



DISABILITIES RIGHTS CENTER, Inc.

Investigation Report, Findings & Recommendations

**Regarding Alleged Excessive Use-of-Force during the Course of a
Restraint against L.B., a resident of Lakeview Neurorehabilitation
Center on March 24, 2010**

Prepared by the Disabilities Rights Center

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**DRC 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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I. Introduction

On March 25, 2010, the Disabilities Rights Center, Inc. (“DRC”) received a report from L.B., a female resident of Lakeview Neurorehabilitation Center in Effingham, NH (“Lakeview”), of an alleged incident of abuse. The report alleged that on March 24, 2010, at approximately 3:30 a.m., a Lakeview employee used excessive force during the process of restraining L.B., a 45-year old woman with co-occurring brain injury and mental illness. The alleged incident occurred outside of Monterey I (“Monty I”), the cabin in which L.B. resided. According to the report, L.B. left her cabin without permission at approximately 3:00 a.m., in an effort to secure her *pro re nata* (“p.r.n”) medications. L.B. reported that she had requested these medications approximately two hours earlier that evening because she was having difficulty falling asleep. Frustrated with the residential and nursing staff, L.B. eloped from the cabin and headed towards the health services office. Lakeview staff members called for back-up and followed L.B. outside. L.B. told staff that she would wait outside until the nurse brought her the medications. When Nancy Norris, the Resident Services staff member on duty, arrived to the scene, L.B. yelled expletives at her and challenged Ms. Norris to a fight. By this time, other staff members were approaching L.B. from behind. According to L.B., she was moving around, trying to keep all of the staff members in front of her and, suddenly, Ms. Norris punched L.B. in the eye. At that point, L.B. reports that she attempted to go after Ms. Norris, but that the other staff members grabbed her, took her to the ground and restrained her on the mat used for outdoor restraints. As a result, L.B. suffered a large bruise on and around her right eye.

Pursuant to DRC’s authority as New Hampshire’s designated protection and advocacy system (“P&A”) for individuals with disabilities,¹ DRC conducted an investigation of this

incident. DRC reviewed the circumstances surrounding the reported abuse through interviewing numerous Lakeview Staff members, including direct care workers, nursing, supervisory staff and administrators. In addition, DRC reviewed Lakeview's internal investigation of this incident and obtained and reviewed Lakeview's relevant policies to evaluate its incident response practices, corrective and preventative actions, and its use, review and monitoring of restraint. A summary of the evidence and our findings and conclusions regarding the alleged incident are set forth in Parts IV and V, respectively. Part V summarizes additional findings regarding Lakeview's response to the alleged incident including its investigation procedures. During the course of this complaint investigation, DRC received allegations of abuse regarding two additional Lakeview residents. DRC conducted a brief review of these allegations through interviewing the alleged victims and obtaining and reviewing relevant records. The results of these reviews are addressed in Part V. Parts VI and VII cover DRC's findings and conclusions in this matter. Part VIII provides DRC's recommendations regarding the alleged incident as well as Lakeview's operations in general.

II. Summary of DRC's Investigation and Methodology

DRC conducted 7 site visits at Lakeview and conducted interviews of approximately 50 Lakeview residents and staff. DRC interviewed all of the residents who were staying at Monterey I during the alleged incident as well as each of the direct care staff who worked at Monterey I during the relevant time-frame. In addition, DRC interviewed Lakeview managerial

¹ 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 professional staff, including nurses, case managers, psychologists, and program directors. Each staff member and resident was interviewed separately. DRC staff first interviewed L.B. on April 1, 2010, approximately one week after the incident. DRC conducted additional site visits and interviews at Lakeview on April 7, 13, 14, 22; May 19; and August 4, 2010.

DRC conducted telephone interviews with Kris Fox, a former Lakeview employee who was L.B.'s case manager on the date of the incident; L.B.'s guardian, Dorian Bryant and his supervisor, Karen Elliot, of the Maine Department of Health and Human Services' Office of Elder Services; Attorney Helen Bailey and advocate, Jay Harper, of the Disabilities Rights Center Maine (L.B. is considered a resident of the state of Maine); L.A. (L.B.'s sister); Dr. Carolyn Criss, psychiatrist, Riverview Psychiatric Center, L.B.'s prior placement and Maine's state psychiatric hospital; and Gary Wolcott, Program Manager, Brain Injury Services for the State of Maine. DRC staff visited Monterey I on three occasions. DRC staff photographed L.B.'s injury as well as injury sustained by another Lakeview resident (K.M) during a restraint.

A complete list of the individuals DRC's investigators interviewed is attached in the Appendix.

The DRC reviewed records provided by Lakeview as follows:

- 1) Lakeview Policies and Procedures:
 - a. Staff Practices Internal Investigation Process
 - b. Suspected Abuse
 - c. Physical Intervention Policy
 - d. Physical Management
 - e. P.R.N. policy
- 2) Professional Crisis Management (PCM) Practitioners Manual
- 3) L.B. medical records
- 4) L.B. incident reports
- 5) Monterey 1 cabin log
- 6) Monterey 1 maintenance log
- 7) Universal Training Document, 3/24/10
- 8) Nursing logs
- 9) Investigation Summary, 3/24/10 incident

- 10) Lakeview resident M.B.'s medical records
- 11) Lakeview resident K.M.'s medical records
- 12) Monterey 1 staffing rosters

III. Responsibilities of Residential Care Facilities/Governing Standards.

There are a number of laws that: (1) protect adult individuals with disabilities living in residential facilities from physical and emotional abuse; and (2) require fair treatment, preservation of dignity and respect for residents of such facilities. In addition, Lakeview Neurorehabilitation has adopted internal policies prohibiting abuse, neglect and exploitation of its residents as well as procedures for the investigation of alleged abuse, neglect or exploitation.

A. Statutory and Regulatory Requirements.

1. 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 subject to abuse, 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 "emotional abuse" as "the misuse of power, authority, or both, verbal harassment, or unreasonable confinement which results or could result in the mental anguish or emotional distress of an incapacitated adult." RSA 161-F:43,II,(a). "Physical abuse" is defined as "the use of physical force which results or could result in physical injury to an incapacitated adult." *Id*, *Sub-section (b)*. "Neglect" is defined 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.

Neither the Adult Protection Act nor the regulations promulgated pursuant to the act includes any specific provisions regarding suspected abuse or neglect of persons residing in public or private residential homes, institutions or agencies. The Act does, however, outline the process by which reports of suspected abuse, neglect and/or exploitation are to be made to, and investigated by, the Commissioner of the Department of Health and Human Services (NH DHHS) or his authorized representative.² R.S.A. 161-F:46. The Act requires the Commissioner or his authorized representative to provide necessary protective services to incapacitated adults upon the substantiation of a report of abuse, neglect or exploitation. RSA 161-F:51. Further, the Commissioner is required to report cases of abuse, neglect or exploitation to local law enforcement, the department of justice, or the county attorney’s office for possible criminal prosecution in cases of serious bodily injury and/or if there is reason to believe a crime has been committed. *Id.*

2. State Licensing Standards for Residential Care and Health Facilities. Pursuant to RSA 151:1, *et seq.*, Residential Care and Health facilities, such as Lakeview, are required to meet basic care and operating standards to obtain the necessary license(s) to operate. DHHS is charged with reviewing applications for licenses and inspecting licensed facilities to ensure compliance with state standards. The Commissioner is required to promulgate rules outlining the standards for licensing for residential care and health facilities including provisions for health, safety and medication. RSA 151:9, I(a). At the time of the incident under investigation, New Hampshire’s

² In accordance with regulations promulgated by the NH DHHS, the Bureau of Adult Services (BEAS) is charged with receiving reports of, and investigating, alleged abuse, neglect, self-neglect and exploitation of incapacitated adults in New Hampshire. He-E 702.02. Further, BEAS is charged with recommending, providing and/or arranging protective services for incapacitated adults, when necessary. *Id.*

Rules for Residential Treatment and Rehabilitation Facilities, He-P 807, *et seq.* had expired.³ Although the rules had expired DHHS maintained its statutory obligation and authority, as outlined in the statute, to review and issue licenses to residential care and health facilities, to conduct investigations of suspected violations and, if indicated, to deny, suspend or revoke a facility's license. *See e.g. Smith v. New Hampshire Board of Examiners of Psychologists*, 138 N.H. 548, 553 (1994) (holding, despite expiration of its rules, the board of examiners of psychologists retained authority to conduct disciplinary proceedings due to clear statutory authority to do so). Relevant to this investigation is the requirement that licensed facilities conduct a needs assessment of each individual prior to admission, and every six months thereafter, to determine that "the needs of the individual are compatible with the facility and the services and programs offered within the facility." (RSA 151:5-a, I). Grounds for the denial, suspension or revocation of a facility's license include, in relevant part, "conduct or practices detrimental to the health or safety or well-being of patients, residents . . . of said facilities." (RSA 151:7, II(c)).

3. Patients' Bill of Rights. New Hampshire's Patients' Bill of Rights, RSA 151:21 requires that residential care facilities ensure certain rights to each of its residents including, in relevant part:

"I. The patient shall be treated with consideration, respect and full recognition of the patient's dignity and individuality . . . VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances . . . to facility staff or outside representatives free from restraint, interference, coercion, discrimination or reprisal

³ The rules expired on December 2, 1999. The department promulgated new rules for such facilities which became effective on February 24, 2011.

. . . VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion, IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.”

4. PAIMI Regulations. Federal regulations applicable to protection and advocacy for individuals with mental illness (PAIMI) define “abuse” as:

“any act or failures to act by an employee of a facility rendering care or treatment which was performed, or which failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness and includes but is not limited to acts such as . . . striking; the use of excessive force when placing an individual with mental illness in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment; and any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue.”

42 CFR 51.2 (emphasis added).

“Neglect” is defined 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.* (Emphasis added).

B. Lakeview’s Policies.

Lakeview’s written policies and procedures for the use of physical intervention are grounded in the concept that residents who exhibit behaviors they consider “maladaptive” should be managed using the least restrictive means possible, but which protects the individual’s safety. The physical management policies permit a range of interventions, including the use of physical restraint.

1. Physical Management. Policy No. 4.09. Lakeview’s policy concerning the use of physical interventions permits certain physical management interventions that are less intrusive than physical restraints. In particular, this policy authorizes the use of passive physical intervention (“the re-direction of the person’s physical energy and mobility”), for example, blocking blows, or re-directing individuals wandering toward hazards. The policy provides that its purpose is to “manage maladaptive behavior in the least restrictive, least intrusive manner possible, while maintaining the safety of individuals served and the clinical integrity of the treatment program.” The use of the alternate physical management procedures is intended “to

provide for minimally intrusive procedures that support safe management, prevention of property destruction and greatly reduce the probably of physical restraint.” At the time of the incident under investigation, Lakeview’s written policies permitted the use of physical intervention “only to prevent an individual served from injuring self or others after redirection, verbal efforts and any other physical management intervention delineated in the behavior program have not had a calming effect on the potentially harmful behavior.” Policy No. 4.09.1. Further, this policy provides, “the purpose of a physical intervention procedure is to provide a protective intervention for safeguarding the individual served or others from endangering behavior. The least restrictive form of physical intervention should always be initially attempted, based on the Facility’s Management of Aggressive Behavior System.” *Id.* At the time of the incident, and until approximately September 27, 2010, Lakeview’s physical intervention policy permitted a spectrum of approved physical intervention procedures ranging from physically escorting a person away from harm to placing the person in a prone restraint. *Id.* On or about October 8, 2010, Lakeview notified DRC’s investigators that it had revised its policies to eliminate the use of prone restraint. (Letter to Adrienne Mallinson and Karen L. Rosenberg dated October 8, 2010).

