

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

PRINTED: 11/25/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MINERAL SPRINGS I AND II	STREET ADDRESS, CITY, STATE, ZIP CODE 410 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707
---	---

(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 Complaint survey was completed on 11/18/20 for Intake #NC00169929 the complaint was Substantiated and standard deficiencies were cited.	W 000		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive Behavior Support Plan for 1 of 2 audit clients (#3) was only conducted with the written informed consent of the legal guardian. The findings are: Client #3's BSP did not include written informed consent from the guardian. Review on 11/9/20 of client #3's BSP dated 5/27/2020 revealed an objective to exhibit 0 episodes of self-injury, property destruction, and physical aggression per month for 12 consecutive months. The plan identified the use of Zyprexa, Seroquel, Klonopin, Amantadine and Depakene. Further review of the record did not include a current written informed consent for the BSP from his guardian. Interview on 11/9/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated a written informed consent had been sent to client #3's guardian; however, it had not been returned.	W 263	W 263: The QIDDP has obtained the guardian's consent for Client #3's current Behavior Support Plan. Monitoring of the consents for Behavior Support Plans will occur with QIDDP completing a Q-review and routine chart reviews by the Clinical Team. In the future, the QIDDP will ensure all necessary consents for restrictive Behavior Support Plans are completed and filed in the chart.	1/19/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *Thomas [Signature] Administrator* 12/02/20 (X5) 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.

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

PRINTED: 11/25/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MINERAL SPRINGS I AND II	STREET ADDRESS, CITY, STATE, ZIP CODE 410 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707
---	---

(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 418	<p>CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii)</p> <p>The facility must provide each client with a clean, comfortable mattress.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #3 had a comfortable mattress. This affected 1 of 2 audit clients. The finding is:</p> <p>Client #3 was in need of a new mattress.</p> <p>During observations in the group home on 11/9/2020, client #3's mattress was noted to have a large indentation or dip in the middle of it. The head and foot of the mattress were noticeably higher than the middle of the mattress.</p> <p>During an interview on 11/9/2020, staff A acknowledged the mattress had a noticeably large dip or sink in the middle.</p> <p>Interview on 3/5/2020 with the qualified intellectual disabilities professional (QIDP) confirmed the mattress had a large dip in the middle and was also slanted to one side. Additional interview revealed she further the mattress order was placed on 10/28/2020 however the mattress had not been delivered as of 11/9/2020</p>	W 418	<p>W418:The QIDDP will follow up on the initial request to ensure the mattress is replaced. Monitoring the condition of the mattresses will occur with the Clinical Team conducting Monthly Environmental Assessments in the home. In the future the QIDDP will ensure that each client has a clean comfortable mattress.</p>	1/19/2021
-------	---	-------	---	-----------



RHA Health Services, LLC
 2527 E. Lyon Station Rd
 Creedmoor, NC 27522
 Phone: 919-528-2558
 Fax: 919-528-2971

FAX TRANSMISSION

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

.

To:	Ms. Wambui Thuku	Fax:	919-715-8078	
From:	Morris Thomas	Date:	12/02/20	
Re:		Pages:	3 (Including Cover)	
CC:				
Urgent	For Review	As Requested	Please Reply	Please Recycle

Additional Comments: _____

Confidentiality Note: The enclosed facsimile transmission contains confidential medical record information. This information has been disclosed to the recipient identified above and is protected by State and Federal law. Those laws limit your ability to further disclose this confidential medical information without the prior written consent of the patient/client and his/her legal guardian or unless otherwise permitted by State and Federal law. If you are not the intended recipient, you are hereby notified that any USE, disclosure, copying, distribution, or OTHER action taken WITHOUT RESPECT TO the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.



December 2, 2020

Ms. Wambui Thuku
2718 Mail Service Center
Raleigh, North Carolina 27699

Re: Complaint Survey Completed November 18, 2020
Mineral Springs I & II 414 Mineral Springs Road, Durham, NC 27703
Provider Number: 34G157
MHL# 032-056, 032-057

Dear Ms. Thuku:

Thank you for your recent survey of Mineral Spring I and II. It was a pleasure working with you. We look forward to your follow up return to ensure all deficient practices have been corrected.

Enclosed you will find the plan of correction for all deficiencies cited. Please do not hesitate to contact me if additional information is needed.

Sincerely,

A handwritten signature in black ink, appearing to read "Morris Thomas", is written over a horizontal line. The signature is fluid and cursive, with a large, prominent initial "M".

Morris Thomas
Administrator

Enclosures