



***In the Matter of
Molly Reed***

***A Client of Two Oliver Street
Community Residence Operated by
Manhattan Developmental Center***

**A Report by the New York State
Commission on Quality of Care
for the Mentally Disabled
and
The Mental Hygiene
Medical Review Board**

March 1982

CLARENCE J. SUNDRAM, *Chairman*

**MILDRED B. SHAPIRO
I. JOSEPH HARRIS, *Commissioners***

*Designated by Governor Hugh L. Carey as New York State's Protection and Advocacy System for the Developmentally Disabled, pursuant to Public Law 94-103 as amended.

PREFACE

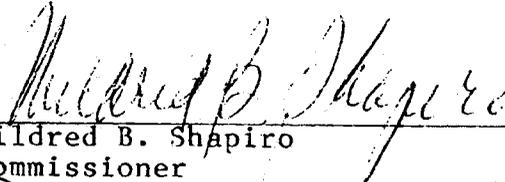
This investigation into the circumstances surrounding the death of Molly Reed,* a client of the Two Oliver Street Community Residence, operated by Manhattan Developmental Center, was undertaken by the Commission and its panel of physicians, the Mental Hygiene Medical Review Board, as part of the Commission and Board's on-going responsibility to review all deaths of mentally disabled persons.

Findings, conclusions and recommendations set forth in the report represent the unanimous opinion of the members of the Commission and the Mental Hygiene Medical Review Board.

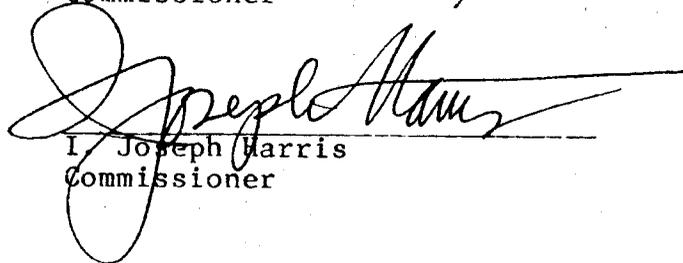
The contents of this report have been shared with the Commissioner of the State Office of Mental Retardation and Developmental Disabilities and the Associate Commissioner for the New York City County Service Group. The response of the Office of Mental Retardation and Developmental Disabilities to the Commission's findings and recommendations is appended to the report.



