



# **DISABILITY RIGHTS CENTER - NH**

## **ISOLATED, SEGREGATED AND VULNERABLE**

### **A Report and Call to Action Concerning Lakeview Neurorehabilitation Center**

**September 30, 2014**

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**The Disability Rights Center - NH is the designated federal protection and  
advocacy system for New Hampshire and is a member of the National  
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## **I. Report Summary.**

This paper is being released concurrently with the Disability Rights Center - NH's<sup>1</sup> ("DRC") investigation report regarding the 2012 death of "J.D."<sup>2</sup>, a young man who was residing at Lakeview Neurorehabilitation Center in Effingham, NH ("Lakeview"). This paper is prompted not only by the tragic and disturbing circumstances leading to J.D.'s death, but because the deficiencies cited in the DRC's Investigation Report are representative of longstanding deficiencies at Lakeview that have compromised the safety and well-being of the individuals it purports to treat.<sup>3</sup> The DRC is releasing this paper and companion Report of its investigation of J.D.'s death to inform stakeholders, policymakers, and members of the public of recurring incidents of abuse and neglect of Lakeview's residents as well as longstanding deficiencies in care and treatment with the goal of spurring swift and comprehensive remedial action.

Lakeview is a residential treatment facility, licensed pursuant to RSA 151 and He-P 807, that provides residential services for approximately 85 adults and children with neurobehavioral or neurorehabilitation needs. Most of Lakeview's residents are believed to present with challenging behaviors and have acquired brain injuries and/or developmental disabilities. Lakeview is located in Effingham, New Hampshire, a small town in northern New Hampshire (population approximately 1500). Lakeview's residents are from New Hampshire as well as other states including Maine, New York, and Pennsylvania. It is in a remote location. There is no public transportation available to assist family members without automobiles to visit their loved ones. Contrary to the community integration imperatives of both federal and state law and the

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<sup>1</sup> The Disability Rights Center - NH (DRC) is New Hampshire's federal protection and advocacy system for individuals with disabilities.

<sup>2</sup> To protect individual privacy, this report uses pseudonyms. The identities of the individuals referred to in this report are being disclosed to Lakeview Neurorehabilitation Center. In addition to using pseudonyms, the DRC has redacted information, such as exact dates, which could lead to the discovery of any individual's identity.

<sup>3</sup> The Report of DRC's investigation of the circumstances surrounding J.D.'s death may be viewed at [www.drcnh.org/Lakeview.html](http://www.drcnh.org/Lakeview.html).

rights and interests of people with disabilities generally, Lakeview's residents are largely isolated and segregated from individuals, other than staff, who do not have disabilities.

Lakeview's website describes the services and care it provides as "person-centered" and represents that it uses "positive behavioral supports to address challenging behaviors that interfere with successful rehabilitation and the return to living in the community." Further, Lakeview maintains that its programs "address improving healthy choices, increasing behavioral success, reducing unwanted behaviors, improving self management techniques and developing new skills and strategies that allow an individual to transition to living in the community." <http://lakeviewssystem.com/programs-and-services/neurobehavioral>. Yet, the circumstances leading to J.D.'s death, the serious incidents of abuse and neglect summarized in this and other agencies' reports, and other reports raising client safety issues issued by news organizations illustrate a pattern of abuse, neglect, and inadequate care at Lakeview. Despite its representations, in reality, Lakeview does not provide the quality services it purports to deliver. Rather, its residents are subjected to substandard treatment and inadequate staffing which places them at risk of serious physical and emotional harm.

Incidents of abuse and neglect of Lakeview's residents have been well-documented in reports issued by various agencies including the DRC, Maine's Disability Rights Center ("DRC Maine") and the New York State Justice Center for the Protection of People with Special Needs ("NYS Justice Center"), as well as in reports of abuse founded by the New Hampshire Bureau of Elderly and Adult Services and at least one of the Area Agencies that receives State funding to serve individuals with Developmental Disabilities and Acquired Brain Disorders.<sup>4</sup> Management,

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<sup>4</sup>This paper reports on incidents and conditions of which DRC has become aware. While DRC conducted a thorough search and investigation in preparing this paper, there may be other incidents or tragedies to which DRC is

upper level programmatic and direct support staff neglect of Lakeview's residents has resulted in at least one resident being sexually assaulted by a peer. Other residents have suffered physical or emotional injuries. Media outlets have reported multiple instances in which Lakeview residents have wandered off the campus, including a young woman missing for several days, wearing nothing but pajamas. The Occupational Safety Health Administration (OSHA) has cited Lakeview for workplace violence due, in part, to insufficient staffing levels and lack of proper staff training. A review of the Carroll County Sheriff's logs regarding 911 calls and responses between January 1, 2013 and March 23, 2014 reveals numerous incidents in which Lakeview's residents have been injured, abused, or neglected as a result of inadequate supervision. Incidents resulting in 911 calls include residents ingesting potentially dangerous materials such as cleaning supplies and, in one case, a one-inch rubber ball, residents assaulting other residents or staff members, and residents walking off the grounds and missing for several hours to several days. These call logs also indicate what appears to be perennial deficiencies in Lakeview's fire alarm system.

In its review of the circumstances leading to J.D.'s death, DRC concluded that Lakeview's response to clear warning signs of a serious health condition was inadequate and likely led to J.D.'s premature death. Further, DRC found that the treatment failures were not simply due to carelessness of a few individual staff members. Rather DRC determined that there is a lack of interdisciplinary communication between and among the professionals who work in its various treatment domains (medical, psychiatric, and neurologic) as well as between and among Lakeview's professional and direct support staff. This lack of communication resulted in Lakeview's failure to provide appropriate treatment to address J.D.'s medical, neurological, and

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not privy. In either case, DRC believes that the extent, nature, and seriousness of the information contained in this report warrant swift and comprehensive remedial action.

psychiatric needs. In addition, DRC found that Lakeview failed to provide sufficient staffing levels to meet J.D.'s supervision needs. Lakeview failed to communicate and implement the level of supervision ordered by Lakeview's psychologist. Finally, Lakeview did not provide sufficient information to J.D.'s guardian to enable her to make informed decisions regarding his care, including his continuing placement at Lakeview.

