5. Lakeview failed to recognize the limitations in its ability to adequately meet J.D.’s healthcare needs and, contrary to its own policies, failed to assess whether J.D.’s continued placement at Lakeview was contraindicated.**

Lakeview’s operating policies indicate that the Effingham facility serves clients who are “medically stable.” (Policy No. 2.03, “Written Plan for Clinical Services,” p. 10). Its medical staffing is reflective of this policy. Lakeview’s Primary Care Medical Director, Dr. Dennis Badman, spends only one day per week on the Lakeview campus. A Physician’s Assistant is available on Lakeview’s campus three days per week. Dr. Badman reported that the scope of the

medical care provided at Lakeview is limited. Typically, Dr. Badman and the Physician Assistant handle issues like monitoring blood pressure, sore throats, and ordering basic PRN medications. According to Dr. Badman, residents with seizure disorders should be stable by the time they arrive at Lakeview. If a Lakeview resident has a seizure, he or she would be referred to Lakeview's consulting neurologist, Dr. Gary Usher, not Dr. Badman. Dr. Usher spends approximately one day per week at Lakeview. Residents who require psychotropic medications are followed by the psychiatrist or ARNP.

Other than the limited neurology consulting services provided by Dr. Usher, Lakeview does not have the necessary on-site medical personnel to provide medical interventions for individuals who require medical services beyond routine healthcare services. According to Lakeview's Policy No. 2.03, "if at any time a program participant requires services that are not available at Lakeview, referral will be made to outside agencies and/or services provision will be made available through contractual services." (p. 15). In addition, emergency intervention and treatment is to be provided by Huggins Hospital in Wolfeboro, which is approximately twenty (20) miles from Lakeview.

Residents whose medical conditions become unstable are not appropriate candidates for Lakeview. At some point, J.D.'s medical condition deteriorated to the point where he could no longer be considered "medically stable." According to DRC's interview with Dr. Cooley, J.D. was not medically stable at the time he met with Dr. Badman on September 19, 2012, if not earlier.

Lakeview's internal Policies include a provision for circumstances in which the facility might consider terminating a resident's treatment. *See* Treatment Initiation/Termination Policy. Policy No. 5.02.12. In relevant part, Lakeview's termination policy provides, "The termination

of treatment shall occur when: . . . 3. The client develops a physical or psychological condition that contraindicates continuation of a treatment being provided. Alternative treatment approaches to facilitate achievement of related goals and objectives should then be developed by the clinical team with client involvement.” (Emphasis added). J.D.’s health declined to the point that he was no longer medically stable and required a higher level of care than that which is offered at Lakeview. However, despite J.D.’s compromised health status, and contrary to its own policies and standard practice, the medical and other treatment staff made no effort to consider whether termination and transfer to a facility offering a higher level of care was the appropriate course of action to address J.D.’s healthcare needs.

C. Lakeview failed to ensure sufficient staffing levels to provide J.D.’s ordered level of supervision.

The morning J.D. died, there were approximately eight (8) to nine (9) residents in his cabin. Yet, results from staff interviews indicate that, for several hours, J.D.’s cabin was staffed by only one Lakeview employee. Overnight staff member Dwayne McNeil informed DRC he was the sole staff member in J.D.’s cabin between 5:00 and 7:00 a.m. Alex Adinolfi, one of the staff members assigned to first shift in J.D.’s cabin, had been employed at Lakeview for less than one year, but was left alone in the cabin between 8:00 and 9:00 a.m. Throughout this time, J.D. was lying naked, in a pool of urine, on the floor, virtually unattended.

The beginning hours of first shift are a particularly busy time in the cabin, requiring a high degree of attention from direct care staff members. Residents are starting their morning routines, washing, brushing teeth, and getting dressed. Many of these residents, including J.D., require assistance from staff to complete these tasks. Given the competing needs of 8 to 9 cabin residents, with no other staff to assist him, it would have been extremely difficult, if not impossible, for Mr. Adinolfi to comply with J.D.’s watch level and attend to all of the other

residents for the hour he was left alone. According to Dr. Cooley, “given the medical and behavioral complexity of some of the patients at Lakeview, leaving a residence for a group of patients attended by only one staff member especially with one patient on an every 5-minute suicide watch, does not constitute safe practice.” (Dr. Cooley’s Report, p. 5.)

- D. Lakeview’s staff assigned to care for J.D. during his final hours failed to appropriately address J.D.’s condition and demonstrated a lack of human decency by allowing him to remain lying naked, on the floor, and in a pool of urine for more than four hours.

