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PRINTED: 09/17/2020
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL047-166	A. BUILDING: _____ B. WING _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL RESOURCES CENTER-GRO	2423 HIGHWAY 401 BUSINESS RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on September 10, 2020. The complaint was unsubstantiated (Intake #NC00167504). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G.5600A Supervised Living for Adults with Mental Illness	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112	DHSR-Mental Health SEP 29 2020 Lic. & Cert. Section	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dr Joseph Brady — TITLE: DIRECTOR — (X6) DATE: 9/28/20

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on observation, record review and interviews, the facility failed to develop and implement strategies to address the needs and behaviors for one of three clients (#1). The findings are:

Review on 9/9/20 of client #1's record revealed:
-Admission date of 5/2/18.
-Diagnoses of Bipolar Disorder and Borderline Personality Disorder.
-"Comprehensive Clinical Assessment" dated 8/7/19 had the following: "[Client #1] has a history of self-injurious behaviors. [Client #1] has a history of multiple emergency room visits for self-injurious behaviors (cutting), but reported it's been almost two months since he cut...[Client #1] needs a lot of assistance managing his symptoms, decreasing self injurious behaviors (cutting)..."
-Person Centered Plan dated 4/13/20 and updated 8/20/20 had no strategies to address his self-injurious behaviors (cutting).

Observation on 9/10/20 at approximately 2:00 PM revealed:
-There were approximately 80 reddish cuts on each one of client #1's arms.
-The cuts expanded from his upper shoulder to the wrist on both arms.
-There were cuts on the inner and outer portion of client #1's arms.
-Most of the cuts were healed.
-The cuts were approximately ½ inch to 1 inch in length.

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V 112	Continued From page 2 Review of facility incident reports on 9/9/20 and 9/10/20 for client #1's self injurious behavior (cutting) for the last 6 months revealed: Incident reports : -8/14/20-Client #1 had 4 pieces of glass and gave them to staff. He had a cut on his upper right arm. -8/6/20-Client #1 admitted he cut himself yesterday during 3rd shift. Emergency Medical Services (EMS) was called for client #1. -8/3/20-Client #1 was complaining about his arm hurting in the area he was cutting. Client #1 went to local hospital in order to have a cut stitched up. -8/2/20-"[Client #1]stolen a light bulb and broke it with the intensions to self-harm." -8/1/20-Staff noticed that client #1 had blood on his shorts and shirt. Staff asked client #1 to remove his jacket and he refused. Staff asked client #1 if he had cut himself and he replied no. Staff looked around client #1's bedroom for any sharp objects. Client #1 handed over a light bulb broken into pieces. -7/18/20-Staff was checking on client #1 while he was in the bathroom. Staff asked if he was ok and he said no. Staff asked him to open the door and client #1 refused. Staff opened the door slowly and saw client sitting on toilet with a towel with blood on it. Staff noticed client #1 was picking at his arm and it was bleeding. EMS was called and client #1 had to go to the hospital. Client #1 was treated and released back to the facility with instructions to follow up with primary care physician in 7-10 days to have stitches removed. -7/17/20 Client #1 was cutting himself with a bladed object. Staff intervened by moving client #1's hand away from the blade and taking the blade away. Client #1 told staff it was ok because he had another blade in his vent. Client #1 was taken to the hospital at 5:20 PM. Client #1	V 112		

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V 112	Continued From page 3 returned to group home. Later that night client #1 asked staff to call police and EMS back because he wanted to cut himself again. Client #1 was taken to hospital again around 8:41 PM. -7/12/20-Client #1 cut his right arm, minor wound no hospital visit. -7/4/20-Client #1 approached staff and had cut on his right forearm from self injurious behavior. EMS was called and client #1 was transported to the hospital. Client #1 received stitches and was released back to the group home. -7/2/20-Staff saw blood on the floor in client #1's bedroom. Client #1 had cut himself. EMS was called and client #1 was transported to the hospital. -6/18/20-Client #1 walked away from the facility. Client returned a few hours later. Staff saw blood on client #1's pants and asked if he had been cutting and he replied that he had cut himself. Client #1 had self harmed by cutting his arm. EMS was called and client #1 was transported to the hospital. Client #1 received staples to close his wound. -3/21/20-Client #1 had self injurious behavior by cutting his forearm with a small piece of metal from a can. Staff called EMS and client #1 was transported to the hospital. Client #1 received two staples in order to close the wound. Review of facility records on 9/9/20 and 9/10/20 revealed: *Hospital Discharge Summaries for client #1's cutting behaviors for the last 6 months: -8/3/20-Client #1 was seen at emergency room for laceration-Open wound of arm. He got sutures for the wound. -7/18/20-Client #1 was seen at emergency room for laceration-Laceration of left upper extremity, self mutilation. -7/17/20-Client #1 was seen at emergency room	V 112		