Lakeview has adopted Professional Crisis Management (PCM) physical intervention method and requires that direct support staff become PCM certified. New staff members are provided with PCM training during the first week of employment, retrained within 6 months after hire and annually thereafter. Pursuant to Lakeview’s physical intervention policy, before initiating a restraint, staff must inform the resident that a restrictive procedure is going to occur. Policy No. 4.09.1, para. 3. In addition, physical management is only to be applied “in strict accordance with Emergency Procedures Protocols and practitioner orders as developed by the

client's treatment team in consultation with the individual served, the clients' guardian, . . . with written approval by the Psychologist and Psychiatrist." *Id. Para 4.* Further, Lakeview's policy provides that the Unit Coordinator or his/her designee must supervise all individuals served in physical intervention, "to ensure that the least restrictive physical intervention procedure is being utilized." *Id. at para 10.*

Under Lakeview's physical intervention Policy No. 4.09.2, "every attempt shall be made to anticipate and de-escalate the behavior using a more therapeutic intervention" (rather than a "restrictive procedure," including a personal restraint). Further, the use of personal restraints is permitted only "in response to an emergency safety situation," which is defined as "the unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs, and that calls for an emergency safety intervention." Further, "personal restraint must be ordered by a licensed practitioner at the time of and solely for the duration of the emergency safety situation." 4.09.2

2. Additional Requirements Under Policy No. 4.09.2. Lakeview mandates the following additional procedures under its physical management policy: 1. When faced with an emergency safety situation, staff must immediately take steps to notify the program participant's licensed practitioner who will then order the least restrictive intervention; 2. The licensed practitioner's verbal order must be received by a registered nurse or other licensed staff member, and recorded on an order form within 24 hours and documented in the medical record;⁴ 3. the licensed practitioner who ordered the restraint must be available to staff for consultation in person or via telephone for the duration of the intervention; 4. a trained observer must record the resident's

⁴ Each order must include the name of the practitioner ordering the restraint, the date and time the order was obtained, the type of restraint ordered, including duration, the time that the restraint began and ended, the time and results of the nurse assessment (which must be within one hour of the restraint's conclusion), the name, title and credentials of staff involved in the restraint and the date and time the practitioner consulted with the team physician. Policy No. 4.09.2, Page 2, Para. 2.

physical and psychological status during the restraint, at a minimum every 5 minutes and place this document in the resident's medical record; 5. within one hour of the intervention, a physician, RN or approved licensed practitioner must conduct a face-to-face assessment of the resident's physical and psychological well-being; 6. any restraint-related injury of a program participant or staff member must be recorded on the Incident Report Form for documentation in the medical record; and 7. the ordering practitioner must review the emergency safety intervention with the resident's team physician as soon as possible, and document such on the written order form. *Id.*

3. Post-Intervention Debriefing. Within 24 hours after a restraint, staff involved in the incident are required to participate in a "face-to-face debriefing with the resident (exceptions may be granted if the physical presence of a particular staff member jeopardizes the well-being of the resident.)" (*Id.*, at p.3 (emphasis added)). The purpose of the debriefing is to identify the circumstances that led to the restraint and to identify alternative treatment strategies. Staff are required to document the debriefing and forward this information to the resident's medical record. Staff involved in the emergency safety intervention are also required to participate in a face-to-face debriefing and situation review "with appropriate team members, supervisory and administrative staff" within 24 hours after the restraint to "identify areas requiring modification to administrative policy and procedures, and if injuries were present, to prevent future injuries." This meeting must be documented and forwarded to the medical record. *Id.*, at p.3.

4. Policy No. 4.21. Reporting Suspected Abuse. The purpose of this policy is "to proactively ensure the safety of all individuals served . . . and to comply with all Federal, State and local regulations regarding alleged or suspected abuse, or any violation of an individual's rights." This policy requires that "any report or suspicion" of an alleged abuse incident be

reported immediately and documented on an Incident Report form. Further, the reporter must **“address any present safety concern then immediately notify”** his/her supervisor, who must take any immediate action necessary to ensure the safety and well being of the individual. *Id. at p.1, para.1* (emphasis in original). The supervisor is required to notify the Program Director, who must immediately inform the Clinical Director of the situation and “report the allegation to the Director of QA/QI for initiation of a staff practices investigation.” Upon receipt of an allegation of abuse, the Program Director is required to take whatever actions are necessary to “ensure the safety of all individuals served.”⁵ Following notification to the appropriate party, but not later than the close of business day, the Director of QA/QI is required to initiate a full-scale internal investigation pursuant to Policy No. 4.24, Lakeview’s Internal Investigation Process for reviewing staff practices.

5. Policy No. 4.24. Staff Practices Internal Investigation Process. The purpose of this policy is, “to meet both the mandatory reporting requirements of New Hampshire state law regulations and to provide the facility with an effective, consistent and prompt procedure to address events where the quality of care is called into question.” This policy outlines the procedures that the Director of Training, Quality Assurance/Quality Improvement (currently Michelle Radloff), must take upon receipt of an allegation of abuse or neglect as well as any allegations “implicating quality of care issues.” Pursuant to this policy, the Director of Training, Quality Assurance/Quality Improvement (“the QA Director”) must assign a trained investigator immediately. The investigator’s responsibilities include confirming reporting to the appropriate

⁵ This policy lists the following, non-exhaustive, list of actions the Program Director may take in response to a report of alleged abuse: reassigning or suspending the staff member alleged to have been involved, arranging for immediate medical and/or psychological examinations of the alleged victim, notifying the Clinical Director to determine appropriate risk management actions, having the Case Manager notify the individual’s family, directing the QA/QI Director to “review the information with legal counsel and . . . notify the appropriate state protective agency (as indicated), . . . if the alleged victim is not a minor, notification must be made by the close of business by telephone to . . . the NH Division of Elderly and Adult Services (DEAS).”

State Agency should the alleged incident meet the criteria for reporting, assuring client safety has been addressed and documenting his/her efforts to assure safety, immediately referring the alleged victim for medical and behavioral health examinations, and forwarding copies of the assessment findings to the investigator as well as the individual's medical record. Lakeview must make "all efforts . . . to facilitate rapid collection of relevant supporting documentation and to plan and conduct necessary staff/client interviews." *Id. at p.2*. The investigator is charged with conducting the investigation within 72 hours of the assignment. The investigator prepares a summary of his/her findings in conjunction with the QA Director. The V.P. of Clinical Services/Clinical Director is charged with reviewing the findings and identifying recommendations. These recommendations must indicate "supervisory responsibility and timeframes of any needed follow up." Documentary evidence of recommended follow-up must be included in the investigation file.6. P.R.N. Medication Policy. Policy No. 6.07 provides, in relevant part, "Every client has the right to request or refuse a P.R.N. medication and the nurse is responsible to educate the client regarding his/her P.R.N. medications and the rationale for their use."

IV. REVIEW SUMMARY

A. L.B. – Pertinent History

L.B. is a forty-six year old woman with a dual diagnosis of brain injury and mental illness. Her diagnoses include Post-Traumatic Stress Disorder (PTSD), Psychotic Disorder, NOS, Dysthymic Disorder, Organic Brain Syndrome, and Personality Disorder NOS with borderline and antisocial features. Before an illness that caused brain injury and her institutionalization, L.B. had a stellar career as an Emergency Medical Technician (EMT). After her illness, she was unable to continue to work and has spent her life in and out of psychiatric institutions. In 2004,

she was placed at Riverview Psychiatric Center (RPC), the state hospital in Augusta, Maine, following an attempt to hang herself. At that time, she was facing criminal charges, but ultimately was found Not Criminally Responsible (NCR) for these charges by reason of her mental illness and remained at RPC until her court-ordered placement at Lakeview in December 2009.

While at RPC, L.B. struggled with aggressive and assaultive behavior, suicidal ideation, and command hallucinations. She is reported to have a history of serious assaults on staff as well as self-injury, including reportedly banging her own head to the point of blackening her eyes and rubbing her forehead raw. At RPC, she was routinely subject to physical, mechanical, and chemical restraints and seclusion. After 5 years with no progress in the psychiatric system, her advocates sought specialized treatment for L.B.'s brain injury and petitioned the court for placement at Lakeview. She was admitted on December 7, 2009, on the condition that she receives 1:1 staffing during A and B shifts and on weekends. A review of L.B.'s medical and treatment records indicates that L.B. presents behavior challenges and that the manner in which staff members react to her behavior impacts her ability to respond to interventions. For example, a three-month service review report dated 3/24/2010 authored by L.B.'s primary therapist, Stephanie Griffin, states that when L.B. "becomes agitated she will often physically posture, become physically assaultive, threaten the job status of the individual she is talking to and demand immediate corrective action regarding her complaints." (p.2). Recommendations include: "when L.B. becomes agitated, staff are encouraged to remain calm, assume a neutral stance and maintain safe proximity." L.B. "benefits from consistent expectations and approaches by the various staff members working with her" (p.5).

B. Lakeview – General Background.

Lakeview is a residential care facility that provides programs to address neurobehavioral complications and neuro-rehabilitative needs of children and adults with acquired brain injury and neuro-developmental disorders. Lakeview also provides community-based living arrangements and runs an accredited Special Education school for children aged 8 through 21. The majority of Lakeview's residents, are funded through Medicaid waiver programs. Lakeview has contracts with most states and many of its residents are from Maine. It serves New Hampshire residents through the Medicaid ABD and DD waiver programs and is apparently treated as a community residence rather than an institutional placement, even though the majority of its population resides at the Effingham campus, which is an isolated, non-integrated rehabilitation facility on top of Green Mountain.

Lakeview's approach to neurorehabilitation does not include seclusion as a behavioral management tool, nor does it rely on mechanical or chemical restraints. Although physical restraint was used at the time of the incident under investigation, Lakeview reports efforts to reduce, and eventually eliminate, the use of physical restraint as well. According to David Armstrong, Lakeview's Administrator, one of his goals is to eliminate the use of restraint and to become certified by the Academy of Certified Brain Injury Specialists (ACBIS). This would involve providing all staff members with intensive training concerning how to work with people with brain injuries. At the time of DRC's investigation, two of Lakeview's Administrative Staff members were actively involved with ACBIS. Dr. Michael Mozzoni, Director of Behavioral Services and Training, was on the ACBIS Board and Andrew Egan, Program Director, was a certified trainer. According to a letter DRC received from Lakeview on October 8, 2010,

Lakeview has discontinued the use of prone restraints and has made eliminating the use of physical restraint entirely a priority goal for the organization.

C. Review of Incident and Lakeview's Response

1. L.B.'s Account of the Incident

L.B.'s account of the incident under investigation is as follows. L.B. refused to take her evening medications, which are typically presented to her at approximately 9:00 p.m. Thereafter, she was having difficulty getting to sleep and, at around midnight, left her room, which is on the second floor of Monty 1, and went down to the first floor common area. L.B. saw two staff members, Frank Nardello and Brandon Rivard, sitting in the common area and watching television. She asked them to call Health Services and have the nurse on duty bring her P.R.N. medications to the residence. L.B. told Frank and Brandon that she wanted these medications to help her sleep. Frank or Brandon, she did not recall who, told her to go upstairs to her room and then they would call Health Services. They informed her that there was a new policy that prevented them from calling the nurse for medications unless the resident is in his or her room. L.B. did not believe these staff members. She thought they would tell the nurse she was in bed and that she would not get her medications. But, she returned to her room.

Shortly before 1:00 a.m., the nurse had not yet delivered her medications. L.B. went back downstairs and told Frank and Brandon that she could not sleep. She said she needed them to call Health Services to bring her medication. Frank and Brandon told her to go to bed and said that Health Services would not come to the cabin unless she was in bed. L.B. told them she would not go to her room. This was because they had "pulled this" before and she never got the medication she had requested. L.B. did not return to her room and, instead, sat down on the couch in the community room. M.B., another resident, came downstairs and asked to see the

nurse. A staff member told M.B. the nurse would refuse to see her unless she went to bed. Both L.B. and M.B. remained on the main floor.

At about 1:40 a.m, Nancy Norris, the Residential Supervisor (RS) came into the cabin. L.B. asked Nancy whether the nurse would only come to deliver her medicine if she was in her room. Nancy responded that she did not know if that was correct, but if that is what Frank and Brandon said, it must be correct. Nancy told L.B. that there was nothing she could do. Nancy told L.B. she needed to go to bed. Nancy left the cabin, but L.B. stayed on the couch.