Clarence J. Sundram
Chairman

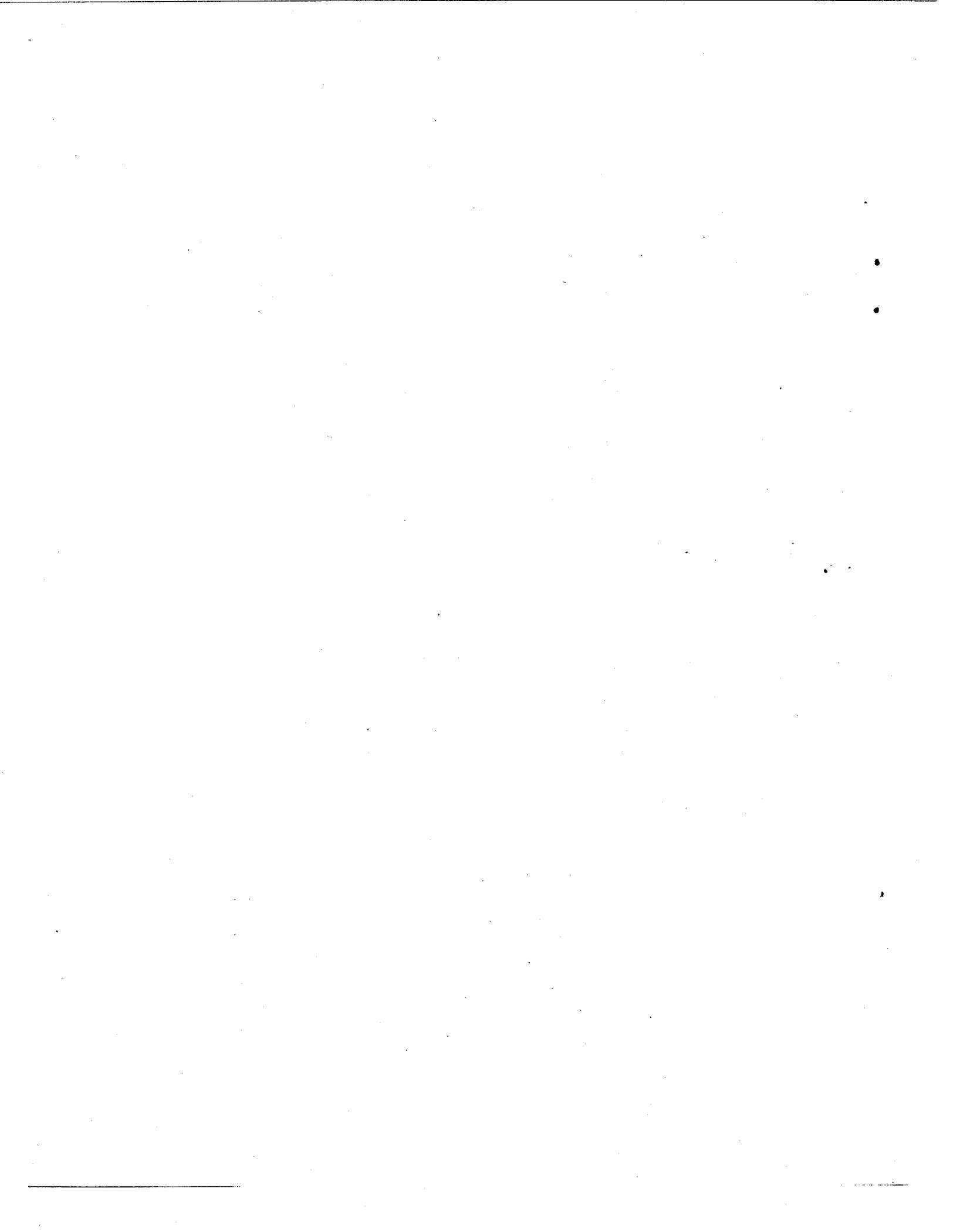


Mildred B. Shapiro
Commissioner



Joseph Harris
Commissioner

*A pseudonym.



INTRODUCTION

Molly Reed,* a 31-year-old resident of a community residence operated by Manhattan Developmental Center at Two Oliver Street in Manhattan, died on May 13, 1981 in St. Vincent's Hospital-- days after she was admitted for treatment of severe burns over approximately 30% of her body suffered while a resident at Two Oliver Street.

An investigation into the death of Molly Reed was initiated in order to determine the circumstances surrounding the death and whether the care afforded the patient prior to her injury and death was adequate and appropriate.

SCOPE OF INVESTIGATION

During the course of this investigation, Commission staff reviewed investigative reports by the investigations unit of Staten Island Developmental Center (SIDC), the New York City County Services Group of the Office of Mental Retardation and Developmental Disabilities (OMRDD), and Manhattan Developmental Center (MDC), as well as correspondence from the Mental Health Information Service (MHIS) and the Professional Advisory Board appointed under the Willowbrook Consent Decree. In addition, medical records at St. Vincent's Hospital were reviewed. Interviews were conducted with members of the Consumer Advisory Board, MDC's Board of Visitors, a facilities development corporation engineer, administrative and clinical staff of MDC, Oliver Street residential staff, staff from the Young Adult Institute (YAI), the District Attorney's Office, and the Medical Examiner's Office.

*A pseudonym.