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V 112	Continued From page 4 for laceration-Laceration on multiple sites of arm, staples removed and evaluation completed. -7/7/20-Client #1 was seen at emergency room for laceration-Laceration of right upper extremity. -7/2/20-Client #1 was seen at emergency room for laceration-Open wound of arm. -6/18/20-Client #1 had a laceration and had to get sutures. Interview with client #1 on 9/9/20 and 9/10/20 revealed: -He had gone to hospital several times for cutting. -He had been cutting himself since he was 13. -He tried to commit suicide once when he was 17, however he was not successful. -He cuts himself "just to be doing it." -He was not cutting himself because he wanted to commit suicide. -He was mainly cutting his arms. -He would use any sharp item. -He would often hide items for cutting. -He found a lot of different sharp items outside on the ground. -Sometimes he would purposely break a glass item and use the glass to cut his arms. -He was normally in his bedroom and bathroom when he does the cutting. -If he could not stop the bleeding, he would inform staff. -Staff would normally call EMS for him. -He had to be transported to the hospital several times to receive medical treatment for cutting his arms. -He had to get sutures, staples or stitches on numerous occasions. -He could not remember in the last few months how often he had to get sutures, staples or stitches due to a cut being too deep. Interview with staff #1 on 9/10/20 revealed:	V 112		

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V 112	Continued From page 5 -He called EMS two or three times within the last two-three months for client #1 cutting his arms. -Client #1 would normally find the items for cutting outside on the ground. -Client #1 had shown him several cuts after he cut his arms. -Client #1 cut himself several times when he was not on shift and would show him the cuts the next day. -Client #1 had given him several items that he had used to cut himself like pieces of glass and a metal can top. -Client #1 would often find items and hide them in his bedroom. -He called EMS the times when Client #1's cuts was severe and the cuts was either deep or bled a lot. -He would normally call management about the issues with the cutting. -He confirmed client #1 had no strategies to address his self-injurious behaviors (cutting). Interview on 9/9/20 and 9/10/20 with the Facility Manager revealed: -Client #1 had a history of cutting. -Client #1 was in a psychiatric hospital prior to admission. -Client #1 had several cutting episodes since living at the group home. -Client #1 was constantly finding items to cut himself, he would use anything sharp. -Client #1 would use items like glass, tops from a can, any sharp item. -Client #1 likes to pace back and forth outside in the yard. -He would sometimes find items on the ground while he is pacing to cut himself -Client #1 would hide items to cut, most of time the wounds are superficial. -Client #1 would often hide items in his bedroom	V 112		

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V 112	Continued From page 6 for cutting. -When he was going to the day program he would find items for cutting. -Client #1 would bring the items back to the group home and hide them. -He stopped going to the day program the earlier part of 2020. -Client #1 was going to therapy for cutting. -He thought his last therapy session was January or February 2020. -Client #1 refused to continue the therapy sessions. -He did not think the cutting was due to suicidal ideations. -He thought client #1 just "gets a kick out of the cutting, sometimes to see how deep he can get." -Client #1 would tell him he was frustrated and that made him start cutting. -He never specified why he was frustrated. -Most of the time client #1 would tell staff if he cut himself and needed to go to the hospital. -Client #1 would sometimes go for several months without cutting himself. -The cutting behaviors started getting bad again around July 2020. -Client #1 only had about three episodes of cutting between March and May 2020. -Client #1 possibly had about ten cutting incidents within the last three months. -Sometimes the cuts are deep and first aid at the home is not appropriate. -If staff see blood when client #1 cuts himself and/or the wound will not stop bleeding staff should call EMS. -Client #1 had to the hospital several times due to some of the cuts being deep and/or too much blood. -Client #1 had never stayed overnight in hospital for cutting. -Client #1 would normally go to the Emergency	V 112		

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V 112	Continued From page 7 Room and return the same day. -Client #1 would sometimes get sutures, stitches or staples for his wounds when he visits the hospitals. -He confirmed client #1 had no strategies to address his self-injurious behaviors (cutting). Review on 9-10-20 of a Plan of Protection written by the Facility Director dated 9-10-20 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care: " (1) Monitor actions of [client #1] for increased agitation or seclusion. (2) Check facility and grounds for items or debris that can be used by [client #1] to cut. (3) Check facility and grounds for items to ensure they are secure for intended purpose. (4) Keep constant eye on [client #1] to prevent him from obtaining items that can be used to cut. (5) Check and annotate [Client #1's] room inspection/inventory for items that can be used to cut. Remove dangerous items. Conducted daily. (6) Notify staff of steps to follow if [client #1] does cut himself." Describe your plans to make sure the above happens: " (1) Develop checklist of steps to complete when [client #1] cuts himself. (2) Increase staff involvement to monitor actions of [client #1]. (3) Notify staff of steps to check facility and grounds for items and debris that can be used to cut. (4) Complete inventory of confiscated items and date of room check on [client #1] (5) Revise treatment plan to identify strategies to prevent and decrease cutting incidents by [client #1]." Client #1 had diagnoses of Bipolar Disorder and Borderline Personality Disorder. Client #1 had a long history of self injurious behavior (cutting) and multiple Emergency Room visits. Client #1 had eleven documented incidents of cutting his arms	V 112		