The morning of his death, staff found J.D., naked, in a pool of urine, on the floor of his room. Staff suspected he had experienced a seizure and described J.D.’s affect as, at first, lethargic and later, “unresponsive.” Overnight staff member, Dwayne McNeil, told DRC’s investigators that he suspected J.D. had experienced a seizure, but he did not report this suspicion to health services. Nor did he attempt to clean J.D., assist him back into bed, or even check him every 5 minutes as ordered. Mr. McNeil told the first shift staff members, Kyle Johnston and Alex Adinolfi, that he suspected J.D. had experienced a seizure. Mr. Johnston and Mr. Adinolfi were aware that J.D. had wet himself and was lying naked on the floor. Yet neither of these staff members attempted to clean J.D. or assist him back to his bed. Rather, J.D. was left lying in a pool of urine, virtually unattended to, between 5:00 a.m. and 9:10 a.m. Further, results from staff interviews indicate that J.D. was left unattended for some time after Mr. Adinolfi observed that J.D. was “unresponsive” and until the nurse arrived in his room at approximately 9:10 a.m. to deliver J.D.’s medications.

- E. Lakeview failed to ensure that direct care staff was adequately trained to respond to medical emergencies.

The morning he died, multiple staff members noted that J.D. was naked and lying on the floor of his bedroom in a pool of urine. Overnight staff member Dwayne McNeil told DRC’s

investigators that, when he noted J.D.'s condition, he suspected J.D. had experienced a seizure. Yet, Mr. McNeil did not call Health Services to report this suspicion or J.D.'s condition. Nor did he attempt to clean up J.D. or return him to his bed. He just left J.D. lying on the floor, naked and in a pool of urine.

First shift staff members described J.D. as lethargic, but responsive, at the beginning of their shift. At some point that morning, J.D.'s health status further deteriorated. Alex Adinolfi, then the sole staff member in the cabin, noted that J.D. was "unresponsive." However, Mr. Adinolfi failed to make any attempt to assess whether J.D. was conscious or breathing. Nor did he call Health Services, or even his supervisor, for assistance. Rather, Mr. Adinolfi left J.D. alone and tended to the other cabin residents. Mr. Adinolfi's failure to take any action to assist J.D. after noting he was unresponsive demonstrates Lakeview's failure to ensure all direct care staff receive adequate training and supervision regarding the handling of medical emergencies.

- F. Contrary to its own policies, Lakeview's case manager was not provided with, and/or failed to obtain, pertinent information regarding J.D.'s declining health status.

Pursuant to Lakeview's Policy entitled "Written Plan for Clinical Services," Policy No. 2.03, Lakeview offers Case Management services which "coordinate all aspects of assessment, treatment planning and service delivery." In addition, according to this policy, Lakeview's case management includes serving as the "primary liaison between family, treatment team and funding source," and is responsible for designing individual service plans with residents' teams. (p. 8, Para. F.) Given the case manager's pivotal responsibilities for coordinating and reporting on resident's care, it is incumbent upon Lakeview to put policies and practices into place to ensure that case managers are fully apprised of residents' treatment needs and challenges so they may communicate those concerns to family members and guardians.

Lakeview's case management system failed with regard to J.D.'s treatment in that his case manager, the individual charged with coordinating his treatment planning and service delivery and communicating with J.D.'s guardian, did not have full information about his health care needs and extent of his declining behavioral and health status during his time at Lakeview. Renee Ouellette, J.D.'s case manager, saw J.D. only twice during the month she served as his case manager.<sup>20</sup> Contrary to Lakeview Policy No. 6.05 which requires health services to provide the monthly staffing summary reports to the case manager, there is no indication in J.D.'s record indicating that his case manager was provided with copies of these reports.

Ms. Ouellette told DRC's investigators that she was not aware J.D. had lost weight since his arrival at Lakeview. She recalled that J.D. "had started to decline" or words to that effect, and recalled that nursing had gone to see him and checked his vitals. She was not aware that J.D. had seen Dr. Badman. Ms. Ouellette told DRC's investigators that direct care staff did not speak with her about any concerns regarding J.D.. According to Ms. Ouellette, direct care staff would have reported concerns to the behavior analyst. Ms. Ouellette was aware that the behavior analyst was concerned that J.D. was not eating and that she was working with staff to address this issue. However, she did not know any details about what staff was doing about J.D.'s refusal to eat.

