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AGAPE HOME LIVING CARE, LLC	310 FIELDS STREET GREENSBORO, NC 27405

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 9/20/2022. The complaints were substantiated (intake #NC192023, #NC192025 & #NC192879). Deficiencies were 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 6 and has a census of 5. The survey sample consisted of audits of 5 current clients. This survey originally closed on 9/7/2022 but was reopened on 9/12/2022 due to additional complaints. 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.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program	V 111		

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V 111	Continued From page 1 shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an assessment was completed prior to providing services affecting 4 of 5 clients (#2, #3, #4 & #5). The findings are: Review on 8/15/2022 of the facility's license revealed: - The date of initial licensure was 2/1/2022. Reviews on 8/15/2022 and 8/16/2022 of Client #2's record revealed: - Admission date: 2/26/2018 to sister facility A. - No documentation of the date she moved to	V 111		

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this facility.
- Diagnoses: Major Depressive Disorder; Mild Intellectual Developmental Disorder (IDD); History of Club Foot with 8 previous surgeries; History of Seizures and Traumatic Brain injury; and a history of physical and sexual abuse.
- An admission assessment dated 1/9/2018 for sister facility A revealed a history of Department of Social Services (DSS) involvement due to the family living in a tent, mental illness and substance use disorders in immediate family members, "weed" use by client, physical fights with a sibling, her father's aggression, her uncle had allegedly attempted to have sex with her when she was 17, and her hitting and kicking her mother.
- No documentation of an assessment having been completed prior to admission to the current facility.

Review on 8/15/2022 of Client #3's record revealed:
- Admission date: 7/21/2020 to sister facility A.
- No documentation of the date she moved to this facility.
- Diagnoses: Schizoaffective Disorder, bipolar type; Moderate Intellectual Disability; Diabetes type II; Hypothyroidism
- An assessment dated 7/21/2020 revealed a history of Fetal Alcohol Syndrome at birth, adoptive parents rescinded the adoption on an unspecified date, placement at residential facilities, and AWOL (absent without leave) from facilities.
- No documentation of an assessment having been completed prior to admission to the current facility.

Reviews on 8/15/2022 and 8/17/2022 of Client

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#4's record revealed:
- Admission date: 1/8/2021 to sister facility A.
- No documentation of the date she was moved to this facility.
- Diagnoses: Post Traumatic Stress Disorder; Generalized Anxiety Disorder; and Mild Intellectual Developmental Disorder
- An assessment dated 1/8/2021 revealed a history of verbal and physical aggression, assaulting staff members at previous placements, multiple residential placements, including hospitals, and was a victim of rape.
- No documentation of an assessment having been completed prior to admission to the current facility.

Reviews on 8/15/2022 and 8/17/2022 of Client #5's record revealed:
- Admission date: 9/15/2017 to sister facility A.
- No documentation of the date she was moved to this facility.
- Diagnoses: Bipolar I Disorder; Post-Traumatic Stress Disorder; Mild Intellectual Disability; Incontinence of urine; Gastroesophageal Reflux Disease (GERD); Constipation; Allergic Rhinitis; and Acne vulgaris
- A Psychiatric Consult and Liaison Service History and Physical Evaluation dated 5/7/2017 revealed a history of suicidal thoughts since she was a young child, and involuntary commitment proceedings at the time of the assessment due to having picked a scab on her wrist and attempted to cut her wrist with a rock.
- No documentation of an assessment having been completed prior to admission to the current facility.

Interviews on 8/17/2022 and 9/6/2022 with the Qualified Professional (QP) revealed:

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V 111	Continued From page 4 - Clients #2, #3, #4 and #5 had been moved from a sister facility to the current facility. - She did not realize that they needed a new assessment when they were admitted. Interview on 8/15/2022 with the Director revealed: - Four of the five clients at the facility had previously lived at a sister facility. - She moved Clients #2, #3, #4 and #5 into the facility after she obtained the license. - The QP was responsible for completing assessments.	V 111		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care	V 132		

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V 132	Continued From page 5 facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of all allegations against facility staff and the results of investigations were reported to HCPR within five working days of the initial report affecting 3 of 6 audited staff (#2, #3 & the Director). The findings are: Reviews on 8/17/2022 and 9/7/2022 of the facility's level 2 and 3 incident reports in the Incident Response Improvement System (IRIS) revealed: - There were no incident reports present with	V 132		

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V 132	Continued From page 6 24-hour notification or 5-working report of investigation results related to allegations of abuse made against Staff #2, Staff #3 and the Director on 8/11/2022. Review on 8/17/2022 of HCPR forms with fax cover sheets provided by the Qualified Professional (QP) revealed: - A packet of "Initial Allegation Report" forms was faxed to HCPR with a timestamp of 8/12/2022, but had the date of 3/11/2022 listed on the cover sheet completed by the QP. - There were three reports for Client #3 with allegations against Staff #2, Staff #3, and the Director. - The allegation dates were listed at "3/11/2022." - A packet with a "5-Working Day Report" form was addressed to HCPR but did not have a timestamp showing the date it was sent. - The cover sheet had the date of 3/16/2022 listed on the cover sheet completed by the QP. - There was one 5-Working Day Report for Client #3 with the investigation for Staff #2 only. Review on 8/17/2022 of printouts of incident report forms provided by the Qualified Professional (QP) revealed: - There were five printouts present, one for each client. - Each printout listed "Date of Incident: 8/11/2022" and "Date Last Submitted: 1/1/0001" on the first page. - There was no confirmation of submission to IRIS on the printouts. Interview on 9/1/2022 with Client #1 revealed: - Staff #2 had punched her in the face, hit her with a paddle, hit her with her own (Client #1's) belt, and hit Client #3 with a paddle and her	V 132		

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V 132	Continued From page 7 hands on multiple days. Interview on 8/24/2022 with Client #2 revealed: - Staff #2 yelled at her and put her in a corner for an hour because she had not made her bed, had put a basket of dirty clothes on her head, and instructed her (Client #2) to fight her (Staff #2). - " ... [Staff #2] whooped [Client #1] and left a big ol' bruise on her ..." with a paddle. - She had overheard the Director tell Staff #2 to place a sock in Client #3's mouth. - She was unable to specify dates of the above incidents. Interview on 8/22/2022 with Client #3 revealed: - "They (Staff #2, Staff #3 and the Director) would switch you and punch you and stuff like that." - All clients except Client #2 had been physically abused by facility staff. - Staff #2 had stuffed a sock in her mouth once when she was yelling for help because she was being beaten. - Client #1 had bruises on her body "because they (facility staff) use a paddle or belt or switches on her ..." - She was not able to specify dates that verbal or physical abuse had occurred. Interview on 8/30/2022 with Client #4 revealed: - Staff #2 hit her "almost every day. She hit me upside my head, on my arm and she bent my arm back." - Staff #2 had called her a "b***h." - Staff #3 "hit me with a switch on my back ... a lot ..." - The Director had choked her. - Staff #2 had also put Client #3 "on the ground and was punching her in the face ... in her (Client	V 132		

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#3's) room."
- She could not remember the dates these incidents occurred.

