Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PI

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		MHL032-335	B. WING	07/08/20	
DURHAM	ROVIDER OR SUPPLIER WOMEN'S HALFWAY HO	DUSE 407 SAL	DDRESS, CITY, STATEM STREET M, NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE	
∨ 000	on July 8, 2021. The c #NC00177564) was u Deficiencies cited. This facility is licensed category: 10A NCAC	nsubstantiated. I for the following service	V 000		
	which: (1) specifies the competency, work expectations for the process of the position; (2) specifies the the position; (3) is signed by the supervisor; and (4) is retained in (b) All facilities shall eleach staff member or a provides care or service the facility: (1) is at least 18 (2) is able to read follow directions; (3) meets the min competency, work expectations for the process of	ave a written job ctor and each staff position minimum level ofeducation, erience and other osition; duties and responsibilities of the staff member and the the staff member's file. Insure that the director, any other person who es to clients on behalf of years of age; , write, understand and limum level ofeducation, erience, skills and other	V 107	JUL 2 3 2021 Lic. & Cert. Secti	

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

TITLE

(X6) DATE

CL7211

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B. WING MHL032-335 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **407 SALEM STREET DURHAM WOMEN'S HALFWAY HOUSE** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PR CORRECTIVE ACTION SHOULD BE COMP REGULATORY OR LSC IDENTIFYING INFORMATION) TAG EFI CROSS-REFERENCED TO THE APPROPRIATE LETE DEFICIENCY) DATE TA G Measures to Correct: Staff was re-contacted to 7/15/21 V 107 V 107 Continued From page 1 submit evidence of her educational level. Staff conviction. The impact of this information on a was able to obtain and forward to HR decision regarding employment shall be based upon the offense in relationship to the job for Measure to Prevent: HR staff have been which the applicant is applying. reminded that all new hires must present evidence (d) Staff of a facility or a service shall be of their education for the HR file. currently licensed, registered or certified in accordance with applicable state laws for the services provided. Who will monitor and frequency: Program (e) A file shall be maintained for each individual Managers and HR will ensure that all new hires employed indicating the training, experience and present evidence of educational level at the time other qualifications for the position, including of hire. verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure each staff employed personnel record included educational credentials for one of two audited staff (#2). The findings are: Review on 7/8/21 of Staff #2's personnel record revealed: -Hired date: 4/12/19. -Title: Health Care Counselor. -There was no evidence staff met the minimum level of education. -There was no credentials in the record. Interview on 7/8/21 with the Quality Management Director revealed: -Staff #2 had difficulties obtaining a copy of her Division of Health Bedent Relsubition in Ioma. STATE FORM CL7211 If continuation sheet 2 of 9

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	
			A. BUILDING:		COMP	PLETED
		MHL032-335	B. WING		07/08/2021	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
DURHAM	DURHAM WOMEN'S HALFWAY HOUSE 407 SALEM STREET					
	OLD MAN DV OT		M, NC 27703			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
V 107	Continued From page	2	V 107			
	-She was working with speed up the process	h Human Resources to				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	(g) Employee training provided and, at a min following: (1) general organizat (2) training on client delineated in 10A NCA 10A NCAC 26B; (3) training to meet the client as specified in the plan; and (4) training in infection bloodborne pathogens (h) Except as permitte .5602(b) of this Subchmember shall be availated times when a client is member shall be trained including seizure manato provide cardiopulmot trained in the Heimlich techniques such as the equivalence for relievir (i) The governing body implement policies and reporting, investigating	ion shall be documented. In programs shall be alimum, shall consist of the sional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the me treatment/habilitation are treatment/habilitation. In a MCAC 27G apter, at least one staff able in the facility at all present. That staff add in basic first aid agement, currently trained anary resuscitation and maneuver or other first aid as provided by Red Cross, association or their and airway obstruction.				

Division of Health Service Regulation

CL7211

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING	5:		
		MHL032-335	B. WING		07/	08/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
DURHAM	WOMEN'S HALFWAY HO	DUSE	EM STREET 1, NC 27703			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETE DATE
	This Rule is not met a Based on record reviet failed to ensure the Professional, Staff #1 training in First Aid an Resuscitation (CPR). Review on 7/7/21 of the personnel record reversional record r	ew and interview the facility rogram Manager/Qualified and Staff #2 had current d Cardiopulmonary The findings are: The Program Manager/QP aled: pired 2/26/21. De of a current First Aid and cord. Itaff #1's personnel record Dired 3/26/21. De of a current First Aid and cord. Dired 3/26/21.	V 108	Measures to correct: Due to COV cpr and first aid trainings have not be scheduled on a regular basis. Our Hostiton was vacant for a few month also affected timely scheduling of staneeding certifications. CPR / First Aid training has been so for July 27, 2021. All three staff with attendance. Measures to Prevent: HR staff and program manager will monitor staff certifications to ensure timely renew Also regular trainings are now being scheduled due to COVID-19 lapse. WHO will monitor and frequency: and Program Managers will ensure the initial and annual certifications are scheduled on a regular basis.	een IR as which aff heduled ll be in al. are-	
	27E .0107 Client Rights Int.	s - Training on Alt to Rest.	V 536			

