STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL047-174	B. WING		03/27/2025	
NAME OF F	PROVIDER OR SUPPLIER	L	DDRESS, CITY, ST			
		6188 AR	ABIA ROAD			
MULTICU	JLTURAL RESOURCE	S CENTER GRO	R BRIDGE, NC	28357		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
	An annual survey was completed on February 27, 2025. Deficiencies were cited.		,			
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
	This facility is licensed for 4 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.					
V 107	27G .0202 (A-E) Pe	ersonnel Requirements	V 107			
	description for the of which: (1) specifies the competency, work of qualifications for the (2) specifies the the position; (3) is signed by supervisor; and (4) is retained (b) All facilities shall each staff member provides care or set the facility: (1) is at least 1	Ill have a written job director and each staff position e minimum level of education experience and other e position; ne duties and responsibilities o y the staff member and the in the staff member's file. Ill ensure that the director, or any other person who rvices to clients on behalf of	,			
	(3) meets the rcompetency, work equalifications for the(4) has no sub	stantiated findings of abuse or e North Carolina Health Care				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-174					(X3) DATE SURVEY COMPLETED	
		B. WING		03/	03/27/2025	
AME OF PRO	OVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
IULTICULI	TURAL RESOURCE	ES CENTER GROU	ABIA ROAD R BRIDGE, NC	28357		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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) COMPLE ⁻ DATE
(0 a c d u w (0 c c a c c a s (6 e o v v	Continued From page 1 (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.		V 107			
B fa fi fi R si -L -I r Ir	ased on record re acility failed to com ffecting one of thro ndings are:	ntial Specialist. rification. 5 with the Facility				

				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL047-174	B. WING		03/27/2025		
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	·		
	JLTURAL RESOURCE	S CENTER CROI	ABIA ROAD				
	JETUKAL RESOURCE	LUMBER	R BRIDGE, NC	28357			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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) COMPLET DATE	
V 107	Continued From page 2		V 107				
	-He acknowledged	that it was misplaced. that documentation of staff bloma was not available.					
V 289	27G .5601 Supervis	sed Living - Scope	V 289				
	provides residential home environment these services is th rehabilitation of indi illness, a developm or a substance abu supervision when ir (b) A supervised liv the facility serves e (1) one or mo (2) two or mo (3) the facility. (3) "A" design serves adults whos developmental disa diagnoses; (3) "C" design serves adults whos developmental disa diagnoses; (4) "D" design serves minors whos	ng is a 24-hour facility which services to individuals in a where the primary purpose of e care, habilitation or viduals who have a mental ental disability or disabilities, se disorder, and who require in the residence. ving facility shall be licensed if					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL047-174	B. WING		03/27/2025	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	·	
NULTICU	ILTURAL RESOURCE		ABIA ROAD R BRIDGE, NC	28357		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From page 3 (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living					
	failed to ensure res provided in a home are:	et as evidenced by: ions and interviews the facility idential services were environment. The findings g room on 2/26/25 at				
	approximately 12:3					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL047-174	B. WING		03/27/2025	
AME OF F	PROVIDER OR SUPPLIER		I DRESS, CITY, ST		1 00/	
	ILTURAL RESOURCE	6188 ARA	BIA ROAD			
		LUMBER	BRIDGE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y 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) COMPLET DATE
V 289	Continued From pa	ige 4	V 289			
	wicker couch, and top.	1 wicker coffee table with glass				
	revealed:	5 with the House Manager				
	-There used to be a living room set in the living room. -A former client urinated the couch and destroyed					
	it. -The wicker set had been in the living room for five months or less.					
		5 with the Facility Professional revealed: the furniture in the living room				
	area. -The sofa set was r furniture.	eplaced with wicker patio				

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