As demonstrated by the incidents and reports summarized in this paper, the deficiencies DRC found through investigating J.D.'s death are not isolated occurrences. Rather, the deficits DRC identified are representative of a long-term pattern of poor treatment that Lakeview's residents experience on a daily basis due to a lack of professional oversight; inadequate coordination of medical, neurologic, and psychiatric care; inadequate staffing levels; lack of training for, and indifference of some direct support staff; and broad failures in communication between and among Lakeview's staff as well as between Lakeview and its residents' families and guardians. Despite Lakeview's promises to take corrective action to ameliorate the deficiencies noted by the DRC and others, beginning as early as 2010, continuing incidents implicating deficits in the very areas Lakeview represented it has addressed demonstrate its failure to make actual or meaningful improvements. Additionally, a lack of governmental oversight has contributed to perpetuate the deficiencies DRC and others have identified at Lakeview. The agencies that are required to inspect, oversee, monitor, and license Lakeview (e.g., New Hampshire's Department of Health and Human Services, Bureau of Developmental Services and Licensing, and the Area Agencies that arrange funding for Lakeview's residents) have failed to consider founded reports of abuse and neglect and other reports of Lakeview's inadequacies or to conduct sufficiently robust monitoring activities to identify these, and possibly other, deficiencies at Lakeview which compromise the health and safety of the

individuals these agencies and organizations are required to serve. As a result, Lakeview's residents remain at risk of physical and emotional harm.

Based on all of the above incidents, conditions, and factors, DRC urges closure of the Effingham facility and calls upon the State of New Hampshire, the Department of Health and Human Services (DHHS), its agents and policymakers to take swift remedial action to ensure the health, safety, and well-being of Lakeview's residents. Additionally, and as previous reports have recommended, DRC urges DHHS to further develop a range of community-based housing and supportive service options to ensure that all individuals, including those with challenging physical, emotional, and behavioral needs, are able to remain in their home communities and be fully integrated into community life.

## **II. Summary of Investigations Demonstrating Longstanding and Recurring Patterns of Deficiencies, Mistreatment, and Neglect.**

DRC's review of its own investigation as well as investigations of alleged abuse and neglect conducted by DRC Maine, the State of New Hampshire's Bureau of Adult and Elderly Services (BEAS), and one Area Agency, reveal systemic and longstanding deficiencies in Lakeview's operations. Deficiencies noted include:

- inadequate numbers of qualified direct support staff to meet the needs of individuals residing at Lakeview;
- staff indifference to residents' treatment needs;
- lack of oversight to ensure clinical orders are followed;
- failure to provide timely medical treatment;
- recurrent gaps in communication between and among medical and clinical professionals and direct staff members; and
- insufficient efforts to communicate with residents' family members and guardians.



Lakeview's residents with high supervision needs are regularly left unsupervised or with inadequate levels of supervision, leaving them vulnerable to abuse or having their medical needs left unattended. Lakeview's residents have been subjected to abuse and/or neglect by staff members who, due to lack of skills, training, or supervision, are not equipped to provide the support and services residents with complex physical and behavioral challenges may require.

A. Summary of DRC's Investigations and Findings.

1. **Death of J.D. - 2012**

J.D. was twenty-two years old when he entered Lakeview for what was intended to be a short term (90-day) residential placement to secure evaluations and enable his community-based residential treatment team time to locate an appropriate residence in, or near, the Southern NH community he considered home. Although behavioral challenges and concerns about J.D.'s safety were the impetus for the temporary placement at Lakeview, J.D.'s physical health had been stable for a prolonged period of time prior to his admission to Lakeview. However, upon his arrival at Lakeview, J.D. regularly refused medications and food. His refusal to eat steadily worsened to the point that during his last month at Lakeview, J.D. virtually stopped eating. He lost 47 pounds in just over two months and suffered two severe seizures which resulted in his admission to Huggins Hospital. Seventy-two (72) days after he entered Lakeview, J.D. was found lying on the floor of his room in a pool of urine, naked and unresponsive. He was transported to Huggins Hospital where he was pronounced dead.

DRC conducted a thorough investigation into the circumstances leading to J.D.'s death, including retaining the services of W. Carl Cooley, MD, a physician with over twenty-five years of clinical experience working with children, youth, and adults with developmental disabilities who, for the past 14 years, has served as the medical director and currently chief medical officer for a residential facility that serves children and youth with complex medical and behavioral

challenges. Dr. Cooley reviewed J.D.'s medical records as well as the State of New Hampshire Chief Medical Examiner's Autopsy Reports.

As a result of its thorough investigation, including the expert's reports, DRC determined that there was a lack of interdisciplinary communication between and among Lakeview's medical and other professional and direct care staff. In J.D.'s case, this resulted in Lakeview's failure to provide J.D. with a coordinated plan of care among the various disciplines of care (medical, neurologic, psychological/psychiatric) he required. DRC determined that J.D.'s death was likely preventable and the result of Lakeview's lack of adherence to basic standards of care. Derelictions included:

- Neglecting to complete necessary evaluations in a timely manner;
- Failure to develop adequate treatment plans;
- Minimizing J.D.'s symptoms and an inadequate response to his precipitously declining physical and emotional health status;
- Failure to ensure sufficient numbers of direct care staff were available to meet J.D. and other residents' supervision needs;
- Failure to ensure staff were adequately trained and supervised to address what should have been recognized as a medical emergency; and
- Failure to provide timely and complete information regarding J.D.'s declining health status to his guardian, the Area Agency that served him or community-based residential care providers who had expressed concern for his well-being.

During his time at Lakeview, J.D.'s health status precipitously declined. Despite his near complete refusal to eat, and resulting weight loss,<sup>5</sup> Lakeview measured J.D.'s weight on only three occasions. According to Dr. Cooley's review of laboratory testing results obtained by Lakeview's Primary Care Medical Director just four days before his death, J.D. was in a metabolic state of starvation. Yet, Lakeview's Primary Care Medical Director did not seem to feel any sense of urgency to address J.D.'s refusals to eat or metabolic imbalance.

Six days before his death, a Lakeview staff member overheard J.D. say he wanted to kill himself. He was referred to the psychologist who, that same day, ordered that J.D.'s supervision level be increased to a five-minute watch status. The psychologist's notes indicate that she informed Lakeview's clinical team and the program manager at J.D.'s cabin of her order for increased supervision. However, none of the staff members interviewed by DRC were aware of J.D.'s supervision level.