At that point, Frank and Brandon opened all the doors and windows in the cabin and told another staff member to turn off the furnace. M.B. got cold and went to her room. L.B. told Frank and Brandon that she wanted her medications and would not go upstairs. Frank and/or Brandon stated to L.B. they had spoken with Steve Fox (Lakeview's Behavior Specialist) several times that evening, that Steve was angry with L.B., that she would be in "big trouble," and ordered L.B. to go to bed. L.B. reported that, after this interaction, she went to her room and stayed there for a while. Still unable to sleep, L.B. went downstairs again, at approximately 3:00 a.m. to ask for her medications. She noticed that Frank Nardello was asleep on the couch. L.B. asked Brandon Rivard to call Health Services. He complied with L.B.'s request. L.B. reported that she spoke loudly to wake up Frank. Brandon told Frank they were waiting for Health Services. Frank was angry at being woken up and told Brandon to tell Health Services to cancel the nurse. L.B. told Brandon and Frank that if the nurse was not there in five minutes, she would leave the cabin and go to Health Services. Brandon and Frank went into the staff office and closed the door. L.B. thought they were going to cancel Health Services. L.B. then left the cabin and ran down the side of the hill towards Health Services. Brandon and Frank ran after, and got ahead of, her. Nancy Norris, the RS on duty, arrived on the scene.

Nancy told the other staff to get the mat they use to restrain residents outside. A staff member brought out the mat and L.B. sat on it. She said she would wait there for her medications. A staff member told L.B. that they had spoken with Steve Fox who said she was going to be in trouble. The staff pulled the mat out from under L.B. At that point, L.B. shouted expletives at Nancy and challenged her to a fight. Nancy walked up the hill towards L.B. At the same time, Frank and Brandon moved closer to L.B. L.B. recalled that some additional staff members appeared at the scene as well. She estimates there were a total of 6-7 staff members, including Nancy.

L.B. reached for Nancy Norris when, as L.B. recalled the incident, Nancy went after her and punched her in the eye. L.B. thinks Nancy may have been wearing a ring on her right hand, but was not certain. After Nancy hit her, L.B. started to go after Nancy. Then the male staff members grabbed her and took her down onto the mat. L.B. reported that she was thrown to the ground. She ended up face down, with her shirt over her head. L.B. did not recall the position in which she initially landed. She reported that someone sat on her back. Also, a staff member had his hands on her head. Other staff members held her arms and legs. L.B. stopped fighting at that point and asked for her medications again. Nancy Norris left the scene.

While she was still on the ground, the nurse, Morna Mashrick, came down the hill to L.B. L.B. demanded her medications. Nurse Mashrik left to look for the medication order. She returned to the scene without the medications. L.B. explained what she wanted and told Ms. Mashrick she would not go back to her cabin until she was given her medications. Ms. Mashrick left again and returned with L.B.'s medications. After she took the pills, staff left L.B. alone on the mat for approximately twenty minutes. Then, L.B. walked back to her cabin. Frank and Brandon followed her into the cabin. L.B. walked past a woman staff member (Chelsea), who

was providing 1:1 supervision of another resident, and went to her room. A few minutes later, Chelsea showed up at L.B.'s door and asked L.B. if she was okay. L.B. thought Chelsea had noticed her black eye. L.B. asked for the nurse.

Nurse Mashrick came to L.B.'s room and examined her eye at approximately 5:00 a.m.. L.B. told Ms. Mashrick that she got hit, but didn't say who hit her. L.B. informed DRC's investigators that she was afraid to name Nancy Norris as the person who injured her because she did not know if Morna Mashrick and Nancy were friends and she feared retaliation. L.B. reported she was crying and that Ms. Mashrick told L.B., "I think it's time for me to be around Monty 1 more," or words to that effect. Ms. Mashrick offered ice, but L.B. refused. During the mid-morning of March 24, 2010, Jeremiah Adinolfi, a Monty 1 staff member, made a comment to L.B. about her black eye. L.B., informed DRC that she "sarcastically" responded that she had painted mascara on her eye and then, again sarcastically, said she hit herself in the eye. Further, L.B. reported that later that day, she told Jeremiah she did not injure herself.

2. Staff Member Witnesses

a) Brandon Rivard's Account

At the time of the incident under investigation, Brandon Rivard had worked at Lakeview for 9 months as a Rehabilitation Specialist. He was interviewed on April 14, 2010. According to Brandon, L.B. "runs the mountain." Whatever she wants, she gets.

On the evening of the incident, Brandon was working C-Shift at Monty 1. When he arrived for work, L.B. was upstairs stomping. Brandon stated he assumed she was stomping because she was in a bad mood and/or that she had not taken her medications. Brandon reported that L.B. continued stomping until approximately 1:00 a.m. when she went downstairs and began having a conversation with Frank Nardello, another staff member. At this point, Brandon was

upstairs. However, Brandon reported that he overheard L.B.'s conversation with Frank. Brandon stated L.B. was asking Frank for her p.r.n. medications. Frank told her to go to her room because she was being rude. L.B. went to her room, but came down a couple of hours later and asked for the nurse. Brandon reported that he called the nurse. However, according to Brandon, when L.B. wants something, she wants it right away. Brandon said, L.B. did not want to wait for the nurse to arrive. So she ran out to the hill.

Brandon reported that he or Frank called for extra help and followed L.B. outside. While they were waiting for other staff to arrive, L.B. was irate and talked about how she was going to get him and Frank fired. Nancy Norris arrived and asked L.B. what this was all about. L.B. said "You know". Brandon said it seemed to him like L.B. had an underlying problem with Nancy.

L.B. started coming down the hill towards Nancy. Brandon and Frank stood by Nancy to protect her. Brandon stated L.B. was too mad to listen and that she "came at" Nancy and tried to punch or grab her. Brandon said he and Frank grabbed L.B. to keep her from hitting Nancy, but that L.B. did make contact with Nancy's face. Brandon said Nancy was not seriously injured from this contact and that it was "not a full punch." He and Frank and grabbed L.B.'s arms and "removed Nancy from the situation". Nancy made the call that staff should get the mat used for outdoor prone restraints. A staff member (he did not recall who) ran inside for the mat.

Brandon's opinion was that it was necessary to restrain L.B. He stated that he and the other staff members were careful to use PCM techniques and described the take-down as follows. Frank and Brandon had L.B.'s arms in a "Sunday stroll" position. L.B. struggled and someone put a mat down. Another staff member had L.B.'s legs. He and three other staff members "lifted her down," absorbing her weight. They held L.B. down but not with a lot of pressure because she was not struggling. L.B. did not seem hurt. She knew the restraint was

going to happen. In Brandon's opinion, being restrained suited her "agenda". She had said she wanted to get Nancy fired. After the restraint, L.B. sat on the mat, laughing about the incident, and didn't want to move.

After this incident, L.B. went inside and went to her room. Approximately ten (10) minutes later, another staff member told Brandon that it looked like L.B. had a black eye. Brandon believes L.B. was heading to use the bathroom when this staff member noticed L.B.'s eye.

b) Frank Nardello's Account

Frank Nardello was interviewed on April 22, 2010. Frank works in Direct Support as a Rehabilitation Specialist at Monty 1. He had been employed by Lakeview for approximately 1 year, 4 months at the time of the incident under investigation. Frank described L.B. as polite 95% of the time. But, the remaining 5%, if something sets her off, she is irrational. Frank stated he has a good relationship with L.B. Also, L.B. is a "special case." She is different from the other residents. Frank stated that L.B.'s behavior is not predictable. Sometimes she is better when she gets her p.r.n. medications. Sometimes she is much worse. According to Frank, L.B. gets very agitated if she has to wait for anything. Frank also stated that he thinks it is good for L.B. to wait. When asked about L.B.'s behavior plan, Franks responded that sometimes it is to give her what she wants – the more they keep her happy the more she cooperates with the program.

Frank was working third shift at Monty 1 during the overnight hours between March 23 and 24th, the time of the incident under investigation. Frank reported that at approximately 11:00 p.m., L.B. was stomping on the floor in the upstairs breezeway. He and other staff attempted to cajole L.B. to go into her room, but she refused. She continued stomping for 2 – 3 hours and finally went to bed. Later, she came downstairs and asked staff to contact the nurse.

Frank reported that L.B. was being unsafe, yelling and making odd movements. Frank said he called the nurse, but the nurse wanted L.B. to calm down before she would come over to the cabin. Frank said he told L.B. what the nurse had said and that L.B. got upset. Frank reported that Brandon then called the nurse and L.B. stated, “if the nurse is not here in 10 seconds, I’m going to leave,” or words to that effect. Then, L.B. went out of the cabin and onto the grass. Frank called for additional help.

Nancy Norris and Sarah Cooper, another staff member, came up to the cabin. L.B. saw Nancy and started screaming, “let’s go” or words to that effect. Frank said he ran up to the cabin and got the mat they use for outdoor client restraints. He called for additional help.

At this point, Frank reported, L.B. was really agitated and yelling statements including, “I’m gonna get you,” at Nancy. Then, L.B. took a swing at Nancy and grabbed her face. Frank said he and Brandon, another staff member, grabbed L.B.’s arms and put her into a “Double Sunday Stroll,” a type of standing restraint. Then, according to Frank, they slowly lowered L.B. onto the mat, chest first. He characterized L.B.’s transfer from the standing “Sunday Stroll” to the prone restraint on the mat as controlled, with no excess movement or need to flip L.B. from back to final, chest-down, position. Frank reported that he and Brandon held L.B.’s arms and Sarah held her legs.

After she was put onto the mat, Frank reported they held her down for 10 to 15 minutes. L.B. flayed around for a short time and yelled that she hated Nancy. However, she calmed down quickly and, when Nancy left the scene, “it was over.” The nurse brought L.B.’s p.r.n. medications to her while she was on the mat. L.B. lay on the mat for 30 – 45 minutes after she received her medications and then went to her room.

Frank did not notice the black eye after the restraint. He and others were behind L.B. when she went back to the cabin. After the prone restraint she laid on the mat for a while. In response to DRC inquiry about the black eye, Frank said it's a mystery. It doesn't make sense. The black eye was very bad – there would have had to be multiple punches. He thinks L.B. could have injured herself while she was lying on the mat. Although he was outside with L.B. during that time, he did not observe L.B. engage in any self-injurious behavior while she was on the mat.

After the incident, he, Brandon and Sarah debriefed. L.B. did not participate in the debriefing. He believes the only time a client would participate in a debriefing would be if a psychologist is available to assist. During the debriefing, they discussed what could have been done better. They did not come up with any ideas. Frank believes L.B. would have attacked Nancy regardless of their efforts.

Frank recalled that the next morning, L.B. wore sunglasses. A couple days after the incident, a B-Shift staff member told Frank that L.B. admitted to punching herself in the eye several times.

DRC investigators reviewed Frank's account of the events as described in two incident reports he drafted before L.B. eloped from the cabin. According to these reports, L.B. was stomping in the upstairs breezeway from about 11 – 11:45 p.m. Staff asked her to stop, but she ignored staff's request and continued this behavior until she calmed down at 11:45. The second report indicates that at about 1:15 a.m., L.B. "came down very agitated asking for health services." Further, this report provides, "staff asked client to calm first and show safe behavior before the call was mad.(sic) Client refused to calm and layed (sic) on couch and ignored staff. Health services was informed. Client continued behavior by stomping foot on end of couch."

After reviewing the incident report with DRC's investigators, Frank said he recalled telling the nurse she should wait to come to the cabin, but stated it is really the nurse's decision. Frank said he thought the nurse had other clients who she needed to assist before bringing L.B. her medications. Frank recalled telling L.B., after his conversation with the nurse, that they would like her to calm down a little, but L.B. stormed upstairs. Frank volunteered that there is no way around the nurse's schedule. She had other things to do.

c) Sarah Cooper's Account

Sarah Cooper was interviewed on April 14, 2010. She has worked at Lakeview since October 2008. On the night in question, she was the C Shift Supervisor at the Main House and had no responsibilities for Monty 1. Between 3:30 and 4:00 a.m., she heard over the radio that L.B. had eloped from the cabin. Sarah ran out to assist because there is not a lot of staff available to help at that time of night. She saw L.B. standing at the top of the hill in front of Monty 1 screaming "Where's Nancy, I want Nancy, she's going to be all done, I'll have her job," or words to that effect. Nancy Norris was just coming around the corner behind Sarah and asked Sarah what was going on. Sarah told Nancy L.B. was posturing and threatening to have her job.

