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W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure privacy for 1 of 6 audit clients (#9) while receiving personal care. The finding is: During observations on medication administration on 11/1/22 at 3:30pm in house 2, Staff A was preparing to apply ointment to client #9's buttocks to promote wound healing, in the medication room. Client #9 was seated in his power wheelchair. The home manager (HM) suggested to Staff A that he take client #9 to his bedroom and apply the ointment there, in his bed. Staff A lifted client #9 out of his wheelchair and laid him on his side on the bed. The door to the bedroom remained opened, as well as the blinds and curtains on the window, next to the bed. Staff A pulled down client #9's pants and briefs and applied ointment on buttocks. Review on 11/1/22 of client #9's Individual Program Plan (IPP) dated 10/5/21 revealed diagnosis of spastic cerebral palsy and scoliosis. Client #9 was dependent on staff for activities of daily living. Interview on 11/2/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that clients should be afforded privacy and should close the doors to the bathroom or bedroom or receive assistance by staff to have privacy.	W 130		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)	W 189		

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W 189	Continued From page 1 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that all staff were competent in transporting clients in wheelchairs in the van. This affected 2 of 6 audit clients (#8 and #9). The findings are: A. During morning observations at House II on 11/2/22 at 9:38am revealed Staff N loaded client #9 in his power wheelchair on the van, and then Staff C secured client #9 using 4 floor brakes on stationary parts underneath the wheelchair. There was no evidence of a shoulder/chest seatbelt on client #9. Client #9 wore a seatbelt across his waist. Review on 11/2/22 of client #9's power wheelchair repair quote on 5/18/22 revealed the equipment needed $13,330.14 in repairs and replacement parts. B. During morning observations at House II on 11/2/22 at 9:46am, Staff N loaded client #8 in his power wheelchair on the van with Staff C securing it to the floor. Continued observation revealed that only two front brakes were secured to client #8's wheelchair stationary parts. There were no rear floor locks and no shoulder/chest seatbelt. Client #8 only wore a seatbelt across his waist and was unable to sit at a 90-degree angle, due to his medical condition. Review on 11/2/22 of client #8's power wheelchair repair quotes revealed the power wheelchair had	W 189		

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needed repeated repairs since 12/9/21 and the last quote was made on 10/31/22.

Review on 11/2/22 of the facility's van inspection report for House II revealed during the October 2022 inspection, no repair needs were identified by the inspector.

Interview on 11/1/22 with Staff A revealed he was staying in the home with clients #8 and #9 because their power wheelchairs needed to be repaired.

Interview on 11/2/22 with Staff C and Staff N revealed the van was not equipped with shoulder/chest seatbelts for clients using wheelchairs. Staff C revealed that she had received training how to secure wheelchairs on the van, but the male staff usually loaded clients #8 and #9 on the van and she was not familiar with the parts and how to use them.

In addition, Staff C was asked by the surveyor if there was other equipment to secure the power wheelchair. Staff C attempted to add another floor brake lock that was on the floor in the back of the van to client #8's wheelchair but did not know how to properly install extra equipment. Staff C gently shook the rear handles of client #8's power wheelchair to demonstrate that it was secure. Staff C was aware that the brakes on the wheelchair were broken and acknowledged it allowed some movement with manipulation.

Interview on 11/2/22 with the qualified intellectual disabilities professional (QIDP) revealed that she started in August 2022 and clients #8 and #9 had already been evaluating for wheelchair repairs but none had been made yet, due to cost to replace

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W 189	Continued From page 3 old parts. The facility was trying to get client #8 and #9's wheelchairs replaced. The QIDP could not locate any evidence of staff training for van transport. Interview on 11/2/22 with the Administrator revealed that van equipment should not be removed.	W 189		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Individual Program Plan (IPP) for 2 of 6 audit clients (#7 and #8) was updated. The findings are: A. Review on 11/1/22 of client #7's IPP revealed a date of 9/16/21. Interview on 11/2/22 with the qualified intellectual disabilities professional (QIDP) revealed that no recent IPP had been planned or completed. B. Review on 11/1/22 of client #8's IPP revealed a date of 7/3/21. Interview on 11/2/22 with the QIDP revealed the facility did not have a QIDP for three months and she was still in training and the IPP for client #8 had not been coordinated.	W 260		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with	W 340		

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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 interview, the facility to ensure that staff were competently trained in notifying the nurse for medication errors for 2 of 6 audit clients (#1 and #3) and adhering to their COVID-19 policy. The findings are:

A. During morning observations in House II during medication administration on 11/2/22 between 7:20am - 7:34am, Staff L made 4 medication errors with clients #1 and #3. The errors involved Staff L placing eye drops in the wrong eye of client #9. Staff L also administered a medication to client #9 that he should have received after eating breakfast and it was given prior to his meal. Client #9 should have received a medication that was not observed given by Staff L at the prescribed time. Staff L did not contact the nurse when she became aware the mistakes were made.