Interview on 8/30/2022 with Client #5 revealed:
- "They (facility staff) beat the living crap out of me because I took food ..."
- This had occurred "a whole lot."
- The most recent time she had been beaten was last month.
- Staff #2 and #3 had been the staff who beat her.
- She had a scar on her right arm that resulted from Staff #3 hitting her with a piece of wire that came out of a clothes hamper.
- She had witnessed Clients #1, #2, #3 and #4 being beaten by facility staff.
- Facility staff also called her names such as "b***h and S**t."
- Staff #2 and #3 sometimes used their fists and sometimes used objects such as chairs or "slammed us to the floor."
- Staff #2 brought a belt from her own home to use on facility clients but took it home and "tries to pretend nothing happened."
- On an unknown date, she was attempting to roll down a car window and was told by the Director that she would 'break my fingers if I touched her stuff."

Interview on
Interviews on 8/17/2022 and 9/6/2022 with the QP revealed:
- On 8/11/2022, Staff #3 was coming in for her shift to relieve Staff#2 when the local DSS (Department of Social Services) Staff arrived.
- When she arrived at the facility, DSS was still there.
- She was informed that allegations that Staff #2,

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V 132	Continued From page 9 Staff #3 and the Director had abused clients #1, #2, #3, #4 and #5 had been made. - She had sent a fax to HCPR to make the initial notification of the allegations of abuse made on 8/11/2022. - The date of "3/11/2022" on the forms and the fax cover sheet was an error. - The correct date should have been 8/11/2022. - She thought that she had sent initial and 5-working day reports for each client. Interviews on 8/15/202 and 9/6/2022 with the Director revealed: - She learned that clients had made allegations against facility staff on 8/11/2022, when staff from the local DSS went to the facility. - The QP had investigated and reported the allegations made against facility staff.	V 132		
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	V 291		

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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 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 failed to maintain coordination of care between the facility operator and qualified professionals responsible for treatment/habilitation or case management affecting 1 of 5 clients (#1). The findings are:

Review on 8/17/2022 of Client #1's record revealed:
- Admission date: 8/20/2021 (when the facility was unlicensed)
- Diagnoses: Oppositional Defiant Disorder, severe; Attention Deficit-Hyperactivity Disorder (ADHD); Mild Intellectual Developmental Disorder (IDD); Other Specified Obsessive-Compulsive & related disorder; Enuresis, nocturnal & diurnal; and Smith-Magennis Syndrome (a developmental disorder that affects many parts of the body).

Review on 9/16/2022 of a local Police report revealed:
- On 9/8/2022, A male "Qualified Professional"

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(Staff #A-5) from the facility approached Police and requested assistance with Client #1 because she was causing a disturbance in the parked van.
- There were several clients inside the parked van with the female "Qualified Professional" driver (Staff #1).
- Staff #1 and Client #1 were arguing while sitting in the van.
- The Behavior Specialist from the Police Department spoke with Client #1 after Staff #1 exited the vehicle.
- " ... After a few minutes of talking to [Client #1], it appeared the biggest issue is [Client #1]'s dislike of the adult female QP (Staff #1) and [Client #1] showed signs of intellectual disability with her delayed responses. In reference to the female QP, [Client #1] stated "Old lady abusing me!" ... [Client #1] abruptly exited the rear passenger side of the vehicle and walked north towards [a nearby street]. I followed behind [Client #1] and attempted to communicate with her ... [Client #1] sat and lay in the middle of the roadway. At that time [Client #1] purposely struck the back of her head several times on the pavement. At that time, [Client #1] was placed in our custody for suicidal ideations and to prevent any further harm to herself. When I walked back to my patrol vehicle, I observed that the "Qualified Professionals," their van, and clients were no longer in the PVA (public vehicular area). They were no longer on scene. It is unknown where the staff and residents of AGAPE Home Care Living went to. The QPs were not asked to leave, and they did not inform anyone on [the Police Department] that they were leaving. Before the QPs left, they did not provide any information on [Client #1]. [The Behavior Specialist] and I did not confirm [Client #1]'s home address, we did not know who was [Client

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#1]'s guardian, and we did not know anything about [Client #1] except what was observed on the scene ..."
- Client #1 was taken to a local hospital Emergency Department (ED).

Review on 9/14/2022 of Client #1's hospital records revealed:
- Client #1 was admitted to the emergency department (ED) under involuntary commitment paperwork.
- Police Officers accompanied Client #1 at the time of her admission.
- The Behavior Specialist from the Police Department informed ED staff that facility staff had " ...abandoned the pt (patient), just left. Per [the Behavior Specialist], she spoke to the group home director who reported, the pt is a nuisance, she lies on them; the pt and four other female residents caused them to loose their license ..."
- On 9/11/2022 at 1527 (3:27 pm) ED staff "Attempted to contact Agape regarding transport of patient back to group home. No answer; voicemail left."
- On 9/11/2022 at 1704 (5:04 pm) an ED note revealed: "[The Director], from Agape, returned phone call regarding this patient. Informed [the Director] that the patient is getting discharged and needs transport back to the group home. [The Director] stated that they don't have any staff on the weekends and there isn't anybody to pick her up. [The Director] also stated that the patient made reports that the staff members were abusing her and there is a DSS (Department of Social Services) case. Due to the DSS case, [the Director] is not able to be around her. [The Director] expressed concerns regarding the patient's need for "higher level of care" and stated that this concern was expressed to the

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V 291	Continued From page 13 social worker on Thursday (9/8/2022). [The Director] explained that if the patient is "sent back and [client #1] threatens my staff, I have to protect my staff." [The Director] denies speaking with the social worker that made multiple attempts to contact someone from Agape ..." Interview on 9/20/2022 with Client #1's Psychologist revealed: - Client #1 had a behavior support plan that required documentation of any behaviors to be completed on an electronic behavior data form. - He did not receive any behavior data forms regarding Client #1's incident involving Police on 9/8/2022. - He should have been notified of Client #1's behavior immediately for coordination of care purposes. - He was reviewing documentation submitted to him from the facility, and it did not appear the facility staff were documenting Client #1's behaviors. Interview on 9/20/2022 with the QP revealed: - She personally went to the hospital ED to provide information about Client #1 on 9/8/2022. - She was allowed to go back into the ED to see Client #1. - She provided all of the information hospital staff requested to a pharmacy technician at the ED. - She sent an electronic link to Client #1's behavior data sheets to all facility staff. - The behavior data sheets were supposed to be filled out by whichever staff was present during Client #1's behaviors. Interview on 9/20/2022 with the Director revealed:	V 291		

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V 291	Continued From page 14 - She had spoken with the Police Officers by telephone on 9/8/2022 during Client #1's incident. - The Police Officers had been provided with all of Client #1's information. - She had offered to have the QP go pick up Client #1, but the Police said they were going to take her to the hospital. - The QP had gone to the hospital on 9/8/2022 and gave hospital staff information about Client #1. - On9/9/2022, Client #1 called her from the hospital. - While she was on the call, she spoke to a Nurse at the hospital. - Hospital staff did try to call her on Sunday, 9/11/2022 to tell her that Client #1 was ready to be picked up from the hospital. - Client #1's Guardian had told facility staff not to pick Client #1 up as she was going to try to locate a higher level of care for her. - Client #1's behavior data sheets had been submitted on time. - Client #1 had not been having many behavior issues until recently.	V 291		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where	V 367		

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V 367	Continued From page 15 services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident.	V 367		