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

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<sup>5</sup> J.D.'s weight upon arrival at Lakeview was recorded as 269 pounds. Sixty-eight days after his arrival at Lakeview, just four days before his death, Lakeview's Primary Care Medical Director measured and recorded J.D.'s weight as 222 pounds. This represents a loss of 47 pounds -- more than 17 percent of J.D.'s weight.

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

## **2. Injury resulting from restraint of L.B.**

L.B. contacted DRC in March 2010 to report that a member of Lakeview's staff had punched her in the eye during an incident in which she was taken to the ground and held in a prone restraint. L.B. informed DRC that the incident was precipitated by her cabin staffs' refusal to contact Lakeview's Health Services Department to request her PRN medications. L.B. alleged that she had been requesting her medications for approximately three hours and that she had become frustrated because cabin staff lied to her about Lakeview's policies for the request and delivery of PRN medications. In particular, L.B. alleged staff told her that a new policy required that she be in bed before staff could place the call for her PRN medications. L.B. knew there was no such policy and, therefore, left her cabin at approximately 3:00 a.m. to walk to the Health Services Department and secure the medications on her own. According to L.B., staff members followed her outside. L.B. got into an argument with a supervisor who, earlier that evening, had refused to contradict the cabin staff's misrepresentation of Lakeview's PRN delivery policy. L.B. reported that she reached for the supervisor who then punched her in the eye. At that point, L.B. said she started to go after the supervisor to fight back, but other Lakeview staff members grabbed her and took her down onto a mat and held her, face down, until she calmed down.

DRC conducted a full investigation of the incident including interviewing all staff members involved in the incident, administrators, and clinical staff and reviewing relevant medical records, incident reports, and cabin logs. DRC concluded that a Lakeview staff member engaged in emotionally abusive behavior by repeatedly refusing to call health services to secure

L.B.'s PRN medications and lying to her regarding Lakeview's PRN policy. Further, DRC found Lakeview's staff culpable of neglect for failing to implement positive behavior strategies or other less-restrictive alternatives, including implementing de-escalation strategies to appropriately manage L.B.'s behavior and avoid the use of physical restraint. Finally, although DRC did not find sufficient information to support a finding of physical abuse, DRC's investigation raised serious concerns regarding Lakeview's direct support staff. Specifically, DRC found:

- Lakeview's training and supervision of direct support staff is insufficient, and that with the exception of an initial training, direct support staff members receive little continuing education or direct supervision from clinical staff to support the implementation of its residents' programs.
- Lakeview failed to provide L.B. with a consistently delivered treatment plan. L.B. had a history of challenging behaviors. Yet, several staff members reported they had not received clear instructions regarding the strategies they should implement when working with L.B. Rather than review L.B.'s treatment plan or consult with qualified clinicians, some staff acted without authority, making unilateral decisions regarding L.B.'s treatment at Lakeview.
- Lakeview lacks sufficient staff resources to meet the treatment needs of its residents. Direct support staff reported 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.

B. Summaries of Investigations Conducted by Agencies Other Than DRC.

1. **Summary of Gateways Community Service's investigation and findings of client rights violations with regard to N.P.**

In April 2010, N.P., a young woman residing in one of Lakeview's cabins was sexually assaulted by another resident. Although, according to N.P.'s treatment plan, she required continuous eyes-on staff supervision, Gateways Community Services' ("Gateways") investigation report indicates that she and a male resident had been left unsupervised, sitting on a couch on the 2nd floor of N.P.'s cabin, for an indeterminate amount of time during the evening in question. During the time they were left unsupervised the male resident fondled N.P.'s breasts and buttocks, and put his hand down her pants.

Gateways, the Area Agency that coordinated N.P.'s State-funded placement at Lakeview, conducted an investigation of this incident. The investigator determined that Lakeview violated N.P.'s personal and service rights required by He-M 310.05(b) and He-M 310.06(a). In particular, the investigator found that:

- Staff members assigned to supervise N.P. and the other 7 individuals in her cabin did not know N.P.'s level of supervision or the supervision level of the male who assaulted her;<sup>6</sup>
- Prior to the assault, only one staff member was present on the 2nd floor and that staff was assigned to provide one-on-one supervision to another resident on that floor. The assault occurred after this staff member went downstairs, leaving N.P. and the male resident alone on the 2<sup>nd</sup> floor;
- Cabin staff did not check the supervision sheet, which is supposed to contain information concerning each resident's prescribed supervision level;
- Cabin staff did not use common sense when leaving N.P. alone with a male resident who was known to be sexually inappropriate at times;

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<sup>6</sup> The male client who assaulted N.P. did not reside in N.P.'s cabin. He was there for a visit.

- Staff members seemed to have no awareness of where other staff were during the evening in question; and
- There was no information available regarding the protocols and supervision level ordered for the male resident.

Further, the investigator determined that, in addition to the direct care staff assigned to N.P.'s cabin, Lakeview's management was culpable for the assault she suffered because:

- There was no unit supervisor at N.P.'s cabin;
- Lakeview failed to provide sufficient staffing for the number of consumers given their needs; and
- "There seems no one person communicating on a management level [to cabin staff] policy and procedure, supervision needs, and to be there for guidance for a very young and sometimes inexperienced staff."

## 2. **Summary of the Disability Rights Center of Maine's investigation and findings regarding alleged abuse and neglect of L.R.<sup>7</sup>**

L.R. is a teenage Maine resident with autism, emotional and other disabilities who requires assistance with his activities of daily living. He was admitted to Lakeview in 2011 as a step-down program from a prior placement at an acute care hospital where he had been treated for aggression, self-injurious behavior, property destruction, and significant behaviors related to his diagnosis of obsessive compulsive disorder. L.R. was 13 years old at this time. The goal of placement at Lakeview was to enable L.R. to stabilize and return to community living. However, after residing at Lakeview for only fifty-one (51) days, L.R.'s condition deteriorated so significantly that he required acute care hospitalization. More troubling was that, upon his

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<sup>7</sup> This is a summary of an investigation report completed by Disability Rights Center of Maine, which was provided to Lakeview, and the NH Division of Children Youth and Families, as well as to various Maine officials in August 2013.

discharge from Lakeview, L.R.'s body was covered with more than two-dozen marks, including significant bruising and abrasions.

