STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411222	A. BUILDING: _____ B. WING _____	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	INITIAL COMMENTS A complaint survey was completed on May 10, 2024. The complaint was unsubstantiated (#NC00216444). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement goals and strategies in client #1's treatment plan to address elopement tendencies. The findings are:

Review on 5/9/24 of client #1's record revealed:
-An admission date of 12/19/22
-Diagnoses of Intellectual Disability, Mild and Schizophrenia
-Age 49
-An admission assessment dated 12/19/24 noted "is being transitioned from another facility under the Agape Home Living Care umbrella. [Client #1] enjoys reenacting [a musician's name]'s concerts and listening to music. [Client #1] is a chain smoker and becomes irritable when he's unable to get a cigarette. [Client #1] has moments of distressing memories and will endorse delusions. Was referred from a hospital prior to admission, has no contact with family members, history of arrests and conduct problems resulting in hospitalizations, property destruction when upset or doesn't get his way, has had to have a tooth pulled recently and needs to cut back on smoking, is not motivated for treatment, needs redirection, prompting, demonstration for tasks and every day living skills, has moments of recalling events from the past as if they are in real time, constantly goes to the bathroom throughout the night, eats extremely fast and is at risk of

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V 112	Continued From page 2	V 112		

indigestion, needs education on proper eating skills and reducing the amount of cigarette smoking."
-A treatment plan dated 12/21/24 noted "will work on managing his medical conditions and learn how to take his medication appropriately with no more than 2 out of 7 days refusing to follow the physician orders will learn to complete everyday living tasks such as completing a proper hygiene routine, completing daily chores, maintaining a clean-living space with no more than 3 prompts per each task, and will learn to use effective coping skills in order to reduce his verbal aggression. Carl will learn to use these skills at least 3 out of 5 times when he is upset or feel disrespected or annoyed."
-No goals or strategies to reduce client #1's recent elopement tendencies.

Review on 5/1/24 of the facility's incident report, dated 4/26/24 and completed by the Qualified Professional (QP) revealed:
-"On 4/26/24, This incident report is being completed due to [the LME/MCO] sending the provider a complaint letter that states 'Agape Home Living Care, LLC failed to supervise [client #1] and that a complaint of allegations of abuse/neglect was filed as a 'provider concern.' [Client #1] eloped from the facility on 04/23/2024 while staff was preparing breakfast. [Client #1] was outside smoking a cigarette where he reports that he had a lot on his mind and wanted to walk it off. [Client #1] stated that he was told by his father that when he turned 50 years old, he could be a 'pedestrian' and since he is close to being 50 years old, he decided to pack his belongings and leave out of the side door of the house after smoking his cigarette. Staff looked for [client #1] once learning of his elopement, however, was unable to locate him initially. The Director began

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V 112	Continued From page 3 looking for him as well and notified the guardian that he had left the residential facility. Director saw a police officer and provided him with a description of [client #1] and explained that he eloped from a residential group home for DD (Developmentally Disabled] adults. Staff continuously checked with local hospitals throughout the day to see if [client #1] had come to either hospital and rode pass spots that were frequently visited on outings to see if [client #1] was there. The following day [client #1] went to [a local hospital]'s Emergency Room, refused to be seen and left on foot, where the police officer from the day before spotted him. The police officer contacted the residential facility, and staff left to immediately transport him back to the residential facility. [Client #1] stated that he slept in a tent, and outside of having complaints of his feet hurting, he was fine. [Client #1] did report that he dumped his clothes in a ditch but was unable to explain where to attempt to retrieve his belongings. An incident report was completed for this elopement." -"[Client #1] let the residential facility premises for more than three hours. [The LME/MCO] has initiated a provider complaint for allegations of abuse/neglect for this incident. The Guardian, provider and care manager for [client #1] has discussed options such as a one-on-one staff to be put in place to have enhanced supervision for [client #1]. The QP discussed [client #1] expressing his thoughts and concerns with staff prior to him wanting to leave the residential facility for an extended period of time. Agape Home Living Care, LLC has discussed with guardian, other family support that could possibly come and visit with [client #1], as he talks about his family often, but doesn't have any contact with any natural supports."	V 112		

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V 112	Continued From page 4 Review on 5/1/24 of a 911 print out to the facility revealed: -"4/23/24 at 08:57:52 (8:57am), Missing Person. Age 49, the caller advised several 10-96 (unable to locate) issues. Caller on the scene. Last saw client at shift change at 7:00am. Left on foot. Has a history of missing, previously found downtown." Observations and interview on 5/9/24 at 10:38am with client #1 revealed: -"I left here (the facility) by mistake. I walked off by mistake. That's all. I was no further than the store. I was away three nights, and I did not do anything bad ...I can't explain why I walked off. I just needed to take a break." -"I have left two times, and this was my last time." -Was unable to remember which staff worked on the day he left the facility. -"I went out the back door. I walked away for a couple of days. I just went off the scene." Interview on 5/10/24 with the Assistant House Manager (AHM) revealed: -"I called the police (on 4/23/24) to file a missing person's report. The hospital called me...when I got to the hospital, he was gone, but the police had located him nearby. I went to pick him up and I returned him to the facility." -"[Client #1] has left the facility before, but wasn't gone for 2 days like this time." -The facility had locks on the doors, but no alarms. -"We don't have anything to alert us if he walks out the back door. It would be a good idea to have them..." Interview on 5/10/24 with client #1's Legal Guardian revealed: -"The only concern my Agency has was for his safety. We have no concerns with the facility. As	V 112		

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V 112	Continued From page 5 soon as he (client #1) left, the Director notified me and the police. [Client #1] had left before, I think towards the end of February (2024). I think adding goals and strategies in his treatment plan (to address elopement tendencies) would be a good idea." Interview on 5/9/24 with the Qualified Professional revealed: -"[Client #1] left the facility in the morning (on 4/23/24) while staff was cooking breakfast. He was gone and left on foot. He took clothing with him. He was gone for that day and the following day. [The AHM] received a call from the hospital and brought him back to the facility." -"We have not discussed goals and strategies to prevent [client #1] from leaving the facility...I am trying to schedule a meeting to address this." -"..we do need to add a strategy to his plan..his plan is to be updated at the end of the month..." Interview on 5/9/24 with the Director revealed: -Would ensure goals and strategies were added to client #1's treatment plan to address his elopement tendencies.	V 112		