Division of Health Service Regulation STATEMENT OF DEFICIENCIES

1	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY	
		500 (1996 1000) (1908 100 100 100 100 100 100 100 100 100 1	A. BUILDING:		COM		
		MHL032-335	B. WING		07/08/2021		
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
DURHAM	WOMEN'S HALFWAY HO	DUSE	M STREET , NC 27703				
(V4) ID	SLIMMARY ST						
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 536	Continued From page	2 4	V 536				
	10A NCAC 27E .0107 ALTERNATIVES TO F INTERVENTIONS (a) Facilities shall impractices that emphas to restrictive interventif (b) Prior to providing disabilities, staff include employees, students of demonstrate compete completing training in other strategies for cre which the likelihood of or injury to a person w property damage is pri (c) Provider agencies based on state compet compliance and demo gathered. (d) The training shall be include measurable lea measurable testing (wi behavior) on those obj methods to determine course. (e) Formal refresher tr by each service provid annually). (f) Content of the train provider wishes to emp the Division of MH/DD/ Paragraph (g) of this R (g) Staff shall demons following core areas: (1) knowledge ar people being served;	TRAINING ON RESTRICTIVE columnt policies and size the use of alternatives sions. services to people with ding service providers, or volunteers, shall nce by successfully communication skills and eating an environment in imminent danger of abuse with disabilities or others or evented. shall establish training tencies, monitor for internal instrate they acted on data are competency-based, arning objectives, ritten and by observation of ectives and measurable passing or failing the raining must be completed er periodically (minimum sing that the service ploy must be approved by SAS pursuant to					

Division of Health Service Regulation

Division of Health Service Regulation

	T OF PERIOR NO.						
1	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	PLETED	
1			5				
		MHL032-335	B. WING		07	/08/2021	
NAME OF P	ROVIDER OR SUPPLIER	CTDEET A	DDDESS SITE S			-	
INAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
DURHAM	WOMEN'S HALFWAY HO	OUSE 407 SAL	EM STREET				
5.500			M, NC 27703				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NI.	T	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE	
				DEFICIENCY)			
V 536	Continued From need	· E	14500			 	
V 330	Continued From page	3	V 536				
	(3) recognizing	the effect of internal and					
		it may affect people with					
	disabilities;	it may affect people with					
		or building positive					
	relationships with pers						
		cultural, environmental and					
		that may affect people with					
	disabilities;						
		the importance of and					
	assisting in the persor	n's involvement in making					
	decisions about their I	ife;					
	(7) skills in asse	essing individual riskfor					
	escalating behavior;						
		ion strategies for defusing					
		entially dangerous behavior;					
	and	critiany dangerous benavior,					
		avioral augments (providing					
		avioral supports(providing					
	means for people with						
	activities which directly						
	behaviors which are u						
	(h) Service providers s						
	documentation of initia	al and refresher training for					
4	at least three years.						
	(1) Documentati	on shall include:					
	(A) who participated in the training and the						
	outcomes (pass/fail);					1	
		here they attended; and					
	(C) instructor's n					- 1	
		of MH/DD/SAS may				- 1	
		cumentation at anytime.				- 1	
	(i) Instructor Qualificati						
	Requirements:	one and training				- 1	
		I domonatrata act					
		Il demonstrate competence					
		sting in a training program					
		ducing and eliminating the					
	need for restrictive inte					- 1	
	(2) Trainers shall	I demonstrate competence				- 1	
	by scoring a passing g	rade on testing in an				- 1	
	instructor training progr					- 1	
and the second s		1					

Division of Health Service Regulation

STATE FORM CL7211 If continuation sheet 6 of 9

PRINTED: 07/08/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING: B. WING MHL032-335 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **407 SALEM STREET DURHAM WOMEN'S HALFWAY HOUSE** DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 536 Continued From page 6 V 536 The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6)Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete arefresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor

Division of Health Service Regulation

(1)

(A)

(B) (C)

training for at least three years.

instructor's name.

outcomes (pass/fail);

Documentation shall include:

when and where attended; and

The Division of MH/DD/SAS may request and review this documentation any time.

who participated in the training and the

CL7211

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PR

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE COMP	SURVEY	
		MHL032-335	B. WING		07/	07/08/2021	
	PROVIDER OR SUPPLIER WOMEN'S HALFWAY H	STREET A 407 SALI DUSE DURHAN	DDRESS, CITY, SEM STREET M, NC 27703	STATE, ZIP CODE		08/2021	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE				
V 536	requirements as a tra (2) Coaches sh the course which is be (3) Coaches sh competence by comp train-the-trainer instru	Coaches: all meet all preparation iner. all teach at least three times eing coached. all demonstrate letion of coaching or	V 536	Measures to correct: Trainin Alternatives to restrictive interventic completed on 11-20-2020 and 4-2-2 current. Certificates had not been folder due to staff vacancy. Measures to Prevent: Since th position has been filled, trainic certificates will be filed in the in a timely manner. Who will monitor and frequent of the in-house mindset trainer will fo certificate to HR for filling.	ons had been 2021. All are saved to HR e HR ng HR folder ency:	7/15//21	
	current training on the restrictive intervention Review on 7/7/21 of the personnel record reverse. Hired date of 5/5/16. - Alternative restrictive 7/25/20. - There was no evident use of alternatives to revealed: - Hired date of 4/2/19. - Alternative restrictive 3/29/21.	ew and interviews, the a the Program of sistendary of alternatives to use of alternatives to s. The findings are: The Program Manager/QP aled: Intervention expired of current training on the estrictive interventions. The findings are: The Program Manager/QP aled: Intervention expired of current training on the estrictive interventions. The Program Manager/QP aled: Intervention expired of current training on the of the Program of the Progra					

