Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					F	2	
		MHL032-367	B. WING			7/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		529 HOLI	OWAY STRE				
DURHAN	MEN'S HALFWAY H	OUSE DURHAM	, NC 27701				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
17.0			1710	DEFICIENCY)			
V 000	INITIAL COMMENT	TS	V 000				
		w up survey was completed					
	on 11/7/2018. Defic	lencies were cited.					
	This facility is licens	sed for the following service					
		C 27G.5600E Supervised					
	Living for Adults wit	h Substance Abuse					
	Dependency.						
V 108	27G 0202 (F-I) Per	sonnel Requirements	V 108				
	270 .0202 (1 1) 1 01	comic requirements					
	10A NCAC 27G .02	202 PERSONNEL					
	REQUIREMENTS						
		cation shall be documented. ing programs shall be					
		minimum, shall consist of the					
	following:	, , , , , , , , , , , , , , , , , , , ,					
	(1) general organiz						
		nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and					
	10A NCAC 26B;	CAC 27C, 27D, 27E, 27F and					
		t the mh/dd/sa needs of the					
		n the treatment/habilitation					
	plan; and	tious diseases and					
	(4) training in infectionbloodborne pathoge						
		itted under 10a NCAC 27G					
		chapter, at least one staff					
		ailable in the facility at all					
		is present. That staff ained in basic first aid					
		anagement, currently trained					
	to provide cardiopul	lmonary resuscitation and					
		ich maneuver or other first aid					
		those provided by Red Cross, Association or their					
		eving airway obstruction.					
		ody shall develop and					
		and procedures for identifying,					
		ting and controlling infectious					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
					F	
		MHL032-367	B. WING	<u></u>	11/0	7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
I DURHAM MEN'S HAI FWAY HOUSE			OWAY STRE	EET		
0/0.15	CLIMMA DV CTA		NC 27701	DDOVIDEDIC DI ANI OF CODDECTIO	ON!	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 1	V 108			
	and communicable clients.	diseases of personnel and				
	facility failed to ens Cardiopulmonary R	et as evidenced by: view and interviews, the ure staff had training in lesuscitation (CPR) and First five audited staff (staff #1).				
	revealed: -Staff #1 had a hire -Staff #1 was hired -There was no docu	of the facility's personnel files date of 7/30/18. as a Health Care Counselor. umentation of training in tesuscitation and First Aid for				
	Director revealed: -Staff #1 told her th Cardiopulmonary R trainingStaff #1 told her he Resuscitation and R agencyStaff #1 had been and FA training the -She confirmed the	e took the Cardiopulmonary First Aid training with another scheduled to take the CPR later part of November 2018. re was no documentation of ulmonary Resuscitation and				
	revealed:	8 with the Program Manager ne had the CPR and FA er agency.				

Division of Health Service Regulation

STATE FORM 9PFH11 If continuation sheet 2 of 12

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		SURVEY PLETED
, , , , , , , , , , , , , , , , , , , ,	or contribution	IDENTIFICATION NO.	A. BUILDING:			
		MHL032-367	B. WING			R 07/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
DURHAN	/I MEN'S HALFWAY H	IOUSE	LOWAY STRE	≣ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 108	Continued From pa	age 2	V 108			
	-Staff #1 had worke home. -He confirmed there training in Cardiopu First Aid for staff #1 Interview on 11/7/16 Improvement Direct	ed alone with the clients in the e was no documentation of ulmonary Resuscitation and 1. 8 with the Quality				
	staff #1.					
V 131	G.S. 131E-256 (D2 Verification) HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring h health care facility of health care facility of Personnel Registry	EALTH CARE PERSONNEL nealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident propriate business files.				
	Based on record refacility failed to acc Registry (HCPR) profive audited staff (sometime and staff (sometime). Review on 11/7/18 revealed: -Staff #1 had a hired-Staff #1 was hired	et as evidenced by: eview and interviews, the ess the Health Care Personnel rior to employment for one of taff #1). The findings are: of the facility's personnel files e date of 7/30/18. as a Health Care Counselor. PR check completed on				

