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 _____	07/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE, LLC	310 FIELDS STREET GREENSBORO, NC 27405

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on July 29, 2024. The complaint was substantiated (intake #NC00218936). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

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V 105	Continued From page 1 can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement its written policy for client discharge. The findings are:

Review on 7/29/24 of the facility's policy for client discharge revealed:
-The facility "shall provide a written copy of a discharge plan to the resident, or his/her legal guardian, unless a discharge plan is not required because of an unanticipated discontinuation of a consumer's treatment. The plan shall contain recommendations for further services designed to enable the resident to live as normally as possible."
-A service planning meeting "shall be held within five business days of an emergency transfer or discharge."

Reviews on 7/25/24 and 7/26/24 of Former Client (FC#7)'s record revealed:
-Date of admission: 12/19/22.
-Date of discharge: 6/26/24.
-Diagnoses: Mild to Moderate Intellectual Developmental Disability, Autistic Disorder, Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder, and Adult Anti-Social behavior.
-Behavioral history of elopements with at least 12 incidents of elopement from the facility from 5/13/23-6/25/24.
-No written discharge summary or plan.

Interview on 7/24/24 with FC#7's Care Coordinator revealed:

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V 105	Continued From page 3 -When FC #7 was being discharged from the hospital on 6/26/24, he refused to return to the facility with facility staff. -The Director said she was no longer "putting up with [FC#7]'s behavior" and could no longer handle him in her facility. -The Director provided no written discharge notice or discharge plan for FC#7. Interview on 7/24/24 with the Director revealed: -"I did an IVC (Involuntary Commitment). That was his discharge." -She did not have a written discharge notice or discharge plan.	V 105	Beginning the end of August 2024, there will be a change in staff for the Qualified Professional. A transition/discharge plan will be put in place for all residents. If a discharge is being completed, the transition/discharge plan will be provided the resident and his/her guardian as well as any other providers that are deemed necessary. A 30 or 60 day notice will be provided for residents that are being discharged from the home. The notice will be followed unless it is deemed an emergency discharge for things regarding continuous self-harm, harm to others or extensive property damage.	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.	V 114		

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V 114	Continued From page 4	V 114		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure fire and disaster drills were done quarterly on each shift. The findings are:

Review on 7/26/24 of the facility's fire and disaster log between 10/26/24 to 7/10/24 revealed:
-No documentation of a fire or disaster drill on 2nd and 3rd shifts for January-March 2024 (1st quarter).
-No documentation of a fire or disaster drill on 3rd shift for April-June 2024 (2nd quarter).
-No documentation of a fire or disaster drill on 3rd shift for July 2024 -September 2023 (3rd quarter).
-No documentation of a fire or disaster drill on 2nd and 3rd shifts for October-December 2023 (4th quarter).

Interview on 7/24/24 with Client #1 revealed:
-"Sometimes we go outside when we hear the alarm (when asked about fire drills).
-"No ma'am, we don't do them," when asked about disaster drills such as tornado drills.

Interview on 7/24/24 with Client #2 revealed:
-Initially stated the facility did not practice fire drills; later stated they went out the front or back doors during fire drills.
-The facility practiced tornado drills.
-He could not recall when the last drill was practiced.

Interview on 7/26/24 with the Director revealed:
-3 shifts are run at the facility- 1st shift from 7 am-5 pm, 2nd shift from 5 pm-10:30 pm, and 3rd

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V 114	Continued From page 5 shift from 10:30 pm-7 am. -She and the staff were working on conducting the fire and disaster drills. -She would make sure the drills were done on each shift.	V 114	Beginning September 2024, there will be fire drills conducted on each shift during each month (there will be a 1st, 2nd, and 3rd shift fire drill for each month. There are 6 disaster drills that are to be practiced throughout the year. These drill will be completed every month going forward so that the all drills are completed as required. A new form was devised to make sure that all drills are completed each month.	
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 6	V 118		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the clients' MARs were kept current affecting 2 of 3 audited clients (Clients #1, #2 and FC#7). The findings are:

Reviews on 7/25/24 and 7/26/24 of Client #1's record revealed:
-Admission date: 10/12/23.
-Diagnoses: Mild Intellectual Developmental Disability, Schizophrenia, Hypertension, Type 2 Diabetes Mellitus (DMII), Gastroesophageal Reflux Disease (GERD), Seizure Disorder, and Hyperlipidemia.
-Physician orders for the following medications:
-10/4/23, Docusate Sodium 100 milligrams (mg)-1 capsule (cap) daily (constipation).
-11/10/23, Lisinopril 10 mg-1 tablet (tab) daily (high blood pressure).
-12/4/23, Atorvastatin 40 mg- 1 tab every evening (high cholesterol).
-2/21/24, Vitamin D2 1.25 mg- 1 tab every week on Friday mornings (Vitamin D deficiency).
-3/1/24, Folic Acid 1 mg- 1 tab daily (folate deficiency).
-3/6/24, Pantoprazole Sodium 40 mg-1 tab in the mornings at 7:30 am (GERD).
-4/25/24, Olanzapine 10 mg, 1 tab twice daily (schizophrenia), Hydroxyzine Hydrochloride (HCL) 50 mg-1 tab 3 times daily (anxiety), Risperidone 2 mg-1 tab twice daily (schizophrenia), and Benztropine Mesylate 1 mg-1 tab twice daily (side effects from other medications).

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V 118	Continued From page 7 Review on 7/26/24 of Client #1's MARs from 5/1/24- 7/25/24 revealed: -No documentation of administration of the following medications: -Docusate Sodium at 8 am on 5/29/24-5/31/24, 6/29/24 and 6/30/24. -Lisinopril at 8 am on 6/29/24 and 6/30/29. -Atorvastatin at 8 pm on 5/22/24-5/31/24, 6/1/24-6/3/24 and 6/5/24-6/30/24. -Vitamin D2 at 8 am on 5/10/24, 5/17/24, 6/14/24, 6/21/24, 6/28/24, 7/12/24 and 7/19/24. -Folic Acid at 8 am on 5/29/24-5/31/24. -Pantoprazole Sodium at 7:30 am on 5/29/24-5/31/24, 6/29/24 and 6/30/24. -Olanzapine at 8 am on 5/31/24, 6/29/24, 6/30/24, and at 8 pm on 5/22/24-5/31/24, 6/1/24-6/3/24, 6/5/24-6/30/24. -Hydroxyzine HCL at 8 am on 5/31/24 6/29/24 and 6/30/24,7/5/24, at 4 pm on 5/22/24-5/31/24,6/1/24-6/3/24, 6/5/24-6/30/24, and at 8 pm on 5/22/24-5/31/24, and 6/5/24-6/30/24. -Risperidone at 8 am on 5/31/24, 6/29/24, 6/30/24, and at 8 pm on 5/22/24-5/31/24, 6/1/24-6/3/24, 6/5/24-6/30/24. -Benztropine Mesylate at 8 am on 5/31/24,6/29/24, 6/30/24, and at 8 pm on 5/22/24-5/31/24, 6/5/24-6/30/24. Reviews on 7/25/24 and 7/26/24 of Client #2's record revealed: -Admission date: 6/4/24. -Diagnoses: Mild Intellectual Developmental Disability, Paranoid Schizophrenia. -Physician orders on 6/4/24 for the following medications: -Chlorpromazine HCL 200 mg-1 tab at bedtime (schizophrenia). -Chlorpromazine 50 mg-3 tabs twice daily	V 118		

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before breakfast and before lunch (schizophrenia).
-Haloperidol 5 mg-1 tab daily at 3 pm (psychosis).
-Haloperidol 10 mg- 1 tab twice daily (psychosis).
-Geri-kot 8.6 mg- 1 tab every evening (constipation).
-Metoprolol Succinate 25 mg- 1 tab daily (high blood pressure).
-Hydroxyzine Pamoate 25 mg-1 tab daily (anxiety).
-Hydroxyzine Pamoate 50 mg-1 cap at bedtime (anxiety).
-QC Stool Softener 100 mg-1 cap daily (constipation).
-Divalproex Sodium 500 mg-2 tabs in the morning and 3 tabs at bedtime (seizure disorder).
-Pantoprazole Sodium 40 mg- 1 tab at 6 am daily (GERD).
-Docusate Sodium 100 mg-2 tabs daily (constipation).
-Goodsense Clearlax 17 gram (gm) per scoop-mix 17 gm (1 capful) in liquid and drink daily (constipation).