Sarah and Nancy were standing at the bottom of the hill and L.B. was up on the dirt. L.B. started moving aggressively towards them both. Nancy asked Brandon to get a mat and Brandon went to Monty 1 and got one. Then, L.B. grabbed at Nancy's head and scratched her eye. Brandon and Frank were behind L.B. and grabbed her. Sarah threw the mat down underneath them as they all went down in a "pig pile." L.B. was rolled over into a prone restraint. Then Nancy left to call the doctor for a restraint order.

L.B. struggled but calmed down and was in a hands-on restraint for probably less than a minute. L.B. asked for a nurse. The nurse came out with medications, but L.B. said she had

brought the wrong ones and told the nurse to go and look at the order. The nurse came back with different medications. L.B. did not want to get up from the mat. She asked for a flashlight to see the pills. She took the pills. Sarah sent Noah Hoffman, another staff member who was also there from Main House, back to the Main House, but Frank and Brandon stayed outside with L.B. L.B. lay on the mat for about 20 minutes and then went back to the cabin.

Sarah did not believe L.B. had a black eye when she was lying on the mat. Sarah described L.B. as being on her belly, propped up on her elbows and talking to the nurse, who was at her head. Sarah was at her right hand. After she got up from the mat, she walked in to Monty 1. Frank and Brandon followed her. Sarah had not seen L.B. since the incident and had not seen the black eye but had heard about it. She had no idea why L.B. “had it in for Nancy.”

d) Nancy Norris’ Account

Nancy Norris was the administrative officer (Residential Supervisor) for C-Shift during the incident under investigation. She had worked at Lakeview for approximately 9 years at the time of the incident under investigation. Between the time of the interview and the issuance of this report, Nancy’s employment at Lakeview reportedly ended. She was interviewed by DRC investigators on April 14, 2010.

Nancy worked Monday through Friday, from 9:00 p.m. until 7:30 a.m. Her office was in the Main Building and John Rivard was her supervisor. She worked with staff in each of Lakeview’s buildings, including the nurse on duty. Physically, Nancy is thin and not very tall, but gives an impression of being strong. During her interview, DRC’s investigators noted that she wore rings on each hand.

Although she is a shift supervisor, Nancy does some direct care work, including working with the residents in Monty 1. Nancy mentioned that she had been assigned to Monty 1 since

they were short staffed. Nancy stated that she was one of the first staff members to work directly with L.B. when she arrived at Lakeview. Nancy said she felt she was becoming a “preferred staff member” in L.B.’s eyes. At that point, she backed off.

Nancy stated that there are other staff members who do not want to work with L.B.. Nancy described L.B. as very selfish. According to Nancy, if you don’t give L.B. what she wants right away, she UAs (“unauthorized absence,” leaves the area without permission). Nancy said that the other clients at Lakeview resent L.B. They see L.B. gets what she wants. L.B. gets special treatment – more than any other client she has ever seen at Lakeview.

Nancy stated that she does not believe Lakeview is an appropriate place for L.B.. Nancy describes L.B. as homicidal. She has threatened Nancy in the past and attacked Steve Fox. Nancy said L.B. purposely makes a mess and then tells staff it is their job to clean it up. She has thrown coffee at staff members and then told them to clean it up because it’s the staff’s job; not hers. Nancy has told staff to watch their backs around L.B.. Nancy said there are three circumstances/events that trigger L.B.’s explosive behavior – medications, lack of sleep and having her period.

Nancy reported that at approximately 11:30 p.m. on March 24th, Frank Nardello, Monty 1 direct care staff called and asked her to come to the cabin. When she arrived, L.B. was on the couch, demanding her medications. L.B. asked Nancy whether she needed to be in her bedroom to get her medications. Nancy responded, if Health Services says the policy is as Frank described it; that is the policy. Nancy said she told L.B., if you are not safe the nurse won’t come. Nancy’s impression was that L.B. was going to get her medications. She stated that L.B. wants every need to be met immediately, but there is only one nurse on duty in the evenings. Nancy recalled another resident coming downstairs at that time.

Before she left the cabin, Nancy encouraged both L.B. and the other client to return to bed. Sometime later that evening, Frank called Nancy and told her that L.B. was not going to bed. Nancy recalled telling Frank, if she is not bothering people, leave her alone. At about 3:15 Frank called Nancy again and told her she might want to put someone on standby because L.B. was agitated.

At 3:30 a.m. Nancy received the call that L.B. had run out of the cabin. Nancy stated that she and Sarah Cooper, another staff member, responded to the call. L.B. was outside yelling for Nancy. L.B. said something about how she managed to get Nancy out there. Nancy responded, “what is this about? It’s 3:30 in the morning,” or words to that effect. Nancy said, L.B. responded, “it’s all about you – I’m gonna have your badge,” or words to that effect.

Nancy said that, while on the hill with L.B., she tried to stay away from L.B. and told her this would not go anywhere. Nancy asked another staff member to get the PCM mat and L.B. said that was good and made a comment that they would “have a party until the sun comes out.” At that point, Nancy reported, Frank and Brandon were outside with her, Sarah and L.B.. L.B. was getting into Nancy’s space and posturing. Sarah and the other staff members got closer to L.B. According to Nancy, L.B. then punched her – causing her glasses to fly off her face. The other staff members grabbed L.B. and took her down to the ground. Nancy said L.B. landed on her back. The ground was not even. Nancy described the take-down as “not pretty.” Nancy said she got involved in the restraint to assist with getting L.B. onto her stomach. Staff members were called to relieve Nancy. Nancy noticed the nurse coming towards them, but waived her off at first because L.B. was not stable. Another staff member arrived at the scene.

At that point, Nancy left the scene and called Dr. Errico, the psychologist who was on duty that evening, to report the incident. Dr. Errico told her to stay away from L.B. and ordered

the restraint. Nancy said she went back outside to observe the situation. She called Sarah aside and asked that there be two people watching, without speaking to, L.B., and that they should wait it out. L.B. lay on the mat for approximately 20 to 30 minutes while the two staff members remained about ten (10) feet away, observing the situation as Nancy had directed. Nancy reported that the nurse gave L.B. the medications she had requested. L.B. wanted to look at the medications before she ingested them, which was not unusual for L.B. Nancy stated there was no sign of any trauma.

Nancy observed L.B. walk back to the cabin. Nancy described L.B. as giggly and laughing after the incident. She did not want the nurse to assist her to the cabin. At approximately 5 a.m., Nancy received a call from the nurse, Morna Mashrick, who informed her that L.B. had a black eye. Later that morning, Morna met with Nancy, examined her hands and asked whether she was right or left-handed. Nancy replied she is left handed. Also, Nancy reported there was no injury to either of her hands.

Nancy said she never hit L.B.. It was somewhat difficult to get L.B. down onto the mat because they were on a hill. But, she and the other staff members made sure L.B. went down on the mat. Nancy said she had not seen the black eye, but heard that L.B. told a staff member that she gave herself the black eye. In response to DRC's questions concerning how L.B. would have sustained the black eye, Nancy said L.B. had ample time while she was on the mat, when staff was 10 feet away from her, to injure herself.

In response to DRC's inquiry about whether anything could have been done to prevent the incident, Nancy said if L.B. had received medications earlier, it would have solved the problem. Further, Nancy stated that, generally if a client does not get medications at his/her designated time, but later requests them, staff would call Health Services right away. Generally,

health services can get to the client's cabin within 10 – 15 minutes of receiving a call from the cabin.

e) Morna Mashrick's Account

Morna Mashrick is a registered nurse who has been employed by Lakeview, off and on, for approximately 6 years. Generally, she works from 7:00 p.m. until 7:00 a.m. Morna was the RN on duty during the overnight hours between March 23rd and 24th, 2010, when L.B. eloped from her cabin. Morna was interviewed on April 14 and April 22, 2010. She also responded to inquiries by DRC and left several messages with information concerning the event.

Morna's job responsibilities include giving residents their evening medications. Morna stated that Lakeview's p.r.n. policy is as follows: if a client wants a p.r.n. and is in the cabin, she would expect a call from the cabin. She would then bring the medicine to the cabin. There might be some lag time depending how busy nursing staff is when the call is received.

Morna commented that the clients at Lakeview are very difficult to manage. Morna reported that people get hurt there and staff gets hurt every day – it's an issue that makes it difficult to work at Lakeview.

Morna described L.B. as liking to "call the shots," or words to that effect. She likes to manipulate her environment and is the only client who has successfully demanded to receive medications at a particular time, usually at about 9:30 p.m. Morna stated that the nursing staff does not have the ability to permit clients to choose the exact time they receive medications and she is not sure how L.B. was able to achieve this. L.B. is high functioning. Morna's opinion is that L.B. needs to be in crisis and stated "it is always something with her," or words to that effect.

Ms. Mashrick provided varying, sometimes contradictory, accounts of the incident under investigation. She stated that she could not recall certain salient details, such as whether L.B. was standing or already on the mat when she was called to the scene. During her first interview with DRC's investigators, Ms. Mashrick reported that she did not recall whether L.B. had taken her evening medications on March 23, 2010. But, later, after checking her records, Ms. Mashrick informed DRC investigators that L.B. had refused her evening medications when they were presented to her at approximately 9:30 p.m.

Ms. Mashrick recalled receiving a telephone call from Monty 1 staff sometime after L.B. refused her medications, though she did not recall the exact time of the call. According to Ms. Mashrick, Monty 1 staff called and said something about L.B.'s bedtime medications, but that they also told her she had had those medications. After they terminated the telephone call, Morna said she checked her records and noted that L.B. did not have her medications that evening and thought L.B. was asking for them at that time.

Rather than call back the cabin staff, Morna stated she decided to wait to see if the cabin staff called her back. Morna said this was because sometimes residents will go to bed. Morna said, sometimes she will go down to a cabin regardless of whether she hears back from staff and sometimes the cabin staff will call her back and ask for her to come to the cabin. Morna said she did not remember exactly what happened on the night in question.

Ms. Mashrick recalled that she was at the Health Services office when she heard, over the radio, that a client had UA'd (committed an "unauthorized absence" from the cabin). In accordance with general practice, she went outside to assist and observed L.B. "going off terribly" and screaming that she "wanted the R.S." (Nancy Norris). Morna stated that L.B. was "awful, suicidal or homicidal," or words to that effect. Morna did not recall whether L.B. was

standing or already on the mat when she arrived at the scene. But, Morna said she is pretty certain that other staff members had their hands on L.B. and that she was thrashing and out of control. Then there was a scuffle. Morna thinks L.B. could have gotten an elbow in her eye during the scuffle.

Morna's impression was that L.B. wanted to get Nancy Norris and Lakeview into trouble. Morna stated she thinks L.B. needed to create a crisis and that she wanted to put Nancy into a bad light so she would lose her job.

Morna thought Nancy Norris was trying to call Dr. Errico. She attempted to speak with L.B., but was asked to make the phone call to Dr. Errico for the restraint order. So, she left to make the call. Ms. Mashrick said she went back inside and spoke with Dr. Errico who gave the restraint order. She then went outside and noticed that Nancy Norris was there and that her glasses were on the ground behind the mat Lakeview staff use to restrain clients outdoors. Morna did not recall giving L.B. any medications after the restraint, but said she might have offered L.B. her p.r.n. medications.

Morna stated that she did not notice L.B.'s black eye when she was outside with L.B., but acknowledged it was dark. She did not recall how long it took for L.B. to get back to her cabin and bedroom after the incident. Morna recalled that L.B. needed a nursing assessment right after the restraint and that she did the assessment in L.B.'s room. Morna stated that L.B.'s eye was swollen and that she offered her an ice pack. L.B. refused to take pain medications or use a cold pack. L.B. told Morna that Nancy Norris had hit her.

Ms. Mashrick did not check L.B.'s hands. When DRC staff asked whether it was possible that L.B. caused the injury to herself, and if so, how she could have caused the injury, Morna stated it is possible that L.B. could have caused the black eye by hitting her head on the wall.

However, it does not appear that Ms. Mashrick observed any injury to L.B.'s head other than the bruising on and around her eye.

Morna reported that she spoke with Nancy after this incident and Nancy denied hitting L.B.. Morna examined Nancy's hands and did not see any broken skin or bruising on the back of her hands.

f) Chelsea Skerry's Account

Chelsea Skerry was interviewed on April 14, 2010. She is a Rehabilitation Specialist who was providing eyes-on supervision for another client in Monty 1 during the evening of the incident. However, Chelsea was able to hear what occurred before L.B. eloped from the cabin and saw L.B. immediately after she returned to the cabin.