Direct support staff filed a number of incident reports regarding J.D.'s behaviors between [REDACTED] [the start of his 2<sup>nd</sup> month at Lakeview] and the date J.D. died. The types of incidents reported included reports of medication refusals, attempts to elope, refusals to attend scheduled program activities, refusing food and other self-injurious behavior. It appears from

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<sup>20</sup> When he initially entered Lakeview, Carol Tubman was assigned to be J.D.'s case manager. Ms. Tubman continued in this role [REDACTED] [for approximately 5 weeks] when she left her employment at Lakeview. Renee Ouellette began working at the facility [REDACTED] [approximately one week before Ms. Tubman's last day at Lakeview] and did not meet J.D. until his regular team meeting on [REDACTED] [approximately 1 week after she became J.D.'s case manager].





policy is “to notify the family/guardian/significant other of an individual served whenever any accident, injury, illness or unusual incident occurs.” This policy requires the case manager to review incident reports daily, every morning and to “notify family contacts before the close of the business day regarding any accidents, illnesses or injuries requiring medical intervention beyond the scope of standard first-aid, and all unusual incidents with police or public involvement.” Also, case managers are required to “notify family contacts during their scheduled weekly call regarding any accidents, illnesses or injuries requiring basic first-aid, and all unusual incidents not involving police or members of the public.” (Emphasis added.)

A review of J.D.’s records and interviews with J.D.’s guardian and staff member who served as J.D.’s case manager during his last month at Lakeview reveal that Lakeview’s personnel failed to comply with its policies regarding communications with guardians. Other than his two treatment team meetings and one telephone contact that occurred on or about [REDACTED] [3 days before J.D.’s death], it does not appear that J.D.’s case manager made any attempt to notify J.D.’s guardian of his declining health status, medication or food refusals. Contrary to Lakeview’s policy requiring its case manager to notify guardians of illnesses requiring medical intervention beyond standard first aid by the end of the business day in which such an event occurs, the case manager failed to report J.D.’s hospitalizations for prolonged seizures in a timely manner. J.D.’s case manager did not notify his guardian of his [REDACTED] [first] hospitalization until [REDACTED] [two weeks after he was hospitalized] during a regularly scheduled treatment team meeting. It appears that the case manager never notified J.D.’s guardian of the [REDACTED] hospitalization [that occurred the day after this treatment team meeting].

Furthermore, Lakeview's case manager violated the family contact policy by failing to arrange weekly calls. The guardian, therefore, was not provided with timely notification of "unusual incidents" including food and medication refusals, falling, and attempts to elope from the program. In fact, Lakeview's case manager did not contact J.D.'s guardian regarding any of these concerns until a few days before he died.

When she finally spoke with J.D.'s guardian, the case manager minimized the nature and extent of J.D.'s declining health status. J.D.'s guardian recalled some discussion at the [REDACTED] Team meeting [approximately 6 weeks after his admission to Lakeview] about J.D. being a "fussy eater," or words to that effect, but the guardian thought Lakeview's staff had a good handle on what motivated J.D.. J.D.'s guardian did not recall being informed about the extent of J.D.'s weight loss. Further, the guardian told DRC's investigators that, given the lack of information from Lakeview, she assumed that J.D.'s condition was stable and felt no need to consider alternative arrangements.

J.D. was not able to communicate the extent of his declining physical or mental health to his guardian. It was therefore incumbent upon the case manager to provide J.D.'s guardian with clear and accurate information regarding his health status. Failure to do so deprived the guardian of access to information critical to J.D.'s well-being and impeded her ability to make informed decisions regarding J.D.'s medical and psychiatric treatment needs.

## **IX. Recommendations**

Individuals with disabilities, including those with long-term care needs, are legally entitled to receive services in the most integrated setting appropriate to their needs.<sup>21</sup> The "most integrated setting" is one that enables individuals with disabilities to interact with nondisabled

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<sup>21</sup> Olmstead v. L.C., 527 U.S. 581 (1999)

peers to the fullest extent possible.<sup>22</sup> Placement of an individual with a disability in a segregated or institutional setting when the individual could benefit from community services constitutes unlawful discrimination under federal law in violation of the Americans with Disabilities Act.<sup>23</sup> Similarly, New Hampshire law requires that individuals who, like J.D., receive residential services through the Area Agency System, receive “services that emphasize community living.”<sup>24</sup> Further, New Hampshire law requires that the area agency use “the criterion of the least restrictive environment for the client” and provide “the service which best meets the needs of the client.”<sup>25</sup>

Unfortunately, while J.D.’s placement at Lakeview may have been precipitated by behavioral challenges he presented in the community, it appears that the decision to move J.D. from his community residence to New Hampshire Hospital and finally to Lakeview was driven less by J.D.’s needs than by the lack of alternative appropriate community-based options. This matter serves to reinforce the critical importance for New Hampshire to develop the community capacity to meet the needs of individuals, such as J.D., who, from time to time, require enhanced services to live safely in the community; and underscores the inability of large congregated settings to adequately address those needs.