DRC Maine conducted an investigation into allegations that the injuries L.R. sustained were the result of physical abuse and concerns that L.R. did not receive proper treatment at Lakeview. DRC Maine's investigators reviewed nearly 2000 pages of documentation from Lakeview, other treatment providers and governmental oversight agencies, including admissions reports, notations about L.R.'s visits to Lakeview's medical staff, incident reports, and daily documentation. According to DRC Maine's investigation report, Lakeview's records did not describe the possible causes, or explanation, of L.R.'s injuries.

Due to the absence of documentation, DRC Maine was unable to determine the cause of L.R.'s injuries. However, DRC Maine's investigation raised significant concerns regarding Lakeview's treatment of L.R. including:

- Inadequate documentation regarding injuries he suffered while at Lakeview;
- Lack of communication with family members, including failure to inform L.R.'s parent of injuries he sustained while at Lakeview as well as his overall deteriorating condition;
- Inadequate treatment planning, including failure to develop a treatment plan or even collect data regarding self-injurious behavior; and
- Evidence of substandard care.

**3. Summary of the New Hampshire Bureau of Elderly and Adult Services' ("BEAS") investigation and findings regarding founded abuse of K.N.**

K.N. has an organic brain syndrome, difficulties with receptive and expressive language, a complex seizure disorder, developmental delays, and a history of aggressive behavior. In



December 2012, several Lakeview staff members reported that one of the teachers at Lakeview's school<sup>8</sup> had emotionally abused K.N. by yelling at him and forcing him to put a rolled up sock into his mouth, in an attempt to stop him from screaming. K.N. was an 18-year old residential student at the time.

K.N. had a behavior treatment plan. The plan called for staff to ignore his verbal outbursts and assist him to take a break in a quiet area. The plan did not provide for using a sock to quiet him. During his interview with BEAS's investigator, the teacher in question denied yelling at K.N., but admitted he had both put a sock in K.N.'s mouth and directed K.N. to put a sock in his own mouth on multiple occasions over a two-year period.

BEAS's investigator determined that reported abuse was FOUNDED, finding that the teacher "emotionally abused K.N. in that [the teacher] misused his power and authority, and unreasonably confined K.N., an act that could result in mental anguish and emotional distress."

**4. Summary of four complaint investigation reports completed by BEAS in 2012 and 2013 regarding alleged abuse and neglect of K.A.**

K.A. is a young woman, in her early twenties, with developmental disabilities and challenging behaviors. Due to her challenging behaviors, K.A.'s treatment plan requires that she be provided with 1:1 direct staff support at all times. While at Lakeview, K.A. has been the victim of several founded incidents of abuse and neglect. She has also been the subject of multiple investigations of alleged abuse and neglect which, though not ultimately founded, illustrate deficiencies in Lakeview's ability to provide the level of staff supervision that she requires.

BEAS's investigation reports reveal:

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<sup>8</sup> Lakeview operates a private special education day and residential school on its premises in Effingham.

a. Lakeview has failed to consistently provide K.A. with her required level of staff supervision, resulting in a number of serious incidents involving K.A. aggressing towards peers. These incidents could have been prevented had proper staffing and supervision levels been maintained. For example, in February 2013 a BEAS investigator determined that K.A. was subjected to neglect when a staff member left her unsupervised, during which time K.A. exited her room and assaulted another resident. Two months earlier, in December 2012, a similar incident occurred in which K.A. was left unsupervised and assaulted another resident. A different BEAS staff member investigated this matter. The Lakeview staff member at issue admitted he had left K.A. unsupervised. Though this case was deemed unfounded,<sup>9</sup> the investigator noted in his report that he “did not feel that the orientation/training he was given was comparable to the job he was expected to do.”

b. Lakeview and its staff’s failure to provide K.A. with an adequate level of supervision has put her at serious risk of physical harm. In April of 2013, K.A. engaged in self-injurious behavior – consuming another client’s feces. A complaint was filed with BEAS alleging that K.A.’s conduct was the result of her 1:1 staff’s failure to provide her with an adequate level of supervision. Although BEAS’ investigator determined the staff member’s conduct did not rise to the level of neglect, BEAS’ findings again reveal Lakeview’s inability to appropriately care for and supervise individuals with behavior challenges. K.A. has a known history of consuming feces. During the incident in question, K.A. had told her 1:1 staff person that she needed to defecate. When they walked into the bathroom, they noticed that another resident had defecated in the tub. Rather than escort K.A. to another toilet, K.A.’s staff allowed

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<sup>9</sup> DRC strongly disagrees with the investigator’s conclusion. By any investigation standard this case should not have been unfounded. In any event the employee’s admissions provide further support for the systemic pattern of poor training at this facility.

her to remain in the bathroom. K.A. proceeded to pick the other resident's bowel movement out of the tub and eat it. In response to the BEAS investigator's questions regarding what might have been done to prevent this type of situation from re-occurring, a staff member told the investigator, "We don't have a lot of staff and the residents have a lot of issues. If they are all having a behavior problem it can get dicey."

c. Lakeview's response after K.A. ingested another resident's stool was inadequate. Several hours after the incident, Lakeview emailed K.A.'s parent about the incident and its plan to take no action other than monitoring her for symptoms of gastrointestinal distress. Displeased with this response, K.A.'s parent convinced Lakeview to take her daughter to the nearest hospital's emergency room to be evaluated and for a Hepatitis A shot. Although Lakeview personnel brought K.A. to the emergency room as requested, the emergency room doctor informed K.A.'s parent that the staff member who brought K.A. to the hospital left with K.A. before she had been discharged and before the hospital staff was able to administer a Hepatitis A shot.

d. K.A. has been subjected to physical abuse by Lakeview staff – another result of Lakeview's poor staff training and inadequate staff supervision. During the summer of 2013, a direct support staff member grabbed K.A. by the back of her shirt and dragged her up a ramp, causing her to sustain abrasions to her arms and elbows. BEAS investigated and determined that the staff member's actions constituted physical abuse as defined by RSA 161-F:43, III. The investigation revealed that this incident was precipitated by the direct support staff's refusal to comply with K.A.'s behavior plan. To address K.A.'s anxiety and safety concerns, her plan provided that, upon request, K.A.'s assigned staff member was to hold her hands. On the day in question, K.A.'s assigned staff refused to hold her hand because, as he reported to BEAS'

investigator, "I feel she asks for that too much." Further, this staff member told the BEAS investigator that, despite Lakeview's adoption of MANDT program for behavioral challenges, he never uses MANDT with K.A. In addition, he told the investigator that "sometimes you just have to take matters into your own hands." Finally, K.A.'s staff member could not recall the last time anyone had reviewed her behavior plan with him. He told the investigator "there's a lack of communication in this place and it stinks. They change it (the behavior plan) all the time and I never know what I am supposed to do."

