STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 April 6, 2021. The complaint was unsubstantiated. (intake #NC00175364). Deficiencies were cited. This facility is licensed for the following service category: - 10A NCAC 27G .5600C: Supervised Living for Adults with Developmental Disabilities	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 118	Continued From page 1 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to administer medications on the written order of a person authorized by law, to prescribe drugs, for one (client #1) of three clients surveyed. The findings are: Review on 3-17-21 of client #1 ' s facility record revealed: - admitted 9-15-17 - 23 years old - diagnosed with: - Intellectual Disability, Mild - Bipolar Disorder - Post Traumatic Stress Disorder - an admission assessment on 9-15-17 that noted: - confused thinking - poor judgement - self-injurious behaviors - frequent lying - conduct problems Review on 4-1-21 of client #1 ' s medications revealed: - famotidine 20 milligrams (mg), 2 every	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 118	Continued From page 2	V 118		

morning (am)
- multi-vite tablet, 1 daily
- trazodone 150 mg, 2 at bedtime
- benztropine mesylate .5 mg, 1 at bedtime
- aripiprazole 30 mg, 1 at bedtime
- lithium carbonate 450 mg, 1 twice daily
- propranolol 20 mg, 1 three times daily
- cetirizine 10 mg, 1 daily
- prozosin 1 mg, 3 at bedtime
- quetiapine fumarate 100 mg, 1 twice daily
- quetiapine fumarate 200 mg, 1 at bedtime
- Prior to 2-24-21 client #1 was ordered by her physician to take:
  - quetiapine fumarate 200 mg, 1 three times daily
  - quetiapine fumarate 100 mg, 1 at bedtime (with the third 200 mg dose)
- Prior to 2-24-21, the total daily amount of quetiapine fumarate was 700 mg
- on 2-24-21 a discontinue order was written for the 700 mg per day regimen, and a new order written for 100 mg twice daily with 200 mg at bedtime
- the new physician ' s order provided a total of 400 mg daily

Further review on 4-1-21 of client #1 ' s MAR revealed for the month of February, 2021:
- the 200 mg dose of quetiapine fumarate was not marked as given on 2-14-21
- despite the discontinue order dated 2-24-21 for the regimen of quetiapine fumarate 200 mg, 1 three times daily, that regimen was continued four more days:
  - 2-25-21
  - 2-26-21
  - 2-27-21
  - 2-28-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 118	Continued From page 3 Observation at approximately 10:15 am on 4-6-21 of client #1 ' s medications revealed: - the pharmacy used bubble packs to contain medications - the bubble packs divided each day ' s medications according to dosing time ordered by her physician - the medication count was accurate Interview on 4-6-21 with the Qualified Professional revealed: - the MARs are filled out accurately - "if a staff signed off on a med (medication) saying it was given, then it should be" - sometimes there are changes in medications before the end of a month - It is up to the pharmacy as to how long it takes to get a new medication to the facility Interview on 4-6-21 with Staff #1 revealed: - the MARs are accurate - she reviews previous months MARs for accuracy - the nurse that provides Medication Administration training comes to the facility every other month to review MARs - MARs are initialed immediately after administering each medication - when medications are changed before the end of a month, the pharmacy makes a special trip to the facility to deliver the new medication - if the appointment with the doctor is before noon, the new medication comes the same day - if it ' s afternoon, the new medications come to the facility the next day Interview on 4-6-21 with Staff #3 revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 118	Continued From page 4 - the MARs are accurate - "If the meds on the MAR are noted and initialed as given, then that med was given" - When there is a mid-month change, the pharmacy calls the facility Director ahead of time, to ensure someone will be at the facility to receive the medication - the new medication comes in a little white bag with the client ' s name on it - they often come late in the day to deliver new medication in the middle of the month - "If they don ' t bring it the same day as the doctor ' s appointment, it ' ll be the next day." Interview on 4-6-21 with a Registered Nurse unrelated to the facility revealed: - when a medication is discontinued by a physician, it should be stopped immediately - orders given by a physician should always be followed - if the patient has medication on hand and the exact dose as ordered by the physician can be given, then the order should be followed - if a facility ' s staff are confused or do not know what to do, they should contact their pharmacy for further instructions Interview on 4-6-21 with the facility Director revealed: - the same nurse that provides Medication Administration Training, reviews the facility ' s MARs about every other month, for accuracy - if there were any discrepancies in the MARs, she would have to, "look into it" - medications are delivered to the facility by the pharmacy - using this pharmacy and their bubble packs has drastically reduced med errors	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 118	Continued From page 5 - facility staff have been doing very well using the bubble pack dispensing system of medications, supplied by the pharmacy - if the pharmacy didn ' t deliver the medications on time, it was not her fault - if the MARs were not accurate, it was due to the Co-vid 19 pandemic	V 118		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 6	V 537		

methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Acceptable training programs shall include, but are not limited to, presentation of:
(1) refresher information on alternatives to the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their importance and purpose; and
(8) documentation methods/procedures.
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 7 (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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. (5) 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 (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 8 (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) 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 outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) 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. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on observation, interview and record review, a facility staff employed a physical restraint, without having been trained, for one	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 9 (staff #3) of four staff surveyed. The findings are: Review on 3-17-21 of client #1 ' s facility record revealed: - admitted 9-15-17 - 23 years old - diagnosed with: - Intellectual Disability, Mild - Bipolar Disorder - Post Traumatic Stress Disorder - an admission assessment on 9-15-17 that noted: - confused thinking - poor judgement - self-injurious behaviors - frequent lying - conduct problems Review on 3-17-21 and 4-6-21 of Staff #1 ' s personnel record revealed: - hired 9-28-20 - position was Paraprofessional - completed National Crisis Interventions Plus (NCI+) training on Alternatives to Restrictive Interventions on 12-14-20 - no certificate or document showing successful completion of a training on Seclusion, Physical Restraint and Isolation Time Out Review on 3-16-21 of a Department of Social Services (DSS) Complaint Form completed 3-10-21 revealed : - client #1 was brought to their regular dentist office on 3-10-21 - the purpose of the visit was a chipped tooth and a missing tooth of client #1	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 10 - client #1 told dental office worker, facility staff #3, "forced her to the ground and punched her in the face." - client #1, " ...has a black eye and facial bruising." - "LE (law enforcement) was called and has taken a report." - "LE spoke with the group home owner, [Director (Dir)], who reported the adult (client) attempted to hit staff and staff took her to the ground in a therapeutic hold." - Dir reported once client #1 was secured by staff, she had her own tooth in her hand - Dir reported the other tooth had been chipped for 4 years - client #1 does not need medical attention - DSS staff who interviewed facility staff #3, reported staff #3 stated she secured client #1, "by her arms and taking her to the ground face first. According to the reporter, the adult (client #1) was taken down with no face support." Review on 3-18-21 of incident reports revealed: - an event occurred on 3-6-21 involving client #1 and staff #3 - client #1 pulled her front tooth out - client #1 stated her tooth had been loose all week - client #1 reported, " ...that she didn ' t want a wiggly tooth, because it was embarrassing" - " ...cause of this incident: [client #1] was placed into a hold after being verbally and physically aggressive with staff," - "Incident Prevention: Staff could have used planned ignoring after [client #1] went into her room and was yelling out curse words towards staff and her peer." - "Does this incident include an allegation	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 11 against the facility? No" Review on 3-19-21 of a "Health Care Personnel Registry 5-Working Day Report" prepared by the Dir revealed: - "Client pulled out one of front teeth after complaining about it being loose. Client was placed in a NCI (National Crisis Interventions) hold prior to her pulling out her tooth, which caused a bruise under her eye. While attending a dentist appointment at [dental office] concerning her tooth, a client told a staff member that she was restrained by a staff member at the adult group home in which she resides after she was questioned about a bruise that she had under her eye. The dentistry staff contacted the local police department and Adult Protective Services were called to the dentist office to prompt an investigation." Interview on 3-18-21 with the Office Manager at the dental office revealed: - the Dir called on 3-9-21 to make the appointment for client #1 and reported client #1 had pulled her own tooth - client #1 was triaged by the Office Manager - client #1 ' s, "tooth was chipped, but it didn ' t show up on the x-ray." - stated client #1 said, "I was being bad and they took me down (was restrained)" - client #1 added, "I was messing with my tooth and I pulled it out" - "I asked her if she was sure that ' s what happened, and she said something about possibly hitting it on something, maybe her bed" - "We called 911. Not sure exactly what time. Their appointment was at 11:50 and I think they were a little early. I don ' t have any idea (what	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 12	V 537		