BACKGROUND

The residence at Two Oliver Street is a three-story brownstone located in a residential area in lower Manhattan. The community residence, housing a maximum of six clients, opened approximately two and one half years ago. The first floor includes a kitchen, dining room, laundry room, administrative office and living room. Bedrooms are on the second and third floors. Both floors have full bathrooms (toilet, sink, shower and bathtub). From the first floor it is most difficult, if not impossible, to hear sounds (such as the sounds of running water, closing doors, conversation, etc.) from the second or third floors.

Miss Reed, a member of the Willowbrook Class, was diagnosed as profoundly retarded and was non-verbal. She lived on the second floor, sharing a room with another resident who was also non-verbal. At the time of her injury, Miss Reed was 5 feet 1 inch tall and weighed 76 pounds when she died. She had weighed 84 pounds one year earlier when she was admitted to the residence and was diagnosed as possibly having an intestinal malabsorption syndrome. She suffered from chronic abdominal distention. Her medication regimen consisted of multi-vitamins, which she began taking on October 16, 1980.

While ambulatory, Miss Reed had an unsteady gait, partially caused by deformed feet, which required her to wear orthopedic shoes. She could walk and climb stairs unassisted and had a noticeably strong grip, which was helpful to her in holding on to bannisters.

Miss Reed required assistance in most areas of self care. The staff at the day program operated by the Young Adult Institute (YAI), which she had been attending since September 1979, reported that Miss Reed had been making significant progress in acquiring some self-care skills. For example, even though Miss Reed was unable to dress herself, she was capable of taking off garments, such as pants, blouses, and underwear.

Miss Reed seemed to enjoy activities, such as playing with water and bathing. At YAI, Miss Reed had been learning how to turn on and off water faucets. She mastered the former but not the latter. Staff at the community residence stated it was not unusual to find Miss Reed in the second floor bathroom playing with water in the sink. This often would occur after her bath in the evening, when Miss Reed was in the habit of turning the water on to get a drink, but she would then need help in turning off the water. It is not clear whether she knew how to distinguish between hot and cold water faucets. Molly Reed reportedly was able to get in and out of the tub without assistance. As the water filled the tub, she would lie on her back with her feet elevated and placed against the wall next to the faucets. According to staff reports, Miss Reed enjoyed lying in bed in the same position.

CIRCUMSTANCES OF DEATH

On Sunday evening, March 15, 1981, five clients (three men and two women) and four staff members (the house manager, clinical coordinator and two direct care staff) were at the community residence. The house manager and clinical coordinator were preparing for an Intermediate Care Facility (ICF) audit scheduled for the following day. Because of this impending audit, the assignments of the two direct care staff were changed for that evening. Therapy Aide A, usually assigned to bathe the female clients (Molly Reed and her roommate), was directed by the house manager to assist in tidying up laundry, and to perform some administrative and clerical chores preparatory to the audit.

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Therapy Aide B, usually assigned to bathe the three male residents, was given the additional task of bathing Miss Reed and her roommate, as well as the three male clients. The bathing procedure for all five clients began at approximately 7:30 - 7:45 p.m. and ended at 8:45 - 9 p.m., according to the two aides. Therapy Aide A stated that, sometime between 8:30 and 9 p.m., she saw Therapy Aide B drying Miss Reed in the bathroom and no burns were evident on her body. The aides stated that, by 9 p.m., all five clients were in their pajamas and in bed.

After the clients were in bed, Therapy Aide B, as previously instructed, remained in a back area on the second floor labeling food in a freezer. From there, the aide was able to observe the second floor without difficulty. She stated that, during the hour she remained on the second floor, Molly Reed did not leave her bedroom. At approximately 10 p.m., Therapy Aide B went to the first floor and began labeling food in another freezer. Before going downstairs, Therapy Aide B looked in on Miss Reed and her roommate, who were the only residents on the second floor, and found nothing unusual. When the house manager returned from dinner between 10 and 10:15 p.m. that evening, he instructed Therapy Aide A, who was still on the first floor engaged in clerical duties, to give Miss Reed's roommate her medication. (It should be noted both that Therapy Aide A was not certified to administer medication and that this medication should have been given at 8 p.m., not at 10 p.m.). Therapy Aide A reported that, when she gave Miss Reed's roommate her medication, she noted that Miss Reed was still awake. The therapy aide stated Miss Reed was lying on her back with her legs in the air. (Her thighs were visible and no burns were evident.) The therapy aide did not note anything unusual. Miss Reed asked for a drink and was given water.

