	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL032-367	B. WING		02	02/09/2022	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
		529 HOI	LOWAY STREET				
URHAM	MEN'S HALFWAY HOUS	E DURHA	M, NC 27701				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
V 000	INITIAL COMMENTS		V 000		- ,		
	An annual survey wa 2022. Deficiencies cit	s completed on February 9, ed.					
	category: 10A NCAC	d for the following service 27G. 5600E Substance Abuse Adults					
	The survey sample co current clients.	onsisted of audits of 3					
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108				
	10A NCAC 27G .020 REQUIREMENTS (f) Continuing educa (g) Employee training	tion shall be documented.					
		nimum, shall consist of the					
	(2) training on client	rights and confidentiality as AC 27C, 27D, 27E, 27F and					
	(3) training to meet t	the mh/dd/sa needs of the the treatment/habilitation					
	(4) training in infection bloodborne pathogen						
	.5602(b) of this Subcl member shall be avai	hapter, at least one staff ilable in the facility at all					
	times when a client is member shall be train including seizure mar						
	to provide cardiopulm trained in the Heimlic	nonary resuscitation and h maneuver or other first aid nose provided by Red Cross,					
	the American Heart A	ssociation or their ing airway obstruction.					

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

TITLE

(X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION	(X3) DATE COMF	SURVEY
		MHL032-367			02	/09/2022
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
DURHAM	MEN'S HALFWAY HOUS	SE	I, NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
V 108	Continued From page	e 1	V 108			
	reporting, investigatir	nd procedures for identifying, ng and controlling infectious iseases of personnel and				
	failed to ensure one of (Healthcare Counselo	ew and interview the facility of three audited staff or #1) had current training in ulmonary Resuscitation				
	#1's personnel record -Hired date: 2/3/21. -Worked weekend sh	ift. nce of a current First Aid and				
	revealed: -There were changes Department.	vith the Clinical Director s in the Human Resource department resulted in eing misplaced.				
V 131	G.S. 131E-256 (D2) Verification	HCPR - Prior Employment	V 131			
	REGISTRY (d2) Before hiring heat health care facility or	ALTH CARE PERSONNEL alth care personnel into a service, every employer at a all access the Health Care				

Division of Health Service Regulation STATE FORM

ND PLAN (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		MHL032-367	B. WING			00/00/0000	
AME OF PI	ROVIDER OR SUPPLIER	l.	ET ADDRESS, CITY, STATE, ZIP CODE				
URHAM	MEN'S HALFWAY HOUS	F	LLOWAY STREET M, NC 27701				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 131	Continued From page	2	V 131				
		nd shall note each incident opriate business files.					
	failed to access the H Registry (HCPR) prio Program Manager/Qu of two Healthcare Co are:	ew and interview the facility lealth Care Personnel r to employment for the ualified Professional and one unselor's (#1). The findings					
	personnel record reve -Hired date: 11/20/20	nce the HCPR check was ployment.					
	#1's personnel record -Hired date: 2/3/21.	nce the HCPR check was ployment.					
	revealed: -The Human Resourc	ith the Clinical Director be Department was sing HCPR prior to staff 's					