**5. Summary of New Hampshire Department of Health and Human Services Bureau of Developmental Services ("BDS") investigation and findings of client rights violations regarding H.S. including the right to be free from neglect.**

In 2013, the DRC filed a complaint with BDS on behalf of H.S., a twenty-two (22) year old young woman who at the time the complaint was filed, had resided at Lakeview for approximately 4 months. During her time at Lakeview, H.S. sustained injuries as a result of physical altercations with other residents. Additionally, her eye glasses were broken multiple times and Lakeview failed to take timely action to replace them.

BDS's investigator determined that:

- Lakeview violated H.S.'s right to a safe environment, under He-M 310.09 as H.S. was "living in a situation where she both feels at risk and has actually been a victim of an unprovoked attack."
- Lakeview's case manager violated H.S.'s right to be free from neglect, under He-M 310.05(b), by failing to take appropriate and timely action to replace her eyeglasses after they were broken by another resident as well as ongoing failure to ensure safe keeping of such property as they have been broken on more than one occasion.

- This investigation exemplifies Lakeview's failure to ensure residents' safety as well as persistent deficiencies in the training of, and communication among, Lakeview's treatment providers.

### **III. Additional Incidents and Reports by Government Agencies Illustrating Chronic Nature of Staffing and Programmatic Deficiencies at Lakeview.**

Summarized below are additional reports and accounts which reveal the same or similar patterns of mistreatment, conditions, and causes. Recent reports issued by the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA), and the New York State Justice Center for the Protection of People with Special Needs (Justice Center) highlight continuing deficiencies at Lakeview which place its clients and staff at risk of serious harm. Additional incidents at Lakeview reported by the media identify serious concerns ranging from inadequately supervised residents eloping from the campus to felony drug charges being lodged against its pharmacist. Finally, a review of dispatch logs from the Carroll County Sheriff (which responds to 9-1-1 calls) reveals multiple issues which place Lakeview's residents at risk of harm including chronic defects in Lakeview's fire detection system and numerous instances in which, due to a lack of adequate supervision, Lakeview's residents have eloped from its campus, ingested dangerous substances, or been assaulted by other residents.

#### **A. Reports of Serious Deficiencies Issued by Government Agencies**

##### **1. OSHA – Citation implicating deficiencies related to staffing levels, training, and supervision.**

In May of 2012, OSHA cited Lakeview for exposing its direct care employees to workplace violence hazards.<sup>10</sup> OSHA's investigation indicates that Lakeview's direct care employees have suffered multiple physical injuries while working with clients who have

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<sup>10</sup> Lakeview contested this citation and the parties reached a formal settlement of the matter on September 3, 2014.

behavioral challenges. OSHA determined the employee injuries stemmed from Lakeview's failure to ensure that adequate numbers of properly trained responders are available for each shift should residents' behaviors become aggressive as well as a failure to ensure there is sufficient staff coverage on all shifts so that direct care staff can deliver the required level of supervision for each resident without putting themselves at risk by taking on supervision responsibilities for additional clients.

**2. Justice Center – Report implicating inadequate staffing, supervision, policies, and behavior management practices.**

In January 2014, the Justice Center issued a report of an on-site monitoring visit it conducted during the week of October 20, 2013 to review the services Lakeview provides to residents placed by the State of New York. The Justice Center determined that “the safety of New York residents was not consistently and reliably maintained due to inadequacies in facility staffing, supervision, policies, behavior management practices and incident management practices . . . [and] found evidence of repeated, preventable instances of potentially dangerous resident elopements, self-injurious outbursts and aggression against peers.” (Emphasis added.) The Justice Center concluded that staffing shortages periodically resulted in failure to provide residents with the level of supervision indicated in their behavior plans and contributed to incidents of dangerous aggression and attempts to elope from the facility. In addition, the Justice Center was “troubled to learn that residents assigned to line-of-sight supervision had no specified staff member assigned to maintain this continuous observation,” resulting in inability to assure staff accountability. The Justice Center found deficits in Lakeview's internal investigation procedures and expressed concern that its internal incident investigations of alleged abuse and neglect do not meet best practices. The Justice Center determined there was no evidence that Lakeview's investigators interview residents or consider staff's adherence to residents' treatment

or behavior plans.<sup>11</sup> Further, the Justice Center noted the absence of comprehensive investigation reports with “relevant findings, rationale for determinations or recommendations for needed corrective actions.” Finally the Justice Center noted that Lakeview did not have an incident review committee to review and approve completed investigations.

B. Media Reports and Sheriff’s Log Entries Regarding Serious Incidents at Lakeview.

1. **Media Reports.**

In October 2013, the Pharmacy Director at Lakeview had his license suspended after he was arrested and charged with taking pills from Lakeview’s pharmacy for his personal use. According to a Conway Daily Sun article dated October 30, 2013, the Pharmacy Director faced felony charges for drug possession as well as charges for driving under the influence of drugs and reckless conduct. In its Order of Emergency license suspension, the Pharmacy Board stated it found that “the case involves imminent danger to life and/or health. Further, the Board believes there is a reasonable basis for both immediately suspending [the Lakeview Pharmacist’s] license on a temporary basis, and for commencing an expedited disciplinary proceeding against [him].” The Pharmacist later surrendered his license and resigned from Lakeview.

In June 2013, local news outlets reported that J.F., an 18-year old young woman, walked off Lakeview’s grounds and was missing for two days. She left the facility in the middle of the afternoon, wearing only pajamas and socks. Although she was wearing a tracking bracelet, searchers were not able to detect a signal. The search continued through soaking rain until a hiker finally found her. She was transported to Huggins Hospital and treated for mild

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<sup>11</sup> It should be noted that according to information DRC obtained from Lakeview in April 2012, its internal investigation procedure for abuse and neglect investigations provides, unless the alleged victim refuses to participate, the assigned investigator is required to “conduct a face to face interview with the alleged victim unless he/she is unable to participate as evidenced by information supported by the primary medical provider.”

hypothermia. A former Lakeview Staff member attributed J.F.'s disappearance to insufficient staffing levels and lack of proper staff training.

