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V 000	INITIAL COMMENTS A follow up and complaint survey was completed on April 27, 2022. The complaint (Intake #NC00187584) was unsubstantiated. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have	V 291		

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activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility staff failed to coordinate services with other agencies for 1 of 1 Former Client (FC #1). The findings are:

Review on 4/21/22 of Former Client #1 (FC #1)'s record revealed:
-An admission of 10/1/21
-Diagnoses of a History of Schizoaffective Disorder, Mild to Moderate Intellectual Developmental Disorder (IDD), Post-Traumatic Stress Disorder (PTSD), Impulse Control Disorder, Seizure Disorder, High Cholesterol, Dysarthria (a condition where problems occur with the muscles that help produce speech) and Anarthria (total loss of speech)
-A discharge date of 4/4/22
-An assessment dated 7/10/20 noted "consumer was in need of emergency placement do to his release date (was in a county's jail), history of touching females inappropriately, elopement, needs 1:1 services, has delayed speech, IDD and needs assistance with personal hygiene, patient was presented to [a local agency]'s Crisis and Assessment a total of 3 times in the past 12 months with current episode being a total of 7 days beginning on 12/31/18. Patient presented on 12/31/18 directly from the [a county] court where the judge ordered him to return for 2 sexual assault charges, needs to increase pro-social

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V 291	Continued From page 2 activities with a 1:1 present, LG (Legal Guardian) is seeking residential and service recommendations, date unknown but did assault his adoptive father with a knife and sexually assaulted his adoptive mother, these charges were dropped due to being declared incompetent, was adopted from Russia and was traumatized as a child (no known details), was transported on 1/10/18 by the [a city]'s police department from his Resources for Human Development apartment after reportedly asking females at [a hospital] to have sex with him, but was not admitted to the hospital, on 11/4/18: transported by the police following an incident where he reportedly grabbed a female's buttocks at a gas station, from 6/2/18 to 6/9/18, was presented to [a hospital]'s ED (Emergency Department] for aggression and was not hospitalized, returned with 30-day notice at the group home. [The Local Management Entity/Managed Care Organization (LME/MCO)] assisted with his treatment plan, needs support with completing ADL (Activities of Daily Living) skills, provide the supervision needed, make the most of his self-sufficiency, increase his self-determination, give him the opportunity to be integrated in his community, assist with attending doctor appointments and receiving assistance, behavior support plan should assist him in improving communication, reducing changes of anxiety/frustration, learn social skills and how to appropriately address his sexual urges, history of stealing and anger, requires a high level of structure during the days and evenings, needs a strong male presence, is a severe community safety risk to others related to actual and attempted assault and injury to others and sexual aggression, has been convicted of a crime related to these risks and he has been in jail 3 times, the nature of the charges have involved physical aggression or sexual assault,	V 291		

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V 291	Continued From page 3 requires a specially controlled home environment and direct supervision in the home and in the community at all times, requires extensive caregiver support to prevent emotional outbursts (cursing, screaming and yelling), confrontational with staff, requires verbal redirection, triggers include when he feels as if he is being disrespected, not understanding what is needed and not having routine or structure, requires extensive support with how and when to talk to people, soliciting others for sex, asking women if they will have sex with him, inappropriate language around women and female staff, staff should stay within 5 feet of [FC #1] to assure the safety of women, without these supports, he is at risk of being accused of sexual behaviors or acts, a history of multiple property destruction and spent close to a year in jail, needs to practice de-escalation skills to prevent property damage (breaking furniture, throwing items that can break), due to his history of stealing, he needs periodic room and body searches, needs reminders of boundaries and expectations to prevent him from wandering away." -A treatment plan dated 10/5/21 noted "Long range goals: will strengthen existing ADL skills and develop independence with new skills, will learn appropriate social skills, skills that allow for controlled appropriate expression of emotions when interacting with others in the home and community, will work with professional supports in order to develop, monitor and implement his positive behavior support plan to address his interactions with others, will utilize health and safety throughout the plan year, will receive assistance with medication management, will be monitored 24 hours per day to ensure his safety, will e linked to community resources in order to enhance developmental growth and well-being, needs to develop healthy relationships with	V 291		