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	MHL032-367	B. WING		02	2/09/2022
ROVIDER OR SUPPLIER			, ZIP CODE		
MEN'S HALFWAY HOUS	E				
		ID			(X5)
(PREFIX TAG	CROSS-REFERENCED TO) THE APPROPRIATE	COMPLET DATE
Continued From page	e 3	V 133			
 CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition As used in this section, th "provider" applies to an area authority/co program and any provider of mental heal developmental disability, and substance services that is licensable under Article 2 Chapter. (b) Requirement An offer of employme provider licensed under this Chapter to a applicant to fill a position that does not re applicant to fill a position that does not re applicant to have an occupational license conditioned on consent to a State and na criminal history record check of the appli the applicant has been a resident of this less than five years, then the offer of em- is conditioned on consent to a State and criminal history record check of the appli national criminal history record check share 					
five years or more, th on consent to a State check of the applican employ an applicant criminal history record	en the offer is conditioned criminal history record t. A provider shall not who refuses to consent to a d check required by this				
section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a					
section or shall subm entity to conduct a St check required by this G.S. 114-19.10, the D	it a request to a private ate criminal history record s section. Notwithstanding Department of Justice shall				
	ROVIDER OR SUPPLIER MEN'S HALFWAY HOUS SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page G.S. §122C-80 CRIM CHECK REQUIRED APPLICANTS FOR E (a) Definition As us "provider" applies to a program and any pro developmental disabil services that is license Chapter. (b) Requirement Ar provider licensed und applicant to fill a posi applicant to fill a posi applicant to have an conditioned on conse criminal history record the applicant has bee less than five years, fills is conditioned on conse criminal history record the applicant has bee less than five years, fills include a check of the the applicant has bee five years or more, the on consent to a State check of the applicant criminal history record section. Except as ot subsection, within five the conditional offer of shall submit a request Justice under G.S. 11 criminal history record section or shall submit entity to conduct a St check required by this G.S. 114-19.10, the E	IDENTIFICATION NUMBER: MHL032-367 ROVIDER OR SUPPLIER STREET A MEN'S HALFWAY HOUSE 529 HOL DURHAI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days o	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL032-367 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 3 V 133 G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. V 133 (a) Definition As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to fill a position that does not require the applicant to fill a position that does not require the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private en	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: MHL032-367 B. WING ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTVE AL CROSS-REFERENCED TO CRECTIANI APPLICANTS FOR EMPLOYMENT. ID (a) Definition As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. Chapter. (b) Requirement An offer of employment by a provider licensed under this Chapter to an applicant to flat aposition to that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant to flat sostim cord divers shall include a check of the applicant's fingerprints. If the applicant hor order shall not employ an applicant who refuses to consent to a state ordininal history record check shall include a check of the applicant of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check shall include a check of the applicant shist provider shall not employ an applicant who refuses to consent to a state criminal history record check shall include a check of the applicant's fingerprints. If the applicant the requesto a private motif	PE CORRECTION IDENTIFICATION NUMBER: A BUILDING:

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		MUI 022 267	B. WING			
	ROVIDER OR SUPPLIER	MHL032-367	ADDRESS, CITY, STATE,		02	2/09/2022
NAME OF F	ROVIDER OR SUFFLIER		LOWAY STREET	ZIF CODE		
DURHAM	MEN'S HALFWAY HOUS	E	M, NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 133	Continued From page	e 4	V 133			
	Criminal Records Ch business days of reco history of the person, and Human Services Unit, shall notify the p information received of the applicant. In no national criminal histor with the provider. Pro- upon request verifical check has been com by this section. A cou appropriate local ordi the Division of Crimin may conduct on beha criminal history recor section without the pur request to the Depart case, the county shal criminal history recor section within five bu conditional offer of er All criminal history inf provider is confidenti- except to the applicat (c) of this section. Fo subsection, the term business regularly er criminal history recor records obtained from (c) Action If an app record check reveals a relevant offense, th of the following factor hire the applicant:	a and Human Services, eck Unit. Within five eipt of the national criminal the Department of Health , Criminal Records Check provider as to whether the may affect the employability of case shall the results of the ory record check be shared oviders shall make available tion that a criminal history pleted on any staff covered unty that has adopted an nance and has access to nal Information data bank all of a provider a State d check required by this rovider having to submit a timent of Justice. In such a II commence with the State d check required by this siness days of the mployment by the provider. formation received by the al and may not be disclosed, int as provided in subsection r purposes of this "private entity" means a tagaged in conducting d checks utilizing public in a State agency. licant's criminal history one or more convictions of the provider shall consider all rs in determining whether to tousness of the crime.				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL032-367	B. WING		02	/09/2022
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
DURHAM	MEN'S HALFWAY HOUS	E	LOWAY STREET M, NC 27701			
			ID			(X5)
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
V 133	Continued From page	e 5	V 133			
	(3) The age of the person at the time of the conviction.(4) The circumstances surrounding the					
	commission of the cri					
	(5) The nexus between the criminal conduct of					
	the person and the job duties of the position to be filled.					
	(6) The prison, jail, pi					
		ployment records of the				
	-	e the crime was committed.				
	. ,	commission by the person of				
	a relevant offense.	of a relevant offense alone				
		employment; however, the				
	listed factors shall be considered by the provider.					
	If the provider disqualifies an applicant after					
	consideration of the relevant factors, then the					
	provider may disclose	e information contained in				
		cord check that is relevant				
	-	, but may not provide a copy				
	of the criminal history	record check to the				
	applicant.	A manufal and an a ffiction				
	• • •	- A provider and an officer vider that, in good faith,				
		ction shall be immune from				
	civil liability for:					
		provider to employ an				
	· /	s of information provided in				
	the criminal history re	ecord check of the individual.				
		n employee's history of				
		e employee's criminal				
	•	is requested and received in				
	compliance with this	section. As used in this section,				
		eans a county, state, or				
		ry of conviction or pending				
		, whether a misdemeanor or				
		on an individual's fitness to				
	have responsibility fo					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL032-367	B. WING		02	2/09/2022
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
URHAM I	MEN'S HALFWAY HOUS	SE	LOWAY STREET M, NC 27701			
		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN O (EACH CORRECTIVE AC		(X5) COMPLET
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
V 133	Continued From page	e 6	V 133			
	persons needing mental health, developmental					
		nce abuse services. These				
	crimes include the cri	iminal offenses set forth in				
	any of the following A	articles of Chapter 14 of the				
	General Statutes: Art	ticle 5, Counterfeiting and				
	Issuing Monetary Substitutes; Article 5A,					
	Endangering Executive and Legislative Officers;					
	Article 6, Homicide; A	Article 7A, Rape and Other				
		8, Assaults; Article 10,				
		uction; Article 13, Malicious				
	Injury or Damage by	•				
	-	Material; Article 14, Burglary				
		akings; Article 15, Arson and				
		le 16, Larceny; Article 17,				
		Embezzlement; Article 19,				
	False Pretenses and					
		r Services by False or				
		edit Device or Other Means;				
		I Transaction Card Crime				
		s; Article 21, Forgery; Article				
	26, Offenses Against	•				
	-	, Adult Establishments;				
		n; Article 28, Perjury; Article				
	, , ,	1, Misconduct in Public enses Against the Public				
		Riots and Civil Disorders;				
		of Minors; Article 40,				
	Protection of the Fan					
		cle 60, Computer-Related				
		also include possession or				
		tion of the North Carolina				
	•	es Act, Article 5 of Chapter				
		atutes, and alcohol-related				
		e to underage persons in				
	violation of G.S. 18B-	÷ .				
		of G.S. 20-138.1 through				
	G.S. 20-138.5.	5				
		ning False Information Any				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL032-367	B. WING		02	2/09/2022
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
URHAM	MEN'S HALFWAY HOUS	SE	LOWAY STREET M, NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 133	Continued From pag	e 7	V 133			
	 V 133 Continued From page 7 supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) 					
	failed to ensure the s was ordered within fi the conditional offer o	as evidenced by: we and interview, the facility state criminal record check ve business days of making of employment for one of lealthcare Counselor #1).				
	#1's personnel record -Hired date: 2/3/21.	nce the criminal record rior to employment.				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
		MHL032-367	B. WING		02/09/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
OURHAM	MEN'S HALFWAY HOUS	E	LOWAY STREET M, NC 27701			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 133	Continued From page	8	V 133			
	revealed: -The Human Resourc responsible for orderi check. -Confirmed the crimin	ng the state criminal record al record check was not siness day of making the				
V 536	27E .0107 Client Righ Int.	nts - Training on Alt to Rest.	V 536			
	to restrictive intervent (b) Prior to providing disabilities, staff inclu employees, students demonstrate compete completing training in other strategies for cr which the likelihood o or injury to a person v property damage is p (c) Provider agencies based on state compe compliance and demo gathered. (d) The training shall include measurable le measurable testing (v behavior) on those other	RESTRICTIVE plement policies and size the use of alternatives tions. services to people with ding service providers, or volunteers, shall ence by successfully communication skills and reating an environment in of imminent danger of abuse with disabilities or others or revented. s shall establish training etencies, monitor for internal ponstrate they acted on data be competency-based,				