DRC recommends that the State of New Hampshire, Area Agencies, and providers such as Lakeview work to increase the availability and range of housing and supportive service options to enable individuals to remain in their home communities. In the interim, and to the extent that individuals continue to receive services at Lakeview, DRC offers the following recommendations:

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<sup>22</sup> 28 C.F.R. pt. 35 app. A (2010)

<sup>23</sup> 42 U.S.C. § 12132

<sup>24</sup> RSA 171-A:1

<sup>25</sup> RSA 171-A:6, III

A. Lakeview should ensure there is appropriate coordination among the three domains of medical care provided at its facility (i.e. medical, neurologic, and psychological/psychiatric) as well as a good communication between direct care staff and clinical professionals in accordance with best practices and emerging industry standards.<sup>26</sup> At a minimum, Lakeview should hold in-person medical team meetings, at least weekly, to discuss residents' medical, psychiatric, and neurological needs and to better coordinate care for individual residents with multiple needs. DRC recommends that the Primary Care Medical Director (PCMD) be involved in the monthly health services review meetings. If the PCMD is not able to participate in these meetings, at the very least, the PCMD should review the health services monthly report, any incident reports and the resident's chart and sign off on the nurse's report. Further, Lakeview should ensure that any time one of its medical or clinical professionals examines or evaluates a resident's healthcare needs, that the examining/evaluating healthcare professional receives sufficient information from the individual, his or her guardian, direct support staff and other medical/clinical professionals to secure a full picture of a resident's health status to complete a History of Present Illness. Finally, Lakeview's medical and clinical providers should take all steps necessary to ensure their treatment recommendations are provided in a timely manner to residents and adhered to by all staff members charged with implementing these recommendations.

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<sup>26</sup> See, e.g. Mitchell, Wynia, Golden, McNellis, Okun, Webb, Rorhbach, and VonKohorn, *Core Principles & Values of Effective Team-Based Health Care* Discussion Paper, Institute of Medicine, Washington, DC (2012) available at <https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-Values.pdf>; *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report*, National Quality Forum (2010) available at [http://www.qualityforum.org/projects/care\\_coordination.aspx](http://www.qualityforum.org/projects/care_coordination.aspx); O'Daniel and Rosenstein, *Professional Communication and Team Collaboration*, Chapter 33 of PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services (2008), AHRQ Publication No. 08-0043 available at <http://www.ahrq.gov/professionals/clinicians-providers/resources/nursing/resources/nursesfdbk/index.html>.

B. When presented with a situation, such as J.D.'s, in which a resident's behaviors and health status are rapidly deteriorating, Lakeview should immediately convene a multi-disciplinary team meeting to consider amendments to the individual's treatment plan or, if medically indicated, to determine whether the resident requires a higher level of care than is available at Lakeview.

C. Lakeview should amend its Family Notification Policy (Policy No. 4.22) to specify the individuals with whom the case manager must communicate and how often those communications must take place. In particular, this policy should require that the case manager have weekly contact with the resident's legally-responsible parent(s) or guardian(s) and provide timely information regarding accidents, injuries, illnesses, or "unusual incidents" in accordance with this policy. Finally, Policy No. 4.22 should be amended to specifically define and/or enumerate a non-exhaustive list of the types of incidents considered to be "unusual" and, therefore, must be reported to the parent/legal guardian. In addition to notifying the parent/legal guardian of accidents, injuries, illnesses and incidents with police or public involvement, this policy should require timely communication with the parent/legal guardian to inform them about medication, food and/or program participation refusals, changes in medications, changes in supervision levels, and any recommended changes in treatment or behavior plans.

D. Lakeview should take all steps necessary to ensure that case management staff members timely obtain relevant information regarding the clients for whom they are responsible. Further, Lakeview should take all steps necessary to ensure that case management staff members provide relevant information to residents' parents and legal guardians on a timely basis, in accordance with Policy No. 4.22, paragraphs 3 and 4.

E. Lakeview should discharge an individual to an appropriate alternative care provider when, as in J.D.'s circumstances, an individual's health and safety are threatened by his or her deteriorating condition and Lakeview is unable, for any reason, to timely correct or ameliorate the condition.

F. Lakeview should immediately address and resolve communication deficiencies between and among professional and direct care staff to ensure that all staff members who have contact with residents are aware of each resident's current level of supervision. Assigned clinical staff members must notify all direct care staff and professional staff members of the supervision levels assigned to the individuals they serve, and any changes to those levels, on a timely basis. Supervisory direct care staff should ensure that each resident's level of supervision is documented in a logbook that is maintained in the residence. Further, supervisory direct care staff should ensure that each staff member assigned to a particular residence reviews the supervision level entries daily. Lakeview's supervisors and managerial staff should regularly monitor direct care staff's adherence to the periodic and/or continuous supervision level ordered for each resident.

