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 _____	04/24/2025

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 An annual and complaint survey was completed on 4/24/25. One complaint was substantiated (intake #NC00227874) and the other one was unsubstantiated (intake #NC00229182). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000	RECEIVED MAY 19 2025 DHSR-MH Licensure Sect	
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and	V 107	Beginning 4/25/2025 Director will ensure all new hires will have a job description in their files. The QP will review files on the monthly basis to make sure all elements are in the employee files. All job descriptions will be signed by the employee and the Director of the facility.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Mikisha Simms TITLE QP (X6) DATE 5/13/2025

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 _____	04/24/2025

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 107	Continued From page 1 (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a job description signed by the staff member and supervisor for 2 of 3 staff audited (staff #7 and the Qualified Professional (QP)). The findings are: Finding #1 Review on 4/23/25 of the QP's personnel file revealed: - Hire date: 4/23/25 - No documentation of a job description.	V 107		

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 _____	04/24/2025

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 107	Continued From page 2 Interview on 4/22/25 with the QP revealed: - She was hired recently. - Her start date was 4/8/25. Interview on 4/23/25 with the Licensee/staff #3 revealed: - She did not have the QP's job description. - The QP would provide her job description. Finding #2 Review on 4/16/25 of staff #7's personnel file revealed: - Hire date: 4/1/24 - No documentation of a job description. Interview on 4/16/25 with staff #7 revealed: - His sister (the Licensee/staff #3) had hired him to clean the facility. - "I work 7 days a week. From 9 am- 5 pm." Interview on 4/23/25 with staff #5 revealed: - "Sometimes [staff #7] is in the living room at night and I stay in the front (of the facility). This is due to [client #3] is a runner." - Staff #7 is "periodically" staff. Staff #7 is there "as an extra pair of eyes." Interview on 4/23/25 with staff #4 revealed: - On 4/5/25 when there was an incident where client #5 punched client #1, she called staff #7 "when it first started because [staff #7] lives up the street." - Staff #7 intervened during the 4/5/25 incident and asked client #5 "to calm down or he was going to call the [licensee/staff #3]." Interviews on 4/15/25, 4/23/25 and 4/24/25 with the Licensee/staff #3 revealed:	V 107	The Director provided the new QP with a copy of the QP's job description and it was signed and dated by both parties on 4/25/2025. Effective immediately, All staff including volunteers will have a file which will include job descriptions, training, background checks, supervision plans, client rights and confidentiality, specific population, and general orientation. Healthcare Registry Checks Training will include: North Carolina Intervention Adult CPR/first Aid Seizure Management Infectious disease/blood-borne pathogens Medication administration Effective communication Special population (Effective immediately)	

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 _____	04/24/2025

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 107	Continued From page 3 - Staff #7 worked "just daytime" for "two hours" each day. - Staff #7 had no other responsibilities "besides cleaning." - On 4/5/25 when there was an incident and "[client #5] hit [client #1]. I asked [staff #7] to come over when it was going on and help [staff #4] get things under control." - "[Staff #7] only started helping out since [staff #4] has been working."	V 107		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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 _____	04/24/2025

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 111	Continued From page 4 This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure an assessment was completed prior to the delivery of services affecting 1 of 3 audited clients (#1). The findings are: Review on 4/16/25 of client #1's record revealed: - Admission date: 6/4/24 - Diagnoses: Intermittent Explosive Disorder; Mild Intellectual Disability and Schizophrenia - There was no admission assessment in his record. Interview on 4/24/25 with the Licensee/staff #3 revealed: - The former Qualified Professional (QP) #1 was the QP when client #1 was admitted and would have been the staff who would have completed the admission assessment. . - She did not know why the QP #1 did not complete the admission assessment.	V 111	Effective immediately, the new hire QP will perform an assessment for the client before delivering any services. The assessment will address the following: 1. Client presenting problem 2. Client needs and strengths 3. Admitting diagnosis. 4. Client social/family and medical history 5. evaluations or other assessments, such as medical, substance abuse, psychiatric, and vocational assessments	
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND	V 112		