time the police were called), but it didn ' t take them long to arrive"
- asked what time the police arrived and she stated, "I don ' t know what time that was either."
- "[client #1] did not have a black eye. I don ' t know how that got reported"
- "I feel sorry for these kids every time they come in."

Surveyor requested and was given copies of client #1 ' s dental x-rays

Observation on 3-18-21 at approximately 10:15 am revealed:
- client #1 was in the facility and interviewed
- client #1 was asked about her having a missing tooth, and she exposed the spot where her tooth had been
- there was no other unusual or unexpected marks on client #1 ' s face

Interview on 3-18-21 with client #1 revealed:
- she had been physically restrained on 3-6-21
- "I went crazy. I was so mad, I was using my hands in a bad way."
- when asked if she was face up or face down, client #1 stated, "I ' m not sure, but I think face up because my face was facing her (staff #3 ' s) face"
- her tooth was pulled out by herself, not coming out as a result of the restraint
- her tooth had been " ...loose a long time. It ' s been wiggling all the time. I didn ' t hit my tooth during the restraint. I had calmed down, and later I pulled it out."
- when asked why, client #1 stated, "It was just dangling. I didn ' t want to go around different places and people see my tooth all wiggly. It ' s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 13	V 537		

kind of embarrassing."
- she remembered going to her dental visit 3-10-21
- "the dentist office was like a nightmare. I wanted to get my tooth fixed, but that lady wouldn ' t take my answer. I told her I pulled it myself, but she kept saying, ' I doubt that, I doubt that ' ."
- "I lied to the dentist office people. She wouldn ' t take my answer as I answered her questions. I started getting frustrated in there. I told her I pulled it out and she said, ' I don ' t think so, I think somebody hit you ' ."
- I don ' t know why she said that. Ever since I ' ve been going to that dentist, they always ask me the same questions. She said, ' you just can ' t pull out your own tooth ' ."
- "They wouldn ' t let me leave"
- "She asked me the same questions before. She asked me if anybody ' s ever hit me. I don ' t know if they ' re trying to get something out of me. She wouldn ' t stop badgering me."
- when asked why she didn ' t get her tooth fixed instead of pulling it out client #1 stated, "It was on a Saturday and I didn ' t want to wait."
- "I know nothing happened (during the restraint) in the house (group home), but that ' s not what they wanted me to say."

Interview on 3-19-21 with local law enforcement officer (LEO) revealed:
- client #1 told him she had gotten into an argument with staff #3
- she told him that staff #3 took her down in her room and did so without protecting her face
- "I couldn ' t tell if [client #1] was telling the truth or not. I don ' t know if that ' s really what happened or if she was embellishing it to make her staff look bad."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 14 Interview on 3-31-21 with client #1 ' s legal guardian (LG) revealed: - client #1 has a history of lying - she also has a history of self-injurious behaviors - she was aware of the incident on 3-6-21 - "she said she got upset because she thought I was her turn to go to the dentist the week before, but it turned out to be another client ' s turn, and she got upset and pulled the tooth." - "She always tells me she feels safe in the home, she always responds the same. She ' s always been compliant and forthcoming with me." - "It ' s typical of her to lie or manipulate in situations, then when things get big or blow up, she backpedals on her lies." - "I know there was a restraint done, but I haven ' t heard of her bleeding or getting hurt from it." Interview on 3-31-21 with client #1 ' s former legal guardian and Licensed Professional Counselor (FLG/LPC) revealed: - client #1 has, "done some self-harm when she didn ' t get her way, she scratched herself quite a lot ..." - "she would lie, exaggerate things and manipulate people to get her way." - "she would easily get upset with staff, other residents and really blow up. She would accuse staff of stuff that didn ' t happen" - "it makes sense that she would mess with a tooth until it came out, more so than somebody hit her and knocked it out" - "she has a pattern of behavior of blaming other people for doing things to her, when they really didn ' t ... or accusing a staff person of hurting her. She does this for attention"	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 15	V 537		