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V 367	Continued From page 16 Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 17 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report level 2 and 3 incidents within required timeframes affecting 5 of 5 clients (#1, #2, #3, #4 & #5). The findings are: Reviews on 8/17/2022 and 9/7/2022 of the facility's level 2 and 3 incident reports in the Incident Response Improvement System (IRIS) revealed: - No incident reports had been submitted regarding Client #1'a facial and leg injuries sustained during the week of 8/7/2022. - No incident reports were present related to allegations of abuse made by Clients #1, #2, #3, #4 and #5 against Staff #2, Staff #3 and the Director on 8/11/2022. Review on 8/17/2022 of printouts of incident report forms provided by the Qualified Professional (QP) revealed: - There were five printouts present, one for each client. - Each printout listed "Date of Incident: 8/11/2022" and "Date Last Submitted: 1/1/0001" on the first page. - There was no confirmation of submission to IRIS on the printouts. Interviews from 8/17/2022 to 9/6/2022 with the QP revealed: - On 8/11/2022, Staff #3 was coming in for her shift to relieve Staff#2 when the local DSS (Department of Social Services) Staff arrived. - When she arrived at the facility, DSS was still there. - She was informed that allegations that Staff #2, Staff #3 and the Director had abused clients had been made.	V 367		

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V 367	Continued From page 18 - She had completed incident reports for each client detailing the allegations of abuse made on 8/11/2022. Interviews on 8/15/202 and 9/6/2022 with the Director revealed: - She learned that clients had made allegations against facility staff on 8/11/2022, when staff from the local DSS went to the facility. - The QP was responsible for completing incident reports.	V 367		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512		

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V 512	Continued From page 19 This Rule is not met as evidenced by: Based on observation, record reviews and interviews, 3 of 6 audited staff (#2, #3 & the Director) abused 5 of 5 clients (#1, #2, #3, #4 and #5); 1 of 6 audited staff (the Director) failed to protect 5 of 5 clients (#1, #2, #3, #4 and #5) from harm; and 1 of 6 audited staff (#1) neglected 1 of 5 clients (#1). The findings are: Finding #1: Abuse by Staff #2, Staff #3 and the Director Review on 8/17/2022 of Client #1's record revealed: - Admission date: 8/20/2021 (when the facility was unlicensed). - Diagnoses: Oppositional Defiant Disorder, severe; Attention Deficit-Hyperactivity Disorder (ADHD); Mild Intellectual Developmental Disorder (IDD); Other Specified Obsessive-Compulsive & related disorder; Enuresis, nocturnal & diurnal; and Smith-Magennis Syndrome (a developmental disorder that affects many parts of the body). - An assessment dated 8/20/2021 that revealed a history of threats and physical aggression towards mother; and having spent >200 days in a hospital prior to admission to the facility. - A Behavior Support Plan (BSP) developed by a licensed psychologist and dated 11/10/2021 revealed target behaviors of physical aggression, verbal aggression, non-compliance, self-injurious behavior, and property destruction. - No documentation of facial injuries sustained during an incident on an unknown date in late July 2022 or on 8/8/2022.	V 512		

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V 512	Continued From page 20 Reviews on 8/15/2022 and 8/16/2022 of Client #2's record revealed: - Admission date: 2/26/2018 to sister facility A. - No documentation of the date she moved to this facility. - Diagnoses: Major Depressive Disorder; Mild IDD; History of Club Foot with 8 previous surgeries; History of Seizures and Traumatic Brain injury; and a history of physical and sexual abuse. - An assessment dated 1/9/2018 revealed a history of Department of Social Services (DSS) involvement due to the family living in a tent, mental illness and substance use disorders in immediate family members, "weed" use by client, physical fights with a sibling, her father's aggression, her uncle had allegedly attempted to have sex with her when she was 17, and her hitting and kicking her mother. - A treatment plan dated 9/19/2021 revealed a further history of disrobing in front of others and needs related to hygiene, communication, appropriate physical and sexual boundaries, and accessing services. Review on 8/15/2022 of Client #3's record revealed: - Admission date: 7/21/2020 to sister facility A. - No documentation of the date she moved to this facility. - Diagnoses: Schizoaffective Disorder, bipolar type; Moderate Intellectual Disability; Diabetes type II; Hypothyroidism. - An assessment dated 7/21/2020 revealed a history of Fetal Alcohol Syndrome at birth, adoptive parents rescinded the adoption on an unspecified date, placement at residential facilities, and AWOL (absent without leave) from	V 512		

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facilities.
- A treatment plan dated 6/8/2022 revealed a history of anger outbursts, self-harming behaviors, threatening others, attempts to run away, difficulty getting along with others, argumentativeness with facility staff, peers and instructors, frequent mood changes, and auditory and visual hallucinations.

Reviews on 8/15/2022 and 8/17/2022 of Client #4's record revealed:
- Admission date: 1/8/2021 to sister facility A.
- No documentation of the date she was moved to this facility.
- Diagnoses: Post Traumatic Stress Disorder; Generalized Anxiety Disorder; and Mild Intellectual Developmental Disorder.
- An assessment dated 1/8/2021 revealed a history of verbal and physical aggression, assaulting staff members at previous placements, multiple residential placements, including hospitals, and was a victim of rape.
- An authorization assessment update dated 8/3/2022 revealed: "Continues to struggle with hosting somatic complaints when she doesn't want to comply with redirection or follow prompts given throughout the day. [Client #4] continues to pick at the scabs and sores on her breast, causing the skin to be raw ... Over the past period of authorization, she has stolen from her peers in the facility, 'because she wanted' whatever they had ... She attempted to steal food from staff that they had brought for their lunch ..."
- A treatment plan dated 7/22/2022 revealed " ... [Client #4] was discharged from the hospital setting prior to coming to Agape Home Living Care, LLC. Since being at the residential program, [Client #4] has endorsed AWOL behaviors and wanted to live the facility to live in

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a shelter due to her feeling like she would be treated better. [Client #4] stated that she didn't like being treated like a child and be made to complete chores and other tasks ..."

Reviews on 8/15/2022 and 8/17/2022 of Client #5's record revealed:
- Admission date: 9/15/2017 to sister facility A.
- No documentation of the date she was moved to this facility.
- Diagnoses: Bipolar I Disorder; Post-Traumatic Stress Disorder; Mild Intellectual Disability; Incontinence of urine; Gastroesophageal Reflux Disease (GERD); Constipation; Allergic Rhinitis; and Acne vulgaris.
- A Psychiatric Consult and Liaison Service History and Physical Evaluation dated 5/7/2017 revealed a history of suicidal thoughts since she was a young child, and involuntary commitment proceedings at the time of the assessment due to having picked a scab on her wrist and attempted to cut her wrist with a rock.
- There was no admission assessment to the facility.
- A treatment plan dated 7/1/2022 revealed goals related to completing her laundry, increasing her ability to engage in positive and appropriate social interactions/decrease in the frequency she lies or steals, and increase her ability to follow rules and expectations of the group home.

Review on 8/17/2022 of Staff #2's employee record revealed:
- Hire date: 12/17/2018.
- Training on Client Rights was completed on 12/17/2018.
- Training on "Effective Techniques for Managing Disruptive Behaviors (TACTFUL)" was completed on 12/17/2018.

