Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,		1521111110111101115211	A. BUILDING:			
		MHL0411146	B. WING		11/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AGAPE H	OME LIVING CARE LLC	2708 16TH	STREET DRO, NC 2740	15		
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	, 	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	00 INITIAL COMMENTS		V 000			
		w up survey was completed 22. Deficiencies were cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
	This facility is license	d for 4 and currently has a				
	•	ey sample consisted of				
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	10A NCAC 27G .020 TREATMENT/HABILI PLAN	5 ASSESSMENT AND TATION OR SERVICE				
	(c) The plan shall be assessment, and in p	developed based on the artnership with the client or				
	of admission for clien	erson or both, within 30 days ts who are expected to				
	receive services beyond) The plan shall income	clude:				
	(1) client outcome(s achieved by provisior projected date of ach					
	(2) strategies;(3) staff responsible	•				
	(4) a schedule for re annually in consultation	view of the plan at least on with the client or legally				
	responsible person of (5) basis for evaluations achievement	ion or assessment of				
		it; and or agreement by the client or a written statement by the				
		such consent could not be				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	TEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0411146	B. WING		11/16/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-
			I STREET	·	
AGAPE H	OME LIVING CARE LLC		BORO, NC 2740	05	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
V 112	Continued From page	: 1	V 112		
	facility failed to develor strategies to meet the 3 audited clients (#1 a Review on 11/15/22 or -An admission date of	ews and interviews, the op and implement goals and individualized needs of 2 of and #3). The findings are: of client #1's record revealed: of 3/30/22			
	Diabetes Mellitus, Inte Alcohol Use Disorder, Chronic Hepatitis C a -An assessment date history of property des	d 3/30/22 noted "has a struction, aggressive acts			
	wants to work, is able conduct issues, is a d delayed, history of me alcohol use 15 years past history of alcohol	to does not get his way, to develop friendships, has iabetic, is intellectually ental retardation, history of ago and has not used since, I withdrawal (sweating,			
	aggression and needs -A treatment plan date to complete everyday completing daily chord living space with no m	d has verbal and physical s medication management." ed 11/1/22 noted "will learn living tasks such as es, maintaining a clean nore than 3 prompts per o use effective coping skills			
	aggression, will learn out of 5 times when h	to use these skills at least 3			

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STATE FORM YEHH11 If continuation sheet 2 of 12

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		PLETED
		MHL0411146	B. WING		11/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		2708 16T	H STREET			
AGAPE H	OME LIVING CARE LLC	GREENS	BORO, NC 2740	05		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 112	Continued From page	2	V 112			
		now to take his medication				
	refusing to follow the	more than 2 out of 7 days				
		es to assist client #1 in				
	reducing refined suga					
		es to assist client #1 in				
	limiting calories to 110					
	_	es to assist client #1 in				
	avoiding concentrated					
	-No goals or strategies to assist client #1 in					
	having a high fiber die	et				
		of client #1's visit to a local				
	clinic revealed:					
	-Was dated 10/13/22					
		y for medical conditions that				
	_	: Diabetes Mellitus, Type 2				
	Uncontrolled"	fallandia a inaturationa mana				
		following instructions: your vell controlled with A1 C at				
		oal, continue to reduce				
	ı	limit calories to 1100 per day				
	_	trated sweets as in sugar				
		ocolates, cakes, pies, soda,				
		veet tea. High fiber diet such				
		les were recommended."				
		of client #3's record revealed:				
	-An admission date o					
	-A diagnosis of Intelle	•				
		sment dated 2/8/22 noted				
		de, currently resides in a				
	group home for adults	s with developmental suicidal ideations to an				
	· ·	dical Services) personnel				
		to the hospital where he was				
		has had a least one arrest in				
		ssion, has a history of				
		spitalization, was molested				
		it he has aspirations of				

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STATE FORM YEHH11 If continuation sheet 3 of 12