Division of Health Service Regulation

STATE FORM 9PFH11 If continuation sheet 3 of 12

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(X3) DATE COMP	SURVEY LETED
					F	
		MHL032-367	B. WING		11/0	7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I DURHAM MEN'S HAI FWAY HOUSE			OWAY STRE	EET		
		<u> </u>	NC 27701			
(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 SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
V 131	Continued From pa	ge 3	V 131			
	8/23/18There was no docucompleted for staff	umentation of a HCPR check #1 prior to hire.				
	Director revealed: -She had an Assista ensuring the appropriate staff's foldersThe Assistant had duties just recentlySome of the docur possibly had not be she confirmed the completed for staff Interview on 11/7/18 Improvement Directions	ments/paperwork for staff #1 en filed. HCPR check was not #1 prior to hire. 3 with the Quality				
V 133	G.S. §122C-80 CRI CHECK REQUIREI APPLICANTS FOR (a) Definition As a "provider" applies to program and any prodevelopmental disa services that is licer Chapter. (b) Requirement A provider licensed un applicant to fill a po applicant to have an conditioned on cons criminal history reco		V 133			

Division of Health Service Regulation

STATE FORM 9PFH11 If continuation sheet 4 of 12

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
				R	}
	MHL032-367	B. WING			7/2018
VIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ENI'S HALEWAY H	OUSE 529 HOLL	OWAY STRE	ET		
EN 3 HALFWAT H	DURHAM,	NC 27701			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
ontinued From pa	ge 4	V 133			
ss than five years conditioned on cominal history recontional criminal his clude a check of the applicant has been eyears or more, a consent to a Stateck of the applicant minal history recontion. Except as a bsection, within five conditional offer all submit a requestice under G.S. In the submit and history recontion or shall submit to conduct a seck required by the S. 114-19.10, the turn the results of cord checks for evered by Public Lepartment of Health in the provider. Programment of the applicant. In the turn the provider. Programment of the applicant. In the provider of the seck has been continuous this section. A continuous criminal his the provider. Programment of the continuous criminal his the provider. Programment of the seck has been continuous this section. A continuous criminal his the section. A continuous criminal his section.	then the offer of employment onsent to a State and national ord check of the applicant. The story record check shall he applicant's fingerprints. If seen a resident of this State for then the offer is conditioned the criminal history record ant. A provider shall not the who refuses to consent to a ord check required by this otherwise provided in this we business days of making of employment, a provider set to the Department of 114-19.10 to conduct a ord check required by this mit a request to a private state criminal history record his section. Notwithstanding a Department of Justice shall finational criminal history imployment positions not aw 105-277 to the lith and Human Services, sheck Unit. Within five ceipt of the national criminal in, the Department of Health es, Criminal Records Check is provider as to whether the did may affect the employability no case shall make available cation that a criminal history impleted on any staff covered ounty that has adopted an				
C - V E - O SQUIDSELLOCIBLE SIGNIFICATION OF BOTH STATE OF STATE O	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE ontinued From pa se than five years conditioned on co minal history reco tional criminal his clude a check of the e applicant has be e years or more, consent to a Sta eck of the applican minal history reco tion. Except as o beection, within fi e conditional offer all submit a reque stice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck required by the strice under G.S. minal history reco ction or shall sub tity to conduct a seck of the applicant tity to conduct a seck of the applicant tity to conduct a seck of the applicant tional criminal history tity to conduct a seck of the applicant tional criminal history tity to conduct a seck of the applicant tional criminal history tity to conduct a seck of the applicant tional criminal history to conduct a seck of the applicant tional criminal history to conduct a seck of the applicant tional criminal history to conduct a seck of the applicant tional criminal history to conduct a seck of the applicant tional criminal history to conduct a seck of the applicant tional c	MHL032-367 VIDER OR SUPPLIER STREET ADI FN'S HALFWAY HOUSE SOURCE OF SUPPLIER STREET ADI 529 HOLL	MHL032-367 MHL032-367 STREET ADDRESS, CITY, S 529 HOLLOWAY STRE DURHAM, NC 27701 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 4 State and national minal history record check of the applicant. The tional criminal history record check of this State for e years or more, then the offer is conditioned consent to a State criminal history record eck of the applicant as been a resident of this State for e years or more, then the offer is conditioned consent to a State criminal history record eck of the applicant. A provider shall not apply an applicant who refuses to consent to a minal history record check required by this cition. Except as otherwise provided in this beection, within five business days of making e conditional offer of employment, a provider all submit a request to the Department of stice under G.S. 114-19.10 to conduct a minal history record check required by this cition or shall submit a request to a private tity to conduct a State criminal history record eck required by this cition or shall submit a request to a private tity to conduct a State criminal history record eck required by this sction. Notwithstanding S. 114-19.10, the Department of Justice shall turn the results of national criminal history cord checks for employment positions not vered by Public Law 105-277 to the expartment of Health and Human Services, iminal Records Check Unit. Within five siness days of receipt of the national criminal story of the person, the Department of Health d Human Services, Criminal Records Check hit, shall notify the provider as to whether the ormation received may affect the employability the applicant. In no case shall the results of the tional criminal history record check be shared the provider. Providers shall make available on request verification that a criminal history eck has been completed on any staff covered this section. A county that has adopted an propriate local ordinance and has access to	DENTIFICATION NUMBER: B. WING B. WING	IDENTIFICATION NUMBER MHL032-367 MHL032-367 MHL032-367 STREET ADDRESS, CITY, STATE, ZIP CODE S29 HOLLOWAY STREET DURHAM, NC 27701 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) Tothluned From page 4 St shan five years, then the offer of employment conditioned on consent to a State and national minal history record check of the applicant. The tional criminal history record check of the applicant is fingerprints. If a applicant has been a resident of this State for e years or more, then the offer is conditioned consent to a State criminal history record eck of the applicant is fingerprints. If a caplicant has been a resident of this State for e years or more, then the offer is conditioned consent to a State criminal history record eck of the applicant has been a provider shall not apply an applicant who refuses to consent to a minal history record check required by this cition. Except as otherwise provided in this basection, within five business days of making e conditional offer of employment, a provider all submit a request to the Department of stice under G.S. 114-19-10 to conduct a minal history record check required by this cition or shall submit a request to a private tity to conduct a State criminal history record eck required by this section. Notwithstanding S. 114-19-10, the Department of Justice shall unt the results of national criminal history cord checks for employment positions not vered by Public Law 105-277 to the partment of Health did Human Services, imminal Records Check unit. Within five siness days of receipt of the national criminal tory of the person, the Department of Health did Human Services, imminal Records Check unit, shall notify the provider as to whether the ormation received may affect the employability the applicant. In no case shall make available on request verification that a criminal history cord check be shared the provider. Providers shall make available on request verification that a criminal hist