The therapy aides reported that, sometime after 10 p.m., the house manager and clinical coordinator asked that they all meet on the first floor to discuss the clients. The house manager and the clinical coordinator dispute this statement by the aides. Due to conflicting statements, it is impossible to establish definitely whether the meeting occurred spontaneously or by design. It is beyond dispute that all four staff were gathered in the living room on the first floor when the night shift therapy aide arrived at approximately 11 p.m. The night shift aide, as was her custom, went to the second floor to change her clothing and noticed there was water on the floor in front of the bathroom. The light in the bathroom was off. Upon turning the light on, the night shift aide noted the bathtub water was running slightly and that Miss Reed's pajama top was floating in the tub. Her pajama bottom was on the floor adjacent to the bathtub. (This bathtub is designed not to overflow; there is a check valve in the drain mechanism.) The aide flipped the drain lever and drained the tub. She stated the water was tepid at this time. Following the trail of water and wet foot imprints on the rug leading to Molly Reed's bed, she found Miss Reed lying in a curled-up fetal-like position instead of her usual position of lying flat on her back. Miss Reed was shivering and appeared in pain. Her bed and blanket were damp but did not appear wet from urine. Looking more closely, the aide stated she observed Molly Reed's skin to be "scalded bright red from under her breast to the knees. She was sticking to the sheets." When moved, "the skin came off in strips." The aide ran downstairs and alerted staff. An ambulance was called and Molly Reed was transferred to St. Vincent's Hospital Burn Unit.

Dr. Yee, the physician who admitted Miss Reed to St. Vincent's Hospital, described her injuries as "second and third degree burns covering abdomen, perineum, buttocks and thighs,

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body blistered and erythematous, the back is more involved than the front and the lines of demarcation are straight across." According to the medical staff at St. Vincent's Hospital, the seriousness of Miss Rosa's burns was exacerbated by her mental retardation and her body's immunological dysfunction. She died two months after admission to St. Vincent's Hospital.

When questioned, a St. Vincent's Hospital physician responsible for Miss Reed's care stated her poor nutritional state was evident on admission. She was dehydrated and malnourished, as noted by a low (2.4) albumin and a high (56) hematocrit. She was noted by a physician to be "cachectic" (a malnourished and wasting state) upon admission. Two days after admission, a physician's note states "hypoalbuminemia secondary to burn and possibly to chronic debility, malnutrition." The final diagnoses states: "...course complicated by...malnutrition."

An autopsy performed by the New York City Medical Examiner's Office determined that her death was directly attributable to the burns she sustained on March 15, 1981. Dr. Pervez, New York City Medical Examiner, certified Miss Reed's cause of death as "scald burns of body surface, surviving two months with sepsis; consumptive coagulopathy and hypovolemic shock." The autopsy did not grossly reveal any indication of a gastrointestinal malabsorption problem.

The Incident Review, conducted by Dr. F. at MDC on March 18, 1981, reached the conclusion that "the most probable cause of the injury is due to the person being 'dipped' into the water and then removed." This conclusion represents conjecture by the physician based on circumstantial evidence. Dr. F. also recommended that:

- a) staff be made aware of need for proper supervision;

- b) staff be given in-service training in bathing and aseptic techniques;
- c) appropriate techniques for the administration of medications be established;
- d) staff be trained in maintenance of log book; and
- e) client's suitability for the Oliver Residence be reevaluated.

