

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MULTICULTURAL RESOURCES CENTER-GRO	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on May 5, 2026. The complaints were substantiated (intake #NC00236711 and #NC00237139). A deficiency was 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 4 and has a current census of 2. The survey sample consisted of audits of 2 current clients.</p> <p>A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.</p>	V 000		
V 290	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.</p> <p>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p>	V 290		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MULTICULTURAL RESOURCES CENTER-GRO	STREET ADDRESS, CITY, STATE, ZIP CODE 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 290	<p>Continued From page 1</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed staff meet minimum staffing requirements affecting two of two clients (#1 and #2). The findings are:</p> <p>Review on 4/30/26 of client #1's record revealed: -Admission date of 1/3/25. -Diagnoses of Schizoaffective Disorder-Bipolar Type, Mild Traumatic Brain Injury, Tobacco Use</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MULTICULTURAL RESOURCES CENTER-GRO	STREET ADDRESS, CITY, STATE, ZIP CODE 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 290	<p>Continued From page 2</p> <p>Disorder and Stimulant Use Disorder.</p> <p>Review on 4/30/26 of client #2's record revealed: -Admission date of 5/16/19. -Diagnosis of Schizophrenia.</p> <p>Interview on 5/1/26 with client #1 revealed: -He no longer goes to a day program because "I was kicked out." -He goes to Sister facility A during the day. -"I stay at (Sister facility A) for about 5 hours a day Monday thru Friday." -"I eat lunch there and just hang out." -"I would rather be working or going to a day program instead of going to (Sister facility A) everyday." -"I have been going to (Sister facility A) for about 6 months." -"We have to go to (Sister facility A) because they are short staffed." -"There is no staff working during 1st shift at this facility."</p> <p>Interview on 5/1/26 with client #2 revealed: -He goes to (Sister facility A) during the day. -"I have been going to (Sister facility A) for about 7-8 months." -"We stay at (Sister facility A) from 9:00 am to 2:00 Monday thru Thursday." -"On Fridays we stay at (Sister Facility A) from 9:00 am to 1:00 pm." -"We go over to (Sister facility A) because this home (facility) had no staff working during 1st shift."</p> <p>Interview on 5/4/26 with the House Manager #2 revealed: -There was no 1st shift at Sister facility A. -"[Client#1] and [client #2] go over to (Sister facility A) Monday thru Friday during the day."</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL047-166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2026
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MULTICULTURAL RESOURCES CENTER-GRO	STREET ADDRESS, CITY, STATE, ZIP CODE 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 290	<p>Continued From page 3</p> <p>-"[Client #1] and [client #2] had been going to (Sister facility A) daily for about 8-9 months."</p> <p>Interviews on 4/29/26 and 5/4/26 with the Facility Director/Qualified Professional revealed:</p> <ul style="list-style-type: none"> -This facility had no 1st shift staff. -He was aware clients #1 and #2 were staying at Sister facility A during the day. -Client #1 was going to a day program during the day. -"We are in the process of trying to get clients into a day program." 	V 290		