

# **ISOLATED, SEGREGATED AND VULNERABLE**

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

### **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

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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).

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 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://lakeviewsystem.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, 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

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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 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.

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 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.