	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
74101044	or contraction	BEITH IO/HIOHHOUBER	A. BUILDING:			
		MHL0411222	B. WING		02/1	3/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGAPF	HOME LIVING CARE,	HC	DS STREET			
AOAI E	TOME ENTITO OAKE,	GREENS	BORO, NC 2	7405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS	V 000			
	The complaint was	was completed on 2/13/25 unsubstantiated (intake# ficiencies were cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
		sed for 6 and has a current survey sample consisted of clients.				
V 366	27G .0603 Incident	Response Requirements	V 366			
	implement written presponse to level I, shall require the profession of individuals involved (2) determinition (3) developing measures according timeframes not to equation (4) developing to prevent similar in specified timeframe (5) assigning for implementation preventive measure (6) adhering set forth in G.S. 75 42 CFR Parts 2 and 164; and (7) maintainition of individual contents of the preventive measure (6) adhering set forth in G.S. 75 42 CFR Parts 2 and 164; and (7) maintainition of individual contents of the preventive measure (6) adhering set forth in G.S. 75 42 CFR Parts 2 and 164; and (7) maintainition of the preventive measure (7) maintainition of the preventive measure (8) and 164; and	JIREMENTS FOR D B PROVIDERS I B providers shall develop and policies governing their II or III incidents. The policies povider to respond by: to the health and safety needs wed in the incident; ing the cause of the incident; ing and implementing corrective in the provider specified exceed 45 days; ing and implementing measures incidents according to provider its not to exceed 45 days; it person(s) to be responsible of the corrections and				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 310 FIELDS STREET GREENSBORO, NC 27405 SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY TUIL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFEX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE TAG V 366 V 3	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER AGAPE HOME LIVING CARE, LLC SUMMARY STATEMENT OF DEFICIENCIES (CA) ID PREFIX TAG CONTINUED TO ILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUED TO ILL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUED TO ILL SUMMARY STATEMENT OF DEFICIENCIES TAG V 366 Continued From page 1 (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICP/M/R 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 ICP/M/R 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 will ethe 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 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:							;
AGAPE HOME LIVING CARE, LLC CALL D			MHL0411222	B. WING		02/1	3/2025
X41 D PROVIDER'S PLAN OF CORRECTION X85 D PROVIDER'S PLAN OF CORRECTION X85 CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TA	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CREENSBORD, NC 27405 REGULATORY OR LSC IDENTIFYING INFORMATION) V 366 Continued From page 1 (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 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 for the spond 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 whall consist of individuals who were not involved in the incident. The internal review team shall complete all of the activities as follows:	AGAPE I	HOME LIVING CARE.	IIC .				
PRÉFEX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 366 Continued From page 1 (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, 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; (2) convening a meeting of initernal 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:			GREENSE				
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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:	V 366	Continued From pa	ge 1	V 366			
(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	V 300	(b) In addition to the Paragraph (a) of this shall address incided regulations in 42 CI (c) In addition to the Paragraph (a) of this providers, excluding develop and implementation their response to a while the provider is or while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to a while the client is The policies shall response to the policies shall response to transferring review team; (c) certifying (d) transferring review team within internal review team within internal review team who were not involved were not responsible with direct professions services at the time review team shall confollows: (A) review the determine the facts and make recommon occurrence of future (B) gather off (C) issue writh within five working opreliminary findings	the requirements set forth in its Rule, ICF/MR providers ents as required by the federal FR Part 483 Subpart I. The requirements set forth in its Rule, Category A and B its Rule, Cate	V 300			

6899

Division of Health Service Regulation STATE FORM

	of Health Service Re		I			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
			D WING			
		MHL0411222	B. WING		02/1	3/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ACADE	JOME LIVING CARE	310 FIELD	OS STREET			
AGAPE	HOME LIVING CARE,	GREENSI	BORO, NC 2	7405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	owner within three refinal report shall be catchment area the LME where the client final written report is identified by the interior include all public do incident, and shall reminimizing the occur all documents need available within three LME may give the public three months to subtract (3) immediate (A) the LME rearea where the server Rule .0604;	ral written report signed by the months of the incident. The sent to the LME in whose provider is located and to the nt resides, if different. The shall address the issues ernal review team, shall ocuments pertinent to the make recommendations for arrence of future incidents. If led for the report are not be months of the incident, the provider an extension of up to comit the final report; and all possible for the catchment vices are provided pursuant to	V 366			
	different; (C) the provice for maintaining and treatment plan, if disprovider; (D) the Depar (E) the client' applicable; and (F) any other This Rule is not me Based on record refailed to implement	s legal guardian, as authorities required by law.				

