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 _____	10/27/2021

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 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all staff demonstrate skills needed to implement interventions necessary to manage inappropriate behaviors for 1 of 17 audit clients (#15). The finding is: During observations in Briarwood Unit 1 on 10/26/21 at 4:24pm, client #15 was being escorted down the hallway to the nurses' station by Staff E. He was hitting Staff E with a closed fist in the leg and attempting to hit her in the face. Staff D assisted and continued to escort client #15 to the medication cart. Client #15 continued to hit at Staff E's leg and was attempting to walk away from the medication cart. Staff D was holding both of client #15's arms by his side preventing him from moving his arms freely. He was also prevented from walking away. During an interview on 10/26/21 at 4:25pm with the division director, after being asked at what point that would be considered a restraint or hold, she confirmed it was a restraint. At that time she notified Staff D, Nurse C and Nurse D that client #15 was in a low level restraint and emergency physical restraint paperwork would have to be completed. Record review on 10/27/21 revealed that emergency personal restrictive intervention was used on client #15 for physical aggression at 4:20pm and client was released at 4:21pm	W 193		

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

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W 193	Continued From page 1 During an interview with the unit psychologist on 10/27/21 revealed that restrictive intervention is not part of client #15's Behavior Support Plan (BSP) and it was an emergency occurrence. The psychologist also confirmed that staff did not realize that it was considered a restraint even though the training staff receives teaches that anytime staff puts their hands on a client to restrict movement it is a physical restraint. During an interview with the unit director on 10/27/21 revealed that she believed staff felt it was more of an assist than a restraint. The unit director confirmed that training needed to be implemented to ensure staff knew the occurrence was a restraint.	W 193		
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 observations, record review and interview, the facility failed to ensure 1 of 17 audit clients (#6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of	W 249		

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W 249	Continued From page 2 dining. The finding is: During dinner observations in Royall on 10/25/21 at 5:36pm, a plate of food covered by a plastic lid was placed in front of client. A staff removed the lid and proceeded to feed the client his pureed food. Although two cups of thickened liquid were available on the table throughout the meal, client #6 was not assisted or encouraged to drink until he had finished consuming his entire meal. During breakfast observations in Royall on 10/26/21 at 7:42am, client #6 was brought into the dining room and a plate of food was placed on the table in front of him. The food did not contain a cover. Staff C proceeded to feed the client his entire meal. During this time, no drinks were on the table or provided for client #6. At the end of the meal, the client was given two cups of thickened liquid, which he consumed. Interview on 10/26/21 with Staff C revealed they follow guidelines listed on each client client's dining card at meals. Additional interview indicated client #6 does not have any formal objectives to be implemented during meals. Review on 10/26/21 of client #6's IPP dated 1/28/21 and his dining card (located in the dining room) revealed, "Fluids should be offered throughout the meal, ending meal with fluids." Additonal review of the client's IPP included the objective, "When given the instruction, '[Client #6], take your cover off', [Client #6] removes cover from plate with elbow guidance for 10 consecutive sessions." The objective noted an implementation date of 10/12/21. Interview on 10/27/21 with the Qualified	W 249		

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W 249	Continued From page 3 Intellectual Disabilities Professional (QIDP) confirmed client #6 should be provided fluids throughout his meal as indicated. Additional interview confirmed the client's objective to remove his plate cover should also be implemented at meal times.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all data relative to the accomplishment of specified objectives was documented. This affected 1 of 17 audit clients (#3). The finding is: Review on 10/25/21 of client #3's individual program plan (IPP) dated 6/22/21 revealed an objective to client #3 to exhibit 35 or fewer intervals with target behaviors as defined in her Behavior Support Plan (BSP) for 3 months. Review on 10/25/21 of client #3's BSP dated 7/20/21, revised 8/24/21, revealed target behaviors that includes aggression, self-injurious behavior, property destruction, Pica, elopement, and threats of self harm. Additional review of client #3's BSP revealed guidelines for Pica that includes daily room searches for restricted items and additional searches following any activities completed outside of the division.	W 252		

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W 252	Continued From page 4 Review on 10/26/21 of client #3's Room Search Data Sheet dated 10/7/21 - 10/25/21 revealed missing data for the days of 10/9/21, 10/10/21, 10/14/21, 10/16/21, 10/18/21, 10/19/21, 10/23/21 and 10/24/21. Interview on 10/26/21 with Staff A in Summerset Unit 2 revealed client #3's room searches are completed once on 1st shift, once on 2nd shift and then as needed if staff suspect something or if client #3 leaves the building. Interview on 10/26/21 with Staff B in Summerset Unit 2revealed room searches on every shift, and if staff suspect anything. Interview on 10/26/21 with the qualified intellectual disabilities professional (QIDP) in Summerset Unit 2 revealed staff are to complete the daily room searches once per day, with no specific time and then additional searches if client #3 leaves the division for any reason. The QIDP confirmed the missing data should have been completed.	W 252		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure nursing staff were sufficiently trained regarding	W 340		

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W 340	Continued From page 5	W 340		

appropriate nursing practices and protocols. This affected 1 of 17 audit clients (#17). The findings are:

A. During observations in Royall on 10/26/21 from 7:25am - 7:35am, Nurse A dispensed various medications for two clients. The nurse proceeded to sign the Medication Administration Record (MAR) prior to each client's ingestion of their medication.

Interview on 10/26/21 with Nurse A revealed she had been trained to sign the MAR after clients have ingested their medications.

Review on 10/26/21 of the facility's policy for Administration of Medications and Treatments (effective 3/11/14) revealed, "Medication/treatments shall always be recorded on MAR/TAR immediately after administration. At no time may they be recorded before they are given..."

Interview on 10/26/21 with the Nurse Consultant II confirmed the nurse should not initial the MAR prior to clients receiving their medicine.

B. During observations in Royall on 10/26/21 at 7:43am, Nurse A obtained a bottle of Miralax, removed the bottle's cap, and tilted the cap slightly while pouring the Miralax powder into the cap. The nurse immediately poured the powder into a cup of liquid. The nurse did not hold the bottle cap at eye level or on a level surface prior to placing the powder into the cup.

Immediate interview with Nurse A revealed 17gms of Miralax should be dispensed and this was how she was trained.

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W 340	Continued From page 6 Review on 10/26/21 of the facility's policy for Administration of Medications and Treatments (effective 3/11/14) revealed, "Hold bottles of liquid medication with label toward palm when pouring. Medicine cup is to be at eye level if feasible..." Interview on 10/26/21 with the Nurse Consultant II confirmed the nurse should have held the bottle cap at eye level or placed it on a level surface to ensure proper dosage. C. During observations in Royall on 10/26/21 at 4:20pm, Nurse B administered three separate eye drops to client #17. The nurse waited approximately 10 - 15 seconds between administration of each of the three different eye drops. Interview on 10/26/21 with Nurse B confirmed client #17 received three different eye drops. Additional interview revealed she had been trained to wait "15 seconds" between multiple eye drops. Review on 10/26/21 of the facility's policy for Administration of Medications and Treatments (effective 3/11/14) indicated, "Wait at least 5 minutes between administration of multiple eye drops." Interview on 10/27/21 with the Nurse Consultant II confirmed five minutes should be allotted between administration of multiple eye drops.	W 340		