In November 2011, the Boston Globe and WMWV reported that "J.M.," a 28 year-old Lakeview patient who had been reported missing, was found in Boston, Massachusetts. From the reports, it appears J.M. was able to take one of Lakeview's maintenance vehicles at approximately 1:00 in the morning and drive it to Boston. He was located and taken into custody shortly before noon.

## **2. Carroll County Sheriff Logs.**

Dispatch logs from the Carroll County Sheriff indicate that between January 1, 2013 and March 23, 2014 they received 186 911 calls concerning Lakeview's residents and the facility. Of those calls, approximately forty-seven (47) arose from inadequate supervision of residents. Multiple calls were placed in response to clients ingesting unknown or dangerous substances including an incident in which a patient ingested all-purpose cleaner and another incident in which a patient had a one-inch rubber ball stuck in her throat. The dispatch logs indicate multiple reports of patient-on-patient assaults, as well as individuals walking off Lakeview's grounds and missing for hours, and up to days, at a time. Thirty-four calls were in response to medical emergencies, including seven calls for patients experiencing repeated seizures. Thirty-one calls were due to activation of Lakeview's fire alarm, most of which were caused by faults in Lakeview's fire detection system.

## **IV. Despite Repeated Reports of Management, Treatment, and Staff Inadequacies That Have Resulted in Physical And Emotional Harm to Both Lakeview's Residents and Staff, No Real Improvements Have Been Made.**

As described in the previous sections, Lakeview has been the subject of recurring reports concerning alleged abuse, neglect and mistreatment of residents and safety issues impacting



Lakeview's residents and staff. The root causes of the incidents prompting these reports are, for the most part, identical, involving: insufficient staff training, supervision, and staffing levels, deficient oversight by management, and communication failures between and among Lakeview's clinical, administrative, direct support staff, and parents/guardians. Government agencies and advocacy organizations have made multiple efforts, over a period of several years, to bring these deficits to the attention of Lakeview's management and to advocate for improvements. Yet few, if any, permanent and meaningful improvements have been made. As a result, Lakeview's residents remain at risk of abuse, neglect, physical and emotional harm, and substandard care. The following are some examples of Lakeview's failure to take any meaningful remedial action to address persistent deficiencies in its staffing, management, and programming.

A. Repeated Instances in Which Staff Has Made Poor Decisions Regarding Client Care, Ignored or Refused to Comply With Clients' Treatment Plan Demonstrate Inadequacies in Lakeview's Efforts to Train and Supervise Direct Support Staff.

As a result of inadequate efforts on the part of Lakeview's professional staff to properly train and provide appropriate supervision and oversight of direct support staff regarding individual clients' treatment and behavior plans, Lakeview's direct care staff members are ill-equipped to respond appropriately to residents in crisis. Further, given a lack of adequate training and supervision, it is not unusual for staff members to develop, make up, and apply their own methods in treating the residents in their charge. In some instances, these methods have resulted in physical or emotional harm to Lakeview's clients.

The sexual assault suffered by N.P. and findings in DRC's investigation into the death of J.D. exemplify the tragic results which have occurred at Lakeview due to the lack of sufficient training and supervision and resulting poor decision-making on the part of its staff. In N.P.'s case, Gateways' investigator determined that cabin staff did not use common sense when leaving

N.P. alone with a male resident who was known to be sexually inappropriate at times. DRC's investigation regarding the circumstances leading to J.D.'s death revealed that the sole staff member charged with supervising J.D. and other cabin residents during the morning he died failed to appropriately respond to what should have been recognized as a medical emergency.

In DRC's 2011 Investigation Report regarding L.B., it was found that a member of Lakeview's staff lied to L.B. regarding Lakeview's policy regarding the delivery of clients' medications and refused to call Health Services to request her PRN medications. In its 2012 Report regarding K.N., the NH Bureau of Elderly and Adult Services' investigator found that a Lakeview Staff member had ignored his behavior plan and emotionally abused him by forcing, and later coercing him to put a sock in his mouth to quiet him down. In its 2013 Report finding K.A. had suffered physical abuse, BEAS's investigator stated that K.A.'s assigned staff member freely admitted that he chose not to comply with her behavior plan or to use MANDT, the behavior support protocol Lakeview has supposedly adopted. Finally, this staff member informed the investigator that, "sometimes you just have to take matters into your own hands."

**B. Lack of Adequate Numbers of Staff Results in Harm to Clients.**

Gateways Community Services' 2010 investigation report regarding the sexual assault of N.P. includes a finding that the number of staff members assigned to her cabin was inadequate given the number and needs of the residents in her cabin. DRC raised concerns regarding lack of sufficient numbers of staff in its November 2011 report of its investigation of abuse alleged by L.B. In particular, DRC noted complaints from staff members that Lakeview's administration frequently depends on staff assigned to provide one-on-one supervision for a particular resident to also supervise other residents in a cabin, thereby resulting in lack of adherence to residents' ordered supervision levels. A combination of insufficient training and inadequate level of direct care staff resulted in J.D. being left virtually unattended for nearly four hours, during which time

he lay naked, in a pool of urine on the floor of his bedroom, and ultimately died. Reports issued by OSHA in 2012 and the Justice Center in 2014 and the 2013 disappearance of J.F. further demonstrate Lakeview's continued failure to ensure that sufficient staff members are available to meet residents' supervision needs.

C. Poor Communication Results in Serious Harm to Lakeview's Residents.

Lack of communication between and among Lakeview's employees and between Lakeview and its residents' parents and guardians is an ongoing concern and places Lakeview's clients at risk.

In its 2010 investigation regarding the sexual assault of N.P., Gateways Community Services' investigator determined Lakeview's management bore responsibility for the harm N.P. suffered due, in part, to the lack of management's failure to communicate policies and procedures to cabin staff.

As Dr. Carl Cooley, DRC's consulting medical expert, noted in J.D.'s case, "The major domains of health care at Lakeview (medical, psychiatric, and neurologic) are compartmentalized with little exchange of information, discussion among the doctors responsible for each of these disciplines." Further, Dr. Cooley opined that the lack of coordination may have led to a lack of recognition regarding J.D.'s mental health diagnosis and current behaviors and contributed to Lakeview's failure to identify the severity of J.D.'s situation. Lakeview's failure to communicate timely and accurate information concerning J.D.'s declining health status left his guardian in the dark about the extent of his emotional, behavioral, and physical condition, thereby depriving her of the opportunity to consider whether to terminate J.D.'s placement at Lakeview.

