

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/21/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MULTICULTURAL RESOURCES CENTER - GR	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>A follow up survey was completed on May 21, 2024. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for six and has a current census of six. The survey sample consisted of three current clients.</p>	V 000		

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