- "I could see her having a loose tooth, and taking it to another level, just to get attention. That really sounds like [client #1]"

Interview on 4-5-21 with Department of Social Services Adult Protective Services Investigator (APS) revealed:

- "I talked to everyone, including the guardian, people at the dentist office, the client, and LEO."
- "she said she was lying at the dentist office and that it never happened"
- "she did say her tooth was chipped when she was a child. An old injury."
- " ...her Psychiatrist discontinued her Seroquel and that contributed to the outburst episode when she needed to be restrained. She said she lied and feels safe at the group home."
- "when I talked to the dentist staff, I couldn ' t tell about the time sequence of what happened"
- "based on what she ' s done in the past, she has injured herself in the past, accusing people of things, then later admitted she lied. They said whenever her medication is changed, she exhibits these kinds of behaviors"

Interview on 3-30-21 with staff #3 revealed:

- she was working at the facility on 3-6-21
- she recalled the incident involving client #1 being restrained
- "she went to her room and started yelling, cussing and calling out other consumer ' s names"
- "I went to her room to check on her and she took her jacket off and swung it at me. (then) she started swinging at me, trying to hit me. Then she started tearing up her room, and we ' re not supposed to let them destroy things"
- "I didn ' t want her to get hurt, so I restrained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 16 her. She continued to try to hit me, swinging at me. I did the wrap, and we both went to the floor" - "I was only holding her about 10 minutes" Interview on 3-31-21 with the instructor who provided NCI+ (National Crisis Interventions Plus) training (NCI-Trainer) revealed: - a training was held on 12-14-20 - the training was provided virtually, via the internet - alternatives to restrictive interventions was taught (Part A) - all training provided by him in the last year has been taught virtually, which he was approved to do, as long as it did not include the physical intervention portion of Part B - defensive blocks and self-protection were taught - "I make it very clear when I do the virtual refresher, that (putting) hands on clients, are not part of training from this past year" - "I ' ve been teaching defensive techniques and the prevention (part A) part, but not physical restraints" - When asked specifically about the training on 12-14-20 he stated, "that ' s not okay, I didn ' t give her or anybody over there (at AGAPE Home Living Care LLC) a restrictive (intervention) certificate." - "There ' re no techniques I teach, where you maintain contact with clients on the floor. You ease them down and let them go," he stated Interview on 3-30-21 with the Qualified Professional revealed: - she speaks with each client individually every week - "Nothing has ever, no never, been	V 537		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411146	A. BUILDING: _____ B. WING _____	C 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

(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 537	Continued From page 17	V 537		

mentioned to me about [staff #3] that was concerning"

- she was aware of the incident that took place on 3-6-21, because she was called that day
- client #1 was restrained because, "she was getting irate with Ms. [staff #3] and the other clients. It became physical when she tried to hit Ms. [staff #3]. That ' s what ultimately got her into the (therapeutic) hold. I don ' t know the specific hold, but she did restrain her (client #1) on the floor.
- "[client #1] said she was just restrained, but it wasn ' t anything beyond that, everything was fine. [client #1] actually apologized for what happened (prompted the restraint).
- because of the incident, "We made plans then (3-6-21) to have a meeting at the group home with the clients and staff. We had that meeting on Monday the 8th of March. The meeting went fine. We met with each client individually, not as a group. We were there talking with everyone about 2 and ½ hours."
- "no one denies ..." client #1 was restrained