In its 2013 Report of its investigations regarding L.R., DRC Maine determined that Lakeview failed to inform L.R.'s parent about the injuries he sustained at Lakeview or of his

overall deteriorating condition. Finally, in its 2013 report of its investigation regarding H.S., BDS determined that the failure of Lakeview's administration to communicate with, and provide adequate instructions to, H.S.'s case manager regarding procedures that should be followed when an essential piece of property is damaged was a systemic factor contributing the violation of H.S.'s rights.

**V. The State of New Hampshire's Obligations to Provide for the Safety and Well-Being of Individuals with Disabilities and Ensure Such Individuals Receive Services in the Least Restrictive Environments Appropriate to Their Needs Under RSA 171-A, RSA 126-A, and RSA 151 and Their Implementing Rules.**

DHHS bears responsibility for ensuring the health, well-being, and safety of the individuals it serves. RSA 126-A:4(I), RSA 171-A:1, 3 & 4. As stated in RSA 171-A:4, DHHS "shall maintain a state service delivery system for the care, habilitation, rehabilitation, treatment and training of developmentally disabled persons." Pursuant to RSA 171-A:18 the Commissioner is required to contract with regional Area Agencies to carry out case management, service delivery, and other responsibilities at the community level. RSA 171-A:4 provides, the "service delivery system [including the Area Agencies] shall be under the supervision of the Commissioner."

Provisions of RSA 171-A, as well as implementing regulations, articulate the purpose of the service delivery system and detail the responsibilities of the Department and the system. Fundamental to the purpose of the system is that services be "based on full participation in the community, sharing ordinary places, developing meaningful relationships, and learning things that are useful, as well as enhancing the social and economic status of persons served." RSA 171-A:1, III. Other more specific requirements of the Department and the system include:

- Making service recommendations... based on the criteria of **least restrictive environment**. RSA 171-A: 6. III (emphasis added);

- Promoting the individual's health and safety. He-M 520(b)(3);
- Protecting the individuals' right to freedom from abuse neglect and exploitation. He-M 505.08(b)(4);
- Promoting participation in the community. He-M 503(b)(p) and (o);
- Ensuring the right to adequate and humane habilitation including such psychological and medical...and rehabilitative services as his condition requires to bring about improvement...**within the limits of modern knowledge.** RSA 171-A:13 (emphasis added); and
- Provision of "[s]ervices provided by competent, appropriately trained and competent staff." RSA 171-A:1;VI.

Federal law has corollary requirements. Under the Americans with Disabilities Act, individuals with disabilities, including those with long-term care needs,<sup>12</sup> are legally entitled to receive services in the most integrated setting appropriate to their needs. The "most integrated setting" is one that enables individuals with disabilities to interact with nondisabled peers to the fullest extent possible.<sup>13</sup> This is generally accomplished through serving individuals in their home communities with necessary supports and services.<sup>14</sup>

Under RSA 151:1, DHHS, through its Licensing Bureau, bears responsibility for ensuring that facilities, such as Lakeview, that provide medical, nursing, and remedial care "will ensure safe and adequate treatment of such persons in facilities." Pursuant to its responsibilities and authority provided in RSA 151:1, et seq., the Licensing Bureau is required to conduct at least one

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<sup>12</sup> Olmstead v. L.C., 527 U.S. 581 (1999).

<sup>13</sup> 28 C.F.R. pt. 35 app. A (2010).

<sup>14</sup> See e.g. R.S.A. 171-A:1. ("The policy of this state is that persons with developmental disabilities and their families be provided services that emphasize community living.").

annual unannounced clinical inspection of each licensed facility to determine whether the facility is operating in compliance with all provisions of RSA 151 as well as applicable clinical rules. In the case of residential care facilities, the Licensing Bureau's inspection shall include, in relevant part, "a survey of the most recent individual resident needs determinations . . . to assure that the facility and its programs and services are appropriate to the needs of the residents." RSA 151:6-a, I (emphasis added).

The Licensing Rules applicable to Lakeview require, in part, that Lakeview provide certain core services including:

- Health and safety services to minimize the likelihood of accident or injury, with protective care and oversight provided regarding... the clients' functioning, safety and whereabouts;
- The clients' health status, including the provision of intervention as necessary or required;
- Personnel safety; emergency response and crisis intervention . . . ;
- On-site activities designed to sustain and promote physical, intellectual, social and spiritual well-being of all clients . . . ; and
- Personal supervision of clients when required to offset deficits that may pose a risk to self or others if the client is not supervised.

DHHS may suspend or revoke a facility's license on various grounds including noncompliance with any provision(s) of RSA 151 or rules promulgated by the Department

including “conduct or practices detrimental to the health or safety or well-being of patients, residents, or employees of said facilities.”<sup>15</sup> RSA 151:7, II,(c).

Following development of the area agency system and the closing of the Laconia State School, New Hampshire became the first State in the nation to have a fully community based developmental disability system. Unfortunately, despite the State’s pioneering role and legal mandates requiring the provision of residential services in the most integrated environments appropriate, New Hampshire’s community service system for individuals with developmental disabilities and acquired brain injuries has steadily eroded, with the most profound impact on individuals with developmental disabilities and/or acquired brain injuries who also have significant behavioral and/or medical issues. Legislative and gubernatorial commissions and committees dating back to at least 2001, and DRC’s 2011 White Paper examining six other deaths have documented the system’s deterioration and made recommendations for an increase in the number and variety of community based housing options.<sup>16</sup> While DHHS has made some efforts to address the recommendations included in these reports, the need for enhanced, quality community-based housing options and other services for the population served by the area agency system remains largely unfulfilled.

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<sup>15</sup> Pursuant to RSA 151:6, the Licensing Bureau is also authorized to investigate complaints alleging a licensee has violated the provisions of RSA 151:1, *et seq.*, or its implementing rules as well as to conduct investigations “when it has good reason to believe that the provisions of [RSA 151 or rules adopted under this chapter] have been violated by any facility licensed under [RSA 151].” RSA 151:6.