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 _____	04/24/2025

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 112	Continued From page 5 TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement goals and strategies to meet the individual needs of 1 of 3 clients (Client #5). The findings are: - Reviews on 4/16/25 and 4/23/25 of Client #5's record revealed:	V 112	Effective 4/25/2025, The hired QP will be responsible for creating a PCP for all members. The PCP will need to be updated as authorization for services is needed along with member and guardian input. The Director will ensure that the PCP is in the members File and updated according to the authorization dates.	

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 _____	04/24/2025

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 112	Continued From page 6 - Admission Date: 10/12/23 - Diagnoses: Intellectual Developmental Disability, Mild; Paranoid Schizophrenia; Hypertension; Diabetes Mellitus, Type II; Gastroesophageal Reflux; Seizure Disorder and Hyperlipidemia - Review of client #5's treatment plan dated 9/26/24 revealed: "...is waiting to be transitioned to Agape Home Living Care, LLC in attempts to help him learn the appropriate social skills and other coping strategies in order to help him to achieve his goals." - Further review of client #5's treatment plan goals revealed: "...will learn effective coping skills in order to control his frustrations with his peers, learn to get along with others, and to not become upset when his thoughts are challenge, specifically about his height or his belief that others are laughing at him...Use learned coping skills from therapeutic relationships (individual therapy, staff, qualified professional, director) instead of acting out aggressively (damaging property, using verbal and/or physical aggressiveness)..." Interviews on 4/22/25 and 4/23/25 with staff #4 revealed: - She worked during the daytime. - On 4/5/25 there were 2 different incidents involving client #5. - The 1st incident occurred around lunch time while she, staff #7, and all the clients (clients #1-#5) were sitting on the back porch. Client #5 threw his walker at client #4 and it hit client #4's left hip. She checked client #4's hip and there were no injuries. - The 2nd incident occurred during the evening, client #5 punched client #1 on his lip. - She and client #4 had to separate client #5 and client #1 from each other. She also called staff #7	V 112		

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 _____	04/24/2025

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 112	Continued From page 7	V 112		

for help as well. Client #5 called his sister and he then calmed down. When the 4/5/25 incidents occurred, staff #5 relieved her and worked the night shift.
- "[Client #5] is mad all the time. I am talking about nothing. He gets mad at me all the time. He antagonizes people all the time."
- She did not "see anything in his treatment plan" that addressed goals and strategies for client #5's behaviors.

Interview on 4/23/25 with staff #5 revealed:
- He worked mainly on the 3rd shift
- Client #5 "curses and calls people names."
- On 4/22/25, "I had to stop [client #2] from physically coming after [client #5] because [client #5] called [client #2] a b***h."
- Sometime last week when he came to work 3rd shift client #1 told him that client #5 smacked him. Client #1 did not tell him where client #5 smacked him but client #1 cried when he told him what occurred. He did not see any injuries to client #1.
- "It's a regular thing with [client #5]. Not that hitting thing but his mouth."
- Feels client #5's behaviors "might be getting a little worse."
- The goals/strategies he used with client #1's behaviors were "talking to him. That's basically it."

Interview on 4/23/25 with the Licensee/staff #3 revealed:
- She knew about the two incidents that occurred on 4/5/25 that involved client #5 throwing his walker at client #4 and the incident involving client #5 "busting" client #1's lip.
- Client #5 keeps going into clients' bedrooms and "cussing them out."
- The only goals/strategies she knew to use for client #5's behaviors were to "call crisis (behavioral health)." She had not called crisis yet

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 _____	04/24/2025

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 112	Continued From page 8 "because he usually calms down." Interview on 4/24/25 with client #5's legal guardian revealed: - She had told the Licensee/staff #3 prior to client #5 being admitted "...[Client #5] has very bad behaviors and that he would fight." - After she told the Licensee/staff #3 this information,"[the Licensee/staff #3] said we are equipped to take care of people like that."	V 112		
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	Effective 4/25/2025, emergency drills will be completed on 1st, 2nd, and 3rd shifts randomly throughout each month. At least one emergency drill will be required on each shift once monthly and documented on the drill form in the emergency binder which will remain at the facility at all times.	