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		MHL032-367	B. WING		02/09/2022	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		02	
		529 HOL		, 0002		
DURHAM	MEN'S HALFWAY HOUS	SE	M, NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 536	Continued From page	e 9	V 536			
	annually). (f) Content of the traprovider wishes to enthe Division of MH/DI Paragraph (g) of this (g) Staff shall demore following core areas: (1) knowledge people being served; (2) recognizing behavior; (3) recognizing external stressors that disabilities; (4) strategies for relationships with perfection of the	nploy must be approved by D/SAS pursuant to Rule. Instrate competence in the and understanding of the and interpreting human the effect of internal and at may affect people with or building positive rsons with disabilities; or cultural, environmental and that may affect people with or building positive rsons with disabilities; or cultural, environmental and that may affect people with of the importance of and on's involvement in making life; sessing individual risk for ation strategies for defusing tentially dangerous behavior; havioral supports (providing h disabilities to choose thy oppose or replace unsafe). Is shall maintain ial and refresher training for ation shall include: bated in the training and the				

Division of Health Service Regulation

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		NUL 000 007					
	ROVIDER OR SUPPLIER	MHL032-367	ADDRESS, CITY, STATE		02	/09/2022	
	CONDER ON SUFFLIER		LOWAY STREET	, ZIF CODE			
URHAM	MEN'S HALFWAY HOUS	SE	M, NC 27701				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE	
V 536	 (C) instructor's (2) The Division review/request this d (i) Instructor Qualific Requirements: (1) Trainers ship scoring 100% on taimed at preventing, need for restrictive in (2) Trainers ship scoring a passing instructor training procession of behave measurable methods failing the course. (4) The content service provider plan approved by the Divit to Subparagraph (i)(5) Acceptable shall include but are (A) understand (B) methods for course; (C) methods for performance; and (D) documentaria (6) Trainers ship teaching a training proventions at least 	n name; n of MH/DD/SAS may ocumentation at any time. ations and Training all demonstrate competence testing in a training program reducing and eliminating the terventions. all demonstrate competence grade on testing in an ogram. g shall be nclude measurable learning ble testing (written and by for) on those objectives and a to determine passing or t of the instructor training the s to employ shall be sion of MH/DD/SAS pursuant	V 536				
	review by the coach. (7) Trainers sh aimed at preventing,	all teach a training program reducing and eliminating the terventions at least once					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL032-367	B. WING		02/09/2022	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		02	./05/2022
		529 HOL	LOWAY STREET	,		
URHAM	MEN'S HALFWAY HOUS	DURHA	M, NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 536	Continued From page	e 11	V 536			
	 instructor training at I (j) Service providers documentation of init training for at least the (1) Docume (A) who particip outcomes (pass/fail); (B) when and y (C) instructor's (2) The Division request and review the (k) Qualifications of the (1) Coaches show the course which is be (3) Coaches show the course which is be (3) Coaches show the competence by comp train-the-trainer instructor 	ial and refresher instructor iree years. entation shall include: pated in the training and the where attended; and name. n of MH/DD/SAS may his documentation any time. Coaches: hall meet all preparation ainer. hall teach at least three times being coached. hall demonstrate poletion of coaching or				
	failed to ensure the F Professional had cur	as evidenced by: ew and interview, the facility Program Manager/Qualified rent training on the use of tive interventions. The				
	Review on 2/9/22 of the personnel record revo -Hired date: 11/20/20 alth Service Regulation					

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-367		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE
URHAM	MEN'S HALFWAY HOUS	SF	M, NC 27701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLE NCED TO THE APPROPRIATE DATE	
V 536	Continued From page 12		V 536			
	-Mindset Certification expired 11/19/21. -There was no evidence of current training.					
	Interview on 2/9/22 with the Clinical Director revealed:					
	-Mindset trainings were scheduled monthly. -There were changes in the Human Resource Department.					
	-The changes in the employee trainings b	department resulted in eing misplaced.				