<sup>16</sup> New Hampshire Department of Developmental Disabilities. *Renewing the Vision, New Hampshire’s Plan to Provide Essential Community Supports for Individuals with Developmental Disabilities*, Report to the Governor. November, 2001; New Hampshire. *Report of the Governor’s Commission to Study Area Agencies and their Role in Providing Services to New Hampshire*, Pursuant to Executive Order 2005-03 of Governor John H. Lynch. November 2005.; New Hampshire Bureau of Developmental Services. *High Cost Review Committee Findings and Recommendations*, April 2005; and Disabilities Rights Center, Inc., *Examining Preventable Deaths in the Developmental Services System, A Call to Action – Keeping Vulnerable Citizens Safe from Harm – A White Paper*, November, 2011.

By continuing to allow state-funded placements of individuals at Lakeview, despite the longstanding issues described above, DHHS has neglected its responsibilities to protect the health safety and well-being of the individuals it serves and violates the rights of individuals to receive services in the most integrated setting appropriate to their needs.

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Licensing and external quality assurance are key components of the above described responsibilities of government and the Department of Health and Human Services, particularly with regard to populations that are vulnerable to abuse and neglect and substandard conditions. As with the actual service delivery, licensing/external quality assurance of DHHS has been subject to a number of findings and recommendations for improvement in order to prevent or correct the types of conditions that have been allowed to exist at Lakeview.<sup>17</sup> Unfortunately many of the needed improvements that would impact Lakeview have also not been made.

## **VI. Call to Action.**

### **A. Lakeview Systems.**

The DRC urges the closure of the Lakeview facility in Effingham, NH. Such action is justified given the number of reports that have been issued over the years evidencing systemic problems at the facility which Lakeview's management has been either unwilling or unable to fix. Its segregated, remote, and isolative nature and location is antithetical to the letter, spirit,

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<sup>17</sup> New Hampshire. *Report of the Governor's Commission to Study Area Agencies and their Role in Providing Services to New Hampshire*, Pursuant to Executive Order 2005-03 of Governor John H. Lynch. November 2005, pp. 14, 27-28; Disabilities Rights Center, Inc., *Examining Preventable Deaths in the Developmental Services System, A Call to Action – Keeping Vulnerable Citizens Safe from Harm – A White Paper*, November, 2011, pp. 32-33, 43-44.



and purpose of the service delivery system to provide support to individuals so that they may function and thrive in less restrictive community-based environments. As New Hampshire has itself acknowledged and pioneered with the passage of RSA 171-A, the closure of the Laconia State School, and the development of the community-based service delivery system, persons with even the most significant behavioral and medical challenges can live and thrive in the community when appropriate supports are provided.

B. State of New Hampshire, Department of Health and Human Services.

The DRC calls upon the State of New Hampshire, including the Department of Health and Human Services and its agents as well as the Bureau of Licensing to take swift action to ensure the health, safety, and well-being of Lakeview's current residents as well as to afford these individuals, and others at risk of placement at Lakeview, the right to receive services in the most integrated setting appropriate to meet their needs.

Regarding continuing safety concerns at Lakeview, DRC calls upon DHHS's Licensing Bureau to take immediate action, in accordance with its legislative and regulatory authority, to conduct a thorough investigation of Lakeview's programs and services, including reviewing individual client files and treatment logs, to determine whether clients' treatment and supervision needs are being met. In addition, DRC calls upon the Licensing Bureau to treat this report, including the series of founded allegations of abuse and neglect set forth above, as a "complaint" per RSA 151:6 and to conduct a thorough investigation of Lakeview's facilities, policies, programs and practices and ensure that individuals residing there receive safe and adequate treatment.

As noted, with appropriate supports and services, a number, if not all, of Lakeview's long-term residents could live successfully in the community. A significant barrier to community

living for most of these individuals is the lack of appropriate community-based residential alternatives for individuals who have complex health and/or behavioral needs. DRC is concerned that DHHS and its agents over-rely on Lakeview, a very restrictive and isolated facility, rather than develop community-based residential programs and supports to provide residential services to individuals who would be more appropriately served in their home communities. DHHS should further develop a broad range of community-based residential program and support options to enable individuals with complex developmental disabilities and acquired brain disorders to reside in their home communities, even during times of personal crisis or when challenged by more than one condition, including behavioral issues. The roadmap and recommendations for the restoration of the community system has been set in a number of previous reports.<sup>18</sup> DRC once again urges DHHS to work with its agents and stakeholders to develop an appropriately robust array of community based residential services and supports to enable individuals with acquired brain injuries and developmental disabilities, including individuals with multiple physical, emotional, and behavioral challenges, to live fully integrated lives in their home communities, with appropriate supports and services.

Finally, in light of new Medicaid Home and Community Based Services (HCBS) Rules, which became effective on March 27, 2014, DRC calls upon DHHS to ensure that all HCBS are provided in settings that maximize participants' opportunities to access their home communities and receive services in the most integrated settings. DRC urges DHHS, its agents and stakeholders to work together to ensure that New Hampshire's transition plan to achieve compliance with the new HCBS rules does not permit HCBS funds to be used, directly or indirectly, to support residential placements at institutions, such as Lakeview, in which

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<sup>18</sup> See footnote 14.

individuals with disabilities are isolated from their homes and communities and segregated from individuals without disabilities.<sup>19</sup> In accordance with the new HCBS rules, the state is expected to transition as quickly as possible and show substantial progress during any transition period. DRC urges the State to begin the transition process immediately with the goal of accomplishing full compliance with the new rules as soon as possible.

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<sup>19</sup> In January 2014 the Centers for Medicare and Medicaid Services (CMS) promulgated final regulations to establish requirements for the types of settings that are eligible for reimbursement for Medicaid home and community based services (HCBS) provided under the Social Security Act's §1915(c), waivers, §1915(i) state plan options and §1915(k) state plan options. 42 C.F.R. pts 430, 431, 435, 436, 440, 441 & 447. The new HCBS rules, which have been in effect since March 17, 2014, solidify the emphasis on providing services, including residential services, in community-based, integrated settings. For states, like New Hampshire, that have existing waiver programs, CMS is providing a maximum of one year for the State to evaluate the settings currently in their 1915(c) waivers and submit a transition plan to CMS describing how the State will bring their program(s) into compliance with the new standards. 42 C.F.R. §441.705(3)(ii)(A).