Division of Health Service Regulation

STATE FORM CL7211 If continuation sheet 8 of 9

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PR

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		TE SURVEY MPLETED
		MHL032-335	B. WING 07/08/		7/08/2021	
	PROVIDER OR SUPPLIER WOMEN'S HALFWAY H	OUSE 407 SALI	DDRESS, CITY, STA EM STREET M, NC 27703	ATE, ZIP CODE	•	
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V 536	Interview on 7/8/21 w Director revealed: -Staff with the comparentire agencyConfirmed training hat-They had been trained	ith the Quality Management ny did the training for the ad expired. ed on Mindset virtually and gate reason staff training	V 536			

Division of Health Service Regulation

JUL 2 3 2021



Lic. & Cert. Section DISCLOSURE AND AUTHORIZATION
[IMPORTANT -- PLEASE READ CAREFULLY
BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

ORDER NUMBER:

FAX: 910.343.9731

Company Name: Freedom House Recovery Center

CAC:FR18

Freedom House Recovery Center ("the Company") may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Castle Branch , 1845 Sir Tyler Drive, Wilmington, NC 28405, 888–723-4263 , or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing "the Company" to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a results, you should carefully consider whether to excercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Castle Branch , 1845 Sir Tyler Drive, Wilmington, NC 28405, 888-723-4263 , another outside organization acting on behalf of "the Company", and/or "the Company" itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.
California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.
Last Name HARRIS First Swamta Middle Deane
Other Names/Maiden/Alias Juanta Dlane
Social Security*
Driver's License# State NC Phone# 99.308-363 Email \ NUT (15140242 ma)
Present Address County County
City/State/Zip Wirnam NC 27701
*This information will be used for background screening purposes only and will not be used as hiring criteria.
ENote: If you do business in Utah, you cannot ask for DOB, driver's license, or SSN until either a confidential offer of employment or at the time the background report will be run.]
Applicant Signature Date: 5 /4 / 2





NORTH CAROLINA

Nurse Aide I Registry Medication Aide Registry Health Care Personnel Registry

Verification of Listing/Search Results:

The requested social security number was not found on the Nurse Aide I Registry, the North Carolina Medication Aide Registry or the Health Care Personnel Registry. This verification does not apply to Medication Aides working in Adult Care Homes. Employers of Medication Aides working in Adult Care Homes must verify listing by calling at https://mats.dhhs.state.nc.us/.

Social Security Number:

The listing verification is completed. Please record confirmation number business files to validate this inquiry which was made on 05/02/2016.

Note: If there are pending investigations or substantiated findings noted above, detailed information, including evidence summary, hearing, or rebuttal statement, may only be obtained by calling 919-855-3969 Monday through Friday from 8:00 a.m. to 3:00 p.m. and speaking with a registry representative.

(To print this verification, please click on the Print button in your browser.)

Return to Home Page

Verify More Listings



MindSet Certification

This certification is provisional and the result of online training. It requires attendance at the face-to-face training at the earliest opportunity post-COVID-19 social distancing restrictions.

Juanita Harris

Let it be known, the above named has successfully completed the course requirements for certification in Mind Set Foundations; De-escalation, Crisis Communication, and Avoidance. This certification is good for one calendar year.

Presented on <u>19 November</u>, 2020

Carol McClelland, MindSet Trainer

EDWARDS & ASSOCIATES LLC

P.O. BOX 805

MOUNT AIRY, N.C. 27030

PHONE: 336-786-1962 FAX: 336-789-6779

Email: allen@eabackground.com
Full Name (including maiden) (APX) MCDAVID +APR
Address:
Social Security Numbe Date of Birth:
Driving License: State: NC Number:
I have <u>not been charged or convicted</u> of a misdemeanor or felony within the past
I have been charged or convicted of a misdemeanor or felony within the past 20
Please indicate the date, location, charges and disposition of all cases. Failure to do so may be legitimate reason to terminated employment: Signature: Signa
I hereby authorize Edwards & Associates LLC for FREEDOM/HOUSE RECOVERY to conduct a comprehensive review of my background which may include a consumer report, MVR, criminal history and other reports as deemed necessary by Operation Outreach. I understand that the scope of the consumer report/investigative consumer report may include but is not limited to verification of social security number; current and previous addresses; employment history; education; character references; criminal history for all jurisdictions; motor vehicle records; and all other public documents required. I further authorize any individual, company, firm, corporation or public agency to divulge any and all information, verbal or written, pertaining to me to EDWARDS & ASSOCIATES LLC, for FREEDOM HOUSE RECOVERY and its agents.
I hereby release Edwards & Associates LLC, and its agents, officials, representatives or assigned agencies, including officers, employees or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time result to me, my heirs, family, or associates because of compliance with this authorization and request release.
Signature with Marson Date: 3/26/19

EDWARDS & ASSOCIATES LLC P.O. BOX 805 MOUNT AIRY, NORTH CAROLINA 27030

PHONE: 336-786-1962 FAX: 336-789-6779 allen@eabackground.com

Please complete the information on this form and fax or email to Edwards & Associates to have each order filled.

Associate Name: ALLEN EDWARDS	Phone: 336-786-1962 Fax: 888-722-9221 Cell: 336-401-6222
Information Requested On:	CON
FULL NAME: Caralya McDavid Harris	
ADDRESS	
CITY: Durham STATE: NC	ZIP CODE: 27703
COUNTY: Darham DATE OF BIR	TH:
SOCIAL SECURITY NUMBER	DL#:ST:_NC
REPORTS TO BE COMPLETED:	
SOCIAL SECURITY TRAC	
X_STATE CRIMINAL (Indicate State)). NC
DRIVERS LICENSE (Indicate State & I	7
FEDERAL CRIMINAL	
NATIONAL CRIMINAL	
OTHER	
Order Approved By: J. L. Willem M.	WDate: 3-26-19
Name of Company: Freedom House Recovery Cent	ter
Phone Number: (919) 942-2803 Fax Number: (919)) 442-1838





NORTH CAROLINA

Nurse Aide I Registry Medication Aide Registry Health Care Personnel Registry

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Social Security Number:

The listing verification is completed. Please record confirmation number business files to validate this inquiry which was made on 04/29/2019.

in your

Note: If there are pending investigations or substantiated findings noted above, detailed information, including evidence summary, hearing, or rebuttal statement, may only be obtained by calling 919-855-3969 Monday through Friday from 8:00 a.m. to 3:00 p.m. and speaking with a registry representative.

