		A. BUILDING: _____	
	MHL092-441	B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURCHISON RESIDENTIAL	533 TEXANNA WAY HOLLY SPRINGS, NC 27540

(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed 6/15/22. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/ Alternative Family Living This facility has a current census of three. The survey sample consisted of audits of three current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	The deficiency will be corrected by the Following actions: A. Facility will ensure that all individuals have a current PCP in their charts B. QIDP will monitor annually to ensure an update plan is submitted to the agency 2 weeks after plan meeting date.	06/24/22

Division of Health Service Regulation

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-441	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURCHISON RESIDENTIAL	533 TEXANNA WAY HOLLY SPRINGS, NC 27540

(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) COMPLETE DATE
V 112	Continued From page 1 This Rule is not met as evidenced by: Based on interview and record review the facility failed to develop a treatment plan for one of three clients (#3). The findings are: Review on 6/15/22 of client #3's record revealed: -Admission date of 9/2/17 -No documentation of a diagnosis -No treatment plan present in the home Interview on 6/15/22 the Licensee stated: -Client #3 was a private pay client who received services from an outside provider. -The outside provider did his treatment plan. -The provider had not given her one of his current treatment plan. -Had goals on a grid that she worked with him on in the home. -Had participated in the treatment meeting along with client #3's brother. -His diagnosis was Downs Syndrome. -Client #3 was non verbal and did not attend a day program. -She had some of his older treatment plans, but not the most recent one. -Will contact the provider to obtain a copy to have in the facility.	V 112		

[redacted] S PERSON-CENTERED PROFILE

Name: [redacted] Telephone: 919-753-7306	DOB: [redacted]	Medicaid ID: [redacted]	Record #
(Non - CAP-MR/DD Plans ONLY) PCP Completed on:	(CAP-MR/DD Plans ONLY) Plan Meeting Date: 8/6/2021 Effective Date: 9/1 /21		

WHAT PEOPLE LIKE AND ADMIRE ABOUT.... [redacted]

[redacted]

Helpful with household chores
Friendly
Playing games
Dressing nice

WHAT'S IMPORTANT TO....

[redacted]

Brothers and sisters
Spending time with family
Having a safe environment
Attending day support-a life experiences
Riding in a car

HOW BEST TO SUPPORT....

[redacted] is a 60 year-old male and nonverbal. He can sometimes understand the meaning of no and yes. [redacted] was diagnosed with down syndrome at birth. [redacted] requires monitoring when he is awake but not when he is asleep. He will go to the bathroom at night if he needs to. He typically sleeps through the night and does not get up and wonder around. If he wakes up at night, he will sit in his bed and rock gently back and forth. He will stay in his bed until cued to get up and get dressed. Family feels that [redacted] living in an AFL provide the supports he needs. [redacted] has been known to listen to short stories up to about 30minutes. He will listen to instructions and can follow an instruction with one action but not with two or more. He makes some sounds and gestures and waves goodbye when someone waves to him. He normally will point or gesture to things he prefers. He bathes and dresses himself. [redacted] is not allowed to use a public restroom unassisted. No medical concerns other than medication for allergies. He can assist with simple household chores and will put away his personal possessions. He cleans and wipes his face and hands during and or after meals.

ADD WHAT'S WORKING / WHAT'S NOT WORKING FOR....

What's Working:
Hearing, vision, and motor skills adequate
Having a stable and safe environment
Having supports and providers
Is able to gestures needs
Day support
Friends and Family

What's Not Working:
Non verbal
Does not read or Write

Name: [redacted] **DOB:** [redacted] **Medicaid ID:** [redacted] **Cardinal Record #**

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Comprehensive Clinical Assessment (CCA), the One Page Profile, Characteristics/Observations/Justifications for Goals, and any other supporting documentation.**

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

[redacted] will remain safe in his living environment. For [redacted] to attend a day program at Wake Enterprise.

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

[redacted] has been placed in an AFL home that he loves and his guardian is waiting to hear back from Wake Enterprise.