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<u> Divisio</u> n	<u>of Health Service Re</u>	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0411222	B. WING		02/1) 3/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGAPE I	HOME LIVING CARE,	IIC 310 FIELD	S STREET BORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	Review on 2/10/25 - Admission date - Diagnoses of Ir and Generalized Ar Interview on 2/10/25 - Had pushed client # caused client #2 to - Did not sustain by client #2 - Could not provi Review on 2/13/25 - Admission date Diagnoses: Interview on 2/13/25 - Admission date Diagnoses: Interview Mellitus, Tourney Gastroesophageal and Hyperlipidemia - Had surgery on	2). The findings are: of client #1's record revealed: of 10/20/23 htellectual Disability, Moderate nxiety D/O (Disorder) 5 with client #1 revealed: ent #2 after client #2 entered ruck him with his hand 2 with enough force that it fall any injuries from being struck de the date of the incident of client #2's record revealed: of 10/12/23 ellectual Developmental hizophrenia; Hypertension; Type II; GERD Reflux Disease); Seizure D/O	V 366			
	femur."	nanteric fracture of the right m the hospital on 1/27/25				
	- Had gone into on him with his hand - Client #1 then put to fall to the floor - Was hospitalized - Was better now would not to go back hit him again	5 with client #2 revealed: client #1's bedroom and struck bushed him which caused him ed for a "broken leg." and promised the Director heck into client #1's bedroom or				

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Interviews on 2/10/25 and on 2/13/25 with the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
				С		
		MHL0411222	B. WING		02/1	3/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AGAPE I	HOME LIVING CARE,	HC	S STREET BORO, NC 2	7405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 366	Director revealed: On 1/9/25, clier bedroom and with he forehead After being strupushed client #2 had to fall to the floor When client #2 that day (1/9/25), E (EMS) were called examine client #2 After he was exwas determined cliet treatment nor trans When client #2 without staff assistated and EMS traemergency departntains. After being examined client #2 without staff assistated and EMS traemergency departntains. After being examined client #2 was same day Client #2 was same day Client #1 was necounter with clients. She acknowled should have been same seponse Improversity.	ant #2 went into client #1's his hand struck client #1 on his lick by client #2, client #1 and enough to cause client #2 complained of leg pain later mergency Medical Services to come to the facility to camined by EMS personnel, it ent #2 did not require any port to the hospital was unable to stand or walk ance on 1/10/25, EMS was insported client #2 to the nent of a local hospital mined at the hospital, it was 2's right hip was "fractured" cheduled for surgery on the discharged from the hospital on not injured during the hit #2 on 1/9/25 liged an level II incident report submitted to the Incident ment System (IRIS)	V 366	BEHOLINGTY		
	was responsible for had failed to do so - Although, no re IRIS, she had notificabout his behavior notified client #2's le EMS on his behalf or Remained in co	eport has been submitted to ed client #1's legal guardian on 1/9/25 and she had also egal guardian about calling on 1/9/25 and on 1/10/25 ontact with client #2's legal was hospitalized and since his				

Division of Health Service Regulation

STATE FORM 6899 4ZWK11 If continuation sheet 5 of 11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
741012741	or contribution	BERTH 10/11/01/11/01/BERT	A. BUILDING:			
		MHL0411222	B. WING		02/1	; 3/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGAPE I	HOME LIVING CARE,	II C	OS STREET BORO, NC 2	7405		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 366	Continued From pa	nge 5	V 366			
	- No evidence the been submitted to learn and #2) regarding to 1/10/25 and thus the how the facility had safety needs of the incident; determine the facility had developed to prevent they assigned persistence.	of the IRIS revealed: at a level II incident report had IRIS on behalf of clients (#1 the events of 1/9/25 and there was no documentation of attended to the health and individuals involved in the did the cause of the incident; if eloped and implemented any es; if any measures had been ent similar incidents and had on(s) to be responsible for any corrective/preventative				
V 367	10A NCAC 27G .06 REPORTING REQ CATEGORY A AND (a) Category A and level II incidents, ex the provision of billiconsumer is on the incidents and level to whom the provid 90 days prior to the responsible for the services are provid becoming aware of be submitted on a fill Secretary. The rep in person, facsimile means. The report information: (1) reporting identification inform	UIREMENTS FOR D B PROVIDERS I B providers shall report all accept deaths, that occur during able services or while the providers premises or level III II deaths involving the clients er rendered any service within a incident to the LME catchment area where ed within 72 hours of the incident. The report shall form provided by the port may be submitted via mail, a or encrypted electronic a shall include the following	V 367			

Division of Health Service Regulation

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	or reality Service IN		()(0)	E CONCERNATION:	0.00: = :=:	01101/21/
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
VIAD L'EVIN	OF COMMECTION	IDENTIFICATION NUMBER.	A. BUILDING:			1-0
						; l
		MHL0411222	B. WING		1	3/2025
NAME OF						
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
AGAPE I	HOME LIVING CARE,	116	OS STREET			
		GREENSI	BORO, NC 2	7405		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG	REGOLATOR OR E		IAG	DEFICIENCY)	14,7412	
	0 " 15		1/007			
V 367	Continued From pa	ge 6	V 367			
	(3) type of inc	cident;				
		n of incident;				
		the effort to determine the				
	cause of the incider					
		viduals or authorities notified				
	or responding.					
		B providers shall explain any				
		ete information. The provider				
		lated report to all required				
		the end of the next business				
	day whenever:					
		ler has reason to believe that				
		d in the report may be				
		ing or otherwise unreliable; or				
		ler obtains information				
		dent form that was previously				
	unavailable.	dent form that was providedly				
		B providers shall submit,				
		E LME, other information				
		the incident, including:				
	0 0	ecords including confidential				
	information;	9				
		other authorities; and				
		ler's response to the incident.				
		B providers shall send a copy				
	()	nt reports to the Division of				
		elopmental Disabilities and				
		Services within 72 hours of				
		the incident. Category A				
		d a copy of all level III				
		a client death to the Division of				
		ulation within 72 hours of				
		the incident. In cases of				
		seven days of use of seclusion				
		vider shall report the death				
		uired by 10A NCAC 26C				
		AC 27E .0104(e)(18).				
		B providers shall send a				
		he LME responsible for the				