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Return to Home Page

Verify More Listings



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Carol	yn Harris
White the transfer of the second seco	

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Presented on <u>19 November, 2020</u>

Carol McClelland, MindSet Trainer

EDWARDS & ASSOCIATES LLC P.O. BOX 805

MOUNT AIRY, N.C. 27030 PHONE: 336-786-1962

FAX: 336-789-6779 Email: allen@eabackground.com

Full Name (including maiden) Mia Torres
Address:
City: Louisburg County: NC Zip code: 27549
Social Security Number:Date of Birth:
Email: mianoni24@gmail.com
Driving License: State: NC Number:
Please check one of the following:
* I have not been charged or convicted of a misdemeanor or felony within the past 20 years
I <u>have</u> been charged or convicted of a misdemeanor or felony within the past 20 years.
Please indicate the date, location, charges, and disposition of all cases. Failure to do so may be legitimate reason to terminated employment:
Signature:
I hereby authorize Edwards & Associates LLC for FREEDOM HOUSE RECOVERY to conduct comprehensive review of my background which may include a consumer report, MVR, criminal history and other reports as deemed necessary by Operation Outreach. I understand that the scope of the consumer report/investigative consumer report may include but is not limited to verification of social security number; current and previous addresses; employment history; education; character references criminal history for all jurisdictions; motor vehicle records; and all other public documents required, further authorize any individual, company, firm, corporation or public agency to divulge any and all information, verbal or written, pertaining to me to EDWARDS & ASSOCIATES LLC, for FREEDOM HOUSE RECOVERY and its agents.
I hereby release Edwards & Associates LLC, and its agents, officials, representatives or assigned agencies, including officers, employees or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time result to me, my heirs, family or associates because of compliance with this authorization and request release.
Signature:

DURHAM, NORTH CAROLINA

AMEMBER OF THE UNIVERSITY OF NORTH CAROLINA SYSTEM

TO ALL TO MAHOM THESE POSSESSION

TO ALL TO WHOM THESE PRESENTS MAY COME, GREETINGS

The Board of Trustees of the University upon recommendation of the Faculty has conferred upon

Mia Noni Torres

the degree of

Bachelor of Science

Line Line

with all the rights, honors and privileges thereto appertaining In Testimony Whereof, we have hereunto subscribed our names and caused the Seal of the University to be affixed at Durham, North Carolina, this the fifth day of December, 2020.

Peter Hons

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Total Control of Navel Control

James K Shapard Founder

HARDELOR NORTH (AROLINGCENTRAL

CHARMAN NORTH CARDUNA CENTRAL UNIVERSITA BOARD DE TRUSTES.



MindSet Certification

Th. # "	
1/112	Orrec
IVIIa	Torres

Let it be known, the above named has successfully completed the course requirements for certification in Mind Set Foundations; De-escalation, Crisis Communication, and Avoidance. This certification is good for one calendar year.

**Special Note: This training was provided online via Teams. It did not provide training in Avoidance Techniques. **

Presented on 2 April, 2021

Carol McClelland, MindSet Trainer



ntegrated behavioral health care for children and adults

July 19, 2021

Mental Health Licensure and Certification Section NCDivision of Health Service Regulations 2718 Mail Service Center Raleigh, N.C. 27699- 2718

RE: MHL – 032 – 225 Intake # NC00177564

To Whom It May Concern:

Melanie Thomas, RHIT

Director of Quality Management

Attached you will find the plan of correction for deficiencies cited during July 8, 2021 onsite survey. This information was also sent to you via email.

Sincerely,

DHSR - Mental Health

JUL 2 3 2021

Lic. & Cert. Section

Im ortant Disclosure Information for SA Consumers: Substance Abuse Regulations (42CFR2.32) require each disclosure made with the patient's written consent must be accompanied by the following written statement. This information has been disclosed to you from records protected by federal confidentiality rules (42CFR part2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.





Melanie Thomas

From: Hicks, Caitlin V <caitlin.hicks@dhhs.nc.gov>

Sent: Friday, July 9, 2021 8:24 AM

To: Melanie Thomas

Cc: Alliance Behavioral Health; Pridgen, Pam

Subject: DHSR-Mental Health survey results for Durham Women's Halfway House 032-335 FID

180068

Attachments: 032-335_2567_7-8-21.pdf; 032-335_2567L_7-8-21.pdf

Please find attached the results of the survey completed on 7/8/2021 by the MHL&C Section.

The Mental Health Licensure and Certification section is offering a 3-hour session for providers who currently hold a Mental Health License (MHL) for a mental health, developmental disability or substance abuse service. The purpose of this training is to help providers gain knowledge and understanding regarding North Carolina rules & General Statutes, the MHL&C survey process, administrative sanctions and appeal opportunities, and how these rules and processes fit together. The class is free but spaces are limited and registration is required. If you are interested in finding out more, please visit the web page: https://info.ncdhhs.gov/dhsr/mhlcs/newproviders.html#connectdots

Thank you,

Caitlin Hicks

Administrative Specialist I

Division of Health Service Regulation, Mental Health Licensure & Certification Section

NC Department of Health and Human Services

Help protect your family and neighbors from COVID-19. <u>Know the 3 Ws. Wear. Wait. Wash.</u> #StayStrongNC and get the latest at nc.gov/covid19.