6899

Division of Health Service Regulation STATE FORM

DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMP	רבובט
ĺ						₹
		MHL032-367	B. WING	B. WING		7/2018
NAME OF F	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	STATE ZIP CODE		
			HOLLOWAY STRI			
DURHAN	MEN'S HALFWAY H	OUSE	HAM, NC 27701			
(X4) ID	SI IMMA DV STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU	LD BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				BEI IOIEITOT)		
V 133	Continued From pa	ige 5	V 133			
	may conduct on he	half of a provider a State				
		ord check required by this				
		provider having to submit	a			
		artment of Justice. In such				
		nall commence with the Sta				
		ord check required by this				
	section within five b	ousiness days of the				
		employment by the provide				
		information received by the				
		ntial and may not be disclos				
		cant as provided in subsect	tion			
		For purposes of this				
		m "private entity" means a				
		engaged in conducting				
		ord checks utilizing public om a State agency.				
		on a State agency. oplicant's criminal history				
	` '	als one or more convictions	of			
		the provider shall consider				
		tors in determining whether				
	hire the applicant:	g .				
		eriousness of the crime.				
	(2) The date of the	crime.				
		person at the time of the				
	conviction.					
		ces surrounding the				
	commission of the	· ·	. <u>.</u>			
		een the criminal conduct o				
	filled.	job duties of the position to	o be			
	(6) The prison, jail,	nrobation narole				
		employment records of the				
		ate the crime was committee				
		t commission by the perso				
	a relevant offense.	2.2. 2.7 2.15 p. 0.00				
		on of a relevant offense ald	one			
		employment; however, th				
		be considered by the providence				
		ualifies an applicant after				