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non-disabled peers, requires supervision 24 hours a day 7 days a week and is to never be left alone. Will develop healthy relationships and improve his health by exercising and attending exercise activities and classes in an integrated community setting, will be given crisis support, planning and consultation to better manage his daily functioning, improve his coping skills and increase stability in the community and home settings, staff should always stand within arm's length of him, will receive out of home crisis respite services."
-A Behavior Support Plan (BSP), dated 10/1/21, noted "assist him in improving communication, reducing changes of anxiety/frustration, learn social skills and how to appropriately address his sexual urges, requires a high level of structure during the days and evenings, needs a strong male presence, is a severe community safety risk to others related to actual and attempted assault and injury to others and sexual aggression, requires a specially controlled home environment and direct supervision in the home and in the community at all times, requires extensive caregiver support to prevent emotional outbursts, cursing, screaming and yelling and is to never be left alone, when triggered, [FC #1] has occurrences of attempts to engage in sexually offensive / inappropriate behaviors include invading other people's space/violating personal boundaries for the purpose of sexual gratification, touching others without consent for the purpose of sexual gratification, rubbing his penis against females, touching female private parts. Many of his target behaviors arise when he has an opportunity to engage in the behaviors and is not monitored/supervised: needs to be monitored at all times: should never be left unsupervised with minors or other individuals that would be considered vulnerable this includes being

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supervised in public restrooms, should not be allowed to be unsupervised with a member of the opposite sex."

Review on 4/21/22 of the facility's level II incident report, dated 4/4/22, revealed:
-"[FC #1] was transported to [a local mental health agency] for an emergency appointment due to escalating behaviors at the residential facility (urinating on himself, hallucinations, no following re-direction, agitation, communicating threats and using verbal aggression). Once brought to the back (of the agency) for an assessment, [FC #1] did not want to participate. He knocked the computer screen over and attempted to push the modem off the desk. He then began to strip naked out of his clothes. The therapist that was on screen called her support supervisor who decided to file an IVC (Involuntary Commitment) for [FC #1] for his behaviors after seeing his actions. After the IVC was filed, I was told that we could not leave the property with [FC #1] and that the sheriff would be on their way to pick up [FC #1]. [FC #1] kept stating that he was hot and would take off his shirt and put it back on. [The local mental health agency]'s staff said it was ok for him to go outside and get some fresh air. In the meantime, we had to wait approximately 4 hours before he was picked up. During that time, he ran around the building, laid on the ground as it he was in combat training and rolled around. He would pick up sticks and throw them at cars and against trees. He attempted to lay in the middle of the road but was stopped by staff. Staff continuously asked [FC #1] to go inside but he repeatedly said that he was fine and that he wanted to be outside. Eventually, [FC #1] did come go inside and had some water. He spilled some of the water while drinking it and took off his shirt to wipe up the spilled water,

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despite it being on the carpet. [FC #1] then begun to throw his shirt into a pile across from him and then would move over to the pile and then throw it across from him, again, moving all around the waiting area at [a local mental health agency]. When he saw a sheriff's car drive by, he ducked down under the window and laid down in the middle of the floor and laid flat and still. When he got up, he saw a second car pull into the parking lot and he rolled back on the floor and went underneath the waiting area chairs. [The local mental health agency]'s staff came out and told [FC #1] to put his clothes back on and explained to the sheriff why the IVC was called in. [FC #1] was calm while being escorted [to a hospital] from [a local mental health agency]."
-"[FC #1] was taken to an emergency appointment with [a local mental health agency] and IVCed due to his behaviors at the appointment."

Review on 4/22/22 of the 1st shift's daily summary sheet for FC #1, written by the House Manager (HM), revealed:
-The summary sheet was dated 4/4/22
-"When I arrived, consumer was there and walking around in his room. He had his morning medications then had breakfast. Then we went to [a mental health agency] for an emergency psychiatric evaluation due to his behaviors, things that he has been doing for about a month and a half, we went into the room and he refused to talk to the therapist on the IPad. He closed it down and I told him don't do that. He then started walking around with it. I took it from him to talk to the therapist. He was yelling and following staff around the room, yelling and telling staff he don't want to talk to the lady (therapist), and she didn't know him. Staff explained to the therapist these are the behaviors staff have been dealing with.