Office: 919-855-3963 Fax: 919-715-8078 caitlin.hicks@dhhs.nc.gov

1800 Umstead Drive, Williams Building 2718 Mail Service Center Raleigh, NC 27699-2718

Twitter | Facebook | YouTube | LinkedIn

DHSR - Mental Health

JUL 2 3 2021

Lic. & Cert. Section

Email correspondence to and from this address is subject to the North Carolina Public Records Law and may be disclosed to third parties by an authorized State official. Unauthorized disclosure of juvenile, health, legally privileged, or otherwise confidential information, including confidential information relating to an ongoing State procurement effort, is prohibited by law. If you have received this email in error, please notify the sender immediately and delete all records of this email.

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL032-335	B. WING		07/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
DUDHAM	WOMEN'S HALFWAY HO	AUS SALI	EM STREET		
DUKHAW	WOWEN S HALFWAT H		I, NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 000	INITIAL COMMENTS		V 000		
	on July 8, 2021. The #NC00177564) was u Deficiencies cited.				
	category: 10A NCAC Supervised Living for	27G. 5600E Substance Abuse Adults			
V 107	27G .0202 (A-E) Pers	sonnel Requirements	V 107		
	which: (1) specifies the competency, work ex qualifications for the p (2) specifies the the position; (3) is signed by supervisor; and (4) is retained ir (b) All facilities shall each staff member or provides care or servithe facility: (1) is at least 18 (2) is able to reafollow directions; (3) meets the m competency, work ex qualifications for the p (4) has no subs neglect listed on the I Personnel Registry.	have a written job ector and each staff position e minimum level ofeducation, perience and other position; e duties and responsibilities of the staff member and the in the staff member's file. ensure that the director, any other person who ices to clients on behalf of B years of age; ad, write, understand and inimum level ofeducation, perience, skills and other position; and tantiated findings of abuse or North Carolina Health Care			
		vices shall require that all ment disclose any criminal			

Division of Health Service Regulation

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

TITLE (X6) DATE Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUI COMPLET			
			A. BOILD	NG		
		MHL032-335	B. WING		07/08/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY	r, STATE, ZIP CODE		
DURHAM	WOMEN'S HALFWAY H					
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V 107	Continued From page	21	V 107	Measures to Correct: Staff was re-coupling a videous of her advectional less		1
	decision regarding en upon the offense in re which the applicant is (d) Staff of a facility of currently licensed, re- accordance with appl services provided. (e) A file shall be ma employed indicating to	or a service shall be gistered or certified in icable state laws for the intained for each individual he training, experience and r the position, including		submit evidence of her educational levels able to obtain and forward to HR. Measure to Prevent: HR staff have be reminded that all new hires must prese of their education for the HR file. Who will monitor and frequency: PM Managers and HR will ensure that all present evidence of educational levels of hire.	peen ent evidence rogram new hires	
Division of Hea	failed to ensure each record included educative audited staff (#2) Review on 7/8/21 of Strevealed: -Hired date: 4/12/19Title: Health Care Country -There was no evider level of educationThere was no creder Interview on 7/8/21 we Director revealed:	ew and interview, the facility staff employed personnel ational credentials for one of . The findings are: Staff #2's personnel record ounselor. nice staff met the minimum ntials in the record. ith the Quality Management es obtaining a copy of her				

STATE FORM CL7211 If continuation sheet 2 of 9

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		MHL032-335	B. WING		07	7/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATI	E, ZIP CODE	<u> </u>	
DURHAM	WOMEN'S HALFWAY HO	DUSE	EM STREET			
			M, NC 27703			T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 107	Continued From page	2	V 107			
	-She was working wit speed up the process	h Human Resources to				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	(g) Employee training provided and, at a min following: (1) general organiza (2) training on client delineated in 10A NC. 10A NCAC 26B; (3) training to meet to client as specified in the plan; and (4) training in infection bloodborne pathogen (h) Except as permitted. 5602(b) of this Subclamember shall be avait times when a client is member shall be trainincluding seizure mar to provide cardiopulm trained in the Heimlic techniques such as the the American Heart A equivalence for reliev (i) The governing bod implement policies ar reporting, investigating.	tion shall be documented. It programs shall be nimum, shall consist of the stional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation ous diseases and s. ed under 10a NCAC 27G napter, at least one staff lable in the facility at all present. That staff leed in basic first aid nagement, currently trained an anneuver or other first aid has provided by Red Cross, association or their ing airway obstruction.				

Division of Health Service Regulation

STATE FORM 6899 CL7211 If continuation sheet 3 of 9

Division of Health Service Regulation

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL032-335	B. WING		07/0	8/2021
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V 108	This Rule is not met a Based on record revirfailed to ensure the Professional, Staff #1 training in First Aid ar Resuscitation (CPR). Review on 7/7/21 of the personnel record revelong the record revelong the personnel record revelong. There was no evider CPR training in the record training in the record. Interview on 7/8/21 with Manager revealed: -Due to Covid all in preancelled.	es evidenced by: ew and interview the facility Program Manager/Qualified I and Staff #2 had current and Cardiopulmonary The findings are: the Program Manager/QP ealed: expired 2/26/21. ence of a current First Aid and ecord. Staff #1's personnel record expired 3/26/21. ence of a current First Aid and ecord. Staff #2's personnel record expired 3/26/21. ence of First Aid and CPR expired Aid Aid CPR expired Aid Aid Aid CPR	V 108	Measures to correct: Due to COV cpr and first aid trainings have not a scheduled on a regular basis. Our I position was vacant for a few montalso affected timely scheduling of sneeding certifications. CPR / First Aid training has been so for July 27, 2021. All three staff wattendance. Measures to Prevent: HR staff and program manager will monitor staff certifications to ensure timely renew Also regular trainings are now beint scheduled due to COVID-19 lapse. WHO will monitor and frequency and Program Managers will ensure initial and annual certifications are scheduled on a regular basis.	been HR hs which staff cheduled ill be in d f wal. g re-	7/27/21
V 536	27E .0107 Client RigI Int.	hts - Training on Alt to Rest.	V 536			