G. Lakeview must maintain sufficient staffing levels in each of its residences to meet the supervision needs of each of Lakeview's residents, i.e., there should be sufficient staff available to meet the supervision levels ordered by Lakeview's clinical staff and/or residents' treatment teams at all times. No staff member should ever be left alone in living quarters with more than one resident.

H. Lakeview should amend its emergency response protocol, Policy No. 7.50, to clearly define what constitutes a "medical emergency," by including examples such as: seizures, allergic reactions, choking, serious injuries, loss of consciousness, respiratory arrest, and cardiac

arrest. Further, Lakeview should train, and test to verify understanding, each and every direct care staff member on its emergency response protocols including, but not limited to, the steps staff should take in the event that a resident has experienced a medical emergency including whenever a resident appears “unresponsive.” Finally, Lakeview should provide periodic training for direct care staff to reinforce and refresh their understanding of Lakeview’s emergency response protocols.

## POSTSCRIPT

DRC provided Lakeview with an advance draft of its investigation report and invited comments regarding its factual accuracy. Lakeview, through its counsel, responded with a letter which acknowledged that “for a period of time upon arrival at Lakeview, case management, communication and coordination of care did not reflect our expectations.” See Letter from Attorney Edwinna Vanderzanden dated February 3, 2014, attached hereto as Appendix F. The letter describes a number of quality improvement initiatives Lakeview purported to have made in response to the events leading to Mr. D.’s death<sup>27</sup>. Further, Lakeview’s letter asserted that DRC’s draft investigation report contained “factual inaccuracies” and requested that DRC’s report be amended to address the assertions that Lakeview characterized as inaccurate. DRC requested, and Lakeview provided, clarifying information regarding the assertions in the February 3, 2014 letter. See DRC’s Letter to Lakeview’s counsel dated February 7, 2014 and Excel Spreadsheet authored by Nicholas Cioe, Lakeview’s Quality Assurance/Quality Improvement Director, attached hereto as Appendices G and H, respectively. DRC’s response to the matters raised in Lakeview’s response to the draft investigation report (the February 3, 2014 letter) follows:

1. *Lakeview took exception with DRC’s assertion (in the draft report) that prior to his admission to Lakeview, J.D. had a seizure disorder that had been successfully managed by medication. Rather, Lakeview asserts that J.D. had “intractable seizures,” which it defines as “seizures that fail to respond to at least two appropriate anti-seizure medications – that generally occur once or twice per month.” (Lakeview letter, p. 3.)*

DRC does not adopt Lakeview’s characterization of J.D.’s seizures as “intractable.” In reaching its determination concerning the characterization of J.D.’s seizure disorder, Lakeview relies on a Neuropsychological evaluation completed on [REDACTED], [approximately 1 month before his medications were changed] in which the evaluator stated her review of the records indicated that J.D.’s seizures had been “intractable and generally occur once or twice per month.”<sup>28</sup> This characterization is not consistent with the opinions of either Dr. Gary Usher, Lakeview’s consulting neurologist or Dr. Carl Cooley, DRC’s medical consultant. Dr. Usher’s notes dated [REDACTED] [approximately 2 weeks after J.D.’s admission to Lakeview] regarding his initial evaluation of J.D. indicate that J.D. had been seizure free since [REDACTED] [more than 3 months prior to his admission to Lakeview]. In addition, Dr. Usher’s report provides that he did not recommend any changes in J.D.’s medications because “he is apparently doing well on a combination of depakote and zonisamide.” Finally, according to Dr. Cooley, to be considered “intractable,” an individual would have to experience multiple seizures per day. An individual, like J.D., who experiences one or two seizures per month, does not have “intractable” seizures. Given that J.D. had

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<sup>27</sup> DRC reviewed the policies as described in Lakeview’s letter, but has not verified their implementation. The Final Investigation Report describes the circumstances leading to J.D.’s death and DRC’s findings, conclusions and recommendations based on the policies and procedures that were in effect at the time J.D. died.

<sup>28</sup> It should be noted that, within one month of this neuropsychological evaluation, J.D.’s neurologist adjusted his medications. Thereafter J.D. did not experience any seizures [REDACTED] [until approximately 4 months later], when he had the first of two seizures reported by Lakeview staff.



not experienced a single seizure [for approximately four months] after his medications were adjusted [REDACTED] and the opinions expressed by both Lakeview's consulting neurologist and DRC's medical consultant, DRC did not revise the report to describe J.D.'s seizures as "intractable." However, DRC did modify the report, in line with Dr. Usher's and Cooley's reports to read "J.D. had a seizure disorder and had been under the care of a neurologist prior to his admission to Lakeview. He had been prescribed anti-convulsant medications which, prior to [REDACTED] 2012 [3 ½ weeks after his admission to Lakeview], kept his seizures under good control for an extended period of time."