Correspondence from MHIS showed that, while no investigation was conducted, MHIS tended to agree with Dr. F.'s finding.

The New York City OMRDD County Service Group, which did conduct an investigation, also concurred with Dr. F.'s conclusion that Miss Reed was "dipped in tub" by staff. Again, no evidence other than circumstantial was presented. The County Service Group recommended reassignment of Therapy Aide B, the person who was suspected of having immersed Molly Reed in a tub filled with hot water. This group also recommended that:

- a) the hot water unit be repaired;
- b) supervision be monitored more closely;
- c) client records be upgraded.

The investigation conducted by the Office of the Legal Adviser at Staten Island Developmental Center reached the conclusion that there is "no evidence of any employee being involved in client Molly Reed's injury" and that injuries were self-inflicted.

All investigatory reports agree that supervision on the evening of Miss Reed's injury was inadequate.

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FINDINGS

(1) ON THE EVENING OF MARCH 15, 1981 MOLLY REED WAS UNSUPERVISED FOR A PERIOD OF 30 - 45 MINUTES.

This non-verbal client, who required assistance in most areas of self care, was unobserved while staff were drawn away from their usual duties and assigned tasks elsewhere in the residence preparing for an impending audit. The house manager stated he had not been aware of Molly's "pleasure in playing with water." The therapy aide staff were aware of this and that Miss Reed often went into the bathroom at night after she was put to bed. However, the staff did not share this information with the manager or the clinical coordinator. The house manager also pointed out that, at the time of Miss Reed's injury, there were no written policies regarding supervision of clients during evening hours.

(2) IT IS PROBABLE THAT MISS REED WANDERED INTO THE BATHROOM, AS SHE HAD DONE MANY TIMES BEFORE, AND, WHILE UNOBSERVED, GOT INTO THE BATHTUB FILLED WITH SCALDING HOT WATER.

Since there were no known witnesses to the injury suffered by Molly Reed, it is impossible to conclusively establish the circumstances of her injury. However, based upon our investigation, including interviews with the employees present, review of the results of their investigations and our attempts to recreate the possible sequence of events, we are of the opinion that the injury did not occur as a result of direct abuse by any employee. Rather, we believe that either of the following sequences of events occurred:

(a) While all employees were otherwise engaged on the first floor, she removed her pajamas, entered the tub by placing her buttocks on the edge of the tub and sliding into the tub in that fashion. It cannot be determined

whether she turned on the hot water before or after she got into the tub, or whether the hot water was left running for some unexplained reason. As the hot water became intolerable, she swung both legs over the left side of the tub, and with one hand gripped the handle on the soap dish. This support, together with the other hand gripping the side of the tub, enabled her to raise herself out of the tub. But, apparently this did not occur until after she had been scalded on the anterior and posterior aspects of her body, from below the breasts to the midway portion of her thighs.

- (b) In the alternative, it is conceivable that, after the heat of the water became intolerable, she elevated her torso from the water by stretching her legs with her heels against the wall at the base of the tub. With her right hand clasping the soap dish handle and her left arm braced against the left side of the tub, she was able to support her torso while in the tub. In this position, she inched herself across the left side of the tub and on to the floor. Commission staff recreated this means of egress from the tub which, while difficult, would have been possible.

(3) THE HOT WATER HEATER AT THIS RESIDENCE WAS KNOWN TO BE MALFUNCTIONING FOR AT LEAST 3 - 5 WEEKS PRIOR TO MISS REED'S INJURY.

Staff reported that for at least 3 - 5 weeks before Miss Reed's injury, the hot water at the residence was "hot enough to boil an egg." On the day following the injury, it was documented by the engineers of the Facilities Development Corporation that both the thermostat and the mixing valve attached to the 40 gallon hot water tank in the basement at Two Oliver Street were not functioning, thus permitting scaldingly hot water to flow through the faucets.

