STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G002	A. BUILDING _____ B. WING _____	06/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURDOCH DEVELOPMENTAL CENTER	1600 EAST C STREET BUTNER, NC 27509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification and complaint survey were completed on 6/26/19. Complaint intake #NC00152941. There were no deficiencies cited related to the complaint investigation. However, deficiencies were cited during the recertification survey.	W 000		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the area of adaptive dining equipment. This affected 2 of 12 audit clients (#5, #11). The findings are: 1. Client #5's dycem non-skid placemat was not utilized during dining. During dinner observations on 6/24/19 and 6/25/19, client #5 did not utilize his dycem non-skid placemat. At no time did staff prompt client #5 to utilize his dycem non-skid placemat.	W 249	See attached Plan of Correction. DHSR - Mental Health JUL 23 2019 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: DIRECTOR | (X6) DATE: 7/19/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 249	Continued From page 1 Additional observations during breakfast and lunch during the survey client #5's dycem non-skid placemat was utilized while he consumed his meals. During an interview on 6/25/19, Staff A revealed client #5 utilizes his dycem non-skid placemat to help with preventing his plate from sliding on the table while he consumes his meals. Further interview revealed client #5's dycem non-skid placemat is utilized during all his meals. During an interview on 6/25/19, Staff B indicated he did not know client #5 had a dycem non-skid placemat. Review on 6/24/19 of client #5's IPP dated 4/10/19 stated, "Adaptive equipment:...Dycem non-skid placemat...." Review on 6/24/19 of client #5's nutritional evaluation dated 4/10/19 revealed his uses a dycem non-skid placemat during all his meals. Review on 6/25/19 of client #5's dining card dated 5/23/19 indicated his adaptive equipment consists of a dycem non-skid placemat. During an interview on 6/25/19, the qualified intellectual disabilities professional (QIDP) confirmed client #5 utilizes a dycem non-skid placemat during all his meals. Further interview revealed staff should have prompted client #5 to utilized his dycem non-skid placemat.	W 249	See attached Plan of Correction.	

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W 249	Continued From page 2 2. Client #11's foot stool was not utilized during dining. During dinner observations on 6/24/19 and 6/25/19, client #11 did not utilize foot stool. At no time did staff provide the foot stool. Additional observations revealed client #11utilized wheelchair during dinner with his feet tucked under his buttocks. During an interview on 6/25/19, division director (DD) revealed client #11 refused to transfer from wheelchair during meals which sometimes increases his agitation, then he will refuse the meal. During an interview on 6/26/19, DD indicated she will involved the occupational therapist for evaluation. Review on 6/25/19 of client #11's IPP dated 5/19/19 stated, "Adaptive equipment:... foot stool during meal...." Further review of the IPP did not indicate refusal/non-compliance as a target behavior. Review on 6/25/19 of client #11's nutritional evaluation dated 4/19/19 revealed foot stool should be used during all meals. During an interview on 6/25/19, the qualified intellectual disabilities professional (QIDP) confirmed client #11 should utilizes a foot stool as indicated on the IPP	W 249	See attached Plan of Correction.	
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3)	W 287	See attached Plan of Correction.	

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W 287	Continued From page 3 Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 12 audit clients (#5) received a technique to manage inappropriate behavior was not used for the convenience of staff. The finding is: The facility failed to ensure a technique to manage the inappropriate behavior of client #4 was not used for the convenience of staff. During observations on 6/24/19 at 3:45pm, the door leading into client #5's unit was closed. Further observations revealed a staff person was sitting on a stool, which was in front of the door when the surveyor entered. Further observations revealed the door was again closed by staff when the surveyor entered the unit. Additional observations revealed client #5 pacing back and forth on the unit. During observations on 6/24/19 at 5:13pm, client #5 independently opened the unit door and stood there. Staff immediately stated, "Don't go out there" and shut the door. During an interview on 6/24/19, Staff C revealed the door to the unit is being shut by staff due to the fact client #5 will run off the unit and run down the hallway to the other side of the building. Further interview revealed client #5 has a behavior support plan that addresses his running off the unit. Staff C revealed the door has been	W 287	See attached Plan of Correction.	