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 _____	04/24/2025

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 114	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a fire and disaster drill was held at least quarterly for each shift. The findings are: Review on 4/16/25 of the facility's fire drill log from April 2024 - April 2025 revealed: - There were no documented fire drills nor disaster drills conducted during the third quarter (July 2024 - September 2024). - There were no documented fire drills nor disaster drills conducted during the fourth quarter (October 2024 - December 2024). Interview on 4/16/25 with client #1 revealed: - Initially, indicated the facility did not practice fire and disaster drills. - Then stated "yes" the facility practiced fire drills. - He was unable to provide information on how often the facility practiced fire and disaster drills. Interview on 4/23/25 with the Licensee/staff #3 revealed: - She had 3rd and 4th quarter fire and disaster drills documented. - "I may have filed them."	V 114		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) *Non-prescription drug containers not* dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the	V 117		

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 _____	04/24/2025

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 117	Continued From page 10 risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to ensure prescription medications were dispensed in a tamper resistant packaging that minimized the risk of accidental ingestion and failed to ensure the packaging label of each prescription drug dispensed included the client's name, the prescriber's name, the current dispensing date, the name, strength, quantity and expiration date of the prescribed drug and the name, address and phone number of the pharmacy and the name of the dispensing practitioner for 5 of 5 clients (#1 - #5). The findings are: Observations on 4/23/25 at approximately 2:37	V 117	Effective 4/25/2025, all staff will receive medication management training to ensure everyone is appropriately administrating medication. The Director will complete weekly checks to ensure meds are being stored properly. The Director will send MARS for quarterly review, and the QP will complete monthly reviews to ensure medication is administered properly and stored appropriately.	

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 _____	04/24/2025

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 117	Continued From page 11 pm of plastic cups in locked medication closet revealed: -Clients #1-5 had individual plastic cups stacked on top of each other in 4 rows. - The 1st row had 4 plastic cups with the names of clients' #1, #2, #3 and #5 written on the plastic cups along with "4 pm." Different pills were found in the "4 pm" cups. - The 2nd row had 5 plastic cups with the names of clients' #1-5 written on the plastic cups along with "am." - The 3rd row had 2 plastic cups with client #1's name written on one plastic cup along with "12 pm." The second cup had no visible name. - The 4th row had 5 plastic cups with clients' #1-5 names written on the plastic cups along with "pm." Interview on 4/23/25 with client #4 revealed: - He was always administered his medications from "a cup." Interview on 4/23/25 with client #1 revealed: - He did not know how staff administered his medications. Interview on 4/23/25 client #2 revealed: - He was always administered his medications from "a cup." - All the staff give "everybody" their medications from a cup. Interview on 4/22/25 with staff #4 revealed: - In the morning, she "sets up medications" for all the clients in their "little medications cups." - The medications are in cups with their names written on the cups along with 8 am, 12 pm, 3 pm, and 4 pm. - "That's how I keep up with it (administering medications) there is so much going on".	V 117		

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 _____	04/24/2025

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 117	Continued From page 12 - "I try to set up a system that works for me." Interview on 4/22/25 with staff #5 revealed: - He placed all the clients' medications in the cups with the clients' names. - "I prep all meds at one time." - As they come through the line, I hand them their cups." Interview on 4/23/25 with the Licensee/staff #3 revealed: - The reason medications were administered from cups was because "we can't put it in our hand or theirs (clients' hands). Just like in the hospital they (staff) put it in a cup to give it." - Staff #4 was the only staff member who put clients' medications in cups for medications being administered throughout the day. - "[Staff #4] said she does it, I have told her not to do that. It is supposed to be punched out in the cup at the time given..."	V 117		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing	V 291		