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A memo, dated November 19, 1980 from the Assistant to the Director of MDC to the MDC Business Officer, requests that the maintenance department make regular inspections of hot water in all community residences to insure they are receiving an adequate and safe supply. On December 1, 1980, the maintenance department inspected four residences, including Two Oliver Street, and determined that Oliver Street was "okay." Despite the fact that direct care staff had noted problems with the hot water valve, they did not report these problems to any supervisory staff.

An engineer on the staff of Facilities Development Corporation was consulted by the Commission. The engineer stated it is extremely difficult to maintain a hot water system that would adequately serve a clothes washer and a dishwasher requiring water at 140°, as well as provide water at 110° for bathing needs. He stated an immediate solution to this difficulty would be to install two separate hot water heaters and that this possibility previously had been suggested. However, due to budgetary considerations, it was never implemented.

In the early part of June 1981, following the death of Molly Reed, a second hot water heater was installed at Two Oliver Street. One hot water heater is used exclusively for the washing machine and the dishwasher, the other for client's bathing needs, etc.

CONCLUSIONS

The Commission investigation was unable to find any evidence of willful client abuse in this case. However, it has established beyond doubt that Molly Reed's death resulted from client neglect. The explanation that there were no written policies or procedures regarding observation and supervision of clients is unacceptable. Common sense would dictate that a non-verbal

client who requires assistance in caring for many of her needs should not be left alone for an extended period of time, especially when staff knew of her tendency to wander out of her room into the bathroom and play with water. The entire staff gathered on the first floor for a meeting on the upcoming audit. While there, they were unable to hear any sounds emanating from the second floor and certainly would be unable to observe anything which might be happening on the second floor. Supervisory and direct care staff relinquished their primary duty to assure client safety by assigning a higher priority to preparation for the upcoming inspection.

The staff were aware of the malfunctioning thermostat and mixing valve, which certainly contributed to her death, yet were lax in seeking prompt correction. The Facilities Development Corporation's suggestion that two hot water heaters be installed had been vetoed for budgetary reasons; however, after the death, funds to install such heaters were found. Program personnel must initiate more effective ways to convince budget personnel of the need to correct deficiencies which may impact on client safety.

RECOMMENDATIONS

- 1) OMRDD should assure that there are adequate and appropriate policies regarding client supervision and observation in community residences. OMRDD should consider disciplinary measures against staff involved in the neglect manifested in this case.
- 2) MDC should assure that client care is not compromised by reassigning direct care staff to other than client-related duties for purposes of assisting administrators or supervisory staff with their responsibilities.
- 3) Hot water mixing valves and all plumbing devices should be checked periodically and defects should be reported for immediate repair.

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4) Community Residence staff should be provided training which will emphasize the potential problem of unsafe environmental and mechanical aspects of the residence. Further, staff should understand the importance of reporting any perceived malfunctions and should be provided a vehicle or mechanism to record such malfunctions.

5) We strongly recommend that if dual hot water heaters are needed in other community residences to provide safe and adequate supplies of hot water to meet both bathing needs and dishwashing and laundering needs, such heaters be promptly installed. We recommend that OMRDD survey all state operated and licensed residences for this purpose.

6) Policy and procedures for medication administration should be addressed by MDC regarding its entire community residential program. The facility's own investigation noted this to be a concern.

7) MDC should make dietary/nutrition issues part of the treatment plan of community residential clients who exhibit weight loss or who are recorded as having any difficulty (i.e. malabsorption with nutrition).

8.) The Commission concurs with the above re-stated recommendations made by Dr. F. of MDC and the New York City County Service Group of OMRDD and recommends not only timely implementation of these recommendations but also close monitoring by both groups to ensure continued compliance.



STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

44 HOLLAND AVENUE • ALBANY • NEW YORK • 12229

JAMES E. INTRONE
Commissioner

January 25, 1982

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Mr. Sundram:

This is in response to the confidential draft report of your investigation into the death on May 13, 1981 of Ms. Molly Reed who was a resident of the state-operated ICF/DD at Two Oliver Street in Manhattan. Please note that this program is not certified as a community residence. However, we will refer to these terms interchangeably throughout our response since our policy statements cover both types of programs.

We are in agreement with the facts presented except that there is a statement in the Introduction that we suggest be changed. Ms. Reed did not expire "days after" her admission to St. Vincent's Hospital. She was admitted on March 16, 1981 and died on May 13, 1981--almost two months after being hospitalized.

Our comments on your specific recommendations are indicated below:

Recommendation #1

Adequate and appropriate policies are in effect regarding client supervision and observation in state-operated community residences and we believe that there is no acceptable reason for the serious client neglect that occurred. Our policies apply to all state-operated programs whether the client is a resident of a developmental center or a community residence. In this connection, attached is a copy of Policy Topic 6.5.1 regarding the responsibilities of direct care staff for residential clients. This Policy Topic makes clear that their primary responsibility is the well-being and development of each residential client. Also attached is a copy of some sections of the Regulation on the operation of community residences (Part 86). Section 86.1 indicates that one common characteristic of such residences is "continuously responsible staff to support and assist the resident as needed in his or her movement to independence." The attached Section 27.3



Being retarded never stopped anyone from being a good neighbor.

of the Part 27 regulation on the quality of care and treatment requires services that are commensurate with each patient's needs and well-being. Section 681.4(b)(2)(vi) of the Part 681 regulation on operating standards for ICFs (copy attached) requires that the facility and services adequately meet the physical and other needs of the clients and that there is adequate protection of each client's health, safety, comfort, well-being, etc.

There are three other attachments which also deal with the responsibilities of staff for the health and safety of the residents, including their supervision and observation and special sensitivity to their individualized needs. These are copies of a January 18, 1980 memorandum to Directors on Staffing State Operated Community Residences, Policy Topic 6.25.2 on Staff Development and In-Service Training, and the Civil Service Department Classification Standard for Mental Hygiene Therapy Aides. The training and other standards relating to Mental Hygiene Therapy Aides are also for the most part applied to the Community Residence Aides that are described in the January 18, 1980 memorandum.

In addition, Manhattan Developmental Center has issued a written policy to all community residence staff on client observation and supervision that indicates "at no time are clients to be left unattended" and "all clients should be checked every fifteen minutes from the time they go to bed until they awaken."

Recommendation #2

It is implicit in the above policies that client care is not to be compromised as the result of other than client-related duties or for any other reason because the primary responsibility of direct care staff is always the well-being of the clients they serve. Manhattan Developmental Center has reminded community residence managers of their responsibility to ensure that client well-being is ensured to the maximum possible extent.

Recommendation #3

The Standing Committee on Architectural Standards Review in a memorandum issued on November 19, 1981 (copy attached) has revised previous guidelines/regulations for domestic hot water distribution. The new version excludes the use of any type of thermostatic mixing valve in cases where buildings are exclusively occupied by clients.

In cases where clients share building occupancy with non-clients such as apartments in which centralized hot water control is not possible, certain types of mixing valves are prescribed which are deemed most safe from malfunctions.

The Standing Committee is addressing the issue of developing an appropriate on-site test that can be periodically made to ensure that mixing valves are functioning properly.