Division of Health Service Regulation

STATE FORM 6899 CL7211 If continuation sheet 4 of 9

Division of Health Service Regulation

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL032-335	B. WING		07/08/2021
	ROVIDER OR SUPPLIER WOMEN'S HALFWAY HO	407 SAL	DDRESS, CITY, STAT	E, ZIP CODE	
2011171111		DURHAI	M, NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
V 536	Continued From page 10A NCAC 27E .0107 ALTERNATIVES TO INTERVENTIONS (a) Facilities shall impractices that emphasto restrictive intervent (b) Prior to providing disabilities, staff incluemployees, students demonstrate compete completing training in other strategies for crwhich the likelihood or injury to a person with property damage is possed on state compete compliance and demogathered. (d) The training shall include measurable testing (with behavior) on those of methods to determine course. (e) Formal refresher by each service proviannually). (f) Content of the training training shall include measurable testing (with the likelihood or injury to a person with the likelihood or injury to a pe	TRAINING ON RESTRICTIVE plement policies and size the use of alternatives ions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in fimminent danger of abuse with disabilities or others or revented. Is shall establish training retencies, monitor for internal constrate they acted on data the competency-based, rearning objectives, written and by observation of objectives and measurable repassing or failing the training must be completed der periodically (minimum ning that the service	V 536		OPRIATE DATE
	the Division of MH/DI Paragraph (g) of this (g) Staff shall demon following core areas: (1) knowledge a people being served;	•			

Division of Health Service Regulation

STATE FORM 6899 CL7211 If continuation sheet 5 of 9

Division of Health Service Regulation

AND PLAN OF CORRECTION			CONSTRUCTION	(X3) DATE SURVEY
	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		D 14/11/0		
	MHL032-335	B. WING		07/08/2021
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
DURHAM WOMEN'S HALFWAY HOUS	SE .	M STREET		
	DURHAM	, NC 27703		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 536 Continued From page 5		V 536		
(3) recognizing the external stressors that madisabilities; (4) strategies for but relationships with persons (5) recognizing cultorganizational factors that disabilities; (6) recognizing the assisting in the person's indecisions about their life; (7) skills in assessive escalating behavior; (8) communication and de-escalating potentiand (9) positive behavion means for people with disactivities which directly of behaviors which are unsurable (h) Service providers shad documentation of initial at least three years. (1) Documentation (A) who participated outcomes (pass/fail); (B) when and when (C) instructor's nand (2) The Division of review/request this documents: (1) Trainers shall do by scoring 100% on testing aimed at preventing, reduneed for restrictive interventions.	uilding positive s with disabilities; tural, environmental and at may affect people with importance of and nvolvement in making ing individual riskfor strategies for defusing ially dangerous behavior; oral supports (providing sabilities to choose ppose or replace afe). all maintain and refresher training for shall include: d in the training and the re they attended; and ne; MH/DD/SAS may mentation at any time. as and Training lemonstrate competence ng in a training program ucing and eliminating the entions. lemonstrate competence de on testing in an	V 536		

Division of Health Service Regulation

STATE FORM 6899 CL7211 If continuation sheet 6 of 9

Division of Health Service Regulation

l '	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
	MHL032-335	B. WING		07/08/2021
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	NTE, ZIP CODE	
DURHAM WOMEN'S HALFWAY HOU	407 SALE	M STREET		
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PREFIX (EACH DEFICIENCY N	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
objectives, measurable observation of behavio measurable methods to failing the course. (4) The content of service provider plans if approved by the Division to Subparagraph (i)(5) (5) Acceptable in shall include but are not (A) understanding (B) methods for the course; (C) methods for the course; (D) documentation (6) Trainers shall teaching a training progreducing and eliminating interventions at least of review by the coach. (7) Trainers shall aimed at preventing, reneed for restrictive interventions at least of the course; (B) Trainers shall instructor training at least three (I) Documentation of initial training for at least three (I) Documentation of in	shall be clude measurable learning testing (written and by r) on those objectives and of determine passing or of the instructor training the to employ shall be on of MH/DD/SAS pursuant of this Rule. Instructor training programs to limited to presentation of: of the adult learner; teaching content of the evaluating trainee. In procedures. I have coached experience gram aimed at preventing, and the need for restrictive time, with positive. It teach a training program ducing and eliminating the rentions at least once. I complete a refresher ast every two years. It and refresher instructor the years. It and refresher instructor the years. It and include: It can the training and the later attended; and	V 536		