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V 512	Continued From page 23 Review on 8/17/2022 of Staff #3's employee record revealed: - Hire date: 7/8/2019. - Training on Client Rights was completed on 7/12/2019. - Training on "Effective Techniques for Managing Disruptive Behaviors (TACTFUL)" was completed on 7/12/2019. Review on 9/7/2022 of the Director's employee record revealed: - Hire date: 4/12/2017. - Training on Client Rights was completed on 6/8/2020. Reviews on 8/17/2022 and 9/7/2022 of the facility's level 2 and 3 incident reports in the Incident Response Improvement System (IRIS) revealed: - No incident reports had been submitted regarding Client #1's facial and leg injuries sustained during the week on 8/7/2022. - No incident reports were present related to allegation of abuse made against Staff #2, Staff #3 and the Director on 8/11/2022. Interview with and review of a video provided by former staff (FS) #4 on 9/1/2022 revealed: - On 8/10/2022, she recorded Staff #3 calling Client #1 an "evil spirit" and telling her that she was "full of Hell." - The timestamp on the original video was 8/10/2022 at 8:55pm. - The video only showed the surface of the desk with no person's face or body visible. - Two distinct voices could be heard. - The voice of the staff on the video was reported by FS #4 to be Staff #3.	V 512		

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V 512	Continued From page 24 - The voice of the client was reported by FS #4 to be Client #3. - Staff #3: "You see you're (Client #3) so evil you don't want nothing to do with the good Lord. Every time I say something the Bible, you instantly drop your head. You ain't nothing but a evil spirit ... With that evilness you got in you and that grudge-holding you got in you; you'll always have problems. Cause it's definitely in the Bible you not supposed to (unclear) ..." Client #3: "I just never learned how to forgive. Cause I never was told how to do it". Staff #3: "And that's why you (unclear) evil and full of Hell. I don't bite my tongue. I don't bite my tongue and ya'll know that. That's why you sitting there evil like you are ... You're like, (unclear) about to make me angry. Because I'm not feeding this bullshit you got about your people, this person don't do nothing for you, this person make you mad, you ain't learning, you ain't getting ahead, this person against you. You, you. Let you tell it, the f*****g world is against you. When [Client #3] thinks she's in trouble. (pause) When [Client #3] having a good day or a good week, oh everybody, you love everybody..." Interview on 9/1/2022 with Client #1 revealed: - Staff #2 had punched her in the face, hit her with a paddle, hit her with her own (Client #1's) belt, and hit Client #3 with a paddle and her hands on multiple days. - She could not remember the dates these incidents occurred. - There used to be a piece of wood used as a paddle kept in a corner of the facility staff's office area. - She did not know where the paddle was currently.	V 512		

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V 512	Continued From page 25 - On an unknown date, Staff #2 had hit her with a paddle, and she (Client #1) then fell on the steps at the facility. - She sustained bruises on her legs and scratches on her face. - The bruises on her leg were caused by Staff #2 hitting her with a paddle. - The scratches on her face were caused by Staff #2 "punching me in the face." - FS #4 took photos of the injuries. - "[Staff #2] said don't tell anyone what happened." - She had never told anyone about Staff #2 hitting her because "I was afraid she (Staff #2) was going to do it again." - She had not been mistreated by Staff #3 or the Director. - The only staff working at the facility as of the date of interview were Staff #1 and the Qualified Professional (QP). - She felt safe with Staff #1 and the QP. Interview on 8/29/2022 with Client #1's Guardian revealed: - She had received mixed information about the allegations of abuse made against facility staff on 8/11/2022. - She initially thought that Client #1 had not been involved with the allegations of abuse. - She had requested an investigation report from the facility and that report noted that it was a different client that was involved in the allegations. - She later received a call from a local Department of Social Services, Adult Protective Services (DSS-APS) investigator that informed her that Client #1 had also made allegations against facility staff. - Earlier that week, Client #1 had sustained	V 512		

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injuries to her face and leg during an incident in which she was chasing another client around the house with a brick.
- While Client #1 could be "child-like," she could reliably report information about events.
- She was not certain about how accurately Client #1 could report dates.
- Prior to 8/11/2022, she did not have any concerns about how facility staff treated Client #1.

Attempted interview on 9/6/2022 with Client #1's Behavior Specialist was unsuccessful due to no return call having been received from the Behavior Specialist by time of exit.

Interview on 8/24/2022 with Client #2 revealed:
- Staff #2 yelled at her and put her in a corner for an hour because she had not made her bed, had put a basket of dirty clothes on her head, and instructed her (Client #2) to fight her (Staff #2).
- " ... [Staff #2] whooped [Client #1] and left a big ol' bruise on her ..." with a paddle.
- She had heard Staff #2 "whoop" Client #3.
- Staff #2 had sent her to a common area in the facility, so she did not see what Staff #2 did to Client #3.
- Client #3 had been screaming "help, help, help" during the incident.
- She had overheard the Director tell Staff #2 to place a sock in Client #3's mouth.
- Staff #2 had also put Client #4 in the corner with her.
- She was unable to specify dates of the above incidents.
- "They (clients) are not safe there (at the facility). You have to get them out ..."

Interview on 8/22/2022 with Client #2's Guardian

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V 512	Continued From page 27 revealed: - Client #2 had never said anything about being abused at the facility until the local DSS APS Investigators went to the facility on 8/11/2022. - Client #2 reported that the Director had pushed her down on a bed and choked her. - On 8/17/2022, while she was still residing at the facility, Client #2 recanted her statements about the Director choking her but did state that Staff #3 had grabbed her mouth really hard on one occasion; that Client #1 had sustained bruises on her legs from a rock she had picked up and not from abuse; that Client #3 had made up the abuse allegations and that they (facility clients) were all going to say that they were hit and spanked so they could move. - Client #2 did not make any allegations against Staff #2. - On 8/19/2022, Client #2 changed her statement and said the Director had choked her one time, but she could not clarify when it occurred. - She was able to get Client #2 moved out of the facility on 8/22/2022. - When she asked Client #2 why she had not reported the allegations of abuse before, Client #2 told her that she was scared, and that facility staff were always there when she would have had opportunity to report it. Interview on 8/22/2022 with Client #3 revealed: - "They (Staff #2, Staff #3 and the Director) would switch you and punch you and stuff like that." - All clients except Client #2 had been physically abused by facility staff. - Staff #2 had stuffed a sock in her mouth once when she was yelling for help because "they was beating me..." - Client #1 had bruises on her body "because	V 512		

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V 512	Continued From page 28 they (facility staff) use a paddle or belt or switches on her. Same thing they used on me. It's just that when they used it on me, it didn't make a difference 'cause I was already used to it. I was used to it because they did it before." - She had sustained injuries due to physical abuse but was never taken for her injuries to be assessed by a medical professional. - She had been told " ... you stay here, and we'll fix you right on up. You ain't going nowhere ..." - She did not want to talk about how facility staff spoke to her but acknowledged that they did say "mean" things to her. - She was not able to specify dates that verbal or physical abuse had occurred. Interview on 8/18/2022 with Client #3's Guardian revealed: - She had visited Client #3 at the facility routinely. - Facility staff were always present when she visited Client #3. - There had been an opportunity for Client #3 to go on a home visit with a family member last year, but she was not allowed to go without staff accompanying her on the visit because the Director had a rule that clients could not go on home visits without staff. - Staff #2 had gone on the home visit with Client #3. - Client #3 did not have an opportunity to report allegations of abuse due to facility staff always being present during visits. - She had visited the facility on 8/11/2022. - After she left the facility on 8/11/2022, she was flagged down by FS #4. - FS #4 showed her a video of a facility staff yelling and cursing at Client #3 and telling Client #3 that she was "dumb and evil."	V 512		

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- The video did not show the faces of the staff or client being recorded.
- FS #4 told her that the staff on the video was Staff #3.
- She could tell that it was Client #3's voice on the video.
- Client #3 told her that when Client #3 was screaming, the Director had told facility staff to put a sock in her mouth.
- FS #4 confirmed that Staff #2 had placed a sock in Client #3's mouth.
- FS #4 had also sent her photos of Client #1 which showed injuries on Client #1's face, shoulder and leg.
- She and a colleague removed Client #3 from the facility on 8/12/2022 in order to move her to a new residential placement.

