DEPARTMENT OF HEALT	H AND HUMAN SERVICES			FORM APPROVED
CENTERS FOR MEDICAR	E & MEDICAID SERVICES	-	0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G157	B. WING		12/10/2024
NAME OF PROVIDER OR SUPPLIE	२		STREET ADDRESS, CITY, STATE, ZIP CODE	
MINERAL SPRINGS I AND II			410 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
W 000 INITIAL COMMEN	NTS	W 000)	
completed on 12/ and NC00224562 substantiated and During the recerti	nd complaint surveys were 10/24 for intakes #NC00224565 ; the allegation was no deficiencies were cited. fication, deficiencies were cited. F CLIENTS RIGHTS a)(7)	W 130)	
Therefore, the fac treatment and car This STANDARD Based on observ interview, the faci	ensure the rights of all clients. ility must ensure privacy during e of personal needs. is not met as evidenced by: ations, record review and lity failed to ensure 1 of 6 audit afforded privacy during personal The finding is:			
6:45am, client #3 using the toilet wi the bathroom was observation, a sta	the home on 12/10/24 at was observed in the bathroom th his pants down. The door to s open, and during the ff yelled from the front of the s to close the door.			
Behavior Inventor	12/10/24 of client #3's Adaptive y (ABI) dated 4/2/24 requires minders to close doors and			
revealed staff sho		W 189)	
initial and continu	provide each employee with ing training that enables the /IDER/SUPPLIER REPRESENTATIVE'S SIGI		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.

PRINTED: 12/12/2024

		AND HUMAN SERVICES				FORM	12/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		34G157	B. WING			12/ [,]	10/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINERAI	L SPRINGS I AND II				10 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 189	efficiently, and com This STANDARD is Based on observat failed to ensure star the disposable of m disposable gloves. A. During morning 12/10/24 in the hom dropped a capsule #7 continue with the and he opened up t contents into his ap observed consumin During an interview the capsule should another one. During an interview nurse stated Staff E she would have ins #7's capsule with at B. Dinner preparation on 12/9/24 at 5:00p while touching varior meal preparation an kitchen pantry to re	rm his or her duties effectively, ipetently. s not met as evidenced by: tions and interviews, the facility ff were sufficiently trained in nedications and the usage of The findings are: medication administration on ne at 9:24am, client #7 on the floor. Staff B let client e medication administration the capsule and put the oplesauce. Client #7 was ng the contents of the capsule. on 12/10/24, Staff B revealed have been replaced with	W	189			
	preceded to prepar in serving dishes.	al preparation area and e dinner and place food items servations in the home on					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·			(X3) DATE	E SURVEY PLETED
		34G157	B. WING			12/ [,]	10/2024
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MINERA	L SPRINGS I AND II				110 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 189	12/10/24 at 8:30am while preparing breat touching various su clients wheelchair of back into the kitche table. The staff was gloves during this of Interview on 12/10/2 revealed she has all cross contamination do the same. PROGRAM IMPLEI CFR(s): 483.440(d) As soon as the inte formulated a client's each client must reat treatment program interventions and se and frequency to su objectives identified plan. This STANDARD is Based on observat failed to ensure each active treatment program This affected 5 of 6 and #12). The findi Observation in the f	Staff C wore latex gloves akfast in the kitchen while rfaces. Staff C moved a closer to the table then went n to bring more dishes to the not observed t change her bservation. 24 with the home manager ways worn gloves to avoid n and she has trained staff to MENTATION (1) rdisciplinary team has individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the t in the individual program s not met as evidenced by: ions and interview, the facility ch client received a continuous ogram consisting of needed ervices as identified in the Plan (IPP) implementation. audit clients (#3, #8, #9, #11 ings are: nome on 12/10/24 at	W 1				
	failed to ensure eac active treatment pro- interventions and se Individual Program This affected 5 of 6 and #12). The findi Observation in the F 7:00am-8:30am, cli	ch client received a continuous ogram consisting of needed ervices as identified in the Plan (IPP) implementation. audit clients (#3, #8, #9, #11 ings are:					

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		AND HUMAN SERVICES				FORM	12/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G157	B. WING			12/ [,]	10/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINERAI	L SPRINGS I AND II				10 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	Continued From pa on breakfast.	ge 3	W 2	249			
	confirmed the client	24 with the home manager ts usually sit at the table and nd to take their medications.					
W 263	Intellectual Disabilit confirmed clients sh treatment during the	ORING & CHANGE	W 2	263			
	are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record re failed to ensure res conducted with the legal guardian. This	ould insure that these programs with the written informed at, parents (if the client is a rdian. s not met as evidenced by: eview and interview, the facility trictive programs were only written informed consent of a s affected 4 of 6 audit clients). The findings are:					
	Support Plan (BSP) is no signed BSP co	/24 of client #6's Behavior) dated 7/1/24, revealed there onsent. Further review has behavior medications.					
	10/1/24, revealed th	/24 of client #7's BSP dated here there is no signed BSP. ealed client #7 has behavior					
	Intellectual Disabilit confirmed clients #6	on 12/10/24, the Qualified ies Professional (QIDP) 6, #7, #8 and #11 BSP ave current written informed					

