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 _____	C 02/13/2025

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 2/13/25 The complaint was unsubstantiated (intake# NC00226955). 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 current census of 6. The survey sample consisted of audits of 4 current clients.	V 000		
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.	V 366		

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V 366	Continued From page 1	V 366		

(b) In addition to the requirements set forth in 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,

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V 366	Continued From page 2 if different; and (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 to implement written policies governing their responses to level II incidents affecting 2 of	V 366		

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V 366	Continued From page 3 6 clients (#1 and #2). The findings are: Review on 2/10/25 of client #1's record revealed: - Admission date of 10/20/23 - Diagnoses of Intellectual Disability, Moderate and Generalized Anxiety D/O (Disorder) Interview on 2/10/25 with client #1 revealed: - Had pushed client #2 after client #2 entered his bedroom and struck him with his hand - Pushed client #2 with enough force that it caused client #2 to fall - Did not sustain any injuries from being struck by client #2 - Could not provide the date of the incident Review on 2/13/25 of client #2's record revealed: - Admission date of 10/12/23 Diagnoses: Intellectual Developmental Disability, Mild; Schizophrenia; Hypertension; Diabetes Mellitus, Type II; GERD (Gastroesophageal Reflux Disease); Seizure D/O and Hyperlipidemia - Had surgery on 1/10/25 for a "closed displaced intertrochanteric fracture of the right femur." - Discharged from the hospital on 1/27/25 Interview on 2/13/25 with client #2 revealed: - Had gone into client #1's bedroom and struck him with his hand - Client #1 then pushed him which caused him to fall to the floor - Was hospitalized for a "broken leg." - Was better now and promised the Director he would not to go back into client #1's bedroom or hit him again - Could not recall the date of the incident Interviews on 2/10/25 and on 2/13/25 with the	V 366		

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V 366	Continued From page 4 Director revealed: - On 1/9/25, client #2 went into client #1's bedroom and with his hand struck client #1 on his forehead - After being struck by client #2, client #1 pushed client #2 hard enough to cause client #2 to fall to the floor - When client #2 complained of leg pain later that day (1/9/25), Emergency Medical Services (EMS) were called to come to the facility to examine client #2 - After he was examined by EMS personnel, it was determined client #2 did not require any treatment nor transport to the hospital - When client #2 was unable to stand or walk without staff assistance on 1/10/25, EMS was called and EMS transported client #2 to the emergency department of a local hospital - After being examined at the hospital, it was discovered client #2's right hip was "fractured" and client #2 was scheduled for surgery on the same day - Client #2 was discharged from the hospital on 1/27/25 - Client #1 was not injured during the encounter with client #2 on 1/9/25 - She acknowledged an level II incident report should have been submitted to the Incident Response Improvement System (IRIS) - The facility's former Qualified Professional was responsible for submitting IRIS reports and had failed to do so in this instance - Although, no report has been submitted to IRIS, she had notified client #1's legal guardian about his behavior on 1/9/25 and she had also notified client #2's legal guardian about calling EMS on his behalf on 1/9/25 and on 1/10/25 - Remained in contact with client #2's legal guardian while he was hospitalized and since his discharge from the hospital	V 366		

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V 366	Continued From page 5 Review on 2/13/25 of the IRIS revealed: - No evidence that a level II incident report had been submitted to IRIS on behalf of clients (#1 and #2) regarding the events of 1/9/25 and 1/10/25 and thus there was no documentation of how the facility had attended to the health and safety needs of the individuals involved in the incident; determined the cause of the incident; if the facility had developed and implemented any corrective measures; if any measures had been developed to prevent similar incidents and had they assigned person(s) to be responsible for implementation of any corrective/preventative measures	V 366		
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 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;	V 367		

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(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. 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

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V 367	Continued From page 7 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. This Rule is not met as evidenced by: Based on record review and interview, the provider failed to report all level II incidents to the Local Management Entity (LME) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident affecting 2 of 6 clients (#1 and #2). The findings are: Review on 2/10/25 of client #1's record revealed: - Admission date of 10/20/23 - Diagnoses of Intellectual Disability, Moderate and Generalized Anxiety D/O (Disorder)	V 367		

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V 367	Continued From page 8 Interview on 2/10/25 with client #1 revealed: - Had pushed client #2 after client #2 entered his bedroom and struck him with his hand - Pushed client #2 with enough force that it caused client #2 to fall - Did not sustain any injuries from being struck by client #2 - Could not provide the date of the incident Review on 2/13/25 of client #2's record revealed: - Admission date of 10/12/23 Diagnoses: Intellectual Developmental Disability, Mild; Schizophrenia; Hypertension; Diabetes Mellitus, Type II; GERD (Gastroesophageal Reflux Disease); Seizure D/O and Hyperlipidemia - Had surgery on 1/10/25 for a "closed displaced intertrochanteric fracture of the right femur." - Discharged from the hospital on 1/27/25 Interview on 2/13/25 with client #2 revealed: - Had gone into client #1's bedroom and struck him with his hand - Client #1 then pushed him which caused him to fall to the floor - Was hospitalized for a "broken leg." - Was better now and promised the Director he would not to go back into client #1's bedroom or hit him again - Could not recall the date of the incident Interviews on 2/10/25 and on 2/13/25 with the Director revealed: - On 1/9/25, client #2 went into client #1's bedroom and with his hand struck client #1 on his forehead - After being struck by client #2, client #1 pushed client #2 hard enough to cause client #2	V 367		

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V 367	Continued From page 9	V 367		

to fall to the floor
- When client #2 complained of leg pain later that day (1/9/25), Emergency Medical Services (EMS) were called to come to the facility to examine client #2
- After he was examined by EMS personnel, it was determined that client #2 did not require any treatment nor transport to the hospital
- When client #2 was unable to stand or walk without staff assistance on 1/10/25, EMS was called and EMS transported client #2 to the emergency department of a local hospital
- After being examined at the hospital, it was discovered client #2's right hip was "fractured" and client #2 was scheduled for surgery on the same day
- Client #2 was discharged from the hospital on 1/27/25
- Client #1 was not injured during the encounter with client #2 on 1/9/25
- She acknowledged an level II incident report should have been submitted to the Incident Response Improvement System (IRIS)
- The facility's former Qualified Professional was responsible for submitting IRIS reports and had failed to do so in this instance
- Although, no report has been submitted to IRIS, she had notified client #1's legal guardian about his behavior on 1/9/25 and she had also notified client #2's legal guardian about calling EMS on his behalf on 1/9/25 and on 1/10/25
- Remained in contact with client #2's legal guardian while he was hospitalized and upon his discharge from the hospital

Review on 2/13/25 of IRIS revealed:
- No level II incident reports regarding clients (#1 and #2) and the events involving them on 1/9/25 and 1/10/25 had been submitted to the Local Management Entity/Managed Care

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V 367	Continued From page 10 Organization (LME/MCO)	V 367		