Division of Health Service Regulation

STATE FORM 6899 CL7211 If continuation sheet 7 of 9

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		MHL032-335	B. WING		07/08/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	
DURHAM	WOMEN'S HALFWAY H	OUSE	LEM STREET		
	OLUMANA DV. OT		AM, NC 27703	PROVIDENIA DI ANI OF CORRECTIO	
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V 536	(k) Qualifications of C (1) Coaches sh requirements as a tra (2) Coaches sh the course which is b (3) Coaches sh competence by comp train-the-trainer instru	Coaches: nall meet all preparation nainer. nall teach at least three times reing coached. nall demonstrate oletion of coaching or	V 536	Measures to correct: Trainings Alternatives to restrictive interventions completed on 11-20-2020 and 4-2-202 current. Certificates had not been say folder due to staff vacancy. Measures to Prevent: Since the I position has been filled, training certificates will be filed in the HI in a timely manner. Who will monitor and frequer The in-house mindset trainer will forw certificate to HR for filling.	s had been 21. All are ved to HR HR B R folder
	facility failed to ensur Manager/Qualified Procurrent training on the restrictive intervention. Review on 7/7/21 of the personnel record reversed the date of 5/5/16 and the Alternative restrictive 7/25/20. There was no evident use of alternatives to the Review on 7/7/21 of Strevealed: Hired date of 4/2/19 and Alternative restrictive 3/29/21.	ew and interviews, the re the Program rofessional and Staff #1 had e use of alternatives to ns. The findings are: the Program Manager/QP ealed: b. re Intervention expired nce of current training on the restrictive interventions. Staff #1's personnel record b. re Intervention expired			
		nce of current training on the restrictive interventions.			

Division of Health Service Regulation

STATE FORM 6899 CL7211 If continuation sheet 8 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
	MHL032-335	B. WING		07	/08/2021
NAME OF PROVIDER OR SUPPLIER DURHAM WOMEN'S HALFWAY HO	0USE 407 SALE	DRESS, CITY, STATE M STREET , NC 27703	TE, ZIP CODE		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Director revealed: -Staff with the comparentire agencyConfirmed training hat-They had been traine	th the Quality Management ny did the training for the ad expired. ed on Mindset virtually and gate reason staff training	V 536			

Division of Health Service Regulation

STATE FORM 6899 CL7211 If continuation sheet 9 of 9



DISCLOSURE AND AUTHORIZATION

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

ORDER NUMBER:

ŕAX: 910.343.9731

Company Name: Freedom House Recovery Center

CAC:FR18

Freedom House Recovery Center ("the Company") may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Castle Branch , 1845 Sir Tyler Drive, Wilmington, NC 28405, 888-723-4263 , or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing "the Company" to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a results, you should carefully consider whether to excercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. To this end, or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. To this end, or "investigative consumer reports" and throughout my employment, if applicable. To this end, information service bureau, employer, or insurance company to furnish any and all background information requested by Castle Branch , 1845 Sir Tyler Drive, Wilmington, NC 28405, 888-723-4263 , another outside organization acting on behalf of "the Company", and/or "the Company" itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

the state of the s
New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.
California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.
Last Name HARRIS, First Svanta Middle Dlane
Other Names/Maiden/Alias Juanta Deane
Social Security*#
Driver's License#State_NC_Phone#99385365365Email_\NUT(15140269ma
Present Address
City/State/Zip_City/S
*This information will be used for background screening purposes only and will not be used as hiring criteria.
ENote: If you do business in Utah, you cannot ask for DOB, driver's license, or SSN until either a confidential offer of employment or at the time the background report will be run.] Applicant Signature. Date:



Juaneta Starris

NORTH CAROLINA

Nurse Aide I Registry Medication Aide Registry Health Care Personnel Registry

Verification of Listing/Search Results:

The requested social security number was not found on the Nurse Aide I Registry, the North Carolina Medication Aide Registry or the Health Care Personnel Registry. This verification does not apply to Medication Aides working in Adult Care Homes. Employers of Medication Aides working in Adult Care Homes must verify listing by calling at https://mats.dhhs.state.nc.us/.

Social Security Number: The listing verification is completed. Please record confirmation number in your business files to validate this inquiry which was made on 05/02/2016. Note: If there are pending investigations or substantiated findings noted above, detailed information, including evidence summary, hearing, or rebuttal statement, may only be obtained by calling 919-855-3969 Monday through Friday from 8:00 a.m. to 3:00 p.m. and speaking with a registry representative.

(To print this verification, please click on the Print button in your browser.)

Return to Home Page

Verify More Listings



MindSet Certification

This certification is provisional and the result of online training. It requires attendance at the face-to-face training at the earliest opportunity post-COVID-19 social distancing restrictions.

Juanita Harris	

Let it be known, the above named has successfully completed the course requirements for certification in Mind Set Foundations; De-escalation, Crisis Communication, and Avoidance. This certification is good for one calendar year.

Presented on <u>19 November, 2020</u>

Carol McClelland, MindSet Trainer

EDWARDS & ASSOCIATES LLC

P.O. BOX 805

MOUNT AIRY, N.C. 27030

PHONE: 336-786-1962 FAX: 336-789-6779

Email: allen@eabackground.com
Full Name (including maiden) APX/VI McDAVI & +APRI
Address:
Social Security Number: Date of Birth: $\frac{3}{28}/9$
Driving License: State: NC Number: Number: Number:
I have <u>not been charged or convicted</u> of a misdemeanor or felony within the past 20 years
<u>I have been charged or convicted</u> of a misdemeanor or felony within the past 20 years.
Please indicate the date, location, charges and disposition of all cases. Failure to do so may be legitimate reason to terminated employment:
Signature: arbly M. Arzu
I hereby authorize Edwards & Associates LLC for FREEDOM HOUSE RECOVERY to conduct a comprehensive review of my background which may include a consumer report, MVR, criminal history and other reports as deemed necessary by Operation Outreach. I understand that the scope of the consumer report/investigative consumer report may include but is not limited to verification of social security number; current and previous addresses; employment history; education; character references; criminal history for all jurisdictions; motor vehicle records; and all other public documents required. I further authorize any individual, company, firm, corporation or public agency to divulge any and all information, verbal or written, pertaining to me to EDWARDS & ASSOCIATES LLC, for FREEDOM HOUSE RECOVERY and its agents.
I hereby release Edwards & Associates LLC, and its agents, officials, representatives or assigned agencies, including officers, employees or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time result to me, my heirs, family, or associates because of compliance with this authorization and request release.