Review on 7/26/24 of Client #2's MAR from 6/4/24- 7/25/24 revealed:
-No documentation of administration of the following medications:
-Chlorpromazine HCL 200 at 8 pm on 6/25/24-6/30/24.
-Chlorpromazine 50 mg at 8 am, and at 12 pm on 6/29/24 and 6/30/24,7/1/24-7/3/24.
-Haloperidol 5 mg at 3 pm on 6/25/24-6/30/24, 7/1/24-7/3/24.
-Haloperidol 10 mg at 8 am on 6/29/24 and 6/30/24, 7/1/24-7/3/24, and at 8 pm on 6/11/24, 6/25/24-6/30/24.
-Geri-kot at 3 pm on 6/25/24-6/30/24,

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7/1/24-7/3/24.
-Metoprolol Succinate at 8 am on 6/29/24 and 6/30/24, 7/1/24-7/3/24.
-Hydroxyzine Pamoate 25 mg at 8 am on 6/29/24 and 6/30/24,7/1/24-7/3/24.
-Hydroxyzine Pamoate 50 mg at 8 pm on 6/25/24-6/30/24.
-QC Stool Softener at 8 am on 6/29/24 and 6/30/24.
-Divalproex Sodium at 8 am on 6/29/24 and 6/30/24, 7/1/24-7/3/24, and at 8 pm on 6/25/24-6/30/24.
-Pantoprazole Sodium at 6 am on 6/29/24 and 6/30/24, 7/1/24-7/3/24.
-Docusate Sodium at 8 am on 6/29/24 and 6/30/24, 7/1/24-7/3/24.
-Goodsense Clearlax at 8 pm on 6/25/24-6/30/24, 7/1/24-7/3/24.

Reviews on 7/25/24 and 7/26/24 of Former Client (FC#7)'s record revealed:
-Date of admission: 12/19/22.
-Date of discharge: 6/26/24.
-Diagnoses: Mild to Moderate Intellectual Developmental Disability, Autistic Disorder, Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder, and Adult Anti-Social behavior.
-Physician orders for the following medications:
-6/9/23, SSD 1% cream, apply cream topically to infected area daily (skin antibiotic).
-1/3/24, Benztropine Mesylate 1 mg-1 tab twice daily (side effects from other medications), Hydroxyzine HCL 0.2 mg- 1 tab 3 times daily (anxiety).
-1/17/24,Divalproex Sodium 250 mg-1 tab every day (seizure disorder).
-1/25/24, Amlodipine Besylate 10 mg- 1 tab daily (hypertension), Propranolol 40 mg-1 tab at bedtime (anxiety)

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V 118	Continued From page 10 -2/21/24, Risperidone 1 mg- 1 tab twice daily (Autism). -3/14/24, Belsomra 20 mg- 1 tab at bedtime daily (sleep). -6/15/24, Clonidine HCL 0.2 mg- 1 tab twice daily at noon and bedtime (hyperactivity). Review on 7/26/24 of Client #1's MAR from 5/1/24- 6/30/24 revealed: -No documentation of administration of the following medications: -SSD 1% cream at 8 am on 5/28/24-5/31/24. -Benztropine Mesylate at 8 am on 5/29/24-5/31/24, and at 8 pm on 5/9/24-5/31/24, 6/1/24-6/25/24. -Hydroxyzine HCL at 8 am on 5/29/24-5/31/24, at 5 pm on 5/9/24-5/31/24, 6/1/24-6/18/24, and at 8 pm on 5/9/24-5/31/24, 6/1/24, 6/3/24 and 6/5/24. -Divalproex Sodium at 8 pm on 5/9/24-5/31/24, 6/1/24-6/3/24, and 6/5/24-6/12/24. -Amlodipine Besylate at 8 am on 5/29/24-5/31/24. -Risperidone at 8 am on 5/29/24-5/31/24, and at 8 pm on 5/10/24-5/31/24, 6/1/24-6/3/24, 6/5/24-6/12/24, 6/16/24 and 6/19/24. -Belsomra at 8 pm on 5/9/24-5/31/24, 6/1/24-6/3/24, and 6/5/24-6/12/24. -Clonidine at 12 pm on 5/29/24-5/31/24, and at 8 pm on 5/9/24-5/31/24, 6/1/24-6/3/24, 6/5/24-6/12/24. Interview on 7/24/24 with Client #1 revealed: -He took his medication every morning and at night. -He had no problem taking his medications. -"I take them (medication) every day. Staff gives it (medication) to me." Interview on 7/24/24 with Client #2 revealed: -He took his medication after he ate breakfast in the mornings and at night.	V 118		

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V 118	Continued From page 11 -He did not know what his medications were for. -Staff gave him his medications. Interview on 7/24/24 with FC #7 revealed: -He named his mental health medications and stated they were for his anxiety. -One medication was for anger and another medication was for blood pressure. -Staff gave him his medications and he had no problem taking his medications. Interview on 7/24/24 with Staff #1 revealed: -She worked as a paraprofessional at the facility since February 2024. -She completed her required medication training and administered client medications on the weekends when she worked. -Staff #2 and #3 were the primary staff who gave the clients their medications during the weekdays. -She would have to look at the clients' MARs to identify their medications because they received a lot of different medications. -She initialed the MAR for each client she gave medications to. -She did not know why the MARs for Clients #1, #2 and FC#7 were not initialed daily during May and June. Interview on 7/24/24 with Staff #2 revealed: -He worked as a direct care staff at the facility. -He had completed medication training as a requirement of his position. -Staff #3 usually gave the clients their medications daily while he helped clients with their daily living activities. Interview on 7/25/24 with Staff #3 revealed: -He had been the House Manager at the facility for 6 months (since January 2024). -He worked at the facility from 7 am-2 pm,	V 118		

