PRINTED: 03/07/2022
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
	MHL047-140	A. BUILDING: _____ B. WING _____	R 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL RESOURCE CENTER - GROUP HOM	249 JOYCE LANE 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 An annual and follow-up survey was completed on March 3, 2022. Deficiency cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness The survey sample consisted of audits of 3 current clients.	V 000		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) 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. (e) Formal refresher training must be completed	V 536		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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V 536	Continued From page 1 by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and	V 536		

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MULTICULTURAL RESOURCE CENTER - GROUP HOM	249 JOYCE LANE RAEFORD, NC 28376

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V 536	Continued From page 2 (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) 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. (5) 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. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.	V 536		

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MULTICULTURAL RESOURCE CENTER - GROUP HOM	249 JOYCE LANE RAEFORD, NC 28376

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V 536	Continued From page 3 (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the House Manager had current training on the use of alternatives to restrictive interventions. The findings are: Review on 3/3/22 of the House Manager's personnel record revealed: - Hired date of 7/23/18. - Evidence Based Protective Intervention training	V 536		

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V 536	Continued From page 4 expired 2/23/22. - There was no evidence of current training. Interview on 3/3/22 with the Qualified Professional/Facility Coordinator revealed: -Confirmed the house manager's EBPI training expired. -The house manager was unable to attend training scheduled on 3/2/22. -Trainings were done via zoom. -The house manager would be scheduled for EBPI training this week.	V 536		

Appendix 1-B: Plan of Correction Form

Plan of Correction 03/03/2022	
Please complete all requested information and submit completed Plan of Correction form to: **Frances E. Hicks, MSW** **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) 848-5515**
Provider Contact Person for follow-up:	**Jerome White, Facility Coordinator**	**Fax:**	**(910) 230-5542**
		Email:	**cdcmcrcinc@gmail.com**
Address:	249 Joyce Lane Raeford, NC 28376	**Provider #** 6006873	

Finding	Corrective Action Steps	Responsible Party	Time Line
Personnel Training on Alternatives to Restrictive Interventions **Reference: 10A NCAC 27E.0107**	Multicultural Resources Center, Inc. QP will ensure each employee receives training and continuous training on alternatives to restrictive interventions as they are employed to provide services to individuals with disabilities. Employee initial and annual refresher training will be documented and a copy of their certification shall be maintained within the employee file. QP will ensure employees are notified in timely manner to attend training and able to schedule make-up training date in case situation arises preventing them from attending originally scheduled training ensuring the employee does not fall out of compliance by having training certification expiring. QP will ensure that employee files will be securely maintained at the job site for access and accountability at any time.	QP – will ensure each employee has a current certificate for training on alternatives to restrictive interventions for employment and annual certification on file and that it is securely maintained at the site. QP will inform Facility Director and Director of status of employee training and their certification is placed in employee file. Facility Director - will review documentation of each employees training to ensure completeness notifying QP of any oversight and the Director of status for employment and annual training. Director – will review employee file for completeness.	**Implementation Date:** 03/03/2022 – On going **Projected Completion Date:** 05/01/2022

(Signature)

Jerome White — Facility Director
(Name / Title)

3/11/2022
(Date)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL047-140 (Y1)	A. Building B. Wing (Y2)	3/3/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MULTICULTURAL RESOURCE CENTER - GROUP HOME #1	249 JOYCE LANE RAEFORD, NC 28376

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 03/03/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY	REVIEWED BY	DATE	SIGNATURE OF SURVEYOR	DATE
STATE AGENCY ☐	(INITIALS)		Frances E. Hicks, MSW	
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE** Facility Compliance Consultant I	**DATE** 3/3/22
FOLLOWUP TO SURVEY COMPLETED ON 12/19/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

 EVENT ID: J9RL12

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

March 8, 2022

Mr. Jerome White, Facility Coordinator
Multicultural Resources Center, Inc.
980 Kennesaw Drive
Fayetteville, NC 28314

Re: Annual & Follow-up Survey Completed March 3, 2022
Multicultural Resource Center – Group Home #1, 249 Joyce Lane, Raeford, NC 28376
MHL# 047-140
E-mail Address: cdcmcrcinc@gmail.com

Dear Mr. White:

Thank you for the cooperation and courtesy extended during the annual and follow-up survey completed March 3, 2022.

As a result of the follow-up survey, it was determined that the deficiency is now in compliance, which is reflected on the enclosed Revisit Report. An additional deficiency was cited during the survey.

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

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is May 2, 2022.

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, Team Leader at 919-855-3822.

Sincerely,

Frances Hicks

Frances E. Hicks, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
QM@partnersbhm.org
dhhs@vayahealth.com
DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Assistant