Division of Health Service Reg	julation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
	MHL0411146	B. WING		11/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
	2708 16TH	STREET		
AGAPE HOME LIVING CARE LL	GREENSB	ORO, NC 2740	05	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
V 112 Continued From pa	ge 3	V 112		
becoming an EMT Technician), has ne SSI, has a significa and fathers, he doe significant relations of truancy, is unable suicide attempts an aggressive acts, ne and Psychosocial F-A treatment plan dhow to complete incompleting chores, washing his clothes and will complete the more than 3 verbal will increase his abia appropriate social in having a decrease and verbal aggress being prompted no enhance his skills at times a week with reprompts." -No goals or strategory history of suicidal and	Emergency Medical ver been employed, receives at relationship with his mother is not have any close and/or hips with peers, has a history is to care for himself, history of distriction o			

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STATE FORM 6899 YEHH11 If continuation sheet 4 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMP	LETED
		MHL0411146	B. WING		11/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ΓE, ZIP CODE		
AGAPE H	OME LIVING CARE LLC	2708 16T	H STREET			
AGAPLII	ONIE EIVING CARE EEC	GREENS	BORO, NC 2740	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 112	Continued From page	2 4	V 112			
	salty snacks, salted p bacon, sausage, phot foods." -Was counseled exter of high calorie foods (Healthy eating habits routine lasting at least times per week. Interview on 11/15/22 -"I can barely eat pizz Fried food is the wors Today, I had fried chick	eanuts, popcorn, pizza, to chips, fries, and canned nsively on dietary restriction				
	doctor said I don't nee sugary drinks. Just di sugar we eat pasta	ed to drink any kind of et. Nothing over 2 grams of and noodles sometimes. otatoes. I eat potato chips				
	snacks I eat some typ	meatballs and noodles. For be of healthy stuff. I am not anges. I had one today"				
	Interview on 11/15/22 with client #3 revealed: -"The doctor talked to me about diet and exercise. He said I needed to go on a diet or exercise. I haven't done that yet" -Was seen at the hospital for suicidal ideation -"I did not want to kill myselfI just thought about it"					
	-Wanted to get the cli exercise.	with staff #1 revealed: ents to the gym so they can ed a lot of weight since he's lity)"				
	•					

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STATE FORM YEHH11 If continuation sheet 5 of 12

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Division	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D MING		
		MHL0411146	B. WING		11/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
AGAPE H	OME LIVING CARE LLC		H STREET		
		GREENS	BORO, NC 2740	U5	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
				52.10.2.101)	
V 112	Continued From page	e 5	V 112		
	knew he needed to ex	xercise and eat healthy			
	-"It is important also t	o have the clients with			
	Diabetes exercise on	a regular basis."			
	-The QP tried to make	e sure the clients ate			
	healthier and had holi	istic meals.			
	-"I try to not use proce	essed foods."			
		s to eat. He will eat his food			
	-	her client's food. We have			
	addressed these num				
		e treatment plan to address			
		and exercise for client #3			
	•				
		try to monitor his diet and			
		nd why his plate may have			
	_	no pasta unless made with			
		doctor talked to us about			
	that and I was there a				
		e clients drink a lot of water			
	and we do buy zero s	ugar drinks. We don't do a			
	lot of Kool-Aid and do	n't have a lot of candy			
	aroundI will add go	als to their treatment plans			
	that are specific to ea	ch client."			
	•				
	Interview on 11/16/22	with the Director revealed:			
	-Treatment plans are	done by the QP along with			
	the guardian and the	-			
	-"[Staff #1] does exer	cise with the clients. The Y			
		es anymore. I will have to			
	• .	vill pay for it. They walk in			
		ve do have them on a very			
		asses at [the sister facility]			
	where we had exercis				
	-	ey instead of refined sugar			
		client #1, eating fruits and			
	vegetables that were				
		out fruits and vegetables			
	that are high in fiber."				
	-Client #3 needed to				
	-Will have the QP add	d goals and strategies to the			
	clients' treatment plar	าร			

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STATE FORM YEHH11 If continuation sheet 6 of 12