2. *Lakeview took exception to DRC's assertion that "Lakeview failed to provide appropriate medical and/or behavioral interventions to address J.D.'s physical, emotional and behavioral issues (p. 1, 2<sup>nd</sup> paragraph 5<sup>th</sup> sentence). Lakeview raises several claims in its defense at pages 4 and 5 of its response. Those points (in italics) and DRC's response are as follows:*

- a. *Mr. D. met with or was reviewed by a member of Lakeview's treatment team on at least 40 occasions to address longstanding, complex physical, emotional and behavioral issues.*

No amendments were made in response to the above assertion. DRC disagrees with Lakeview's characterization of the number of occasions its treatment team met with or reviewed J.D. to address his complex issues. In response to DRC's inquiry, Lakeview produced an excel spreadsheet listing the records it relied upon in the above assertion. Of the contacts or reviews listed on the spreadsheet, 11 were initial evaluations. Notably, the initial psychiatric evaluation was not conducted until [REDACTED], more than two months after J.D.'s placement at Lakeview and only three (3) days before he died. Six of the reported "contacts" involved staff of Huggins Hospital. Lakeview's behaviorist did not record any personal contact with J.D.. More importantly, even if Lakeview's representation concerning the number of occasions its treatment team met with or reviewed J.D.'s circumstances is accurate, J.D.'s steadily declining health status and, ultimately, his death indicate that Lakeview's attempts to address his physical, emotional, and behavioral issues were not effective.

- b. *Lakeview asserts that appropriate follow-up occurred both times J.D. experienced seizures during his time there. Further, Lakeview asserts that J.D.'s levels of seizure medication remained therapeutic throughout his stay at Lakeview.*

DRC does not find any amendments necessary. DRC agrees that transferring J.D. to Huggins Hospital's Emergency Department following the two seizures he experienced in August was appropriate. DRC acknowledges that Lakeview's neurologist reviewed J.D.'s valproic acid (Depakote) levels and adjusted J.D.'s medications following the second hospitalization in mid-August. In addition, DRC acknowledges that, as indicated in the OCME report, [REDACTED] [REDACTED] However, Lakeview's staff

repeatedly reported medication refusals. Despite these reports, neither Lakeview's Primary Care Medical Director nor the Neurologist ordered tests to check J.D.'s valproic acid level after mid-August. Lakeview's Primary Care Medical Director ordered lab work in connection with his September 19, 2012 appointment with J.D., but did not check J.D.'s valproic acid level. Finally, the OCME's finding [REDACTED]

[REDACTED] is inconsistent with Lakeview's assertion that J.D.'s levels of seizure medication remained therapeutic throughout his stay.

- c. *Lakeview asserts that J.D.'s weight was a concern and that records "reflect that Mr. D. had a history of eating issues, at times being a 'picky' eater and consuming minimal amounts, and at other times over-eating uncontrollably." Lakeview reports that J.D.'s weight upon admission was 269 pounds, "which is considered obese for a man of his height." Lakeview set a goal to help J.D. lose weight with an eventual goal of 205 pounds. Lakeview asserts, "when it was noted that his appetite was poor and his weight loss was occurring at an accelerated rate, his treatment team made modifications to his diet and behavior plan to encourage consumption of calories." Finally, Lakeview asserts that J.D. was seen "multiple times" by the dietician and medical director for his ongoing weight loss, offered preferred foods and supplements, and provided opportunities to eat in private."*

DRC did not make any amendments in response to the above claims for the following reasons. It appears from the records Lakeview provided that its dietician never met with J.D.. Lakeview's dietician completed an initial nutritional assessment [REDACTED] [approximately 3 weeks after J.D.'s admission]. In addition, the spreadsheet Lakeview created indicates that on [REDACTED] [approximately 1 month after his arrival at Lakeview] one of its nurses measured J.D.'s weight as 248 pounds, which represents a loss of twenty-one (21) pounds from his weight upon admission to Lakeview. Approximately one week later, the dietitian developed a Nutrition Protocol, again without meeting with J.D.. The only remaining contact or review listed involving the dietician is an email the dietitian sent to a cabin supervisor and nurse reiterating prior recommendations.

Lakeview's primary care medical director met with J.D. on only two occasions – [REDACTED] [5 days after his admission to Lakeview], during his initial medical health assessment, and on [REDACTED] [4 days before his death], an appointment that was scheduled as a result of concerns expressed by direct support staff. The investigation report reflects the efforts described in Lakeview's February 3, 2014 letter. None of the activities outlined in Lakeview's records or correspondence provided in response to the draft investigation report was successful in addressing J.D.'s food consumption. In fact, he stopped eating altogether. Therefore, DRC did not believe any modifications in this area were warranted.