Manhattan Developmental Center has directly taken various actions with regard to its community residences. A second stand-alone gas-fired hot water heater was installed at the Oliver Street, Cliff Street, 24th Street and 92nd Street ICFs. Hot water to all taps is supplied via a tank regulated at 110 degrees; hot water supplied to dish washers and washing machines is provided by a separate tank regulated at 130 degrees. The 59th Street ICF is located in a high-rise apartment building which precludes the dual system. Manhattan is exploring an alternate mixing valve system in each individual apartment. The 123rd Street ICF is a large building. The hot water comes from the boiler which is equipped with an electric mixing valve and alarm system. In addition, there is a full time maintenance person on staff. An alarm system has been installed to trigger a bell and light if the domestic water temperature exceeds 110 degrees at Oliver Street and 123rd Street. A monitoring procedure has been implemented which mandates a maintenance person and Safety Officer each make independent monthly site visits to test water temperatures at each ICF. Written reports are kept on file at the facility Business Office. All ICF domestic water temperatures are checked and logged on a daily basis by the home staff. The dials on the domestic hot water tank were secured and padlocked. All ICF hot water systems are being monitored by the house staff, the maintenance department and Safety Officers. Should a problem be discovered the Business Office is to be notified immediately and corrective action taken.

Recommendation #4

The Standing Committee on Architectural Standards Review will be reviewing the topic on its next agenda of developing appropriate checklists and reporting procedures for ensuring that environmental and mechanical aspects of community residences/ICF-DDs are properly functioning. In addition, the concept of Risk Management Committees that is being introduced at our developmental centers will be extended to all state-operated community residences. This concept provides for the identification and reporting on an ongoing basis of potential problems relating to unsafe environmental and mechanical conditions.

In addition, Manhattan Developmental Center is having environmental and mechanical inspections made on a monthly basis. In-service training for the state-operated CR staff in this area has commenced and is continuing. In-service training in maintenance of a log book has been given to state-operated CR staff. In-service training in bathing and aseptic techniques has been and will continue to be given.

Recommendation #5

As indicated in the attachments relating to Recommendation #3, the revised standards developed by the Architectural Standards Review Committee provide for a dual hot system in community residences. New community residences will be equipped in that manner. The survey you recommended of all existing community residences will be undertaken and necessary corrective measures will be taken based on the availability of funding.

Recommendation #6

Attached is a copy of a June 18, 1980 memorandum and policy material relating to Community Residence Medication, Administration and Incident Review Policies. The attached policy material is in final draft form but, as indicated in the memorandum, the policies were and will continue to be the official OMRDD guidelines for all operators of community residences pending the issuance of a final set of policies.

Manhattan Developmental Center has taken various steps to improve medication administration in its community residences. A Community Mental Health Nurse has been assigned 20 hours per week to each state-operated community residence. Medication policy and procedures have been written and disseminated to all such residences and in-service education has been implemented and is continuing.

Recommendation #7

Manhattan Developmental Center has made dietary and nutritional issues part of the client's individual treatment plan. The assigned Community Mental Health Nurse will monitor and follow-up on any client who exhibits weight loss or shows symptoms of malabsorption.

Recommendation #8

As indicated above, actions have already been taken to implement the recommendations made by the Commission. Both the staff at Manhattan Developmental Center and the New York City County Service Group will continue to monitor the state-operated community residences to ensure continuing compliance.

In addition, client records have been upgraded and are being maintained by an in-place clinical staff, and all clients at Oliver Street were evaluated for suitability by a certified psychologist.

While we feel confident that sufficient regulatory and policy guidelines are in effect, we are very much aware that this is no guarantee that either direct care staff or their supervisors will be properly motivated to adequately meet the needs of the clients they serve. It is extremely difficult to assure that staff will always act in strict accordance with the requirements and intent of our policies and procedures. However, we will continue to strive to attain our goal of providing staff with adequate training in terms of our policies, procedures, and client needs so that they will understand what actions are

required and how to take them in a manner that will best serve and promote the well-being of our clientele. We will also continue to try to encourage staff to have the individual motivation that is so very essential to proper client care and treatment.

We trust that the above comments and the several attachments will be useful to you. All the efforts that were made in connection with your investigation into the death of Ms. Molly Reed are very much appreciated.

Sincerely,



Raymond L. Slezak
Acting Commissioner

Attachments