Review on 11/2/22 of the Physician Orders, dated 10/20/22 for client #3 revealed the Brimonidine Sol 0.2% should have 1 drop instill in right eye three times a day for eye pressure. Dorzol/Timol Sol 22.3-6.8 should instill 1 drop in right eye twice a day for eye pressure.

Review on 11/2/22 of client #1's Physician Orders dated 10/20/22 revealed Tamsulosin Cap 0.4mg should have been given to client #1 every morning 30 minutes after breakfast for urinary retention. There is an order to give Lactulose So

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W 340	Continued From page 5 10gm/15 every morning at 8:00am. Interview on 11/2/22 with the Nurse revealed she was not contacted by Staff L this morning regarding client #3 received eye drops in the wrong eye, or that client #1 did not receive Lactulose and had breakfast over an hour after he received Tamsulosin Cap 0.4mg. B. During observations in House II during the survey on 11/1/22 and 11/2/22, staff did not follow the face mask policy. On 11/1/22 from 3:00pm -4:00pm, Staff D, the Home Manager (HM), Staff B, Staff A and Staff O went in and out the house, interacting with clients with their face masks not covering their noses. On 11/1/22 at 5:13pm, Staff C was observed in the dining room not wearing a face mask. At 5:45pm, Staff C sat down next to client #9, without a mask and assisting him with his meal. On 11/2/22 at 8:45am, Staff C entered the home without wearing a mask and walked through rooms to go to the front room to complete the temperature screening. When Staff C re-entered the dining room, she was wearing one face mask. Record Review on 11/2/22 of Staff C's vaccine record revealed she received a religious exemption to not receive the COVID-19 vaccine. The exemption required unvaccinated staff to wear a double mask. Interview on 11/2/22 with the nurse revealed the proper way to wear a face mask was over the nose and mouth and pinched across the nose.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2)	W 369		

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W 369	Continued From page 6 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 2 of 6 audit clients (#1 and #3). The findings are: A. During morning medication observations in House II on 11/2/22 at 7:30am, Staff L administered 1 drop of Brimonidine Sol 0.2%, into the left eye of client #3. Staff L told client #3 that she had to wait 5 minutes before placing the 2nd medication in eye. At 7:24am, Staff L administered 1 drop of Dorzol/Timol Sol 22.3-6.8 into the left eye of client #3. The surveyor asked Staff L to review the instructions on the eyedrops containers. At 7:26am, Staff administered 1 drop of Brimonidine Sol 0.2% and 1 drop of Dorzol/Timol Sol 22.3-6-8 into the right eye of client #3 with back-to-back drops. Review on 11/2/22 of the Physician Orders, dated 10/20/22 for client #3 revealed the Brimonidine Sol 0.2% should have 1 drop instill in right eye three times a day for eye pressure. Dorzol/Timol Sol 22.3-6.8 should instill 1 drop in right eye twice a day for eye pressure. Interview on 11/2/22 with Staff L revealed when she read the bottles of eye drop medications, she did not realize the medication should be placed in the right eye. Interview on 11/2/22 with the nurse revealed that staff have been trained to wait 5 minutes after	W 369		

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W 369	Continued From page 7 eye drops and to contact the nurse whenever there is a medication error. B. During morning medications observations in House II on 11/2/22 at 7:32am, Staff L administered Loratadine 10mg, Risperidone 1mg, Oyster Cal 500/Vit D 500mg/200 IU, Tamsulosin Cap 0.4mg, Vit D3 2000 unit and Benztropine 0.5mg and 2mg = 2.5mg to client #1. Client #1 was not observed getting Lactulose Sol 10gm/15. During breakfast in House II on 11/2/22 at 8:42am client #1 was observed eating a meal. Review on 11/2/22 of client #1's Physician Orders dated 10/20/22 revealed Tamsulosin Cap 0.4mg should have been given to client #1 every morning 30 minutes after breakfast for urinary retention. There is an order to give Lactulose So 10gm/15 every morning at 8:00am. Interview on 11/2/22 with the nurse revealed staff have been trained on preparing medications to administer and should contact her if make an error.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the medication room remained locked when not in use. This affected 1 of 6 audit clients (#9). The finding is:	W 382		