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6899 4ZWK11 If continuation sheet 7 of 11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			,
		MHL0411222	B. WING			3/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGAPE	HOME LIVING CARE,	HC	OS STREET BORO, NC 2	7405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 367	The report shall be by the Secretary via include summary in (1) medication definition of a level (2) restrictive the definition of a let (3) searches (4) seizures (4) seizures (5) the total restriction incidents that occur (6) a statement been no reportable incidents have occur meet any of the crit (a) and (d) of this Feather (b) this Feather (b) this Feather (c) and (d) of this Feather (d)	ere services are provided. submitted on a form provided a electronic means and shall aformation as follows: on errors that do not meet the II or level III incident; interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in a client; number of level II and level III cred; and ent indicating that there have incidents whenever no curred during the quarter that teria as set forth in Paragraphs Rule and Subparagraphs (1) Paragraph.	V 367			
	provider failed to re Local Management the catchment area within 72 hours of b	eport all level II incidents to the Entity (LME) responsible for where services are provided becoming aware of the incident ents (#1 and #2). The findings				
	Admission dateDiagnoses of Ir	of client #1's record revealed: e of 10/20/23 ntellectual Disability, Moderate nxiety D/O (Disorder)				

Division of Health Service Regulation

STATE FORM 6899 4ZWK11 If continuation sheet 8 of 11

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILDING.			
		MHL0411222	B. WING			13/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
AGAPE	HOME LIVING CARE,	11C	OS STREET BORO, NC 2	7405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
V 367	Continued From pa	nge 8	V 367			
	Interview on 2/10/2 - Had pushed clinhis bedroom and st - Pushed client #caused client #2 to - Did not sustain by client #2 - Could not provi Review on 2/13/25 - Admission date Diagnoses: Interview Mellitus, Tour Castroesophageal and Hyperlipidemia - Had surgery on displaced intertroch femur." - Discharged from Interview on 2/13/2 - Had gone into thim with his hand - Client #1 then put of fall to the floor - Was hospitalized - Was better now would not to go back hit him again - Could not recal Interviews on 2/10/2 - Interviews on 2/10/2 - On 1/9/25, clier bedroom and with his forehead - After being structure.	5 with client #1 revealed: ent #2 after client #2 entered cruck him with his hand #2 with enough force that it fall any injuries from being struck de the date of the incident of client #2's record revealed: e of 10/12/23 ellectual Developmental hizophrenia; Hypertension; Type II; GERD Reflux Disease); Seizure D/O				

Division of Health Service Regulation

DIVISION	<u>of Health Service Re</u>	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
						;
		MHL0411222	B. WING		1	3/2025
NAME OF I	PROVIDER OR SUPPLIER	STDEET AP	INDESS CITY S	STATE, ZIP CODE		
NAME OF I	NOVIDEN ON SOLT EIEN		DS STREET	STATE, ZII GODE		
AGAPE I	HOME LIVING CARE,	IIC .	BORO, NC 2	7.405		
			1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 367	Continued From pa	ge 9	V 367			
	to fall to the floor					
		complained of leg pain later				
		mergency Medical Services				
	(EMS) were called the examine client #2	to come to the facility to				
		camined by EMS personnel, it				
		at client #2 did not require any				
	treatment nor trans					
		was unable to stand or walk				
		ance on 1/10/25, EMS was				
		nsported client #2 to the				
		nent of a local hospital mined at the hospital, it was				
		2's right hip was "fractured"				
		cheduled for surgery on the				
	same day	0 ,				
	- Client #2 was d	lischarged from the hospital on				
	1/27/25					
		not injured during the				
	encounter with clier	lged an level II incident report				
		submitted to the Incident				
		ment System (IRIS)				
		rmer Qualified Professional				
		submitting IRIS reports and				
	had failed to do so					
	•	port has been submitted to				
		ed client #1's legal guardian				
		on 1/9/25 and she had also				
		egal guardian about calling on 1/9/25 and on 1/10/25				
		ontact with client #2's legal				
		vas hospitalized and upon his				
	discharge from the					
	Review on 2/13/25	of IRIS revealed:				
		lent reports regarding clients				
		e events involving them on				
		had been submitted to the				
		Entity/Managed Care				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MUI 0444222			00/4	
NAME OF I	PROVIDER OR SUPPLIER	MHL0411222			02/1	3/2025
	340 FIEL DS STREET					
AGAPE HOME LIVING CARE LLC			BORO, NC 2	27405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 10	V 367			
	Organization (LME	(MCO)				

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