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	MHL0411222	A. BUILDING: _____ B. WING _____	07/29/2024

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V 118	Continued From page 12 Monday through Friday. -He was trained in medication administration and gave clients their medications in the mornings and noontime. -He did not know why the MARs for Clients #1, #2 and FC#7 were not initialed daily during May and June. -He thought maybe the causes were that Client #1 had a medical procedure the first of July (2024) and FC#7 had several therapeutic leaves in May and June (2024) and his family would have given him his medications. -The 2nd and 3rd shift staff were responsible for administering medications after 2:00 pm. Interviews on 7/25/24, 7/26/24 and 7/29/24 with the Director revealed: -Each staff was responsible for initialing the client MARs right after administering each medication to a client. -Staff could have initialed the MAR after giving each client their medication or used a code from the back of the MAR when a client was on therapeutic leave or in the hospital. -Client #1 had therapeutic leave in May or June, and then a colonoscopy on 7/2/24. -FC #7 had therapeutic leave on 5/14/24, 5/24/24-5/27/24, and 6/15/24-6/18/24. -She believed all the clients received their medications and the "blanks" on the MARs for Client #1, #2 and FC #7 occurred because staff did not document. -A nurse came to the facility periodically and conducted a quality assurance check on the client medications and MARs. -She did not know when the last medication quality assurance check was done by the nurse. -The nurse was scheduled for a facility visit on 8/12/24 at 10 am for the next medication quality assurance check.	V 118		

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V 118	Continued From page 13 -There were times she noticed client medications were not listed on a client MAR. -The pharmacy printed and provided each client's monthly MAR when they delivered the monthly medications. -She would follow up with the pharmacy about any medications or dosage times not listed on a MAR or she would have any missing medication written in on a client MAR. -She would make sure the MARs were kept up to date.	V 118	The medication book (MARs) will be reviewed weekly by the new Qualified Professional in order to assure that all medications are provided and given as well as the staff has initialed that all medications have been provided during the time in which they are to be administered. The Qualified Professional will do a review of the MAR to make sure that all staff is aware of what to code when residents are not in the home (for reasons of the resident being in the hospital, out of the home doing home visits, etc).	
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 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	V 132		

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V 132	Continued From page 14 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 review and interview, the facility failed to ensure an allegation of abuse was reported to the Health Care Personnel Registry (HCPR) within 5 working days. The findings are: Review on 7/26/24 of Client #2's record revealed: -Admission date: 6/4/24. -Diagnoses: Mild Intellectual Developmental Disability, Paranoid Schizophrenia. -6/21/24 hospital emergency department (ED) discharge paperwork with a diagnosis of a "burn" listed. Review on 7/26/24 of a 6/21/24 incident report completed and signed by the Qualified Professional (QP) revealed: -The "Director informed doctor that he (Client #2) had a spider bite on lower right leg close to his knee area." -There was no documentation about the ED doctor's report of Client #2's having reported on 6/21/24 he was burned while bathing at the facility "two weeks ago." -No additional incidents were provided for review between 5/1/24- 7/24/24 when requested on 7/24/24. Review on 7/29/24 of a Level III incident report for Client #2 submitted 7/27/24 by the Qualified Professional (QP) to IRIS revealed:	V 132		

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V 132	Continued From page 15 -An attached ED report dated 6/21/24 with Client #2 having reported to a ED physician he was burned while taking a bath at the facility "2 weeks prior." -An internal investigation by the facility was not conducted until the Director told the QP on or about 7/26/24 that an investigation was needed for Client #2 "having a burn mark on his lower right leg." Interviews on 7/24/24 and 7/26/24 with Staff #2 revealed: -He worked as direct staff from 7 am-4 pm on the weekdays. -He helped Client #2 to bathe daily. -He denied having poured hot water on Client #2 in the bathtub. -He denied he heated water up on the stove to put in Client #2's bath. -"He (Client #2) must have gotten bit by a spider ...I really don't know how it happened." Interview on 7/29/24 with the QP revealed: -She did not review Client #2's hospital discharge paperwork on 6/21/24 that diagnosed Client #2 with a burn. -She was at the hospital on 6/21/24 with the Director when Client was being discharged. -The Director told the ED doctor Client #2 had a spider bite on his lower right leg. -The 6/21/24 hospital report for Client #2 was unclear about the source of Client #2's burn. -She completed an incident report on 6/21/24 about Client #2's injury from a spider bite and she did not conduct an internal investigation until 7/27/24 and after the Director told her an investigation was needed about the burn mark on Client #2's leg. Interviews on 7/24/24, 7/25/24, 7/26/24 and	V 132		