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W 287	Continued From page 4 closed for a week. During an interview on 6/25/19, Staff A revealed if client #5 does exit the unit he should be redirected to come back onto the unit. Review on 6/24/19 of client #5's behavior intervention plan (BIP) revised 2/5/19 stated, "... [Client #5] has a history if darting to explore locations for items of interest. Staff should be careful to maintain his supervision guideline. If [Client#5] should dart to an inappropriate area (e.g., peers's bedroom, PATH unit, etc.), staff should attempt to redirect him to more appropriate activities. As [Client #5] can be quite persistent, particularly with new staff, more than one staff person may be necessary to successfully redirect him." Further review revealed, "Updated Supervision Procedures: Staff provide visual supervision from with close proximity during waking hours...." Review on 6/25/19 of client #5's human rights (no date) stated, "...G. To be free from...seclusion except when necessary to prevent danger or injury to self or others." During an interview on 6/25/19, the behavior specialist revealed the door to the unit should never be shut to prevent client #5 from exiting the unit. Further interview revealed staff should be following client #5's BIP. During an interview on 6/25/19, the qualified intellectual disabilities professional (QIDP) stated, "The unit door has been kept shut since last Wednesday, because of another client who has elopement issues." The QIDP confirmed client #5 has the right to move freely around his	W 287	See attached Plan of Correction.	

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W 287	Continued From page 5 environment because "this is his home."	W 287	See attached Plan of Correction.	

Murdoch Developmental Center
2019 ICF/IID Annual Recertification Survey Plan of Correction

W287

483.450(b)(3) Management of Inappropriate Client Behavior
Techniques to manage inappropriate client behavior must never be used for the convenience of staff

Standard not met as evidenced by audit client #5 received a technique for the convenience of staff to manage inappropriate behavior.

The Summerset Treatment Team will reassess factors surrounding Client #5's darting behavior and make modifications to his behavior support plan accordingly. The building Psychologist and the MATCH Qualified Intellectual Disabilities Professional (QIDP) will ensure staff are trained on all modifications to Client #5's behavior plan. For the first month, the psychologist and QIDP will observe plan implementation weekly. Thereafter, Behavior Support Plan (BSP) implementation will be monitored monthly by division management and professional support staff per established BSP Integrity Check system.

Target Date: August 25, 2019

W249

483.440(d)(1) Program Implementation
Each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan

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1. **Standard not met as evidenced by audit Client #5's dycem non-skid placemat was not utilized during dining.**

   The Statewide Program Director will update the *Mealtime Monitoring Checklist* to include adaptive dining equipment. Summerset Cottage's Division Director and QIDP will ensure all direct care staff within the MATCH unit are re-inserviced on established dining guidelines that promote, support, and reinforce dining safety and independence. Division Director will in-service professional staff assigned to weekly meal monitoring observations to assure adaptive equipment is being utilized. The Division Director will review the *Mealtime Monitoring Checklists* bi-weekly for compliance regarding adherence to dining guidelines and utilization of adaptive equipment for Client #5 as well as all other people residing in Summerset.

Target Date: August 2, 2019

2. **Standard not met as evidenced by audit Client #11's foot stool was not utilized during dining.**

Based on OT recommendations following a QIDP request for re-evaluation of client #11's need for a footstool during meals when seated in his wheelchair, use of the footstool was discontinued. Director of Residential Services will in-service Pineview's Division Director and Qualified Intellectual Disabilities Professional regarding procedures for assuring timely referrals are made, and/or needed intervention is provided upon knowledge that services identified in the Person Centered Plan are not occurring. Pineview Cottage's Division Director will then ensure that all direct care staff in Pineview Cottage, Unit I, are in-serviced on procedures for adherence to established guidelines that promote, support, reinforce and encourage people to be as independent as possible. Pineview Cottage professional staff assigned to meal monitoring will complete weekly observations to assure adaptive/supportive equipment is being utilized as specified. The Division Director will review the *Mealtime Monitoring Observation Checklist* bi-weekly for compliance regarding adherence to dining guidelines and utilization of adaptive/supportive equipment for client #11 and other people residing in Pineview.

Target Date: July 31, 2019

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of State Operated Healthcare Facilities
Murdoch Developmental Center

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
KODY KINSLEY • Deputy Secretary for Behavioral Health & IDD
HELEN WOLSTENHOLME • DSOHF Director
PAM KUHNO • Director of Murdoch Developmental Center

July 19, 2019

Ms. Lesa Williams, MSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

RE: Recertification Survey June 24-26, 2019
Murdoch Developmental Center
Provider Number 34G002

Dear Ms. Williams:

Please find enclosed Murdoch Developmental Center's Plan of Correction as a result of the ICF/IID Recertification Survey conducted July 24-26, 2019.

If you have any questions or concerns, please feel free to contact my office at (919) 575-1000.

Sincerely,

Pam Kuhno
Director of Murdoch Developmental Center

Enclosure

Cc: Niki Ashmont
Helen Wolstenholme