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W 382	Continued From page 8 During afternoon medication administration in House II on 11/1/22 at 3:17pm, Staff A was observed giving client #9 one eye drop. Staff A did not have tissue in the medication room to wipe client #9's eyes. Staff A left client #9 and the surveyor alone in the medication room, with the medication cabinet and door opened to get a napkin from the dining area. Staff C promptly returned to the medication room. Record review on 11/2/22 of the facility's Medication Policy, dated October 2018 revealed "All controlled drugs are stored double locked. Interview on 11/2/22 with the Nurse revealed medications should be locked up whenever the room is not occupied by staff.	W 382		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure fire drills were held under varied conditions. This potentially affected 6 of 12 audit clients (#2, #4, #5, #6, #7, and #11 in House I). Review on 11/2/22 of House I fire drills revealed the following third shift drill times: 9/17/22 12:23am 6/10/22 12:07am 3/11/22 12:11am 12/10/22 12:07am Interview on 11/2/22 with the qualified intellectual disabilities professional (QIDP) revealed that there were no other third shift fire drills.	W 441		

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W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure that staff did not contaminate gloves or food. This had the potential to affect clients (#1, #2, #3, #4, #5 and #6) in House 2. The findings are: A. During afternoon medication administration in House 2 on 11/1/22 at 3:30pm, Staff A put on disposable gloves on his hands and considered ointment to client #9 in the medication room but decided to transport client #9 to his bedroom to lay him on the bed. Staff A had to move the trash can, close the medication cabinet, then lock up, while wearing the gloves. Staff A kept the gloves on as he transported client #9 in his wheelchair and transferred him to bed. Staff A removed client #9's garments and applied a topical medication on client #9's buttocks to promote wound healing. Interview with the Nurse on 11/2/22 revealed the gloves that Staff A wore for client #9's wound care became contaminated once he touched something and he needed to put on new gloves. B. During dinner observations in House II on 11/1/22 at 5:45pm, client #3 who's visually impaired was observed extending hand forward and touching the ground beef placed on the table in front of his plate, in a partially covered bowl. Staff C witnessed client #3 touch the ground beef with his bare hands and took the bowl away and passed it to client #8 to prepare his plate.	W 454		

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W 454	Continued From page 10 An additional observation on 11/2/22 at 8:42am, revealed client #3 reaching for the bowl of uncovered waffles in front of his plate and touching the food. Staff A witnessed client #3 touch the waffles and told him to wait, then took the bowl and put it in the kitchen. The waffles were not discarded before brought out to the table at 8:52am. Interview on 11/2/22 with the qualified intellectual disabilities professional (QIDP) revealed once the food became contaminated it should be discarded	W 454		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 3 of 6 audit clients (#7, #8, and #9) received their specially prescribed diet as indicated. The findings are: A. Observations in House I's dining room on 11/2/22 at 8:45am revealed client #7 eating a boiled egg and half bagel with cream cheese. The boiled egg and half bagel were served whole. Client #7 slowly consumed the whole boiled egg in three bites. At 9:03am, staff I verbally prompted client #7 to cut his half bagel into smaller pieces. Staff I then used hand over hand prompting to cut the half bagel into 2" to 3" pieces. During the	W 460		

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observation, client #7 did not have difficulty eating.

Review on 11/1/22 of client #7's Individual Program Plan (IPP), dated 9/16/21, revealed a heart-healthy, regular diet with food cut into ¼" pieces. Additionally, client #7 continues to have safety and swallowing precaution guidelines, last reviewed on 10/1/19.

Review on 11/2/22 of client #7's nursing evaluation, dated 8/18/21, revealed a prescribed heart-healthy diet with regular consistency and food cut to ¼" pieces for choking precautions.

Interview on 11/2/22 with staff I revealed that client #7 was working on cutting his food more independently. When what sized pieces client #7 should eat, staff I stated that client #7 was working on cutting "smaller" pieces.