According to Chelsea, L.B. went downstairs, and asked Brandon to call the nurse. She was being really rude. Frank told her to stop yelling and told her the nurse would not come to the cabin if she was unsafe. Chelsea stated that Frank was "instigating a little bit," or words to that effect. Frank told L.B. to stop yelling or the nurse wouldn't come.

Chelsea saw L.B.'s black eye when she returned to the cabin and before she went to her room. Chelsea reported that she was at the top of the stairs when L.B. was making her way to her room and that is when she noted the injury. Chelsea asked L.B. about her eye, but according to Chelsea, L.B. refused to talk about it and refused to open the door of her bedroom while Chelsea was standing there. L.B. asked for the nurse.

g) Jeremiah Adinolfi's Account

Jeremiah is a Rehabilitation Specialist who had been working B Shift at Monty 1 for approximately 2 months at time of his interview with DRC staff, April 14, 2010. He worked during the evenings of March 23 and 24, 2010, but his shift was over, and he had left Lakeview,

by 11:30 p.m., well before L.B. eloped from the cabin. Jeremiah reported that L.B. was in a “bad space” on the evening of March 23, 2010. He noted that she sporadically refuses medications, but did not indicate whether L.B. took her medications that particular evening. On March 24, 2010, at approximately 7 p.m., Jeremiah noticed L.B.’s eye was black and blue. He said, L.B.’s eye looked like someone had punched her 2-3 times. He said he hadn’t noticed earlier because L.B. was wearing sunglasses.

Jeremiah spoke with her about what happened. Jeremiah reported that L.B. made a sarcastic comment to him in response to his inquiry about what happened to her eye. L.B. told Jeremiah that she had used mascara around her eye and that it took hours for her to put on this makeup, or words to that effect. Jeremiah commented that it looked like someone hit her in the eye – He reported that L.B. flippantly responded, “Yeah, I hit myself in the eye.” L.B. did not say who caused the bruise. She was visibly upset, apologized to Jeremiah for snapping and walked away from him. The next evening L.B. told Jeremiah that she did not injure herself and mentioned that she never told him who did injure her. Jeremiah was instructed by a Resident Services staff member to write up an incident report regarding L.B.’s statement that she had injured herself. Jeremiah did so on March 25th.

3. Incident Debriefing

According to a Debriefing Sheet, dated 3/24/2010, the following staff members participated in the restraint at issue: Frank Nardello, Brandon Rivard, Nancy Norris, Sarah Cooper and Noah Hoffman. However, contrary to Lakeview Policy No. 4.09.2, p.3 (which requires participation of all staff and client involved in the intervention), only Frank and Brandon participated in the debriefing. This form indicates that L.B. refused to participate. This is contrary to L.B.’s statement that she was not invited to participate, nor has she ever been invited

to participate in such a debriefing. Further, contrary to Lakeview policy which requires all staff involved in the intervention to participate in a second debriefing with “appropriate team members, supervisors and administrative staff,” *Id.*, only Nancy Norris participated in this debriefing. The only recommendation was to continue with L.B.’s current treatment plan. Although he did not participate in the debriefing with Nancy Norris and administrative staff, staff member Brandon Rivard participated in a “process training for client L.B.,” with Steve Fox and Dr. Errico on March 24, 2010. It appears that no other staff members received any additional training or debriefing after the incident.

4. Lakeview’s Internal Investigation of the Incident.

DRC’s investigators reviewed Lakeview’s internal investigation protocols (Policy No. 4.24) and interviewed Michelle Radloff, Lakeview’s Director of Quality Assurance/Quality Improvement. DRC’s investigators questioned Ms. Radloff about Lakeview’s policies and practices regarding incidents of alleged abuse or neglect in general as well as the investigation she conducted into the incident that is the subject of this investigation. Ms. Radloff was very helpful and cooperative during the entire investigation process including securing requested documents and scheduling staff and resident interviews. DRC’s investigators interviewed Ms. Radloff on April 22, 2010.

The stated purpose of Lakeview’s Internal Investigation Policy, Policy No. 4.24, is “to meet both the mandatory reporting requirements of New Hampshire state law regulations and to provide the facility with an effective, consistent and prompt procedure to address events where the quality of care is called into question.” In accordance with this policy, “all efforts will be made to facilitate rapid collection of relevant supporting documentation and to plan and conduct necessary staff/client interviews . . . In allegations of abuse or neglect and with participant

consent, interviews will be audiotaped, with date, time, participants present and consent indicated at the onset of the tape.” *Id.* at Par. 5 (emphasis added.).

Ms. Radloff conducted the instant internal investigation and conducts most of Lakeview’s internal investigations. Generally, Ms. Radloff reported, grievances are first reviewed by the resident’s case manager. If abuse or neglect is alleged, the case manager should immediately report this to Ms. Radloff. Depending on the allegations, Lakeview may place the accused staff member on administrative leave or assign them to an administrative duty pending completion of the investigation.

Ms. Radloff conducts witness interviews. She does not tape record the interviews, but has staff members sign off on her interview notes unless she conducts the interview telephonically. According to Ms. Radloff, in instances involving physical restraint, there should be five documents completed – an incident report, safety checklist, emergency intervention order, debriefing sheet and nursing assessment. Ms. Radloff reviews these documents as part of her investigation.

Generally internal investigations are completed within 24 – 48 hours of the incident which resulted in an injury. If there is a founded complaint of abuse or neglect, Ms. Radloff contacts Adult Protective Services.

In addition, the clinical staff reviews the incident and considers what antecedents led to the incident that is the subject of the internal investigation. If the clinical team determines that a staff member’s behavior was problematic, follow-up would be conducted by the clinical supervisors and include the Human Resources Director, Jean Martel. There would be a meeting with the staff member and supervisor. Depending on the circumstances, a corrective action plan

may be developed, Lakeview may provide additional training to the accused staff member and/or the staff member may be given a warning.

Ms. Radloff provided DRC's investigators with her "Investigation Summary," which consisted of a "Pre-Investigation Information" Form, a single-page type-written, report, L.B.'s Photo Identification Sheet, Preadmission Memorandum, the completed Emergency Safety Intervention Order Sheet dated 3/24/2010, a completed Behavior Intervention Checklist for Safety Emergency, dated 3/24/2010, an Incident Report dated 3/24/2010, Steve Fox's notes dated 3/24/2010 and 3/25/2010, a nursing note written by Diane Gosselin, RN, dated 3/24/2010, an incident reported apparently completed by Jeremiah Adinolfi on 3/25/2010,⁶ and a completed debriefing sheet. Neither the Pre-Investigation Information Form nor the type-written report are dated. Therefore, we could not determine how long it took to complete the investigation.

The pre-investigation form lists the following witnesses: Carol Rivard, Sarah Cooper, Frank Nardello and Brandon Rivard. In addition, the report indicates that the "person implicated" was Nancy Norris. The form describes L.B.'s allegation that Nancy Norris punched her in the eye during a "behavioral event" and lists the names of all staff members who witnessed the incident. Michelle Radloff informed DRC's investigators that she interviewed the following witnesses: Brandon Rivard, Noah Hoffman, Frank Nardello, Sarah Cooper, Jeremiah Adinolfi, Morna Mashrick and Nancy Norris. According to the investigation report, Ms. Radloff received L.B.'s statement "as it was related to Steve Fox," Lakeview's Behavior specialist. She did not interview L.B. directly. Nor did Ms. Radloff interview Chelsea Skerry, the Monty 1 Staff member who observed L.B.'s eye was bruised immediately upon her return to the cabin or

⁶ In relevant part, this incident report provides, "L.B. returned from an off campus UA [unauthorized absence]. After continually verbally aggressing towards staff, L.B. brought up her eye. At first L. claimed that she had used mascara. Shortly after she confessed she hit herself in the eye. She later denied that too. L.B. continued to state she had not hit herself." (emphasis in original).

Jeremiah Adinolfi, the staff member to whom L.B. allegedly confessed that the injury was self-inflicted. Further, it appears that Ms. Radloff's investigation did not include an examination of the circumstances preceding L.B.'s elopement from her cabin, notably her repeated requests for her p.r.n. medications, beginning at least two hours before she left the cabin, and staff's response that the nurse would not bring the medications unless she was in her room.

As detailed in her report, Ms. Radloff found that L.B. left her cabin at approximately 3:30 a.m., "apparently upset that the nurse had not yet arrived at the cabin." Further, the investigator found that staff attempted to "redirect" L.B. back to the cabin, but that L.B. "became verbally aggressive" and called for staff member Nancy Norris. Nancy heard L.B. call for her and she approached L.B. and attempted to speak with her. L.B. threatened Nancy verbally and Nancy started to step away and remove herself from the area. According to the report, L.B. "went after Nancy, hitting her in the side of the face, knocking her glasses off. Then continued to grab at Nancy and hit her." A staff member left to retrieve a mat while two other staff members held L.B.'s arms in a "double Sunday stroll" restraint, trying to get her away from Nancy. When the staff member arrived with the mat, "staff attempted to turn L.B. around and get her into the BARR position. L.B. was placed more on her side than on her stomach but did roll over into the BARR position. She was in the BARR restraint for approximately 30 minutes, after which time she calmed." A nurse arrived and, "at L.B.'s request administered her p.r.n. medication." According to the report, L.B. refused nursing assessment, but the nurse reported that "there was enough light out at that time for L.B. to read the inscriptions on her medications and for the nurse to do a cursory assessment. There did not appear to be any signs of injury at that point and L.B. denied any pain or injury." Staff said there was no point at which Nancy was alone with L.B. and that they did not witness anything that could have caused the injury to L.B.'s eye, even

accidentally. Staff reported that, after taking her medicine, L.B. “returned to her room where she was up the rest of the night, but did not have any further incidents.” “When she was assessed in the morning there were signs of redness and bruising around her eye noted.” The report indicates that L.B. told at least one staff member that she had “injured herself to get a staff in trouble.”

Ms. Radloff determined that the allegation was unfounded. In her estimation, there was no opportunity for Nancy Norris to cause the injury. Also, Ms Radloff reported that Jeremiah, a staff person, submitted an incident report in which L.B. admitted to causing the injury. Given her conclusion that the allegation was unfounded, Ms. Radloff did not contact adult protective services regarding this incident.

Finally, it should be noted that, according to Ms. Radloff, typically when staff members are injured they complete and file a “first report of injury.” However, Ms. Radloff reported that the employee health nurse does not have any first report of injury from Nancy related to the incident under investigation.

5. Summary of Additional Interviews.

a) Administrative Staff Summary

Administration staff described L.B. as challenging and volatile. They characterized her as needing to feel in control and refusing to take no for an answer. When L.B. is angry, staff reported that she takes deliberate action to make everyone’s life miserable. She likes to get staff into trouble, has taken pictures of staff members acting inappropriately and has filed numerous grievances. Administration staff also describe L.B. as one of the higher functioning people there and as “dangerous.” When she is emotionally charged, she can be quite divisive. One administrator said, the younger direct support staff members at Lakeview are “no match for L.B.”