EDWARDS & ASSOCIATES LLC P.O. BOX 805

MOUNT AIRY, NORTH CAROLINA 27030 PHONE: 336-786-1962

FAX: 336-789-6779 allen@eabackground.com

Please complete the information on this form and fax or email to Edwards & Associates to have each order filled.

Phone: 336-786-1962

Associate Na	ame:	ALLEN ED	WARDS	Phone: Fax: Cell:	336-786-1962 888-722-9221 336-401-6222	
Information	Reque	sted On:				
FULL NAM	ΙΕ: <u>(</u>)	rulya helda	avid Harris			
ADDRESS:			-			***************************************
CITY:	urha		state:_/\	c zi	P CODE: 277	<u>03</u>
COUNTY:_	D	urhan	DATE OF BI	RTH:_		
SOCIAL SE	CURI	ΓΥ NUMBER		_DL#:_		ST: NC
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	_NATI	ONAL CRIM	INAL			
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Order Appr	oved B	y: <u> </u>	Willen 1	w	_Date: _3-24	- 19
Name of Co	mpany	: Freedom I	House Recovery Co	enter		
Phone Num	her: (9 1	19) 942-2803	Fax Number: (9)19) 44 2-183 8	<u>8</u>	



Carolyn Harris

NORTH CAROLINA

Nurse Aide I Registry Medication Aide Registry Health Care Personnel Registry

Verification of Listing/Search Results:

The requested social security number was not found on the Nurse Aide I Registry, the North Carolina Medication Aide Registry or the Health Care Personnel Registry. This verification does not apply to Medication Aides working in Adult Care Homes. Employers of Medication Aides working in Adult Care Homes must verify listing by calling at https://mats.dhhs.state.nc.us/.

Social Security Number:

The listing verification is completed. Please record confirmation number business files to validate this inquiry which was made on 04/29/2019.

n your

Note: If there are pending investigations or substantiated findings noted above, detailed information, including evidence summary, hearing, or rebuttal statement, may only be obtained by calling 919-855-3969 Monday through Friday from 8:00 a.m. to 3:00 p.m. and speaking with a registry representative.

(To print this verification, please click on the Print button in your browser.)

Return to Home Page

Verify More Listings



MindSet Certification

This certification is provisional and the result of online training. It requires attendance at the face-to-face training at the earliest opportunity post-COVID-19 social distancing restrictions.

Carolyn F	Harris

Let it be known, the above named has successfully completed the course requirements for certification in Mind Set Foundations; De-escalation, Crisis Communication, and Avoidance. This certification is good for one calendar year.

Presented on <u>19 November, 2020</u>

Carol McClelland, MindSet Trainer

EDWARDS & ASSOCIATES LLC P.O. BOX 805

MOUNT AIRY, N.C. 27030

PHONE: 336-786-1962 FAX: 336-789-6779

Email: allen@eabackground.com

Full Name (including maiden) Mia Torres
Address:
City: Louisburg County: NC Zip code: 27549
Social Security Number:Date of Birth:
Email: mianoni24@gmail.com
Driving License: State: NC Number:
Please check one of the following:
* I have not been charged or convicted of a misdemeanor or felony within the past 20 years
I <u>have</u> been charged or convicted of a misdemeanor or felony within the past 20 years.
Please indicate the date, location, charges, and disposition of all cases. Failure to do so may be legitimate reason to terminated employment:
Signature:
I hereby authorize Edwards & Associates LLC for FREEDOM HOUSE RECOVERY to conduct a comprehensive review of my background which may include a consumer report, MVR, criminal history and other reports as deemed necessary by Operation Outreach. I understand that the scope of the consumer report/investigative consumer report may include but is not limited to verification of social security number; current and previous addresses; employment history; education; character references criminal history for all jurisdictions; motor vehicle records; and all other public documents required. further authorize any individual, company, firm, corporation or public agency to divulge any and all information, verbal or written, pertaining to me to EDWARDS & ASSOCIATES LLC, for FREEDOM HOUSE RECOVERY and its agents.
I hereby release Edwards & Associates LLC, and its agents, officials, representatives or assigned agencies, including officers, employees or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time result to me, my heirs, family or associates because of compliance with this authorization and request release.
Signature: Date: 4-1-2021

Corth Earolina Eentral Unitellistical Corth Carolina

AMEMBER OF THE UNIVERSITY OF NORTH CAROLINA SYSTEM

The Board of Trustees of the University upon recommendation of the Faculty has conferred upon

Mia Noni Torres

the degree of

Bachelor of Science Psychology

with all the rights, honors and privileges thereto appertaining In Testimony Whereof, we have become subscribed our names and caused the Seal of the University to be affixed at Durham, North Carolina, this the fifth day of December, 2020.

Larrey & Shapard Pounder



MindSet Certification

M	ia T	orres	

Let it be known, the above named has successfully completed the course requirements for certification in Mind Set Foundations; De-escalation, Crisis Communication, and Avoidance. This certification is good for one calendar year.

**Special Note: This training was provided online via Teams. It did not provide training in Avoidance Techniques. **

Presented on 2 April, 2021

Carol McClelland, MindSet Trainer