Interview on 11/2/22 with the qualified intellectual disability professional (QIDP) revealed that client #7 should have his food cut to ¼" pieces if stated in his plan, with food being cut before coming to the table.

B. Observation on 11/1/22 at 5:00pm in House II revealed client #8 was served ground taco meat on top of a whole soft tortilla. Client #8 fed himself and ate the meat only. At 5:18pm, Staff D used kitchen shears to cut the tortilla into ½ -1-inch pieces.

Additional observations on 11/2/22 at 8:00am, revealed Staff M had prepared sandwiches for lunch and had cut the ham and cheese sandwich into 16 pieces that were larger than ¼ inch pieces. At 8:55am, client #8 was served waffles

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W 460	Continued From page 12 for breakfast that were cut into ½ inch pieces. Client #8 swallowed the pieces without incident. Review on 11/1/22 of client #8's IPP dated 7/15/21, revealed he was on a weight gain diet and food should be cut into ¼ inch pieces. C. Observation on 11/1/22 at 5:00pm in House II revealed client #9 was served ground taco meat on top of a whole soft tortilla. Staff D was observed cutting up the soft tortilla with kitchen shears during the meal. The tortilla was cut into ½ inch pieces. Additional observations on 11/2/22 at 8:00am, Staff M had prepared sandwiches for lunch and had cut the ham and cheese sandwich into 16 pieces that were larger than ¼ inch pieces. At 8:55am, client #9 was served waffles for breakfast that were cut into ½ inch pieces. Review on 11/1/22 of client #9's IPP dated 10/5/21, revealed he was on a heart healthy diet and food should be cut into ¼ inch pieces. Interview on 11/2/22 with the QIDP revealed that food should come to the table, already cut.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure foods were served at appropriate temperature. This affected all the clients in House II (#1, #3, #8, #9, #10 and #12). The findings are: A. During observations of medication	W 473		

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MINERAL SPRINGS I AND II	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 473	Continued From page 13	W 473		

administration on 11/1/22 at 3:15pm, a container of strawberry yogurt was observed sitting on the desk in the medication room. Staff A placed client #8's pills in a small medicine cup filled with yogurt. The yogurt was returned to the refrigerator by Staff A after 3:45pm, when client #8's topical medication was applied. The yogurt was not observed on ice.

B. During observations of medication administration on 11/2/22 at 7:15am, Staff L removed a container of milk and yogurt from the refrigerator to use with medications. The food sat on top of the desk, without ice, until the clients gathered for breakfast at 8:55am.

C. During dinner observations on 11/1/22 at 4:25pm, Staff O was observed cooking one package of ground beef in a skillet. A second packet of meat sat on the counter, without any ice to keep it cold. At 4:40pm, Staff O was observed examining the extra package of meat carefully, then set it aside on the counter. At 5:05pm, Staff D was observed consulting with Staff O about the leftover package of meat on the counter, before placing the package in the skillet and cooked it for tacos. Clients #1, #3, #8, #9, #10 and #12 were served meat from the second package of meat at 5:15pm.

Interview on 11/1/22 with Staff O revealed she did not prepare the meat because she had noticed it expired last week, however she did not discard it. Staff O acknowledge the package of meat was left on the kitchen counter.

Interview on 11/2/22 with the nurse revealed when perishable food is used for medication, staff should remove the necessary serving and then

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W 473	Continued From page 14 return it to the refrigerator.	W 473		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of	W 508		

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W 508	Continued From page 15 the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff	W 508		

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W 508	Continued From page 16 COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully	W 508		

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W 508	Continued From page 17 vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff Covid vaccinations per policy. This potentially affected all clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12) residing in both Home I and II. Review on 11/2/22 of the Covid policy, updated in January 2022, revealed a requirement for all staff to be vaccinated or verified as exempt. In addition, unvaccinated staff are required to wear additional personal protective equipment (PPE) to include double masks and/or shields. Review on 11/2/22 of staff Covid vaccinations revealed 89% vaccination compliance. Further review of staff Covid vaccination cards revealed 28 total staff with 21 vaccinations, 4 verified exemptions, and 3 missing documentations. Interview on 11/2/22 with the qualified intellectual disabilities professional (QIDP) revealed that there was no documentation for three staff. The QIDP stated that all three staff were actively working with clients.	W 508		