Most of the administrative staff felt that Lakeview is an appropriate placement for L.B. At least one administrator (Andrew Egan) described her as having a lot of skills that need to be shaped. He stated that it does not make sense to treat every resident the same. Lakeview staff should consider what is appropriate for L.B. (and other residents) based on the individual's skills and needs. In Mr. Egan's view, a "you can't do this" approach is not sensible for L.B. Lakeview needs to be better than that.

b) Dr. Austin Errico

Dr. Errico was Lakeview's Clinical Director at the time of the incident. Dr. Errico stated the L.B.'s needs are different from many of Lakeview's other residents. He believes she would do better if she were busier and had more structure. Dr. Errico stated that L.B. challenges the staff and points out short-falls in Lakeview's operations, many of which Dr. Errico believes are valid. According to Dr. Errico, a lot of the staff members are young and have little experience working with the population they serve. Staff members don't like being questioned when L.B. complains about her treatment or treatment of others. Dr. Errico characterized L.B. as a challenge. He admitted that staff is sloppy at times which could have resulted in L.B. accidentally suffering a black eye.

c) John Rivard

John Rivard is the Director of Residential Services at Lakeview. He was interviewed on May 19, 2010. Mr. Rivard supervises the direct care staff, reviews budgets and personnel issues. He reports to Dr. Errico and David Armstrong. John described L.B. as very difficult, challenging, intimidating, demanding, high functioning and one of the most challenging residents Lakeview staff has encountered. He acknowledged that it is difficult for staff not to react to what he described as L.B.'s "junk behavior." He described the "process training" as follows: the training

leader listens to the staff's concerns, lets them express their frustrations, then asks how supervisors and administration can support the staff. Mr. Rivard attempts to provide training to ignore those behaviors and avoid the power struggle.

d) Stephen Fox

Stephen Fox ("Mr. Fox" or "Steve") holds two roles at Lakeview – Behavior Specialist and Supervisor for the Adult Team. He holds a master's degree in Rehabilitation Counseling. He had been at Lakeview for approximately 3 years at the time of the incident under investigation. Prior to his employment at Lakeview, Mr. Fox worked as a Rehabilitation Counselor in Florida. Mr. Fox reports that although he is Lakeview's "behavior specialist," this is not his background.

DRC investigators asked what training and supervision direct support staff receives. In addition to Professional Crisis Management (PCM) Training, staff receives "Buttons Training," which is essentially how to maintain a therapeutic relationship with very challenging residents. In addition, when staff members experience a difficulty with a particular client, Mr. Fox and other clinical supervisors provide "process meetings," as necessary, for staff members to examine how they were feeling during the particular incident and what responses do and do not work with that client. Mr. Fox described direct service work as difficult for Lakeview's staff, most of who have only a high school education and must work with very difficult clients with high levels of need. According to Mr. Fox, Lakeview needs at least twice as many staff members as they have.

Mr. Fox described L.B. as "very volatile." She has a difficult time managing her emotions. She is hypercritical and tends to blame others when she experiences difficulties. L.B. becomes fearful if she feels information is not being shared with her. Limit setting with L.B. is challenging and she presents safety concerns.

Regarding L.B.'s differences from Lakeview's typical client, Steve acknowledged that she is different because she came to Lakeview differently than any other resident. The types of interventions that are therapeutic for her are different from those required by other residents.

In response to investigators' questions about the frustration staff have expressed regarding disparate treatment between L.B. and other residents, Mr. Fox said that the way it should be handled is to listen to the staff concerns, then discuss how not all people have the same capacities and needs. They are at Lakeview for different reasons. Some people on staff understand this, but others do not. Mr. Fox sees clinical staff role as assisting staff to get away from simple comparisons and demanding uniformity of treatment to clinical thinking, but this is a struggle. People want to learn and do a good job. Mr. Fox views one of his roles as helping staff understand what is going on with L.B. and assisting Monty 1 staff to better manage her.

Mr. Fox described L.B. as adept at pushing people away and getting them angry. However, it is the staff's job to try to help everyone overcome pathology. He is not sure if they can be of service to L.B.. One suggestion Mr. Fox would consider is assigning people to her team who like to work with her.

e) Dr. Michael Mozzoni.

Dr. Mozzoni is the Director of Behavior Services at Lakeview, a position he has held since January 2010. Dr. Mozzoni was interviewed on May 19, 2010. He was not at Lakeview during the week of the incident at issue, but had learned that L.B. had asked for her medications, that nursing did not get to the cabin soon enough and that in response L.B. decided to walk down to the nursing office. In response to investigator's inquiry about the protocol that should be followed when a resident requests medications, including whether it would be appropriate to require a resident to return to her room before calling nursing, Dr. Mozzoni said the client should

be permitted to sit in the common area and staff should contact nursing without delay. He would think that staff would just do its best to get the client her medications.

f) Clinical Staff Summary

Clinical staff members described L.B. as sarcastic, verbally aggressive and having a wildly variable affect. Her primary therapist noted that she is secretive and does not trust staff. Francis Berks, the ARNP, who prescribes and monitors L.B.'s medications, under the supervision of a psychiatrist, described her as having a "supremely violent potential," much smarter than the average Lakeview resident, capable of planning and as a person who looks to exploit others' vulnerabilities. In Mr. Berks' opinion, Lakeview is not an appropriate placement for L.B. Mr. Berks described tension between the clinical staff and Lakeview management regarding L.B.'s treatment and placement at Lakeview. According to Mr. Berks, L.B. wants an immediate response to any demand. He does not believe providing an immediate response is helpful and, therefore, makes a point to always delay his response to her demands.

g) Direct Support Staff Summary

Many staff members described L.B. as smarter and higher functioning than all of the other residents in her cabin and higher functioning than most of Lakeview's residents. She is a highly demanding person who requires that her demands be met without delay. Also, staff members felt that, no matter how much attention L.B. received, no one could ever do enough for her. Staff described her as volatile, having rapidly shifting moods, quick to snap and suddenly become quite aggressive.

Several staff members DRC interviewed stated that they had not received any clear instructions regarding strategies they should employ when working with L.B. Several staff members expressed concerns about working with L.B. given what they knew of her history. At

least one staff member reported that the doctors at Lakeview have instructed her not to have any power struggles with L.B. Another staff member felt that the Administration gives L.B. everything she wants and does not communicate with the people who provide daily hands-on services. Also, this staff member described receiving conflicting directions from supervisory staff concerning how to work with L.B. Many staff members said they felt L.B. did not belong at Lakeview.

Staff and residents alike felt that L.B. received too many privileges that other residents did not enjoy. Staff members commented that other residents resented the fact that L.B. was given more privileges. Some of the privileges L.B. received that others did not were: permission to make an unlimited number of telephone calls, ability to use the kitchen, and not being required to attend regular programming. Staff members reported that generally residents are permitted to make two telephone calls, two evenings per week. At least one staff member felt that the privilege imbalance resulted in other residents becoming angry and exhibiting escalating negative behaviors. Some staff members reported that working with L.B. takes a lot out of them, especially when assigned as her one-on-one staff for an entire shift. Several staff members reported that L.B. frequently threatens and tries to intimidate staff members. Lower level staff members were not aware of “process meetings” and/or have not been invited to participate in such meetings. One staff member felt he gets mixed messages about L.B. and blamed Administration Staff for continually changing their minds about how to work with L.B.

One staff member who did not witness the incident told DRC’s investigators that he had witnessed staff members making degrading statements to and about residents. Also, he has witnessed staff members attempting to “push L.B.’s buttons.”

h) Interviews with External Parties⁷

The interviews with external parties made it clear that L.B. is capable of self-injurious, attention-seeking, violent, and manipulative behaviors. She is known to have taken Vitamin E and aspirin to increase the chances of bruising, and to try to provoke staff into restraints and other responses when she feels they have a negative attitude towards her. Staff must be confident and well-trained to deal with that type of behavior and keep a positive attitude.

Those who know her well and have dealt with her for a long time also report that she does not lie or willfully withhold information, although she may confabulate if she has a memory loss, or fail to report her own actions if they are too disconcerting for her to accept. L.B. is hawk-eyed, demanding, and litigious about how her care is delivered, and she will escalate in response to negative attitudes among the staff. Consequently, if staff members believe L.B. is over-entitled, she will maximize her entitlements to maintain her self-esteem, and provoke confrontations with offending staff members.

V. Additional Concerns Raised by L.B.

Although L.B. contacted DRC to report the incident which resulted in her sustaining a black eye, she raised additional concerns regarding the quality of Lakeview's services, the manner in which staff treat her and others at the facility and allegations that Lakeview Staff members retaliated against her for contacting the DRC. L.B. alleged that staff members permit residents to remain in soiled clothing, have barricaded clients into rooms and have assaulted other clients. During the pendency of this investigation, L.B. contacted the DRC and reported that Lakeview Staff had abused, and caused physical injury to, two other residents in her cabin. A description of these concerns follows..

⁷ These individuals are comprised of persons who are familiar with L.B. and/or the circumstances surrounding the incident under investigation, but who are not employed by, or residing at, Lakeview. See the Appendix for complete listing of these individuals.

A. Adequacy of Staffing Levels

L.B. raised concerns about inadequate staffing levels. She reported that there are 8 residents at Monty 1; 2 of those residents, including her, are supposed to have 1:1 staff and generally there are, at best, only 1 - 2 additional staff members for the remaining 6 clients. She stated there are 33 clients housed at Main House and, much of the time, there are only two staff members. DRC's investigators heard similar complaints about staffing levels from Lakeview Direct Care Staff and Administrative Staff Members.

B. Lack of Individualized Approaches and Programming

L.B. stated she is the highest functioning resident and expressed concerns about that fact impeding her progress. She believes Lakeview's rules are geared to less-highly functioning individuals and that their programming is not geared to someone with her level of functioning and skills. For example, residents are not permitted in the kitchen or laundry room, but L.B. feels she is capable of cooking and doing laundry. As indicated above, several staff members indicated that L.B. is higher functioning than the majority of Lakeview's residents and that she requires a high degree of structure. At the time of our investigation, Lakeview staff appeared to be making progress in this area. DRC hopes this progress continues, not just for L.B., but for all Lakeview residents, to support them in reaching their potential and transitioning to less-restrictive community based residences.

C. Retaliation Allegations

Shortly after DRC initiated its investigation, L.B. stated she felt that Lakeview staff members were being very cold to her and were not providing her with services, such as relaxation rides, which she enjoys. L.B. alleged that Lakeview staff was retaliating against her for complaining to DRC. L.B. alleged that Lakeview's administrative staff had reduced her

access to the community. Prior to her contact with DRC, L.B. regularly traveled into the community with her one on one staff member. They would go shopping, go out for coffee, go to appointments and church.

DRC confirmed that, approximately two months after DRC began its investigation, Lakeview instituted new requirements for L.B. to go into the community. According to this policy, Administration must receive 24 hours' notice if L.B. is to leave the campus. In addition, Lakeview required that two staff members accompany L.B. into the community unless a single staff member feels comfortable being alone with L.B. DRC's investigators obtained a copy of this policy, entitled "L.B. off mountain supervision." This document was apparently drafted by Andrew Egan, Michael Mozzoni and Stephanie Griffin and is dated 5/21/2010. Further, this document indicates that the revisions to L.B.'s off-mountain supervision were made "due to safety concerns and allegations made by Ms. B." The purpose of requiring a second staff member to accompany L.B. into the community is stated as "to protect both Ms. B. and staff from mistreatment and allegations. Several para-professional and professional staff have expressed concerns regarding false allegations and do not want to be alone with her in the community."

L.B. alleged that, as a result of this new policy, her access to the community had been severely curtailed. During a telephone conference held on May 24, 2010, L.B. informed DRC's investigators that since the policy change, she had not been able to go anywhere in the community except for church. Further, L.B. reported that recently a staff member asked L.B., "why are you so hard on people? Why are you so hard on the staff? Why do you file so many grievances," or questions to that effect. It should be noted, however, that on or about July 29, 2010, L.B. notified DRC's investigators that she had been getting her community visits.

D. Allegations of Mistreatment of other Residents

When she initially contacted the DRC, L.B. reported that, due to staff shortages some residents have been left in soiled clothing for lengthy periods of time. In addition, L.B. reported that staff have barricaded residents into rooms so they could attend to other residents.⁸

On July 29, 2010, L.B. contacted DRC's investigators by telephone. She alleged that Lakeview Staff members had abused two other Monty 1 residents – K.M. and M.B. Regarding, K.M, L.B. stated that, several days earlier Jeremiah Adinolfi, a Rehabilitation Specialist, told L.B. that he had had enough of K.M.'s behavior and that, if K.M. acted out again, he would "beat the living shit out of him and will do it every time until he gets it," or words to that effect. L.B. reported that on 7/28/2010, she observed Jeremiah and 4 – 5 other staff members approach K.M. for no apparent reason and that Jeremiah "got into K.M.'s space." She said K.M. pushed Jeremiah away and that Jeremiah then grabbed K.M.. She said the other staff members jumped on K.M. and took him down to the road without using the mat. She said Jeremiah screamed at K.M. and that she saw Jeremiah make a fist and punch K.M. several times in the ribs.