- d. Lakeview asserts that “given J.D.’s developmental delay, multiple impairments and complex presentation, it was difficult to differentiate behavioral from mood related symptoms. Lakeview represents that J.D. was seen by members of Lakeview’s psychiatry/psychology/behavioral health services team 9 documented times in addition to contacts with his cabin/program manager. Further, Lakeview asserts, “the most probable route for improvement was through behavioral treatment approaches which were implemented and modified during his stay.”

In reviewing the records Lakeview provided, DRC identified only 5 face-to-face meetings with members of Lakeview’s psychiatry/psychology/behavioral health services team. Four of these meetings were conducted as part of J.D.’s initial battery of evaluations. The only other face-to-face service with a member of this team was the meeting J.D. had with Dr. Griffin after he expressed suicidal thoughts. As a result of that meeting, Dr. Griffin increased J.D.’s supervision status to five minute checks. However, as indicated in the investigation report, staff did not comply with the changed supervision level. DRC agrees that, given J.D.’s history of challenging behaviors and subsequent eating and compliance issues upon his admission to Lakeview, it was appropriate to attempt a behavioral treatment approach. As indicated in the Investigation Report, however, DRC found Lakeview’s attempted behavioral approaches inadequate. Therefore, no amendments were made in response to the assertions listed above.

3. Lakeview acknowledges the veracity, in part and denies in part, the following assertion appearing on p. 1, 2<sup>nd</sup> paragraph of the investigation report – “neither J.D.’s guardian nor other members of his treatment team not employed by Lakeview were aware of J.D.’s ongoing refusal to take medications, including his anti-seizure medication, or his near complete refusal to eat during the month preceding his death.”

Lakeview acknowledged that “early management of this case was of concern and, as a result communication with external stakeholders suffered.” Further, Lakeview agrees with DRCs assertion that J.D. refused medications on several occasions during the month of September, but maintains that he only refused his anti-seizure medications on one occasion during the month [redacted] [he died]. Lakeview also maintains [redacted] J.D.’s seizure medications remained in a therapeutic range.

DRC’s investigators took another look at the medication records, nursing progress notes and incident reports. These records are hand-written and challenging to decipher. Some of the medication administration records appear to contradict incident reports. Other medication administration records and nursing progress reports appear to be incomplete. We noted that J.D.’s medication regimen provided for administration of valproic acid, his primary anti-seizure medication, only once per day, in the evening and agree that at least some of his medication refusals occurred at times when he was not scheduled to take valproic acid. [redacted]

[REDACTED] [OCME findings redacted per instructions.] Given that some of J.D.'s medication refusals did not involve refusal to take valproic acid, we amended the investigation report by removing specific references to valproic acid refusals unless clearly documented in the records.

4. *Lakeview took exception with the investigation report's discussion about J.D.'s weight loss, asserting, that he lost only 40, rather than 47 pounds, while at Lakeview and "based on [REDACTED] Mr. D. may have had a slight weight gain in the 5 day period prior to his death."*

DRC determined no amendment to the report is necessary in response to Lakeview's assertion. Lakeview's records clearly indicate that J.D.'s weight upon admission to Lakeview was 269 pounds and had dropped to 222 pounds by [REDACTED] [4 days before his death – the date Dr. Badman examined him], for a total loss of 47 pounds during his time at Lakeview. This represents a rate of nearly 5 pounds per week. There is nothing in the records to indicate that J.D. began eating after his weight was measured [REDACTED] [by Dr. Badman]. Further, it should be noted that scales may differ. Therefore, the weight obtained by [REDACTED] may or may not indicate any fluctuation in J.D.'s weight. Of greater concern is that, despite J.D.'s repeated refusals to eat and acknowledgment in mid-August that he had lost a substantial amount of weight in a short period of time (29 pounds), Lakeview did not implement a plan to regularly weigh J.D.. Nor did it take any immediate action, after ascertaining that his ketones were "large," to address an obvious metabolic imbalance. For these reasons, DRC did not change its report in response to Lakeview's assertions.

5. *Lakeview took exception with the investigation report's representation that "despite the challenges J.D. presented regarding program participation, medication and meal refusals, on [REDACTED] [his 17<sup>th</sup> day at Lakeview], Lakeview mailed a letter and information to his guardian indicating that J.D. tolerated his evaluations well and 'is adjusting well to his residential setting.'" Lakeview asserted that the information contained in this correspondence was from J.D.'s initial services plan meeting, conducted [REDACTED] [a week earlier],, which reflected only his first 10 days at Lakeview during which time, according to Lakeview, J.D.'s behavior did not vary drastically from the behaviors he exhibited prior to his admission to, or while at, New Hampshire Hospital. Further, Lakeview's response states that J.D. was not exhibiting any of the extreme behaviors noted in his preadmission paperwork, such as self-injury, elopement, or aggression.*