Interview on 9/1/2022 with FS #4 revealed:
- She had taken the photos of Client #1 on 8/9/2022.
- She had provided copies of the photos to Client #3's Guardian on 8/11/2022.

Review on 8/22/2022 of photographs of Client #1 provided by Client #3's Guardian revealed:
- Reddish-purple areas covering Client #1's right temple, cheek and eyelid.
- Seven red areas approximately ¼ inch to ½ inch in length on the front shoulder/upper chest area.
- A reddish-purple area approximately 3 inches in diameter located on the upper front of the thigh.
- The photos of the shoulder/chest area and the thigh area did not show the client's face.

Interview on 8/30/2022 with Client #4 revealed:
- Staff #2 hit her "almost every day. She hit me upside my head, on my arm and she bent my

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arm back."
- Staff #2 had called her a "b***h."
- Staff #3 "hit me with a switch on my back ... a lot ..."
- The Director had choked her.
- Staff #2 had also put Client #3 "on the ground and was punching her in the face ... in her (Client #3's) room."
- She could not remember the dates these incidents occurred.
- She had tried to tell her Guardian about how facility staff had treated her and Client #3, but Staff #2 had been outside and she couldn't.

Interview on 8/30/2022 with Client #5 revealed:
- She had lived at the Licensee's facilities for 5 years and "I was too afraid to tell the State because they (facility staff) threatened us ..."
- Some time last year, the Director had told her to say that she had lied about a facility staff who had knocked her tooth out.
- "They beat the living crap out of me because I took food ..."
- This had occurred "a whole lot."
- The most recent time she had been beaten was last month.
- Staff #2 and #3 had been the staff who beat her.
- Her leg was bruised, and her lip was "almost" bruised during the incident.
- She still had a bruise on her leg from Staff #2 punching her while wearing a ring.
- She had a scar on her right arm that resulted from Staff #3 hitting her with a piece of wire that came out of a clothes hamper.
- Staff #3 hit her with the wire because she was talking to her peers about "how bad they (facility staff) were beating me, and I wanted to talk to the State ... It scared me. I didn't know who to go

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V 512	Continued From page 31 to ... That Owner (the Director) coached me to say it didn't happen ..." - She had witnessed Clients #1, #2, #3 and #4 being beaten by facility staff: "I saw a bunch of that, and I was like 'I hope that's not me next' ..." - Facility staff also called her names such as "b***h and S**t." - "Every time I went to the owner (the Director), she was like 'I don't believe it' and she told me to say it didn't happen ..." - Staff #2 and #3 sometimes used their fists and sometimes used objects such as chairs or "slammed us to the floor." - Staff #2 brought a belt from her own home to use on facility clients but took it home and "tries to pretend nothing happened." - A board and branches from trees were also kept in the staff office to use on clients. - She had tried to tell her Guardian about how facility staff treated her, but "about the time I started to tell him, a staff member came, and I froze because I was so scared ..." - On an unknown date, she was attempting to roll down a car window and was told by the Director that she would "break my fingers if I touched her stuff." - "I'm just a little bit shocked ... When she (the Director) was coming to get me at the hospital (upon her initial admission), she was nice. But she turned evil ... She scared me real bad ... I have those dreams and wake up crying ..." Observation at approximately 11:18am on 8/30/2022 of Client #5's injuries revealed: - She was missing one of her front teeth. - She had a scar on her right inner forearm that was approximately 1 inch long. - She had two areas of yellowish-brown discoloration on the front of her left thigh which	V 512		

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V 512	Continued From page 32 were approximately 1 to 1-1/2 inches in diameter. Interview on 8/26/2022 with Clients #4 and #5's Guardian revealed: - After he learned of the allegations of abuse made against facility staff on 8/11/2022, he interviewed Clients #4 and #5 separately via telephone. - Clients #4 and #5 said they were told they would be in trouble if they said anything. - He did not see any injuries on Clients #4 or #5. - A year ago, Client #5 pulled her tooth and she told him that her tooth was knocked out. - He would rather have Clients #4 and #5 directly report their allegations regarding facility staff. - He had not seen or suspected any mistreatment by staff. Interview on 9/1/2022 with FS #4 revealed: - On an unknown date in late July 2022, Client #1 "got out of hand", refused to do her chores, began to push a fish tank off a shelf, pulled a cord from another fish tank, and ran out of the facility while FS #4 was cleaning up water from the fish tank. - She called for backup and went to find Client #1. - Client #1 was on the front porch. - When Staff #2 and #3 arrived to assist, Staff #3 "came in the house ready to fight." - Client #1 had gone to her bedroom. - She heard Staff #2 and #3 punching Client #1 in her room. - When she looked in, she saw Staff #2 hitting Client #1 in the face and Staff #3 "got her licks in too." - Staff #2 and #3 called the Director and put her on speaker.	V 512		

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V 512	Continued From page 33 - She heard the Director say "she (Client #1) tried to break my fish tank, beat her a*s ..." and "put her down." - A "put down" was "like grab them and throw them down ...once on the floor, they (facility staff) put their knees on them and start beating them." - She had witnessed Staff #2 put Client #1 down. - When she returned to work the day after the incident, Client #1 had what appeared to be blisters on her face. - On an unknown date, the Director had instructed her to use a piece of wood that was present in the staff office area to "beat the s**t out of them (clients)." - When she worked on 8/6/2022, Client #1 did not have any injuries. - When she returned to work on 8/9/2022, Client #1 told her that Staff #2 had "beat" her with a paddle on 8/8/2022 causing bruises on her face. - She took photos of Client #1's bruises. - Staff #3 "brainwashed [Client #1] to say you got that (injuries on her face) from that big rock ..." - Staff #2 had obtained makeup for Client #1's face because Client #1's team was scheduled to be at the facility the next day (8/11/2022). - She tried to catch Client #1's team at the facility on 8/11/2022, but she was too late. - When she called the facility and asked how Client #1's team visit went, she was told that Client #3's team was at the facility at the time of her call. - A van with Client #3's home county DSS markings was at the facility, so she followed the van and waved them down after they left. - She reported her concerns about facility staff to the DSS workers and provided them with access to the photos and video she had recorded.	V 512		

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V 512	Continued From page 34 Interview on 8/30/2022 with Staff #2 revealed: - Client #1 and Client #4 liked to fight. - Client #2 liked to get "a lot of stuff started" with her peers and would "tell stories." - Client #3 would tell on everyone but herself. - Client #5 liked to wear her clothes tight and would get bruises because she wore her belt so tight. - When facility clients fought with each other, she would get between them, raise her voice to tell them to stop, send them to their bedrooms, and call the Director. - Client #1 had behavior data sheets that needed to be completed electronically for her behavior Specialist. - On 8/11/2022, someone from the local DSS went to the facility and talked to client #3 alone. - The QP arrived at the facility and spoke with the DSS staff. - After Staff #3 arrived for her shift, the QP met with both of them and told them they needed to leave the premises until she was able to complete an investigation into allegation of abuse. - She did not know what the specific allegations against her were. - A man called her to question her about the allegations of abuse made against her and said that they had photos of bruises that were on Client #1's leg. - Client #1's bruises were sustained on 8/9/2022, when she chased Client #3 around the house with a brick. - She did talk loudly and with authority when she needed to. - She would never abuse a client. - She had never witnessed other facility staff mistreat or abuse clients. - Client #1 wanted to go home, and she was not	V 512		

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sure if Client #1 had made up the allegations of abuse in order to go home.
- She had not obtained makeup to cover up Client #1's bruises.
- She had never put a sock in Client #1's mouth.