Further, L.B. reported that James Knight, a Monty One staff member, broke M.B.'s arm during the prior week-end. She did not witness the actual event, but L.B. reported she heard M.B. screaming that she had lost her wallet and that M.B. left the cabin. L.B. saw James Knight follow M.B. out of the cabin and then heard M.B. screaming in pain. L.B. said, after M.B. and James returned to the cabin, the nurse came to examine M.B. and that she overheard the nurse's conversation with James. According to L.B., James told the nurse that M.B. wrapped her arms around him, that he pushed her away and she landed on her arm, resulting in the injury. M.B. was taken to the hospital and returned with a temporary cast. A couple of days later she received

⁸ DRC investigators received multiple reports of insufficient levels of staffing. However, DRC investigators did not secure sufficient information regarding allegations involving residents remaining in soiled clothing or being barricaded into rooms to support or refute these allegations.

a permanent cast. DRC's investigators secured records regarding each of the above incidents and referred the residents' families to the NH Bureau of Adult and Elderly Services.

VI. Findings and Conclusions Regarding the Incident.

Although there are different accounts of the alleged incident, there seemed to be general consensus regarding the events preceding L.B.'s elopement from the cabin. In particular, L.B. and the direct staff on duty in L.B.'s cabin concur that, at approximately 9:30 p.m., L.B. refused her evening medications, but sometime between 2 and 4 hours later, she asked Monty 1 staff to call the nurse for her p.r.n. medications. There is divergent information regarding what transpired next. However, the information DRC received from L.B., staff witnesses to the events, and documentary evidence indicates that, at approximately 3:30 a.m., which was at least 2 hours after first requesting her p.r.n. medications, the nurse had not brought L.B. her medications. L.B. was agitated and left the cabin.

DRC received differing information concerning what transpired between L.B.'s initial request for her p.r.n. medications and her elopement from the cabin. L.B. reported that staff initially refused to contact Health Services, based on a "new policy," requiring residents to be in their beds before nursing would respond to a request for p.r.n. medications. L.B. had not heard of this policy and did not believe Monty 1 staff was giving her truthful information.

Monty 1 Staff member Frank Nardello, provided contradictory information regarding the reason for the delay after L.B. requested her medications. When first questioned about the events preceding L.B.'s elopement from the cabin, Frank said he had called the nurse when L.B. requested her medications, and that the nurse said she wanted L.B. to calm down before she would come to the cabin. However, after reviewing the incident report he had completed at approximately 1:15 a.m., indicating that he had not contacted Health Services, Frank

acknowledged that, as reported in the incident form, he told L.B. to “calm first and show safe behavior before the call was made. The other two staff members on duty at Monty 1 that evening, Brandon Rivard and Chelsea Skerry, also reported that Frank had not contacted Health Services in response to L.B.’s initial request for her p.r.n. medications. Rather, Brandon reported that Frank told L.B. to go to her room because she was being rude. Chelsea reported that Frank was “instigating” and told L.B. to stop yelling or the nurse would not come to the cabin.

Morna Mashrick, the nurse on duty during the incident, did not recall when or exactly what she heard from Monty 1 Staff regarding L.B.’s request for medications. There does not seem to be a contemporaneous report of a call to Health Services. However, Ms. Mashrick informed DRC’s investigators that generally, if a client wants a p.r.n. medication and is in the cabin, she would expect a call from the cabin staff. She would then bring the medicine to the cabin. There might be some lag time depending how busy nursing staff is when the call is received.

Information we received from various nursing and administrative staff members indicates that, generally nursing is able to respond to requests for medications within 10 to 15 minutes. When questioned about the protocols that should be followed when a resident requests p.r.n. medications, administrative staff was clear that direct support staff should do their best to secure the client’s medications without delay. No administrative staff members interviewed believed clients should be required to wait in their rooms if medications are requested during the overnight hours.

DRC is not aware of any medical or therapeutic reason that would justify staff in delaying L.B.’s request for her p.r.n. medications. Nor does there appear to be any formal policy at Lakeview that would support delaying the provision of a resident’s p.r.n. medications. Monty

1 Staff members, therefore, had no authority to refuse or delay acting upon L.B.'s request for her p.r.n. medications. Their refusal to contact Health Services upon request caused L.B.'s emotions to escalate to a level where she felt there was no option other than to elope from her cabin to secure the medications on her own.

There were a number of less restrictive behavioral interventions staff members could have used to control the situation and de-escalate L.B.'s emotional state – most obviously, calling the nurse, within L.B.'s view and permitting her to wait in the common area until the nurse arrived with her medications. If that strategy did not have the desired result, staff members could have contacted the on-call psychologist for assistance. Unfortunately, rather than taking any action that would have addressed L.B.'s concerns and/or possibly de-escalated the situation, staff acted in a manner which they should have known, and likely did know, would only result in increasing L.B.'s level of anger.

In DRC's view, the entire incident could likely have been avoided if Monty 1 staff members had simply contacted nursing and requested L.B.'s p.r.n. medications when she first requested them. Had they simply secured her medications, L.B. would likely have returned to her room and been able to fall asleep, thereby avoiding her encounter with Nancy Norris and restraint that occurred as a result.

There were substantially divergent accounts of a physical altercation between Nancy Norris and L.B. and the manner in which the restraint was executed. Also, there were differing interpretations of L.B.'s alleged admission of self-injury. Staff members, including Nancy Norris, assert that L.B. took a swing at Nancy and made contact, resulting in her glasses landing on the ground. But, other than staff reports, there is no evidence documenting any injury to Ms. Norris. Ms. Norris did not file an injury report. Nurse Mashrick, who examined Ms. Norris's

hands shortly after the incident, did not note any injury to Ms. Norris' hand or face. L.B. is the only witness claiming that she did not attempt to hit Nancy and, rather, Nancy punched her.

Given the conflicting reports, the fact that the events occurred in darkness, and, as suggested by nearly all witnesses, the events unfolded quickly necessitating rapid staff response to prevent contact between L.B. and Nancy, there is not sufficient information for DRC to conclude that Ms. Norris deliberately punched L.B. in the face. There is no credible information to support a finding that L.B. caused the injury to her eye herself, however.

There does not appear to have been any opportunity for L.B. to have injured herself. Staff members who were present during the restraint stated they did not leave L.B. unattended on the mat. It appears that L.B. remained on the mat for approximately 30 minutes after the restraint ended, but staff remained nearby. None of the staff members we interviewed observed L.B. engage in any self-injurious behavior while she was on the mat. If L.B. was able to injure herself while she was being monitored, there was a breakdown in staff supervision, which appears unlikely. In addition, at least one staff member, Chelsea Skerry, noticed L.B.'s eye was bruised immediately upon her return to the cabin and before she went to her room. This information supports a finding that the injury occurred while L.B. was outside Monty 1.

Finally, DRC's investigators do not interpret L.B.'s alleged confession of self-injury as reported in the incident report authored by Jeremiah Adinolfi as a true confession. Rather, after interviewing Mr. Adinolfi, it seemed to DRC's investigators that L.B. made a flippant and sarcastic response to Mr. Adinolfi's question about what had happened to her eye. She first joked that it was mascara. Mr. Adinolfi reported that, she then, "sarcastically," said "yeah, I hit myself in the eye." As indicated in the incident report, however, L.B. repeatedly stated that she had not hit herself. At the very least, before relying on Mr. Adinolfi's report in determining that L.B.'s

complaint was unfounded, Ms. Radloff should have interviewed Mr. Adinolfi and L.B regarding the alleged confession and, in L.B.'s case, to hear her version of the events.

Information DRC investigators gathered from staff involved in the incident as well as staff members who are generally familiar with L.B. and restraint in general suggests that it is likely that L.B.'s eye injury was the result of physical contact that occurred while taking L.B. down to a prone restraint. Staff and L.B. reported that L.B. was quite agitated. Nancy Norris described the take-down as "not pretty." Sarah Cooper, another staff member who witnessed this event described the take-down as more of a "pig-pile" than a controlled situation. Given staff accounts of L.B.'s struggle when Lakeview staff put their hands on her, as well as L.B.'s escalated emotional state, DRC investigators find it more likely than not that L.B.'s fall onto the mat was not "controlled" as characterized by some staff members. Rather, given reports indicating L.B.'s high level of agitation, and quick response, it is more probable that everyone fell to the ground haphazardly, and that someone's hand or elbow hit L.B.'s eye, causing her to sustain an accidental injury.

With respect to the incident on March 24, 2010, therefore, the DRC makes the following findings:

1. There is INSUFFICIENT INFORMATION to support the allegation of physical abuse against Nancy Norris. It appears more probable that L.B.'s black eye was the result of a poorly executed restraint.

2. Frank Nardello's conduct in repeatedly refusing to call Health Services immediately upon L.B.'s requests for her p.r.n. medications, in lying to L.B. about a new policy requiring her to be in bed before the nurse would come out, and in deliberately instigating L.B. by taking actions he knew would upset her supports a FOUNDED CLAIM OF EMOTIONAL

ABUSE under RSA 161-F:43, II(a). Under the PAIMI definitions, Frank Nardello's conduct also constitutes emotional abuse and neglect. See above, Part III, A.

3. Frank Nardello's conduct, as well as Lakeview's restrictive actions towards L.B. subsequent to the initiation of this investigation described in Part V, constitute violations of the Patients' Bill of Rights, RSA 151:21. Specifically, we find VIOLATIONS of L.B.'s rights to be treated with consideration, respect, and with full recognition of dignity and individuality; to be free of reprisal, interference, or coercion when voicing a grievance; and to be free of abuse and neglect.

4. As treatment providers, Lakeview and its staff are responsible for making efforts to prevent situations in which a resident's behavior escalates to the point where the resident, in this case L.B., engages in behaviors which might place her at risk of harm. In this instance, Lakeview staff who were present during the incident, including all staff members who were with L.B. in her cabin before she eloped and those who were present after she left the cabin, had ample opportunity to successfully prevent L.B.'s emotions from escalating and/or to assist L.B. in de-escalating and are at fault for: (a) not preventing L.B.'s escalation and/or (b) contributing to the escalation which resulted in physical restraint and injury. While staff members may not have intentionally caused the injury L.B. sustained, staff members are nevertheless culpable for their failure to implement positive behavior strategies or other less-restrictive alternatives, including de-escalation strategies, to appropriately manage L.B.'s behavior, and to avoid the use of physical restraint and the risk of physical and emotional injury that is associated with physical interventions. Therefore, Lakeview and its staff members' conduct supports a **FOUNDED CLAIM OF NEGLIGENCE**, pursuant to 42 C.F.R. 51.2 (Part III, A above) and RSA 161-F:43, III.

5. The actions and inactions of Lakeview’s staff violated Lakeview’s own policies. In particular, Policy No. 4.09.2 requires that “every attempt shall be made to anticipate and de-escalate the behavior using a more therapeutic intervention” than a “restrictive procedure,” including personal restraint. Moreover in this case, several Lakeview staff (at minimum, Chelsea Skerry and Brandon Rivard) were aware of Frank Nardello’s conduct, in particular his refusal to make reasonable efforts to secure L.B.’s p.r.n. medications and deliberately lying to L.B. about Lakeview’s medication-delivery policy, and had an affirmative obligation to report suspected emotional abuse under Policy 4.21.

VII. Additional Findings

A. Adequacy of Staff

Administrative, clinical and direct-support staff alike raised concerns about the adequacy of Lakeview’s staff, including qualifications and number of staff members present to meet the intensive needs of Lakeview’s residents.

1. Training and Supervision Is Insufficient

Most direct support staff members have only a high school education. With the exception of the initial training Lakeview provides, direct support staff members receive little continuing education and/or direct supervision from clinical staff to promote implementation of individualized programs tailored to meet each resident’s needs. Rather, Lakeview permits direct support staff to use a “one-size-fits-all” approach to programming and/or to make critical decisions regarding client treatment and programming without regard to the client’s individual treatment plan and without the benefit of consultation with a qualified clinician.

With regard to L.B., many staff members did not understand why it might be appropriate to treat L.B. differently from less-able residents and resented the level of “privileges” afforded to

her. Even more troubling was the fact that some staff members seemed to take matters into their own hands and, rather than assist in the development and consistent application of a behavior plan, have made arbitrary rules and/or decided to make L.B. wait to have her requests honored.