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Goal #1:

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
1a[redacted] will receive 24 hours AFL placement to ensure his health, safety, and overall well-being throughout the plan year.	Individual name [redacted] Community Alternatives AFL Staff	Supervised Living – service name Daily – how often

HOW (Support/Intervention) How is this going to happen? Staff will monitor [redacted] while in the home and community to ensure that he is not in danger. Staff will assist [redacted] developing coping skills to address feelings of sadness, or frustration, etc. He will let you know if you are doing something wrong to him. He will point to it.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
8/31/22	8/6/ 2021	N	NEW PLAN

Name: [redacted] DOB: [redacted] Medicaid ID: [redacted] Cardinal Record #

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL #2:

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
2a [redacted] will participate in completing a personal hygiene routine daily with no more than 3 verbal prompts for the next 12 months. 2b [redacted] will participate in completing household chores to include cleaning his bedroom, bathroom, and completing his laundry 3times weekly with no more than 3 verbal prompts for the next 12 months 2c [redacted] will participate in preparing meals and clean up 3 times weekly with no more than 3 verbal prompts for the next 12 months 2d [redacted] will flush the toilet after voiding with no more than 3 verbal prompts for the next 12 months	[redacted] AFL Staff	Supervised Living – service name Daily – how often

HOW (Support/Intervention)
Staff will assist [redacted] with gathering the required items necessary for him to complete daily hygiene including toothbrush, tooth paste, washing towel, towel, soap. Staff will assist [redacted] in preparing his bath/shower water. (Importance of daily cleansing. Staff will). Staff will model and assist [redacted] in brushing his teeth daily. Staff will provide [redacted] with cleaning supplies and model for him how to appropriately clean in his bathroom. Staff will assist [redacted] in learning how to sort his clothing into whites and colored, assist with measuring correct amount of laundry detergent for his clothing, selecting the appropriate size load and water temperature for his loads and how to operate the washer and dryer. (remembe [redacted] does not know how to read) Staff will educate [redacted] on kitchen safety and assist with prepping meals to include gathering utensils, ingredients, and assisting with cooking the meal. Staff will need to supervise cooking and cooking temperatures. Staff will encourage [redacted] to flush toilet after voiding.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Codes**	**Progress toward goal and justification for continuation or discontinuation of goal.**
8/31/22		N	NEW PLAN

Name [redacted] DOB [redacted] Medicaid ID: [redacted] Cardinal Record #

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

ACTION PLAN

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

[redacted] will socialize and interact with others.

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

[redacted] has limited communication skills and interacts with others. [redacted] has friends and social connection. [redacted] is not in any day program at the moment, but guardian and AFL provider are waiting to hear from Wake Enterprise. The day program will allow him to explore interest and have the opportunity to be social.

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: [redacted] **continues to need and improve on her independent daily living skills.**

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
3a [redacted] will participate in structured day program weekly with no more than 2 gestures or prompts for the next 6 months. 3b [redacted] identify and participate in community activities of his choice 1-2 times weekly with no more than three gestures/prompts for the next 6months.	[redacted] AFL staff member	Supervised living services 3-daily

HOW (Support/Intervention)
Staff will assist [redacted] in identify community events that he would like to attend. Staff will provide [redacted] the opportunity to socialize with [redacted] to explore his personal interest to best identify preferred activities.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
8/3/2022		N	NEW PLAN

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

Name: [redacted] DOB: [redacted] Medicaid ID: [redacted] Cardinal Record #

CRISIS PREVENTION AND INTERVENTION PLAN

Significant event(s) that may create increased stress and trigger the onset of a crisis. (Examples include: Anniversaries, holidays, noise, change in routine, and inability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):

Crisis prevention and early intervention strategies that was effective. (List everything that can be done to help this person **AVOID** a crisis):

Strategies for crisis response and stabilization. (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

Describe the systems prevention and intervention back-up protocols to support the individual. (i.e. Who should be called and when, how can they be reached? Include contact names, phone numbers, hours of operation, etc. Be as specific as possible.)
First Responder: [redacted] AFL Provider Natural Supports: [redacted] Lead Responsible: [redacted] Community Alternatives QP/ [redacted]

Specific recommendations for interacting with the person receiving a Crisis Service:

Name: [redacted] DOB [redacted] Medicaid ID: [redacted] Cardinal Record #

Name: [redacted] DOB: [redacted] Medicaid ID: [redacted] Cardinal Record #

QP SIGNATURE [redacted] 9/1/21 [redacted]

June 24, 2022

Ms. Kimberly Thigpen

Facility Compliance Consultant I

Mental Health Licensure & Certification Section

Dear Ms. Thigpen:

Enclosed you will find the corrections to the deficiencies that were cited on June 15, 2022, and the original copy will be mailed.

Sincerely,

[redacted]

BA/Qualified Professional