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		AND HUMAN SERVICES				FORM	12/12/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G157	B. WING			12/ [,]	10/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MINERAL	SPRINGS I AND II				10 & 414 MINERAL SPRINGS ROAD URHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 263	Continued From pa consent from their I	•	W 2	263			
		24 of client #8's BSP dated ere is no signed BSP. Further ent #8 has behavior					
	5/24/24 revealed th	0/24 of client #11's BSP dated ere is no signed BSP. Further ent #11 has behavior					
W 340	Intellectual Disabilit confirmed clients #6 consents did not ha consent from their I	ES	W 3	40			
	other members of the appropriate protection measures that inclu- training clients and health and hygiene This STANDARD is Based on observate failed to ensure state implement appropri	s not met as evidenced by: tions and interviews, the facility ff were sufficiently trained to iate health and hygiene cted 2 of 6 audit clients (#11					
		home throughout the survey 12/10/24, client #11's and #9's ted to be very long.					

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					FORM	12/12/2024 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	34G157	B. WING	;		12/ [,]	0/2024
OVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGS I AND II						
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Record review on 12 Adaptive Behavior I evealed the client of his skill in nail trimm Record review on 12 Behavior Inventory of client doesn't perfor- nail trimming. Interview on 12/10/2 evealed that all client every Wednesday. Interview on 12/10/2 evealed client #11's rimming. SPACE AND EQUIF CFR(s): 483.470(g) The facility must fur and teach clients to choices about the u hearing and other of and other devices ic interdisciplinary tear This STANDARD is Based on observation therview, the facility urnished eye glass I of 6 audit clients. Observations in the on 12/9-12/10/24, cl glasses. The eye glass coated in the home	2/10/24 of client #11's nventory dated 4/2/24 doesn't perform any portion of ning. 2/10/24 of client #9's Adaptive dated 4/16/24 revealed the m any portion of this skill in 24 with the home manager ents should have nails trimmed 24 with the facility nurse is nails were long and needed PMENT (2) nish, maintain in good repair, use and to make informed se of dentures, eyeglasses, ommunications aids, braces, dentified by the m as needed by the client. is not met as evidenced by: ions, record review and (failed to ensure client #8 was es as indicated. This affected The finding is: home throughout the survey lient #8 did not wear eye asses were unable to be					
	SEPAR MEDICARE F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER SPRINGS I AND II SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS Continued From page Record review on 12 Adaptive Behavior I evealed the client of his skill in nail trimm Record review on 12/10/2 evealed that all clie every Wednesday. Interview on 12/10/2 evealed client #11's Fimming. SPACE AND EQUIF CFR(s): 483.470(g) The facility must fur and teach clients to choices about the u learing and other clients to thoices about the u learing and other clients the thoices about the u learing and other clients the thoices about the u learing and the ach the thome the the thome the thome	CORRECTION IDENTIFICATION NUMBER: 34G157 OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Record review on 12/10/24 of client #11's Adaptive Behavior Inventory dated 4/2/24 evealed the client doesn't perform any portion of his skill in nail trimming. Record review on 12/10/24 of client #9's Adaptive Behavior Inventory dated 4/16/24 revealed the client doesn't perform any portion of this skill in hail trimming. Adaptive on 12/10/24 with the home manager evealed that all clients should have nails trimmed every Wednesday. hterview on 12/10/24 with the facility nurse evealed client #11's nails were long and needed	SPOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MU A BUILD 34G157 B. WING OVIDER OR SUPPLIER SPRINGS I AND II B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAC Continued From page 5 W Record review on 12/10/24 of client #11's vdaptive Behavior Inventory dated 4/2/24 evealed the client doesn't perform any portion of his skill in nail trimming. W Record review on 12/10/24 with the home manager evealed that all clients should have nails trimmed wery Wednesday. W Interview on 12/10/24 with the facility nurse evealed client #11's nails were long and needed imming. W SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) W CFR(s): 483.470(g)(2) W The facility must furnish, maintain in good repair, ind teach clients to use and to make informed shoices about the use of dentures, eyeglasses, iearing and other communications aids, braces, ind other devices identified by the iterdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and iterview, the facility failed to ensure client #8 was urnished eye glasses as indicated. This affected of 6 audit clients. The finding is: Observations in the home throughout the survey in 12/9-12/10/24, client #8 did not wear eye plassees. The eye glasses were	SPOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 34G157 B. WING	EINT OF HEALTH AND HUMAN SERVICES ON E OF MEDICARE & MEDICAID SERVICES ON E DEFICIENCIES (X1) PROVIDERISUPPLIENCLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING SUMDER OR SUPPLIER 34G157 B SPRINGS I AND II B TREET ADDRESS, CITY, STATE, ZP CODE 410 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPX TAG PROVDER'S PLAN OF CORRECTION (EACH DEFICIENCY BASED BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPX TAG PROVDER'S PLAN OF CORRECTION (EACH DEFICIENCY BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPX TAG PROVDER'S PLAN OF CORRECTION (EACH DEFICIENCY BASED ADDURHAM, NC 27707 Continued From page 5 Record review on 12/10/24 of client #11's valaptive Behavior Inventory dated 4/2224 evealed the client doesn't perform any portion of his skill in nail trimming. W 340 Record review on 12/10/24 with the home manager evealed that all clients should have nails trimmed very Wednesday. W 436 httrive on 12/10/24 with the facility nurse evealed client #11's nails were long and needed imming. W 436 PRCE AND EQUIPMENT FR(S): 483.470(g)(2) W 436 The facility must furnish, maintain in good repair, ind teach clients to use and to make informed holices about the use of dentures, eyeglasses, eaaring and other communications alds, braces,	TENT OF HEALTH AND HUMAN SERVICES FORM. EICOR MEDICARE & MEDICAID SERVICES OMB NO. PEFFICIENCIES (X1) PROVIDERSUPPLERCIA DENTIFICATION NUMBER (X2) MULTIFLE CONSTRUCTION (X3) DAT 34G157 B. WING 12/7 DVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2IP CODE 410 & 414 MINERAL SPRINGS ROAD SPRINGS I AND II STREET ADDRESS, CITY, STATE, 2IP CODE 410 & 414 MINERAL SPRINGS ROAD DUIDER OR SUPPLER STREET ADDRESS, CITY, STATE, 2IP CODE 410 & 414 MINERAL SPRINGS ROAD SPRINGS I AND II STREET ADDRESS, CITY, STATE, 2IP CODE 410 & 414 MINERAL SPRINGS ROAD SUMMARY STATEMENT OF DEFICIENCIES (REGULTORY OR LSC IDENTIFYING INFORMATION) FORMATION 12/7 Continued From page 5 W 340 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 5 W 340 V340 V340 Continued From page 5 W 340 V340 Recurd review on 12/10/24 of client #11's valatiot in anil trimming. W 340 V340 Record review on 12/10/24 with the facility nurse verside direct at 11's nails were long and needed timming. W 340 VPACE AND EQUIPMENT W 436 FPRG: 433 470(g)(2) W 436 The facility must furnish, maintain in good repair, not tach clients to use and to make informed horices about th