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0411146	B. WING		11/1	6/2022
	NAME OF PROVIDER OR SUPPLIER STREET AD AGAPE HOME LIVING CARE LLC GREENSI			TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 291	Continued From page	÷ 6	V 291			
V 291	27G .5603 Supervise	d Living - Operations	V 291			
	six clients when the c developmental disabil on June 15, 2001, and than six clients at that provide services at no licensed capacity. (b) Service Coordinal maintained between the qualified professional treatment/habilitation (c) Participation of the Responsible Person. provided the opportural relationship with her can means as visits to the the facility. Reports and legally responsible per Reports may be in work conference and shall progress toward meet (d) Program Activities activity opportunities in needs and the treatm Activities shall be desinclusion. Choices m	ty shall serve no more than lients have mental illness or lities. Any facility licensed d providing services to more time, may continue to more than the facility's tion. Coordination shall be he facility operator and the swho are responsible for or case management. The Family or Legally Each client shall be noty to maintain an ongoing or his family through such a facility and visits outside thall be submitted at least to fa minor resident, or the terson of an adult resident. The iting or take the form of a focus on the client's ting individual goals. The Each client shall have based on her/his choices, ent/habilitation plan. The identical court believed or when health or				
	interviews, the facility	as evidenced by: s, record reviews and failed to ensure activity sed on the clients' choices,				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		MHL0411146	B. WING		11	1/16/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
404051	IOME LINANO CARELLO	2708 167	TH STREET			
AGAPE I	HOME LIVING CARE LLC	GREENS	BORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 291	needs and designed to inclusion for 3 of 3 au #3). The findings are: Observations on 11/1 of the clients revealed -Clients #1, #2 and #3 their rooms and interal-No activities were so: Further observations 12:15pm of the clients -Clients #1, #2 and #3 their rooms and interal-No activities were so: Review on 11/15/22 of -An admission date of -Diagnoses of Intellect Diabetes Mellitus, Interal-No activities were so: Review on 11/15/22 of -An admission date of -Diagnoses of Intellect Diabetes Mellitus, Interal-No activities were so: Review on 11/15/22 of -An admission date of -Diagnoses of Intellect Diabetes Mellitus, Interal-No activities were so: Review on 11/15/22 of -An admission date of -An assessment date history of property detection wards staff when he wants to work, is able conduct issues, is a delayed, history of mealcohol use 15 years past history of alcohol nausea and vomiting) controlling, hostile and aggression and needs -A treatment plan date to complete everyday completing daily chorolliving space with no means the conduct issues, is a delayed, history of alcohol nausea and vomiting) controlling, hostile and aggression and needs -A treatment plan date to complete everyday completing daily chorolliving space with no means of the conduct issues.	o foster community dited clients (#1, #2 and 5/22 from 8:34am to 3:55pm d: 8 watched television, sat in acted with staff heduled in the community on 11/16/22 from 9:12am to 8 revealed: 8 watched television, sat in acted with staff heduled in the community of client #1's record revealed: 6 3/30/22 stual Disability, Mild, Type 1 termittent Explosive Disorder, Vitamin D Deficiency, and Constipation. d 3/30/22 noted "has a struction, aggressive acts a does not get his way, to develop friendships, has iabetic, is intellectually ental retardation, history of ago and has not used since, I withdrawal (sweating, has insomnia, is d has verbal and physical as medication management." ed 11/1/22 noted "will learn living tasks such as es, maintaining a clean nore than 3 prompts per o use effective coping skills	V 291			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		MHL0411146	B. WING		11/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2708 16Ti	STREET			
AGAPE H	OME LIVING CARE LLC		3ORO, NC 2740	05		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
V 291	Continued From page	e 8	V 291			
	out of E times when b	an in unnert or facile				
	out of 5 times when h	rk on managing his medical				
	-	how to take his medication				
		more than 2 out of 7 days				
	refusing to follow the	•				
	relating to follow the	physician's orders.				
	Review on 11/15/22 of	of client #2's record revealed:				
	-An admission date o	f 2/9/22				
	-Diagnoses of Mild In	tellectual Disability, Type 1				