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		MHL032-367	B. WING		11/0	7/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DURHA	M MEN'S HALFWAY H	OUSE	LOWAY STRE I, NC 27701	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 133	consideration of the provider may disclot the criminal history to the disqualification of the criminal history to the disqualification of the criminal history applicant. (d) Limited Immunition or employee of a procomplies with this scivil liability for: (1) The failure of the individual on the bath the criminal history (2) Failure to check criminal offenses if history record check criminal offenses if history record check criminal offenses if history record check criminal history relevant offense relevant offense relevant offense relevant offense relevant offense relevant of a criminal history history record check criminal history record check criminal history record check criminal history record check criminal history record check and offense relevant of a criminal history resons needing midisabilities, or subscrimes include the any of the following General Statutes: A Issuing Monetary Sendangering Executanticle 6, Homicide, Sex Offenses; Artick Kidnapping and Ablinjury or Damage be Incendiary Device of and Other Housebrother Burnings; Art Robbery; Article 18	e relevant factors, then the ose information contained in record check that is relevant on, but may not provide a copy ory record check to the ty A provider and an officer rovider that, in good faith, section shall be immune from the provider to employ an officer of the individual. It is an employee's history of the employee's criminal k is requested and received in				

Division of Health Service Regulation

STATE FORM 9PFH11 If continuation sheet 7 of 12

Division of Health Service Regulation

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '			LETED
			A. BUILDING:		_	
		MHL032-367			11/0	₹ 7/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
529 HOL			OWAY STRE	ET		
DURHAN	I MEN'S HALFWAY H	DURHAM,	NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	Fraudulent Use of C Article 19B, Financi Act; Article 20, Frau 26, Offenses Agains Decency; Article 26 Article 27, Prostituti 29, Bribery; Article 35, O Peace; Article 36A, Article 39, Protection Protection of the Fa Intoxication; and Ar Crime. These crime sale of drugs in viol Controlled Substant 90 of the General S offenses such as sa violation of G.S. 18l impaired in violation G.S. 20-138.5. (f) Penalty for Furni applicant for emplor supplies, or otherwi an employment app criminal history reco shall be guilty of a C (g) Conditional Employan applican obtaining the results check regarding the following requireme (1) The provider shap prior to obtaining the criminal history reco subsection (b) of the	or Services by False or Credit Device or Other Means; al Transaction Card Crime Ids; Article 21, Forgery; Article Ist Public Morality and A, Adult Establishments; on; Article 28, Perjury; Article 31, Misconduct in Public Iffenses Against the Public Iffenses Against the Public Iffenses Against the Public Iffenses Against the Public Iticle 31, Misconduct in Public Iffenses Against the Public Iffenses Against the Public Iticle 31, Article 39, Public Iticle 31, Article 31, Articl	V 133	DEFICIENCY)		
	(2) The provider sha	required in G.S. 114-19.10. all submit the request for a ord check not later than five				

6899

Division of Health Service Regulation STATE FORM

9PFH11 If continuation sheet 8 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL032-367	B. WING		11/0	7/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DURHAN	MEN'S HALFWAY H	OUSE	LOWAY STRE , NC 27701	:E1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	business days after conditional employr 2001-155, s. 1; 200 2005-4, ss. 1, 2, 3,	the individual begins ment. (2000-154, s. 4; 14-124, ss. 10.19D(c), (h); 4, 5(a); 2007-444, s. 3.)	V 133			
	facility failed to ensi check was conduct making the condition	et as evidenced by: view and interviews, the ure the criminal history record ed within five business days of onal offer of employment e audited staff (staff #1). The				
	revealed: -Staff #1 had a hire -Staff #1 was hired -There was no docunistory check for sta	of the facility's personnel files date of 7/30/18. as a Health Care Counselor. umentation of a criminal aff #1 completed within five aking the conditional offer of				
	Director revealed: -She had an Assistatensuring the appropriate ap	ments/paperwork for staff #1 en filed. re was no documentation of a ck for staff #1 completed days of making the				