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/12/2024 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G157	B. WING _		12/	10/2024
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MINERA	SPRINGS I AND II			410 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 436 W 473	under the adaptive revealed client #8 s glasses. Interview on 12/10/2 revealed should coor glasses and doesn' eye glasses. Interview on 12/10/2 Disabilities Professi #8 should have eye wear the eye glasses MEAL SERVICES CFR(s): 483.480(b) Food must be serve This STANDARD is Based on observat failed to ensure foor appropriate tempera 2 of 6 (#6 and #7) a During breakfast ob 12/10/24 at 8:15am serving dish and at was placed in a ser observations reveal 8:43am, followed by At no time were any prior to them eating During an interview food should be refer	 d 10/1/24 listed eye glasses equipment section. The IPP hould be prompted to wear 24 with the Home Manager and not locate client #8 eye trecall the last time seeing the 24 the Qualified Intellectual ional (QIDP) confirmed client eglasses and be prompted to es daily. d(2)(ii) ed at appropriate temperature. Is not met as evidenced by: tions and interviews, the facility d was served at the ature. This potentially affected audit clients. The finding is: poservations in the home on , oatmeal were placed in a 8:18am, the sausage patties ving dish. Further led client #5 began eating at y the other clients in the home. Y of he clients' food reheated 	W 43	36		

		AND HUMAN SERVICES				FORM	12/12/2024 APPROVED 0938-0391
STATEMENT	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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MINERAL SPRINGS I AND II					10 & 414 MINERAL SPRINGS ROAD DURHAM, NC 27707		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 473	Intellectual Disabilit	ige 7 ties Professional (QIDP) hould be reheated after sitting	W 4	473			

Facility ID: 922230

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