DRC acknowledges that Lakeview's correspondence [REDACTED] [referenced above] only referred to J.D.'s initial 10 days at Lakeview (i.e., from [REDACTED] through [REDACTED]), but notes this letter was not sent to the guardian until a week after the end of this reporting period. By this time, it was apparent that, contrary to the representations in the [REDACTED] letter, J.D. had not adjusted well to his residential setting. Further, the [REDACTED] correspondence did not include any

reference to the attack J.D. suffered within his first 10 days at Lakeview from another peer or the impact that attack reportedly had (leaving him in a “bewildered” state). Finally, Lakeview failed to provide timely updates to notify the guardian regarding the overall decline in J.D.’s physical and mental health, his refusals to participate in program activities, repeated assertions that he wanted to return home, or two prolonged seizures he [REDACTED] [during his 2<sup>nd</sup> month at Lakeview]. We, therefore, did not make any modifications to the investigation report based on the above assertions.

6. *Lakeview’s response to the investigation report’s finding that Lakeview failed to provide J.D.’s guardian with timely notification of the seizures he experienced in [REDACTED] [his 2<sup>nd</sup> month at Lakeview] was that “it was not unreasonable for Lakeview to expect that Huggins Hospital personnel contacted the guardian.”*

In its response, Lakeview “acknowledges that case manager communication was not consistent with our expectations.” Nevertheless, Lakeview maintained that, as the treating hospital, Huggins had the legal responsibility to obtain the guardian’s consent prior to administering treatment. Lakeview may be correct in its assertion that Huggins should have secured the guardian’s permission prior to administering treatment. But, under its own policies and procedures, Lakeview was obligated to notify J.D.’s guardian of each incident resulting in his hospitalization by the close of the business day. Family Notification Policy No. 4.22. Therefore, no amendments were made to the investigation report in response to Lakeview’s assertions.

7. *Lakeview took exception with the report’s finding that “the presence of large ketones in Mr. D.’s urine indicated that he was in a metabolic state of starvation.” Lakeview characterized J.D.’s ketone level as “slightly elevated.” Lakeview asserted that the presence of ketones is representative of “fasting not ‘starvation,’” stating that “even an overnight fast can affect this level.” In addition, Lakeview asserted that “zonisamide is well known to cause metabolic acidosis which can produce ketones in the urine.” For the above reasons, Lakeview stated that its Primary Care Medical Doctor was “not unduly alarmed by the elevated ketones which never measured in an extreme range warranting an acute intervention.”*

DRC disagrees with Lakeview’s characterization of J.D.’s ketones as only “slightly elevated” as well as the suggestion that J.D.’s ketone level was due to use of zonisamide or an overnight fast. The results of the urine dipstick test Dr. Badman ordered on [REDACTED] [4 days before J.D.’s death] indicated that J.D.’s ketones were “large,” the highest measure of the dipstick test; not “slightly elevated” as Lakeview now asserts. Further, DRC rejects Lakeview’s suggestion that the presence of ketones in J.D.’s urine was due to use of zonisamide. According to Dr. Cooley, DRC’s consulting medical doctor, use of zonisamide may cause a metabolic acidosis, which could cause the blood to be more acid than normal. Zonisamide would not, however, cause elevated ketones in the blood or urine. See Dr. Cooley’s supplemental report dated February 20, 2014 Appendix E, for a further description of the reasons he and DRC reject Lakeview’s assertions regarding J.D.’s ketone level.

8. *“Contributing information not included in the Investigation Report.” Lakeview asserted that some of the statements in the medical examiner’s report were not “supported by objective findings.” (Lakeview’s February 3, 2014 letter, p. 7). In particular, Lakeview questions the medical examiner’s finding [REDACTED] Finally, Lakeview again avers that zonisamide causes metabolic acidosis which can produce ketones in the urine, [REDACTED]*

DRC’s report relies, in part, on the findings in the medical examiner’s reports. As the medical examiner’s supplemental report, dated October 18, 2013, revises his findings regarding [REDACTED]

[REDACTED] DRC amended the report in accordance with this new information. [REDACTED]

[REDACTED] [information redacted per instructions from OCME]

Nevertheless, given the existence of contradictory information in the records regarding J.D.’s fluid intake and OCME’s findings, DRC made no finding regarding whether J.D. suffered from dehydration. Finally, as noted above, DRC rejects Lakeview’s assertion that J.D.’s use of zonisamide caused elevated ketones in his urine or blood. According to Dr. Cooley, the presence of large ketones in J.D.’s blood “should always evoke concern and further investigation on the part of a health care provider.” See Dr. Cooley’s Supplemental Report, Appendix E, p. 1.