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 _____	04/24/2025

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 291	Continued From page 13 relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the clients' treatment, affecting 1 of 5 (#5). The findings are: - Reviews on 4/16/25 and 4/23/25 of Client #5's record revealed: - Admission Date: 10/12/23 - Diagnoses: Intellectual Developmental Disability, Mild; Paranoid Schizophrenia; Hypertension; Diabetes Mellitus, Type II; Gastroesophageal Reflux; Seizure Disorder and Hyperlipidemia - "After Visit Summary; [Client #5]; cardiac arrest; 3/3/25-3/13/25." Interviews on 4/22/25 and 4/23/25 with staff #4 revealed: - She worked during the daytime.	V 291		

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 _____	04/24/2025

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 291	Continued From page 14 - On 4/5/25 there were 2 different incidents involving client #5. - The 1st incident occurred around lunch time while she, staff #7, and all the clients (clients #1-#5) were sitting on the back porch. Client #5 threw his walker at client #4 and it hit client #4's left hip. She checked client #4's hip and there were no injuries. - The 2nd incident occurred during the evening, client #5 punched client #1 on his lip. - She and client #4 had to separate client #5 and client #1 from each other. She also called staff #7 for help as well. Client #5 called his sister and he then calmed down. When the 4/5/25 incidents occurred, staff #5 relieved her and worked the night shift. - "[Client #5] is mad all the time. I am talking about nothing. He gets mad at me all the time. He antagonizes people all the time." Interview on 4/23/25 with staff #5 revealed: - He worked mainly on the 3rd shift - Client #5 "curses and calls people names." - On 4/22/25, "I had to stop [client #2] from physically coming after [client #5] because [client #5] called [client #2] a b***h." - Sometime last week when he came to work 3rd shift client #1 told him that client #5 smacked him. Client #1 did not tell him where client #5 smacked him but client #1 cried when he told him what occurred. He did not see any injuries to client #1. - "It's a regular thing with [client #5]. Not that hitting thing but his mouth." - Feels client #5's behaviors "might be getting a little worse." Interviews on 4/15/25 and 4/23/25 with the Licensee/staff #3 revealed: - She knew about the two incidents that occurred on 4/5/25 that involved client #5 throwing his	V 291		

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 _____	04/24/2025

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 291	Continued From page 15 walker at client #4 and the incident involving client #5 "busting" client #1's lip. - Client #5 keeps going into clients' bedrooms and "cussing them out." - In addition to client #5's on-going behaviors, he went to the hospital on 3/3/25 after she called Emergency Medical Services due to client #5 "wasn't sounding right and was laying around and couldn't move his leg." Once he was at the hospital he had a heart attack. The hospital told her client #5 "flat lined." - A treatment team meeting to discuss behavioral concerns and recent hospitalization had not been held because client #5 did not receive a "waiver so he doesn't have team meetings. Former Qualified Professional #1 (left in January 2025) updates his treatment plan." Interview on 4/23/25 with client #5's care manager revealed: - She was assigned to be client #5's care manager "about 3 months ago." - Since she had been client #5's care manager she had not had a treatment team meeting with his legal guardian nor the licensee/staff #3.	V 291	Effective 4/25/2025, at least quarterly, team treatment meetings will be held for each member in the residential facility. For members with acute needs, monthly meetings will be held. The Director will be responsible for scheduling the meetings along with QP being present for meetings	
V 368	G.S. 122C-63 Assurance for continuity of care § 122C-63 ASSURANCE FOR CONTINUITY OF CARE FOR INDIVIDUALS WITH MENTAL RETARDATION (a) Any individual with mental retardation admitted for residential care or treatment for other than respite or emergency care to any residential facility operated under the authority of this Chapter and supported all or in part by state-appropriated funds has the right to residential placement in an alternative facility if the client is in need of placement and if the	V 368		