Interview on 8/31/2022 with Staff #3 revealed:
- When she arrived at the facility for her evening shift on 8/11/2022, the QP was on the porch talking to a DSS staff.
- The QP told her and Staff #2 that they had to leave the premises because allegations had been made against them.
- She had been suspended for 7 days while the QP completed her investigation.
- She briefly returned after the 7-day suspension was finished but was told that she was suspended again.
- She did not know why she had to leave the second time because she had completed her 7-day suspension period.
- The only time she put her hands on a client was when she cared for Client #3's hair.
- She never cursed at or used derogatory language towards any facility client.
- She had never used a belt or paddle on facility clients.
- There were no belts or paddles at the facility.
- She had heard that Client #1's bruises resulted from her falling on the porch when she was chasing Client #3 around the house with a big rock.
- She did not see any bruises on Client #1.
- She had never heard anything about a sock being put in any client's mouth.

Interviews on 8/17/2022 and 9/6/2022 with the QP revealed:
- On 8/11/2022, Staff #3 was coming in for her

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shift to relieve Staff #2 when the local DSS Staff arrived.
- When she arrived at the facility, DSS was still there.
- She told Staff #2 and #3 to leave the facility due to allegations made against them.
- On 8/12/2022, DSS Staff returned to the facility and told her that they had called clients' Guardians to have them remove their clients from the facility.
- The allegations against Staff #2 were that she had hit clients.
- Client #3 reported that the Director told Staff #2 to hit clients.
- The allegations against Staff #3 were that she emotionally abused clients by talking very harshly and rudely to them.
- When she asked Client #1 about the allegations, Client #1 just shook her head and didn't say anything to her.
- Client #2 told her and her Guardian that the Director pushed her on a bed and choked her, but she could not remember exactly when it happened, but possibly last January or February.
-Client #3 reported that she had been hit with a belt on 8/10/2022 and had a sock put in her mouth by Staff #2 on 8/11/2022.
- When she asked Client #3 why she did not report having the sock put in her mouth, Client #3 told her that she had reported it to FS #4.
- FS #4 had not told her anything about a sock being put in Client #3's mouth.
- Client #4 said that her arm had been bent back by Staff #2, but when she attempted to ask about when this occurred, Client #4 said she did not remember and did not have time to talk about it because she was packing to leave.
- Client #5 just said that she didn't feel like people listened to her when they talked to her.

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V 512	Continued From page 37 - She had never had concerns about how facility staff treated clients. - She had not seen any bruises or other injuries on clients caused by abuse. - Client #1's bruises could possibly have been sustained when she had an incident on 8/8/2022 or 8/9/2022 when she picked up a paver from the ground outside of the facility and began chasing Client #3 with it. - Prior to the allegations made on 8/11/2022, there had not been any other allegation made against facility staff. - She was not aware if anyone in the facility wore a belt - There were no belts lying around the facility. - When asked about a paddle at the facility, she reported that the only piece of wood that she knew of in the facility was one that was used to prop up an air conditioner. - She had not seen a paddle at the facility. - She had never witnessed facility staff speak to clients in a derogatory manner. Interviews on 8/15/202 and 9/6/2022 with the Director revealed: - Her role with the facility was primarily administrative and she never worked on a shift at the facility. - Facility staff never really called her for instructions about how to handle clients' behaviors. - She learned that clients had made allegations against facility staff on 8/11/2022, when staff from the local DSS went to the facility and interviewed Client #3. - The DSS staff made the clients' Guardians remove them from the facility. - Client #1 met with her Behavior Specialist every month and had never reported allegations	V 512		

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of abuse during those sessions.
- Client #3 met with her therapist every week and had never reported allegations of abuse during those sessions.
- Client #3 had coerced her peers into making false allegations against facility staff because she wanted to go home.
- Client #3 had made false allegations in the past and later admitted that she had lied.
- Facility staff treated clients "good."
- The QP had investigated the allegations and found them to be false.
- From the information she got from the QP, the clients were changing their stories and that FS #4 told the clients to make up the allegations.
- Client #1 had sustained bruises during an incident in which she picked up a stepping stone from the yard in order to beat up Client #3 and not from having been physically abused.
- She had never choked a client.
- She did not know anything about a paddle in the facility.
- The only person who had a belt in the facility was Client #5 because she liked to wear them very tight.
- None of the facility staff would ever abuse a client.
- She heard that Client #3 said something about a sock, but she did not know anything about that.
- Clients were allowed to meet with their Guardians alone when they came to the facility to visit.
- If facility staff had been abusing them, the clients would have told their treatment teams.

Finding #2: Neglect by Staff #1 on 9/8/2022

Review on 8/17/2022 of Staff #1's employee record revealed:

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AGAPE HOME LIVING CARE, LLC	310 FIELDS 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 512	Continued From page 39 - Hire date: 6/22/2022 - Training on Client Rights, Confidentiality, Special Population & HIPAA (Health Insurance Portability and Accountability Act) was completed on 6/22/2022. - Training on "Effective Techniques for Managing Disruptive Behaviors (TACTFUL)" was completed on 6/23/2022. Review on 9/13/2022 of an IRIS report dated 9/8/2022 revealed: - On 9/8/2022 at 2:00pm, "While staff (#1) was driving the car, leaving from the museum, [Client #1] got out of her seatbelt and reached to open the van sliding doors by pushing the open-door button above the rearview mirror. [Client #1] attempted to jump out of the van while it was still moving. Staff immediately pulled the car over, which so happened to be in front of a police station. Staff asked for help from the officers, and they stated that they could not do anything. While standing around and attempting to talk to [Client #1], [Client #1] grabbed her empty soda bottle and reached it back as if she was going to hit staff with it. By this time, the local police contacted a counselor to come to the scene of the incident. She tried to talk to [Client #1], however she wasn't much help in getting her to calm down. Staff called [the Director] and [the Director] called [Client #1's Guardian] in order to come up with a solution for [Client #1]. Guardian requested that she (Client #1) is IVC'd (involuntarily committed) because she was a serious threat to herself. The counselor that was outside agreed to IVC her. [Client #1] took off running down the street and the cops began chasing her. Staff provided an officer with the address to the home after he said that he would drop her back off to the house during the	V 512		