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V 132	Continued From page 16 7/29/24 with the Director revealed: -She was not aware Staff #2 heated up a pot of water on the stove and poured hot water into Client #2's bath until Client #2's statement last week (7/24/24). She and the QP then conducted their internal investigation. -She did not report the allegation to anyone until after the investigation and an IRIS report was submitted (7/27/24) that reported Staff #2 and Staff #3 to the HCPR.	V 132	Upon the report from a resident or other staff regarding harm being done to a resident or staff by another resident or staff, an internal investigation will be completed at the time of the report. The investigation will be completed within 48 hours of the initial report and the findings will be documented and provided to the Director as well as in the incident reporting log. The Director and QP will determine if the allegations need to be reported to the HCPR based on the findings.	
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in	V 366		

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V 366	Continued From page 17 Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and	V 366		

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V 366	Continued From page 18 (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed implement a policy governing their response to Level II and Level III incidents. The findings are:	V 366		

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V 366	Continued From page 19 Review on 7/24/24 of a Level II incident report for Former Client (FC #7) submitted on 7/24/24 by the Qualified Professional (QP) to the North Carolina Incident Response Improvement System (IRIS) revealed: -Date of Incident: 6/25/24 at 5:30 pm. -Date Provider learned of the incident: 6/25/24. -FC #7 eloped from the facility on 6/25/24 which led to his involuntary commitment (IVC) to a hospital. -No documentation the LME was immediately notified of the incident. Review on 7/29/24 of a Level III incident report for Client #2 submitted 7/27/24 by the Qualified Professional (QP) to IRIS revealed: -Date of incident: 7/26/24 at 1:17 pm. -Date of original injury: 6/21/24. -Date of attached emergency department (ED) report: 6/21/24 with Client #2 reported to an ED physician he was burned while taking a bath at the facility 2 weeks prior. Interview on 7/29/24 with the QP revealed: -She was not aware Client #2 had a burn diagnosis on 6/21/24 on his ED discharge paperwork because she did not review the paperwork when she and the Director returned Client #2 to the facility from the hospital. -The 6/21/24 hospital report for Client #2 was unclear about the source of Client #2's burn. -She completed an internal incident report in which the Director informed the ED doctor Client #2 had a spider bite on his right lower leg. -She conducted an internal investigation on 7/27/27 after the Director told her an investigation was needed for Client #2's leg burn. -Her internal investigation concluded the source of Client #2's injury was unclear.	V 366		

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V 366	Continued From page 20 -She submitted the Level II incident report for FC #7 in IRIS and believed the Director had already notified FC #7's Care Coordinator the day after his hospital admission. Interviews on 7/24/24, 7/25/24, 7/26/24 and 7/29/24 with the Director revealed: - Client #2 "went to the hospital and said he got burnt by hot water. The doctor said it looked like he got bit by a bug." -She did not read Client #2's discharge paper that he was diagnosed with a burn because it was around 2:30 in the morning and dark when she returned Client #2 to the facility. -She was not made aware Staff #2 heated up a pot of water on the stove and poured hot water into Client #2's bath until Client #2's statement last week (7/24/24). -Staff #3 was placed in the position of House Manager in December 2023 to oversee the staff and report any client incidents to her or the QP. -She and the QP terminated Staff #2 and #3 because of Staff #2's action with pouring hot water in Client #2's bath and Staff #3 did not report the incident. "They (Staff #2 and #3) were not doing their jobs like they're supposed to." -She notified FC#7's Care Coordinator on 6/26/24 after he was IVC'd at the hospital.	V 366	A staff meeting will be conducted in August 2024 which will include the protocol for reporting incidents. The staff will be informed of what concludes an incident that needs to be reported to the Director and the QP. The QP will be responsible for completing all incident reports, internal investigations and IRIS reports as well as following up on any needed information. All proper professionals associated wit the member (care coordinators, guardians, etc) will be notified within 12 hours of any incident.	
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	V 367		

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V 367	Continued From page 21	V 367		

to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where 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