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V 291	Continued From page 7 Staff tried talking to [FC #1] about speaking with the therapist. He started trying to undress himself on camera. Staff asked him not to do that. Then he was towards staff to so the ....I went to get male staff (staff #1) calm him down. He yelled and told male staff "No. No. Get away" (from him) and staff tried to talk with him, but he still was non complaint to everything. [The Licensee] agree to do an IVC on him herself due to his concerning behavior. Then they (the sheriff's deputy) arrived with the IVC papers. [FC #1] was picked up and taken to the hospital to get help, so he could return home." An interview with FC #1 was not conducted due to his involuntary commitment to a psychiatric unit and not currently being at baseline and FC #1's LG stated he was not at baseline. Interview on 4/21/22 of Former Client #1 (FC #1)'s Legal Guardian (LG) revealed: -FC #1 was currently inpatient at a psychiatric hospital's unit -Was not a decision the LG agreed with when FC #1 was involuntarily committed -"I had a missed call from [the Licensee], around 10pm. but no voicemail message. I was not made aware the decision. Apparently there is some trauma going on with him while he was at [the facility]. I was told he was always doing well, but then things started to reveal themselves ...we are not clear as to why he was IVCed. We were told he was at an appointment at [outpatient counseling agency] ...he was having minimal behaviors and then they escalated ...He was in a safe room while at the hospital and for some reason, [the Licensee] decided to take him outside where he rolled around in the road. There were no behaviors warranting her to remove him from the room ...our Agency was not notified of	V 291		

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V 291	Continued From page 8 him being at the hospital until medical staff called...The facility staff stated [FC #1] had not had any behaviors during our treatment team meeting, then all of a sudden, things started to reveal themselves. I had concerns with his care...we (the treatment team) were not real clear as to why he was IVCed. I know he was seen at [a local mental health agency] for an appointment due to minimal behaviors. I was told by [the Licensee] his behaviors had escalated. [The Licensee] apparently took his outside where he started rolling around in the grass and in the road. No behaviors warranting him to leave the safe room at [the local mental health agency]. I only learned of the IVC when the hospital staff called me and not [the Licensee]..." Interview on 4/22/22 with the House Manager (HM) revealed: -"I took him (FC #1) to do an emergency psych eval for unusual behaviors...we thought maybe his medications were no longer working. Prior to that date (4/4/22), he had some teleconferences with [a new therapist]..." -FC #1 was to have sessions in privacy in his room. -"He would not talk to her. We had an IPad that he was using. I would check on him and saw that he was trying to close the IPad. He kept saying the therapist did not know him and then started to remove his clothes... I had not ever seen him act this way...His behaviors continued when he was taken to [a local mental health agency].. he started removing his clothes again. I told the staff that was the reason we had come and to have him evaluated. It is my understanding his LG did not want him IVCed...when the staff there saw how he was acting, they decided to have him committed. I stayed with him until the sheriff came and I have not seen him since..."	V 291		

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V 291	Continued From page 9 Interview on 4/25/22 with FC #1's Clinical Supervisor at a local mental health agency revealed: -A facility staff member brought FC #1 into their Agency due to several reports of sexually inappropriate sexualized behaving. -"I was not even sure he was appropriate for outpatient services. The Medical Doctor wanted a psychiatric evaluation on him. I witnessed in the hallway of our building, that he was rolling around on the floor. There was a young lady (staff member) with him. When I redirected him to get up off the floor, he followed my voice prompts and was very receptive. Then the Owner, the QP and a male staff arrived and he got agitated and took his shirt off. When it was time for his assessment, he was very calm. Anytime the Licensee and QP came into the room, he went all to pieces. For some reason during the chaos, he became agitated. I had left the room to start in the IVC papers,.a total of 6 people from the group home had arrived. I asked some of them to leave the room and to go and wait in the lobby. After the sheriff was coming to pick him up and the sheriff got lost. The QP and the Licensee had [FC #1] outside. [FC #1] started to roll all over the grass. I was told he needed some air. I also asked him if he wanted any water, but he said he did so I asked him to come inside and he did! When the sheriff arrived, they asked him if he wanted to go with them. He stated please. I feel like it was too much for him (with everyone there)...he needed to be evaluated because his behaviors here were out of control...It would not work to have him return to the facility. It appeared to me that the facility staff were not equipped to handle his behaviors,.." Interview on 4/22/22 with FC #1's Legal Guardian	V 291		