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V 512	Continued From page 40 incident. Staff informed [the Director] that [Client #1] was threatening to hit her and that she had told the police officers that the staff present was abusing her and had put the bruise on her leg that was just previously investigated for another staff allegedly putting the bruise there." - "Describe the cause of this incident: [Client #1] attempted to jump out of the moving van after being out in the community. [Client #1] reports that she was tired. Earlier in the day [Client #1] explained to the QP and Director that she no longer wanted to be in the home and wanted her guardian to find another placement for her. QP contacted her guardian and told her of [Client #1]'s wishes. Guardian agreed that she would continue to make it difficult for staff moving forward until she was placed elsewhere." - "Incident Prevention: Staff will have to make sure that if they notice a consumer taking off their seatbelt, to immediately stop the car and redirect the consumer until sit down and put their seatbelt back on." Review on 9/16/2022 of a local Police report completed on 9/13/2022 revealed: - On 9/8/2022, a male "Qualified Professional" (Staff #A-5) from the facility approached Police and requested assistance with Client #1 because she was causing a disturbance in the parked van. - Staff #1 remained in the van with Client #1 as Staff #A-5 approached the Police. - There were several clients inside the parked van with the female "Qualified Professional" driver (Staff #1). - Staff #1 and Client #1 were arguing while sitting in the van. - The Behavior Specialist from the Police Department spoke with Client #1 after Staff #1 exited the vehicle.	V 512		

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V 512	Continued From page 41 - " ... After a few minutes of talking to [Client #1], it appeared the biggest issue is [Client #1]'s dislike of the adult female QP (Staff #1) and [Client #1] showed signs of intellectual disability with her delayed responses. In reference to the female QP, [Client #1] stated "Old lady abusing me!" ... [Client #1] was willing to ride with us to her group home located at [310 Fields Street, Greensboro, NC]. [The Behavior Specialist] advised the QP's (Staff #1 and Staff #A-5) of the safety plan, and they both, especially the female QP, refuse to hear the safety plan and refused to cooperate. The QP's ordered everyone to reenter the van and we were told that they no longer needed our help. The female QP/driver was extremely upset because we did not immediately take custody of [Client #1] and "take her away." Everyone reentered the van and an argument between the QP driver and [Client #1] ensued while [the Behavior Specialist] attempted again to explain to the male QP, who was standing outside the van, what is the best safety plan for [Client #1] at this time. A few seconds later, [Client #1] abruptly exited the rear passenger side of the vehicle and walked north towards [a nearby street]. I followed behind [Client #1] and attempted to communicate with her. Neither one of the QPs assisted me to help [Client #1] return to the van ... [Client #1] sat and lay in the middle of the roadway. At that time [Client #1] purposely struck the back of her head several times on the pavement. At that time, [Client #1] was placed in our custody for suicidal ideations and to prevent any further harm to herself. When I walked back to my patrol vehicle, I observed that the "Qualified Professionals," their van, and clients were no longer in the PVA (public vehicular area). They were no longer on scene. It is	V 512		

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V 512	Continued From page 42 unknown where the staff and residents of AGAPE Home Care Living went to. The QPs were not asked to leave, and they did not inform anyone on [the Police Department] that they were leaving. Before the QPs left, they did not provide any information on [Client #1]. [The Behavior Specialist] and I did not confirm [Client #1]'s home address, we did not know who was [Client #1]'s guardian, and we did not know anything about [Client #1] except what was observed on the scene ..." - Client #1 was taken to a local hospital Emergency Department (ED). Review on 9/14/2022 of Client #1's hospital records revealed: - On 9/8/2022 " ... (Client #1) Arrived from group home accompanied by [Police]; reported patient was running into traffic and banging head on concrete ... Per IVC (involuntary commitment) paperwork: 'Respondent (Client #1) has walked into oncoming traffic attempted; she also attempted to jump out of a moving car. When team arrived, she was banging her head onto the concrete.' Clinician (hospital staff) spoke to [the Behavior Specialist] to obtain additional information. Per [the Behavior Specialist], she responded with a police officer, the pt (patient) got into an altercation and attempted to jump out of a moving vehicle. Per [the Behavior Specialist], staff was verbally aggressive, pt sat in the middle of the pavement. Per [the Behavior Specialist], pt was no problem, group home staff acted like she was going to put hands on the pt; pt then ran across the street. Per [the Behavior Specialist], group home staff abandoned the pt, just left. Per [the Behavior Specialist], she spoke to the group home director who reported, the pt is a nuisance, she lies on them; the pt and four	V 512		

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V 512	Continued From page 43 other female residents caused them to loose their license ..." Interview on 9/13/2022 with Client #1 revealed: - She did not remember all of the details of the 9/8/2022 incident. - Staff #1, Staff #A-4, and four boys from sister facility A were on an outing at a local museum. - She had tried to get out of the van because she was "tired of being there." - She had been taken to the Police station because she was trying to get out of the facility van. - Staff #1 had been upset about her trying to jump out of the vehicle, but she did not remember what Staff #1 said to her. - The Police Officers took her to the hospital, where she remained at the time of the interview. Interview on 9/20/2022 with Staff #1 revealed: - On 9/8/2022, she had been driving the facility van during an outing in which Client #1, Staff #A-5 and four clients from sister facility A went out to eat and then to a museum. - When they arrived at the museum, Client #1 said she was tired and wanted to go home and lie down. - Client #1 was told that they were still going into the museum. - Client #1 became agitated, so they all left to return to the facility. - Client #1 attempted to get out of the moving vehicle. - She pulled into a Police Station parking lot to ask for help. - Two Officers were in the parking lot. - As one of the Officers was talking to Client #1, she called the Director to tell her what was happening.	V 512		

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V 512	Continued From page 44 - She put the Director on speakerphone, and the Director asked Client #1 what she could do to help. - A Behavior Specialist that worked for the Police Department came out and spoke with Client #1. - Client #1 had an empty soda bottle and was swinging it at her face. - She told Client #1 "I dare you to hit me ..." - Client #1 had been "performing" for the officers, told them "This old lady abusing me," and showed them old bruises on her body. - She was frustrated "because nobody was protecting me ... The system let me down ..." - Client #1 got out of the van and began running away. - Prior to Client #1 running away, one of the Police Officers had said they would take her to the facility. - The Behavior Specialist said "let me tell you what your options are ..." - She already knew what the options were, told the Behavior Specialist that she did not want to hear it, and walked away. - She had been upset because no one "stood up for me ..." - She got in the van and left to return to the facility with the clients from sister facility A because she did not want them to have behavioral outbursts due to Client #1's behavior. - None of the Police Officers had told her to leave because they were running after Client #1. - She thought that the Police Officers were going to bring Client #1 to the facility because that is what they had told her they were going to do. - When she got back to the facility, she did not contact the police for an update on Client #1. - She thought that the Police Officers were in contact with the QP or the Director. - She would never abandon her client.	V 512		

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V 512	Continued From page 45 Interview on 9/20/2022 with Staff #A-5 revealed: - On 9/8/2022, he and four clients from sister facility A had been riding in the facility van with Staff #1 and Client #1 in order to go on an outing to a local museum. - When they arrived at the museum, Client #1 talked about being tired. - Staff #1 was taking him and sister facility A clients back home when Client #1 began banging on the window and attempting to jump out of the door. - They drove to a local Police station and saw two Officers in the parking lot. - He told the Officers what had happened, then took the clients from sister facility A across the parking lot. - When they left the Police station, Staff #1 told him that the Police had Client #1. - He thought that Staff #1 had contacted the Director to let her know about the incident. Interviews on 9/12/2022, 9/13/2022 and 9/20/2022 with the QP revealed: - On 9/8/2022, Staff #1 and Staff #A-5 had taken Client #1 to a local Police station when she had behavior during an outing. - The Director said that she had talked to someone at the Police station during the incident. - She was not aware of any allegations made against facility staff related to the incident. - Client #1 was taken to a local hospital ED under involuntary commitment. - Client #1's Guardian told the facility that they did not need to pick Client #1 up from the hospital. - She had issued a 60-day discharge notice for Client #1.	V 512		