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V 367	Continued From page 22 Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. 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 23 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all Level II and Level III incidents to the Local Management Entity (LME) within 72 hours of becoming aware of each incident. The findings are: Review on 7/24/24 of a Level II incident report for Former Client (FC #7) submitted on 7/24/24 by the Qualified Professional (QP) to the North Carolina Incident Response Improvement System (IRIS) revealed: -No documentation the LME was notified of the incident within 72 hours of FC #7 having eloped from the facility on 6/25/24 which led to his hospital admission by involuntary commitment. Review on 7/29/24 of a Level III incident report for Client #2 submitted on 7/27/24 by the QP to IRIS revealed: -No documentation the LME was notified of the incident within 72 hours of the facility having received a 6/21/24 hospital record of Client #2's burn diagnosis. Refer to V366 regarding interviews with the QP and Director as to their reasons why the LME was not notified within 72 hours of each incident.	V 367	A staff meeting will be conducted in August 2024 which will include the protocol for reporting incidents. The staff will be informed of what concludes an incident that needs to be reported to the Director and the QP. The QP will be responsible for completing all incident reports, internal investigations and IRIS reports as well as following up on any needed information. All proper professionals associated wit the member (care coordinators, guardians, etc) will be notified within 12 hours of any incident.	
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	V 512		

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V 512	Continued From page 24 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. This Rule is not met as evidenced by: Based on record review, observation and interview, 2 of 3 audited staff (Staff #2 and Staff #3) harmed and abused 1 of 3 audited clients (Client #2) to be abused and harmed. The findings are: Review on 7/29/24 of Staff #2's personnel file revealed: -Hire date: 5/30/23. -Position: Paraprofessional. Review on 7/29/24 of Staff #3's personnel file revealed: -Hire date: 9/17/23. -Position: Paraprofessional. Review on 7/26/24 of Client #2's record revealed: -Admission date: 6/4/24.	V 512		

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V 512	Continued From page 25 -Diagnoses: Mild Intellectual Developmental Disability, Paranoid Schizophrenia. -6/21/24 hospital emergency department (ED) discharge paperwork with a diagnosis of a "burn" listed. No additional information was provided about his burn diagnosis. Review on 7/26/24 of a 6/21/24 incident report completed and signed by the Qualified Professional (QP) revealed: -The Director asked the QP to meet her at an emergency medical facility concerning a "bite mark" on Client #2 that appeared infected. -The "Director informed doctor that he (Client #2) had a spider bite on lower right leg close to his knee area." -There was no documentation of Client #2's report to the emergency department (ED) doctor that he was burned while bathing at the facility "two weeks ago." -There was no documentation of Client #2's burn diagnosis from his discharge paperwork. Review on 7/29/24 of a Level III incident report for Client #2 which was submitted on 7/27/24 in the North Carolina Incident Response Improvement System (IRIS) revealed: -Original date of Client #2's injury was reported as 6/21/24. -Attached report dated 7/26/24 of an internal investigation for Client #2's burn included the following: -On 7/26/24, the QP was notified by the Director to investigate Client #2's burn on his lower right leg. -Client #2 stated he was burned by hot water when staff (Staff #2) "boiled water" and added the boiled water to his bath. -Client #2 stated he was sitting in the bathtub when the water from a pot was added .	V 512		

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V 512	Continued From page 26 -Client #2 stated he did not say anything because the water did not hurt him. He stated he was being helped while bathing. -Staff #2 denied he added a pot of hot water to Client #2's bath. -Staff #3 acknowledged "warm water" was added to Client #2's bath because the water was cold. He noticed the "mark" on Client #2's leg "a few days later" and "everyone assumed that he was bite by an insect." -Attached hospital ED report for Client #2 dated 6/21/24 included the following additional information: -"Patient is presenting with a burn to the right lower extremity." -"The patient reportedly got this (burn) while taking a bath at his group home 2 weeks ago." -"The group home employees report they have been applying antibiotic ointment to this (leg area)." -"The patient's group home reports they are not sure if this started as a burn or if it was an insect bite." -Client #2's diagnosis was a burn with agreement from a second physician who oversaw the evaluation and treatment of Client #2. Observation and interview on 7/24/24 at 4:01 pm with Client #2 revealed: -"[Staff #2] burned my leg, my right leg." -He pulled up his right pant leg and revealed a discolored circular area under his kneecap that was approximately 3" x 3" in diameter with a quarter-sized, pink-colored area in the center of the discoloration. -"He (Staff #2) put a pot of water on the stove. I was in the bathroom in the bathtub. He (Staff #2) poured hot water on my leg. Then it started hurting. It's not a bug bite. [Staff #2] said a bug bit me."	V 512		