		lypertension, Seborrheic				
	· ·	Depressive Disorder with				
	Psychotic Features					
		d 2/9/22 noted "currently				
		setting for adults with				
		lities, was admitted to the				
		sing suicidal thoughts at his				
		, was unable to return to that				
		d 12 th grade, history of				
	-	loss of significant family ther and grandmother),				
	,	eers with similar or same				
		vised setting, has aspirations				
		er, has never worked and				
		th his grandmother after				
		ndmother was unable to				
	l	fter increasing behaviors,				
	has no significant rela	ationships, has a history of				
	destruction of propert	y, conduct issues, frequent				
		ay from his home, is a				
		sulin, needs medication				
		y and attend a Psychosocial				
	Rehabilitation Progra					
		ed 11/1/22 noted "will learn				
		pendent living skills such as				
		iking medications, bathing,				
		vith assistance of staff, will				
	•	without receiving more than				
	3 verbal prompts per					
		engage in positive and eractions as evidenced by				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED
		MHL0411146	B. WING		11/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ACADE H	OME LIVING CARE LLC	2708 16T	H STREET			
AGAFE II	OWE LIVING CARE LLC	GREENS	BORO, NC 2740	05		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	THE APPROPRIATE	COMPLETE DATE
V 291	Continued From page	9	V 291			
	having a decrease in	the frequency of physical				
		eness towards others as				
		rompted no more than 2				
	, , ,	e course of the next 12				
	months, will enhance					
		imes a week with no more				
	than 2 verbal prompts					
	months."					
	Review on 11/15/22 of	of client #3's record revealed:				
	-An admission date o	f 2/8/22				
	-A diagnosis of Intelle	ctual Disability				
	-An admission assess	sment dated 2/8/22 noted				
	"completed 12 th grad	de, currently resides in a				
	group home for adults	s with developmental				
	disabilities, endorsed	suicidal ideations to an				
	EMS (Emergency Me	dical Services) personnel				
	· ·	to the hospital where he was				
		has had a least one arrest in				
		ssion, has a history of				
		spitalization, was molested				
	-	t he has aspirations of				
	becoming an EMT (E					
		er been employed, receives relationship with his mother				
	l	not have any close and/or				
		ps with peers, has a history				
	, –	to care for himself, history of				
	suicide attempts and					
		ds medication management				
		habilitation Program."				
		ed 11/1/22 noted "will learn				
		pendent living skills such as				
	-	king medications, bathing,				
		vith assistance from staff,				
		se tasks without receiving				
		ompts per each task given,				
	will increase his abilit	y to engage in positive and				
		eractions as evidenced by				
	having a decrease in	the frequency of physical				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D WING		
		MHL0411146	B. WING		11/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
AGAPE H	OME LIVING CARE LLC	2708 16TH			
		GREENSE	ORO, NC 2740	05	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 291	Continued From page 10		V 291		
	and verbal aggressiveness towards others and being prompted no more than 2 times a week, will enhance his skills and symptom of at least 3 times a week with no more than 2 verbal prompts." Interview on 11/15/22 with client #1 revealed: -"During the day, I was wanting to get into a program. But there ain't no transportation and we are so far out. I don't want to go out and get lost. Basically, we watch tv. Sometimes we go to the mall and spend our money by buying cologne and fragrances. I like to smell good." Interview on 11/15/22 with client #2 revealed: -Liked to watch tv (the news, sports)Denies going anywhere such as shopping, going to the park, the library or to the movies -"I would like to get out and go places."				
	(PSR) programs for the "We have called andthey did not want cland behavior issues. like bowling, the moviand [a local theme pathat and incorporate corafts and things that	l: sychosocial Rehabilitation			
	revealed:	ne PSR programs because			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
		MHL0411146	B. WING		11	/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓE, ZIP CODE		
AGAPE H	OME LIVING CARE LLC		H STREET BORO, NC 2740	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 291	of their levels. They s would not be a good f for all of the clients. V places from local cour PSR at home (the sis park, the museum and -Would work on getting in the community.	aid the level they are on fit for their programs. This is We have been to multiple nties and cities. We did the ter facility)they go to the	V 291			

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