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V 291	Continued From page 10 revealed: -The Licensee admitted him into the facility on or about 10/1/21 -"She moved him without letting us know ahead of time. We were not informed -During treatment team meetings, FC #1's LG stated the facility staff informed him that everything was fine with FC #1 and his behaviors -Did not feel any of his behaviors warranted him being involuntarily committed. -Had a missed call from the Licensee on 4/4/22 but no voicemail message was left by her.. -Was not informed FC #1 was going to be involuntarily committed until the hospital staff called him. -No one from the facility had notified him. -Was not sure why FC #1 was being involuntarily committed. -FC #1 had been declared incompetent. -"She (the Licensee) moved him (to a licensed facility) without letting us know ahead of time. We were not informed, so we just rolled with it. He was doing amazing during all of our monthly meetings (per the Licensee)..." Attempted interviews on 4/25/22 and 4/26/22 with FC #1's therapist was not successful as no return telephone calls were received. Attempted interviews on 4/25/22 and 4/26/22 with FC #1's community navigator was not successful as no return telephone calls were received. Attempted interviews on 4/25/22 and 4/26/22 with FC #1's community crisis prevention and intervention worker from NC Start (Systemic, Therapeutic, Assessment, Resources and Treatment) was not successful as no return telephone calls were received.	V 291		

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V 291	Continued From page 11 Interview on 4/26/22 with FC #1's Clinical Psychologist revealed: -Had been FC #1's Psychologist since 2020 -Was not informed FC #1 had moved to the facility until after the fact -FC #1's LG was not informed of the move prior to a treatment team meeting after he was admitted to the facility -"The LG and I were left out of that decision. Apparently [the Licensee] made the decision on her own to move him..." -Had developed FC #1's Behavior Support Plan in November 2021 -The facility staff was to fill out data forms developed by the Clinical Psychologist -"I had requested the staff to document his actual behaviors and return the forms to me weekly so if we needed to address additional behaviors, we would add them to his BSP ...I never received any data forms from December 2021 to March 31, 2022." -The Licensee had not mentioned any behaviors FC #1 had exhibited during any of our treatment team meetings. -"We (the treatment team) relied on [the Licensee] to have her staff document his behaviors. Then, all of a sudden (April 1, 2022) we learned of an issue where he had a 'melt down' and was rolling around on the ground ..." -The Licensee notified the team she had given FC #1 a 60-day notice to have him discharged from the facility. -"Any time we expressed concerns to [the Licensee], she stated she felt attacked. It is my understanding [a mental health agency] decided to IVC him. We did not feel it was in his best interest to have him IVCed. [The Licensee] stated she felt our demands were too great for serve him. Anytime we mentioned our concerns, she said it was a personal attack on her ...she even	V 291		

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accused us of making a complaint on her and we did not ..."
-The Psychologist had trained the facility's QP on his BSP.
-"The majority of the time, when a BSP is developed, I personally train the staff. This did not happen."
-Was glad FC #1 was no longer at the facility.

Interview on 4/25/22 with the QP revealed:
-Had been trained on FC #1's BSP by his Psychologist
-The Licensee was to have the facility staff document FC #1's behaviors on the data sheets provided by the Psychologist
-"This did not happen and I don't know why. I had trained staff on the data forms and on [FC #1] BSP on 12/4/21..."
-When asked about FC #1's IVC and contacting the LG with this information, the QP stated she had not contacted him.
-"I can't even say if [the Licensee] contacted the LG or not ..."

Interviews on 4/25/22 and 4/26/22 with the Licensee revealed:
-FC #1 was originally placed at an apartment, then to an AFL (Alternate Family Living) home and on 10/1/21, he was placed at his current facility.
-Had been trained on FC #1's BSP
-FC #1's psychologist wanted data forms filled out weekly.
-"In December (2021) we were told the forms were not filled out correctly. The psychologist trained [the QP] on the forms in March (2022)."
-FC #1 showed his Schizophrenia and Bipolar disorders
-"He was having strange behaviors where he crawled under bushes, took a shower with his

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 _____	04/27/2022

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 291	Continued From page 13 clothes on and put rugs in the shower. This prompted me to make an appointment at [a mental health agency] to have him assessed on 4/4/22. The Agency staff witnessed his behaviors. They then decided to have him IVCed. His LG did not want him IVCed. He was very arrogant with me ..." -The Licensee stated she called FC #1's LG to inform him FC #1 had been IVCed. -"I am pretty sure I left a message, but I did not talk to him. We did not have [FC #1] committed, [the mental health agency] did ...I did not have time to keep calling [the LG] to let him know of the IVC ..." Further interview on 4/27/22 with the Licensee revealed: -She had informed the LG that FC #1 was IVCed at the hospital -Staff at the mental health agency could vouch for her -On the way back to the facility, her cell phone had spotty reception	V 291		