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V 512	Continued From page 27 -He could not recall the date of the incident but stated his burn occurred during the daytime. -Staff #2 and Staff #3 helped him with his bath during the day because he could not bathe himself. -He asked, "I'm not in trouble telling this?" Interviews on 7/24/24 and 7/26/24 with Staff #2 revealed: -His usual work hours at the facility were from 7 am to 4 pm during the weekdays. -Helped Client #2 to bathe. Client #2 took a tub bath because he could not stand up long enough to take a shower. -Denied having poured hot water on Client #2 in the bathtub. -Denied he heated water up on the stove and added the water to Client #2's bath. -"He (Client #2) must have gotten bit by a spider ...I really don't know how it happened." Interviews on 7/25/24 and 7/26/24 with Staff #3 revealed: -"[Staff #2] got water warmed on the stove and poured the water in the bathtub. [Client #2] was in the bathtub." -"There were multiple guys (clients) who had already taken their showers and the water was running cooler and that's why he (Staff #2) heated the pot of water up on the stove to put in [Client #2]'s bath." -"I noticed the place on his right leg when I came in that following Monday and asked about his leg. At first, I thought it was a burn, but it wasn't. Everyone said it was a bug bite." -"[Client #2] was taken to the hospital to be checked out and they (the hospital) said it might be a bite." -"[Client #2] told the police who took him to the hospital that we hurt him. He didn't say how."	V 512		

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V 512	Continued From page 28 -"It was a spider bite." -"I did not report about the water being heated up on the stove. It was not boiling water." Interview on 7/29/24 with the QP revealed: -On 6/21/24, she met the Director at the hospital ED when Client #2 was seen for his leg. -The Director informed the ED doctor that Client #2 had a spider bite on his lower right leg. -She did not review Client #2's 6/21/24 discharge paperwork when she and the Director returned him to the facility from the hospital. -She completed an incident report on 6/21/24 about Client #2's ED visit about the spider bite. -The Director told her on 7/27/24 to do an internal investigation about Client #2's burn mark on his leg. -She conducted an internal investigation. Client #2 said his burn could have been from the heated water poured in his bath by Staff #2 or from a cigarette burn. -The hospital report for Client #2 was unclear about the source of his burn. -Her investigation finding was Client #2 may have had his leg burned by a cigarette while smoking or by the water Staff #2 heated up and poured in Client #2's bath. Interviews on 7/24/24, 7/25/24, 7/26/24 and 7/29/24 with the Director revealed: -Client #2 was "always getting bit by something." -Client #2 was transported to the hospital on 6/21/24 by police after police arrived at the facility in response to Staff #3's 911 call about Client #2 having eloped from the facility. -Client #2 "went to the hospital and said he got burnt by hot water. The doctor said it looked like he got bit by a bug." -When she and the QP brought Client #2 back to the facility from the hospital, she did not read	V 512		

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V 512	Continued From page 29 Client #2's discharge paper that he was diagnosed with a burn because it was around 2:30 in the morning and dark when they returned. -She was not aware Staff #2 heated up a pot of water on the stove and poured the water into Client #2's bath until Client #2's statement last week (7/24/24). -An internal investigation about Client #2's allegation against Staff #2 was completed on 7/26/24 by the QP. -She placed Staff #3 in the position of House Manager in December 2023 to oversee the staff and report any client incidents to her or the QP. -She and the QP suspended Staff #2 and #3 on 7/26/24 and then terminated both these staff on 7/27/24 because of Staff #2's action with pouring hot water in Client #2's bath and Staff #3 did not report the incident. "They (Staff #2 and #3) were not doing their jobs like they're supposed to." Review on 7/29/24 of the Plan of Protection dated 7/29/24 written by the QP and Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Immediately read all of the discharge or aftercare summaries from the hospital or doctors offices and take immediate action with starting investigation or following the discharge summary recommendations such as following up with a PCP (Primary Care Physician), or other providers. -Immediately send out a memo to staff alerting them of protocol for harm, abuse or neglect to consumers. -Immediately make sure that all consumers in the home are free of abuse, harm or neglect. -Immediately make sure that allegations are properly investigated and appropriate documentation is completed. Describe your plans to make sure the above	V 512		