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V 512	Continued From page 46 Interview on 9/13/2022 and 9/20/2022 with the Director revealed: - On 9/8/2022, Staff #1, Staff #A-4, Client #1 and four male clients from sister facility A had been on an outing at a local museum. - Staff #A-5 was working with the male clients from sister facility A, while Staff #1 was working with Client #1. - Client #1 attempted to jump out of the van and tried to hit Staff #1 with a bottle. - When Staff #1 went to the Police station, the Police Officers called a Behavior specialist out to talk to Client #1. - She had spoken with the Police Officers via telephone during the incident. - The Police Officers said that they would take Client #1 to the facility. - Client #1 was taken to the hospital ED by Police. - The Police were supposed to protect facility staff. Review on 9/7/2022 of the Plan of Protection written by the QP and dated 9/7/2022 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? [Staff #1] has been terminated from Agape Home Living Care, LLC at 310 Fields Street Greensboro, NC. She will not be allowed to return back to the premises. [Staff #3] will be terminated from Agape Home Living Care, LLC at 310 Fields Street Greensboro, NC. [The Director] will have weekly supervision with Qualified Professional. She will not be allowed to have any unsupervised contact with any staff or consumer moving forward. [Staff #1] will go through effective communication, TACTFUL training, and clients rights training again within	V 512		

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V 512	Continued From page 47 the next two (2) business days. Qualified Professional will communicate with any consumer at least twice a week and complete body checks, and ask about any allegations of harm, abuse, neglect or exploitation and document all findings in a binder that will remain with Qualified Professional at all times to prevent damage or lost information. Any findings of abuse, harm, neglect or exploitation will be immediately reported to the correct officials in the correct format (IRIS reporting system). moving forward, any consumer will have their right to privacy upheld and will be allowed to speak to their guardian, therapist, residential monitor or any other visitor alone, etc without staff, Qualified Professional or Director present. Describe your plans to make sure the above happens. - Qualified Professional will document all weekly supervision with [the Director] and place in her employee file. Beginning the week of September 11, 2022. - Qualified Professional will make sure that all employees are notified that they will not be allowed to have any conversation with [the Director] without someone else being present. Direct Supervision for the paraprofessionals will continue to be the responsibility for the qualified professional beginning September 7th, 2022. - Qualified Professional will make sure that all consumers understand that they are not to have a conversation with [the Director] without someone else being present. If they (consumer) do not feel comfortable with the second staff present, consumer will have the right to decline the conversation or ask Qualified Professional to be present. If they are uncomfortable with the Qualified Professional, they are more than welcome to have a conversation with their	V 512		

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guardian in private about their complaint(s) beginning September 7, 2022.
- Qualified professional will complete training with [Staff #1] within the next two business days and have the documentation in her employee file. This will be completed by September 10, 2022.
- Qualified professional will notify [Staff #2] of the findings substantiated at the State Survey Exit and notify [Staff #2] that she will remain terminated from 310 Fields St in Greensboro, NC 27405. This will be completed on September 7, 2022.
- Qualified professional will notify [Staff #3] of the findings substantiated at the State Survey Exit and notify her that she is terminated from 310 Fields Street in Greensboro, NC 27405. This will be completed on September 7, 2022.
- Beginning September 11, 2022, a notice will be placed in a binder stating that their visit will not be monitored by any staff member of Agape Home Living Care, LLC. The binder will have a sign in/sign out sheet for all visitors to sign in. on the notice, a list of numbers will be provided within to call if they feel like their visit is being interrupted, monitored or recorded."

Review on 9/20/2022 of the Plan of Protection written by the QP and dated 9/20/2022 revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care? Agape Home Living Care, LLC will make sure that all consumers are accounted for regardless of the setting (residential or community) 100% of the time. If there are any incidents involving consumers such as needing to be involuntarily committed, transported to an agency for evaluation, or needing police involvement, the present staff member will make sure to stay with

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the consumer until it is for sure known that they have been properly placed where they need to be or take the consumer back with them. Staff is to make sure that consumer is safe, present and understands what the next steps or what will be taking place regarding their care.
- Describe your plans to make sure the above happens.
- Staff will receive training by 9/23/2022 informing them of the new procedures that will take place concerning the following:
1) if a consumer is needing to be transported to an agency for psychiatric assessment/evaluation or is being IVC'd, or if the police need to be contacted, etc, the staff will provide the agency or staff member with the client "about me" sheet which will include the client's demographic information, medication, address, guardian's information and diagnosis. This information will be kept in the emergency binder that is taken to appointments.
The "about me" sheet will be updated as needed by staff when medications are changed, or any other pertinent information has changed, and copies will be made to place of the emergency binder.
2) Staff will be informed that they need to stay with the consumer at all times during an incident, especially if they need to be transported to another agency/provider/facility and to get information of who they are talking to, documenting what happened not only on the incident report but also on a "consumer care" form. This form should also discuss any changes made, incidents that happen or information that is necessary to report back. Every person that the staff comes into contact with needs to be documented with the full name, phone number (if applicable), badge number (if applicable),

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title/credentials, and agency name. Staff is to let them know that they are taking notes, and to make sure that they ask whoever they are speaking to if they need to repeat anything.
3) Start to make sure that they are remaining with the consumer through any incident/crisis and/or placement transition. Staff are to be courteous to those in the community and use effective communication regarding all and everything relating to the consumer.
4) Staff are to document everything from start to finish regarding any involvement with another agency/provider or facility using the forms provided to them. Staff will be notified to contact [the Director] or [the Qualified Professional] with any questions, concerns or issues.
Any step that is not following the above guidelines after receiving training, right at documentation will be completed by Qualified Professional and could lead to termination from Agape Home Living Care, LLC."

The facility was a 5600C residential treatment program that served five dually diagnosed adult, female clients. Their diagnoses included Major Depressive Disorder, Bipolar Disorder, Traumatic brain injury, Schizoaffective Disorder, Post-Traumatic Stress Disorder, Anxiety Disorder, and Intellectual Development Disorders ranging from mild to moderate. On 8/11/2022, Client #3's Guardian was flagged down by FS #4 following a visit to the facility. FS #4 provided her with information regarding a video of Staff #3 telling Client #3 that she was "evil" and "full of Hell," and shared photos of injuries client #1 had on her face and shoulder. This precipitated a report to the local Department of Social Services Adult Protective Services (DSS-APS) for allegations of abuse perpetrated by Staff #2,

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V 512	Continued From page 51 Staff #3 and the Director. Each of the five clients reported that they had been abused, with the abuse including being hit with belts, a paddle, a wire from a laundry basket, having been punched with facility staffs' fists, and having arms bent back. Clients #1 and #2 had bruises in various stages of healing from recent abuse. The clients reported that they had been afraid to report abuse previously due to concerns of further abuse by facility staff and lack of opportunity to report to outside individuals. Additionally, on 9/8/202, Client #1 had a behavioral incident while on an outing in the community. She was transported to a local Police station where Police assistance was requested. Client #1 attempted to run away from the Police parking lot, requiring Police Officers to chase and detain her. Staff #1 refused to listen to a Behavioral Specialist who worked with the Police when she was attempting to give Staff #1 options for Client #1. Staff #1 abandoned and did not provide identifying information about Client #1 at the Police station and returned to the facility without her. This deficiency constitutes a Type A1 rule violation for serious harm, abuse and neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, and additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		