2. Lack of Consistent Directions Regarding L.B.

DRC is concerned that L.B.'s progress has been impeded by the lack of: a clear commitment to her placement at Lakeview as well as a lack of a consistently delivered treatment plan. Lakeview staff at all levels described the challenges that L.B. presents. She is relatively high functioning, very demanding and, at times, exhibits behaviors which are difficult to handle, especially for direct-support staff members who have the least amount of formal training, but are expected to spend the most amount of time with L.B. DRC's investigators found it troubling that, despite consensus on how difficult L.B. is to manage, there was a lack of communication and direction from Administrative Staff to clinical and direct care staff regarding L.B.'s programming and behavior plan. Several direct support staff members reported that they had not received clear instructions regarding the strategies they should implement when working with L.B. Some direct support staff members reported receiving conflicting directions from clinical and administrative staff.

Various staff members, including administrative and clinical staff, openly expressed their opinions that L.B. does not belong at Lakeview. Direct support staff members are acutely aware of the divergent attitudes of Lakeview's administrators and clinical staff regarding whether Lakeview is an appropriate placement for LB. Many direct support staff members interpreted this lack of consensus as license to come to their own conclusions about whether L.B. should have been placed at Lakeview; for the most part concluding that L.B. should not be there.

Invariably, such negativity adversely impacts L.B.'s treatment and potential to make progress at Lakeview.

3. Lack of Sufficient Staff Resources

Direct support staff and administrators raised concerns about staffing levels. Direct support staff stated that frequently staff assigned as a resident's one-on-one support member is considered available to supervise all of the residents in a particular cabin. One administrator stated that Lakeview needs at least twice as many staff members as they currently have.

B. Lakeview's Response, Reporting & Investigation

As discussed in detail below, the manner in which Lakeview staff responded to, reported and investigated the allegation of staff abuse violated professional and legal standards and Lakeview's own policy.

1. Lakeview Staff Failed to Comply with Policy No. 4.09.2 Regarding Incident Debriefing Requirements.

Contrary to Lakeview's de-briefing policy (which requires participation of all staff and client involved in the intervention), although five staff members participated in the restraint, only two, Frank and Brandon, participated in the debriefing. In addition, and also in violation of this policy, L.B. did not participate in the debriefing. Staff completed an incident report indicating that L.B. refused to de-brief, but DRC finds L.B.'s statement, that she was not provided with an opportunity to debrief, nor has she has never been asked to de-brief an incident, credible. This finding is, in part, informed by Frank Nardello's statement that the only time a client would participate in a debriefing would be if a psychologist is available to assist. Further, contrary to Lakeview policy which requires all staff involved in the intervention to participate in a

debriefing with “appropriate team members, supervisors and administrative staff,”(*Id.*) only Nancy Norris participated in this debriefing.

Other than a “process meeting,” with one staff member, Brandon Rivard, there was no indication that staff involved in the restraint and/or supervisors considered alternative strategies that could have prevented the event and/or decreased the likelihood of similar incidents in the future. Debriefing such events with clinical and administrative staff is an essential means to analyze the antecedents to a critical incident, to prevent re-occurrence, and/or to otherwise learn lessons from the incident. Staff’s failure to de-brief with L.B. and/or with other supervisory staff, contrary to Lakeview’s policies, was neglectful because it created a strong likelihood that incidents, such as the restraint and injury that resulted in the instant matter, will reoccur.

2. Lakeview’s Internal Investigation

We find that Lakeview’s internal incident review and investigation were deficient. Ms. Radloff interviewed staff member witnesses, but did not speak directly with L.B., the alleged victim, to hear her view of the incident. Nor did she speak with Chelsea Skerry, a Monty 1 staff member who observed the incident’s antecedents and observed L.B.’s injury, or Jeremiah Adinolfi, the Lakeview Employee to whom L.B. allegedly confessed, and later rescinded, that she had harmed herself. Lakeview Policy No. 4.24 requires the investigator to “conduct necessary staff/client interviews.” It is clearly necessary to hear directly from the alleged victim. Similarly, it was inappropriate to rely solely on Jeremiah’s cursory report, rather than question him directly regarding his interaction with L.B. Although Chelsea did not observe the restraint, had Ms. Radloff interviewed her, she may have learned important information concerning staffs’ treatment of L.B. which ultimately resulted in escalation of her emotions and her elopement from the cabin.

Ms. Radloff inappropriately limited the investigation to the individual allegation rather than looking at the situation as a whole. She failed to review the circumstances that led to, and potentially triggered, the restraint. In particular, Ms. Radloff failed to secure sufficient information to consider the events leading up to the restraint as was specified in L.B.'s complaint, including staff's failure to contact nursing immediately upon receiving L.B.'s request for her p.r.n. medications. Lakeview's internal investigation, therefore, failed to achieve the most fundamental purpose of such investigations, i.e., to fully analyze the potential contributory actions or inactions involved in the event to reduce the possibility of similar injuries in the future.

C. Telephone Privileges are Overly Restrictive

Through the course of this investigation DRC learned that, although Lakeview has in the past extended greater access to L.B., generally Lakeview's residents are permitted to make only two telephone calls per week. This policy violates residents' rights, guaranteed by New Hampshire's Patient's Bill of Rights, to communicate, and meet privately with, others and to have regular access to the unmonitored use of a telephone. RSA 151:21, XII.

D. General Concern Regarding Duration of Placements

Many of the individual residents interviewed by DRC's investigators reported residing at Lakeview's facility in Effingham, New Hampshire for lengthy periods of time. At least one resident reported that he had lived at the facility for more than twenty (20) years. Most of Lakeview's residents are funded through State Medicaid waivers. New Hampshire residents are generally funded through the Acquired Brain Disorder (ABD) waiver, a program whose primary purpose is to provide community-based services, rather than services of a long-term rehabilitation or skilled nursing facility, for persons with brain injuries who require extensive

care and services. Lakeview's Effingham facility is located at the top of a mountain in rural New Hampshire. Its residents are physically isolated from the general population. Upon information and belief, Lakeview has developed community-based residences in Ossipee, Farmington, and Wolfeboro, New Hampshire that are more in line with the intent and purpose of home and community-based care waivers. Lakeview should do everything possible to relocate residents to community-based programs.

VIII. Recommendations

DRC was pleased to learn that, approximately six months after DRC initiated its investigation of L.B.'s complaints, Lakeview ceased using prone restraint and has adopted goal of eliminating use of physical restraint altogether. We do, however, offer the following recommendations regarding L.B.'s complaints and Lakeview's policies and practices.

A. Recommendations Regarding L.B.'s Program at Lakeview

1. Develop appropriate concrete, specific, informed and behaviorally positive strategies, to therapeutically respond to L.B.'s behavior challenges;
2. Utilize an independent, qualified psychologist or other behavioral specialist to help develop and oversee the plan and approach;
3. Provide staff training and support to ensure that L.B.'s behavior plan is properly implemented.
4. Provide ongoing monitoring and staff supervision to pre-empt a situation in which the direct support staff resents L. B. and considers her "over-entitled;"
5. Staff working with and designing L.B.'s program should remember that L.B. has considerable skills and once had a successful career. Work to maximize L.B.'s positive attributes to boost her self-esteem, including providing her with an

- individually tailored, structured program that includes opportunities for L.B. to use her skills.
6. Fast-track planning efforts to develop a community-based integrated setting with sufficient specialized supports to ensure L.B.'s timely transition to the least restrictive active treatment environment appropriate to meet her needs.
 7. Given L.B.'s behavioral challenges, prioritize providing her with staff who appreciate and like her.

8. B. General Recommendations

- 1) Provide training to all Lakeview staff on medication administration policies including specific instruction to contact Health Services immediately upon receiving a medication request from a client.
- 2) Initiate and continue training of all staff on their mandatory abuse and neglect responsibilities;
- 3) When complaints of abuse or neglect are received, conduct a thorough internal investigation including examining antecedents to the incident and interviewing the alleged victim, any other client witnesses as well as all staff members who may have information concerning the incident and its antecedents. Do not rely on "hearsay."
- 4) Amend the Internal Investigation Policy to mandate that the investigator conduct a face-to-face interview with the client victim unless the client is not able (as documented by the client's primary medical provider) or refuses to participate in the interview.
- 5) Provide, and require all staff members who undertake internal investigations to receive, training in conducting effective internal investigations.

- 6) Ensure adequate staff/resident staffing at each residence. If a particular resident requires a 1:1 staff, do not consider that staff member available to assist other clients.
- 7) For residents who require 1:1 staffing, consider implementing a rotating 1:1 schedule for each shift to reduce burn-out.
- 8) Provide all residents with regular, unmonitored access to a telephone in accordance with New Hampshire's Patients' Bill of Rights, RSA 151:21,XII.
- 9) Make meaningful efforts to provide and/or secure supports and services for all Lakeview clients in integrated community-based settings.

APPENDIX

Complete list of persons interviewed with job titles, if applicable, at time of incident

A. Lakeview Staff members:

- 1) David Armstrong, Administrator
- 2) Austin Errico, PhD, Clinical Director
- 3) Stephen Fox, Behavior Specialist, Associate Program Director, Adult Team
- 4) Michael Mozzoni, PhD, Director of Behavioral Services and Training
- 5) Michelle Radloff, Director of Quality Assurance/Quality Improvement
- 6) John Rivard, Director of Residential Services
- 7) Andrew Egan, Occupational Therapist
- 8) Morna Mashrick, Registered Nurse
- 9) Dr. James E. Taylor, Program Director, Youth Services
- 10) Nancy Norris, Residential Supervisor
- 11) Stephanie Griffin, PhD, L.B.'s primary therapist
- 12) Jeremy Ward, Rehabilitation Specialist
- 13) Jeremiah Adinolfi, Rehabilitation Specialist
- 14) Christian Blais, Rehabilitation Specialist
- 15) Chelsea Skerry, Rehabilitation Specialist
- 16) Frank Nardello, Rehabilitation Specialist
- 17) Brandon Rivard, Rehabilitation Specialist
- 18) Noah Hoffman, Rehabilitation Specialist
- 19) Sarah Cooper, C-Shift Supervisor for Main House
- 20) Mike Johnson, Rehabilitation Specialist
- 21) Diana Gosselin, Registered Nurse
- 22) Ali Forbes, Rehabilitation Specialist
- 23) Mike Elliott, A-Shift Supervisor, Monty 1 and Cambridge
- 24) Mike Connors, Assistant Clinical Coordinator, Residential Services
- 25) Terri Witham, Rehabilitation Specialist
- 26) Ben Skelton, Teacher Assistant, High School, Occupational Therapist, B-Shift
- 27) Kelly Eldridge, Physical Therapist and Rehabilitation Specialist
- 28) Amy Avery
- 29) James Holzrichter, Rehabilitation Specialist
- 30) Francis Berks, ARNP
- 31) Amanda Nelson, Current Case manager
- 32) Ashley Doherty, Rehabilitation Specialist
- 33) Rachel Kilburn, Rehabilitation Specialist
- 34) Joe LaFrance, Rehabilitation Specialist
- 35) Jessica Forte, Rehabilitation Specialist
- 36) Nikki Wales, LNA, Rehabilitation Specialist
- 37) Carol Rivard, Administration Officer, Resident Services
- 38) Niko Miller, Rehabilitation Specialist
- 39) Jackie Canty, Group Leader
- 40) Zach Guilford, Shift Supervisor

41) Henry Damon, Rehabilitation Specialist

B. Twelve (12) Lakeview clients⁹ including:

1. L.B. (complainant)
2. M.B.
3. K.M.

C. External Parties

1. Kris Fox, former Lakeview employee (L.B.'s case manager on date of incident)
2. Dorian Bryant, L.B.'s guardian
3. Karen Elliot, Director Adult Protective Services, Maine Department of Health and Human Services (Dorian Bryant's supervisor)
4. Helen M. Bailey, Esq., General Counsel, Disability Rights Center, Maine
5. J. Harper, Advocate, Disability Rights Center, Maine
6. L.A. (L.B.'s sister)
7. Dr. Carolyn Criss, psychiatrist, Riverview Psychiatric Center (L.B.'s former placement)
8. Gary Wolcott, Program Manager, Brain Injury Services for the State of Maine

⁹ The names of Lakeview's clients are confidential.