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V 512	Continued From page 30 happens. -Staff will be retrain in abuse, neglect and harm by August 7, 2024, which is the next staff meeting -Staff will properly communicate any harm, abuse or reports of harm and neglect to Director, Qualified Professional or House Manager. -Staff will complete the appropriate incident reports to make sure that any and all incidents are reported. -Director and QP will complete random check-ins with the consumers to include full body checks if they report any harm, abuse or neglect. Staff members that are mentioned will be immediately suspended without pay while an investigation will be completed and it could potentially lead up to termination for the named staff. Qualified Professional will send out a message to the staff about the abuse, harm, and neglect protocol and remind the staff of the next meeting on August 7, 2024." The facility served Client #2 who was diagnosed with Mild Intellectual Developmental Disability and Paranoid Schizophrenia. On 6/21/24, Client #2 was medically diagnosed and treated by emergency department physicians for a burn on his lower right leg. Client #2 stated Staff #2 burned his right leg when Staff #2 heated up hot water on the stove and added the water to his bath. Staff #2 denied this event occurred. Staff #3 confirmed Client #2's account of how his leg was burned by hot water by Staff #2 and he chose not to report the incident to the Qualified Professional or Director. This deficiency constitutes a Type A1 rule violation for serious harm and abuse and must be corrected within 23 days.	V 512	A staff meeting will be conducted in August 2024 which will include the protocol for reporting incidents. The staff will be informed of what concludes an incident that needs to be reported to the Director and the QP. The QP will be responsible for completing all incident reports, internal investigations and IRIS reports as well as following up on any needed information. All proper professionals associated wit the member (care coordinators, guardians, etc) will be notified within 12 hours of any incident. Agape administration will follow the protocol that was put into place by the Director and QP at the time of the State Audit.	

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V 736	Continued From page 31	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility was not maintained in a safe manner. The findings are: Review on 7/26/24 of the North Carolina Residential Building Code Section 310.2.1 revealed: -"Emergency Egress-Every sleeping room shall have at least one operable window or emergency door approved for emergency egress. The units must be operable without the use of key or tool to a full clear opening. If a window is provided, the sill height may not be more than 44" above the floor. These must provide a clear opening of 4 square feet. The minimum height shall be 22 inches and minimum width is 20 inches (1996 Building Code). (For buildings built under the previous Residential Building Code the requirements allowed for a sill height of 48" and an opening of 432 square inches in an area with a minim dimension of 16")." Observation of the facility on 7/26/24 at approximately 2:40 pm revealed: -Client #3's bedroom dresser was located in front of 1 bedroom window and the dresser partially blocked his 2nd window that would have made emergency egress difficult in the event of an emergency.	V 736		

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V 736	Continued From page 32 Client #3 was verbally instructed by the Director to move his dresser to one side to unblock his window in case of fire and he needed to use his window to get out. -Client #4 and Client #6's shared bedroom had only 1 window which was obstructed by an air conditioning window unit and would have made emergency egress difficult in the event of an emergency. -Client #2's bedroom had 1 window which was obstructed by an air conditioning window unit and a dresser located in front of his window that would have made emergency egress difficult in the event of an emergency. Interviews on 7/26/24 and 7/29/24 with the Director revealed: -"They (clients) can push the air conditioners out the window and get out if needed during an emergency." -She understood at least 1 bedroom window needed to be clear and available for clients to egress in case of a fire or other emergency. -She would immediately remove the window air conditioning units from Client #4 and Client #6's shared bedroom as well as from Client #2's bedroom. -She would have her staff check the client bedrooms windows to make sure the windows were clear of obstructions. Review on 7/29/24 of the Plan of Protection dated 7/29/24 written by the Qualified Professional and Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Immediate removal of window units out of the windows that have only one window in their room Immediate checks in bedrooms to make sure that there are no furniture fixtures blocking windows or	V 736		

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V 736	Continued From page 33 exits and move the fixture if there are any. Describe your plans to make sure the above happens. [The Director] has removed the window units out of the windows of the bedrooms that only has one window for exit in case of emergencies. [The Director] and staff have checked for any furniture to make sure that there is no furniture blocking the windows or doors. Staff will continuously check on each shift to make sure that all furniture is not blocking an exit (window or door). Qualified Professional will check the consumers rooms on a weekly basis to make sure there are no fixtures blocking an exit during a facility walkthrough." This facility served 6 clients with diagnoses of Intellectual Developmental Disabilities and other mental health disorders. During a 7/26/24 facility walk-through, 3 out of 6 clients (Clients #2, #3 and #6) had one window in their bedroom which was blocked for emergency egress with a window air conditioning unit. Client #2's bedroom dresser also blocked access to his window while Client #3's dresser was in a location that fully obstructed 1 bedroom window and partially obstructed his 2nd window to allow for emergency egress. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 736	As of August 2024, all obstructions have been removed from the access of the windows. The residents have access to their windows in case of an emergency.	