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V 112	Continued From page 8 between March and August 2020. Client #1 received staples, sutures or stitches on five separate occasions in order to close the wound after cutting his arms. Client #1 has continued to cut both arms constantly within the last six months and there were no strategies developed and implemented in his treatment plan to address the self injurious behavior (cutting). This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500 per day will be imposed each day the facility is out of compliance beyond the 23rd day.	V 112		

Appendix 1-B: Plan of Correction Form

Plan of Correction 09/10/2020	
Please complete all requested information and submit completed Plan of Correction form to: **Kimberly R. Sauls** **NC Mental Health Licensure & Certification Section** **Facility Compliance Consultant I** **2718 Mail Service Center** **Raleigh, NC 27699-2718**	**In lieu of mailing the form, you may e-mail the completed electronic form to:**

Provider Name:	**Multicultural Resource Center, Inc.**	**Phone:**	**(910) 878-1656**
Provider Contact Person for follow-up:	**Jerome White, Facility Coordinator**	**Fax:**	**(910) 230-5542**
		Email:	**cdcmcrcinc@gmail.com**
Address:	2423 Hwy 401 Bus. Raeford, NC 28376	**Provider #** 6006873	

Finding	Corrective Action Steps	Responsible Party	Time Line
Assessment/Treatment/Habilitation or Service Plan **Reference: 10A NCAC 27G.0205(C-D)**	Multicultural Resources Center, Inc. QP will revise Treatment Plan with Guardian and Provider for client and identify strategies to prevent and decrease incidents of cutting by client. QP will develop checklist of steps for staff to follow if client cuts himself. Each staff member will review client's treatment plan and checklist of steps to follow if client cuts himself. Staff members will interact with client to allow opportunity to decrease seclusion while monitoring his activities to provide prompts for coping skills and ways to manage frustrations when he seems to become agitated. Staff will check facility grounds daily for debris and objects that can be used by client for cutting. Client's room will be checked daily for contraband and anything that can be used for cutting by client. Staff will annotate date and list of any items that are found. Staff will remove found items that could be used by client for cutting to prevent use by client and ensure proper disposal.	Staff – will conduct checks of grounds and client's room for items to cut with annotating date and items found. Staff will review treatment plan and checklist for client if he cuts. Staff will monitor and provide prompts so client can manage frustrations and remain safe. Staff will notify QP and Facility Director of daily activities. QP – will revise client's treatment plan and develop checklist for steps to follow if client cuts himself. QP will ensure staff is updated of revision to treatment plan and procedures to follow if client cuts himself. Will review daily updates of client's activities and checks. Will inform Facility Director and Director of status client's	**Implementation Date:** 09/10/2020 – On going **Projected Completion Date:** 10/03/2020

		activities and daily activities. Facility Director - will review updates of client's activities and checks made by staff. Will review treatment plan and checklist for client. Will notify Director of client's update for activities and daily checks. Director – will review revision of treatment plan and checklist of procedures for staff to follow if client cuts himself.	

Dr James W. McGrady

(Signature)

Dr. James W. McGrady, Jr. Director

(Name / Title)

9/28/20

(Date)

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

September 18, 2020

James W McGrady, Director
Multicultural Resources Center, Inc.
980 Kennesaw Drive
Fayetteville, NC 28314

Re: Complaint Survey Completed September 10, 2020
Multicultural Resources Center-Group Home #2, 2423 Highway 401 Business, Raeford, NC 28376
MHL# 047-166
E-mail Address: cdcmcrcinc@gmail.com
Intake # NC00167504

Dear Mr. McGrady:

Thank you for the cooperation and courtesy extended during the Complaint survey completed September 10, 2020. The complaint was substantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violation is cited for 10A NCAC 27G .0205 Assessment/Treatment/Habilitation or Service Plan-V112.

Time Frames for Compliance

- Type A1 violations must be ***corrected*** within 23 days from the exit date of the survey, which is 10/3/20. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation(s) by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of $500.00 (Five Hundred) against Multicultural Resources Center, Inc. for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown at 919-855-3822.

Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:

DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Assistant