

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G157</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>MINERAL SPRINGS I AND II</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 &amp; 414 MINERAL SPRINGS ROAD DURHAM, NC 27707</b>		
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E 037	<p>EP Training Program CFR(s): 483.475(d)(1)</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> <li>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</li> <li>(ii) Provide emergency preparedness training at least every 2 years.</li> <li>(iii) Maintain documentation of all emergency preparedness training.</li> <li>(iv) Demonstrate staff knowledge of emergency procedures.</li> <li>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</li> </ul> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <ul style="list-style-type: none"> <li>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</li> <li>(ii) Demonstrate staff knowledge of emergency procedures.</li> <li>(iii) Provide emergency preparedness training at least every 2 years.</li> <li>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the</li> </ul>	E 037			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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E 037	<p>Continued From page 1</p> <p>procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency</p>	E 037			

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E 037	<p>Continued From page 2 preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected</p>	E 037			

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E 037	<p>Continued From page 3</p> <p>roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to assure direct care staff in the home were adequately trained on the facility's emergency plan (EP). This potentially affected all clients in the facility. The finding is:</p> <p>Management did not provide training to direct care staff at home #1 on the facility's EP.</p> <p>Review on 1/14/2020 of the facility's EP training records at home #1 and interview with the qualified intellectual disabilities professional (QIDP) revealed the facility had conducted training with administrative staff as part of the preparation of facility's EP being developed. However, further review of the facility's EP did not</p>	E 037			

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E 037	Continued From page 4 include any records that confirmed that the direct care staff had been trained.  Interview on 1/13/2020 with staff A and staff B at the facility revealed neither staff remembered participating in training on the facility's EP.  Interview on 1/14/2020 with the facility administrator confirmed that he did not have documentation of training of the facility's EP during the past year for direct care staff at home #1 .	E 037			
W 440	<b>EVACUATION DRILLS</b> CFR(s): 483.470(i)(1)  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on fire drill reports and interviews, the facility failed to ensure fire drills were conducted one per shift per quarter. This potentially affected all the clients residing in the home. The finding is:  The facility did not consistently conduct a fire drill every quarter for all three shifts.  Review on 1/13/2020 of the facility's fire drill reports revealed no fire drills were documented from January 2019 thru June 2019.  During an interview on 1/13/2020, the qualified intellectual disabilities professional (QIDP) revealed she was aware the fire drills for January 2019 thru June 2019 were not documented. Further interview revealed the administrator was	W 440			

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W 440	Continued From page 5 also aware the fire drills were not documented.	W 440			