6899

Division of Health Service Regulation STATE FORM

9PFH11 If continuation sheet 9 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,	or contribution	BENTIN ION THOMBER	A. BUILDING	·		
		MHL032-367	B. WING			R 07/2018
NAME OF	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE		
DURHAN	M MEN'S HALFWAY H	IOUSE	OLLOWAY STR AM, NC 27701	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 133	Interview on 11/7/1 Improvement Directory -There was no dochistory check for st	8 with the Quality	V 133			
V 290	numbers specified of this Rule shall be enable staff to respineeds. (b) A minimum of opresent at all times premises, except whabilitation plan docapable of remaining without supervision as needed but not the client continues the home or commispecified periods of (c) Staff shall be picture for abuse disorders should or adolescent (1) children cabuse disorders should be proposed to the governing body (2) children of developmental discone staff present for the governing body (2) children of the governing body (3) children of the governing body (4) children of the governing body (5) children of the governing body (6) children of the governing body (7) children of the governing body (8) children of the governing body (9) children of the governing body (10) children of the governing body (11) children of the governing body (12) children of the governing body (13) children of the governing body (14) children of the governing body (15) children of the governing the governing body (15) children of the governing the governing body (15) children of the governing the governing the governing the governing the governing the governing the gov	so staff of the procedures determined by the facility to cond to individualized client one staff member shall be when any adult client is one when the client's treatment or cuments that the client is ng in the home or community. The plan shall be reviewedless than annually to ensure to be capable of remaining aunity without supervision for fitme. Tresent in a facility in the first of the procedures with a minimulation of the served with a mini	he / I in e n r pe			

Division of Health Service Regulation

STATE FORM 9PFH11 If continuation sheet 10 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		MHL032-367 B. WING R 11/07/		R 07/2018		
	PROVIDER OR SUPPLIER M MEN'S HALFWAY H	OUSE 529 HO	ADDRESS, CITY, S LLOWAY STRE M, NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 290	more clients preser need be present du specified by the em determined by the g (d) In facilities which diagnosis is substa (1) at least of duty shall be trained withdrawal symptor secondary complication; and (2) the service	nt. However, only one staff uring sleeping hours if pergency back-up procedures governing body. The serve clients whose primarence abuse dependency: The staff member who is one of in alcohol and other drug ms and symptoms of ations to alcohol and other drug es of a certified substance hall be available on an				
	failed to ensure at I had training on alco symptoms and sym complications to alco	view and interviews the facilit east one staff member on du phol and other drug withdrawa ptoms of secondary cohol and other drug one of five audited staff (stat	ty al			
	revealed: -Staff #1 had a hire -Staff #1 was hired -There was no evid and other drug with	as a Health Care Counselor. ence of training on alcohol drawal symptoms and dary complications to alcoho				
	Director revealed:	8 with the Human Resources #1 had the training to work with stance abuse.				

Division of Health Service Regulation

STATE FORM 9PFH11 If continuation sheet 11 of 12

Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R	
MHL032-367 B. WING 11/0	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
DURHAM MEN'S HALFWAY HOUSE 529 HOLLOWAY STREET DURHAM, NC 27701	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) COMPLETE DATE
V 290 Continued From page 11 -She had an Assistant who was responsible for ensuring the appropriate documents were in staff's folders. -The Assistant had taken on some additional duties just recently. -Some of the documents/paperwork for staff #1 possibly had not been filed. -She confirmed staff #1 did not have training on alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addictions. Interview on 11/7/18 with the Program Manager revealed: -Staff #1 had worked alone with the clients at the home. -He confirmed staff #1 did not have training on alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addictions. Interview on 11/7/18 with the Quality Improvement Director confirmed: -Staff #1 did not have training on alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug withdrawal symptoms and sym	

6899

Division of Health Service Regulation STATE FORM

9PFH11 If continuation sheet 12 of 12