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 _____	04/24/2025

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 368	Continued From page 16 original facility can no longer provide the necessary care or treatment. (b) The operator of a residential facility providing residential care or treatment, for other than respite or emergency care, for individuals with mental retardation shall notify the area authority serving the client's county of residence of his intent to close a facility or to discharge a client who may be in need of continuing care at least 60 days prior to the closing or discharge. The operator's notification to the area authority of intent to close a facility or to discharge a client who may be in need of continuing care constitutes the operator's acknowledgement of the obligation to continue to serve the client until: (1) The area authority determines that the client is not in need of continuing care; (2) The client is moved to an alternative residential placement; or (3) Sixty days have elapsed; whichever occurs first. In cases in which the safety of the client who may be in need of continuing care, of other clients, of the staff of the residential facility, or of the general public, is concerned, this 60- day notification period may be waived by securing an emergency placement in a more secure and safe facility. The operator of the residential facility shall notify the area authority that an emergency placement has been arranged within 24 hours of the placement. The area authority and the Secretary shall retain their respective responsibilities upon receipt of this notice. (c) An individual who may be in need of continuing care may be discharged from a residential facility without further claim for continuing care against the area authority or the State if: (1) After the parent or guardian, if the client is	V 368		

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 _____	04/24/2025

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 368	Continued From page 17 a minor or an adjudicated incompetent adult, or the client, if an adult not adjudicated incompetent, has entered into a contract with the operator upon the client's admission to the original residential facility the parent, guardian, or client who entered into the contract refuses to carry out the contract, or (2) After an alternative placement for a client in need of continuing care is located, the parent or guardian who admitted the client to the residential facility, if the client is a minor or an adjudicated incompetent adult, or the client if an adult not adjudicated incompetent, refuses the alternative placement. (d) Decisions made by the area authority regarding the need for continued placement or regarding the availability of an alternative placement of a client may be appealed pursuant to the appeals process of the area authority and subsequently to the Secretary or the Commission under their rules. If the appeal process extends beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange a temporary placement in a State facility for the mentally retarded pending the outcome of the appeal. (e) The area authority that serves the county of residence of the client is responsible for assessing the need for continuity of care and for the coordination of the placement among available public and private facilities whenever the authority is notified that a client may be in need of continuing care. If an alternative placement is not available beyond the operator's 60-day obligation to continue to serve the client, the Secretary shall arrange for a temporary placement in a State facility for the mentally retarded. The area authority shall retain responsibility for coordination of placement during	V 368		

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 _____	04/24/2025

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 368	Continued From page 18 a temporary placement in a State facility. (f) The Secretary is responsible for coordinative and financial assistance to the area authority in the performing of its duties to coordinate placement so as to assure continuity of care and for assuring a continuity of care placement beyond the operator's 60-day obligation period. (g) The area authority's financial responsibility, through local and allocated State resources, is limited to: (1) Costs relating to the identification and coordination of alternative placements; (2) If the original facility is an area facility, maintenance of the client in the original facility for up to 60 days; and (3) Release of allocated categorical State funds used to support the care or treatment of the specific client at the time of alternative placement if the Secretary requires the release. (h) In accordance with G.S. 143B-147(a)(1) the Commission shall develop programmatic rules to implement this section, and, in accordance with G.S. 122C-112(a)(6), the Secretary shall adopt budgetary rules to implement this section. (1981, c. 1012; 1985, c. 589, s. 2.) This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to notify the area authority serving the client of intent to discharge an intellectually disabled client at least 60 days prior to discharge	V 368	Effective immediately, the Director will submit a 60 day notice that includes valid reasoning in order to discharge a member. The Director will include the guardian, the MCO, and any providers working with member in notice. The Director will also assist QP with locating at least 3 placement alternatives and complete referrals for member.	

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 _____	04/24/2025

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 368	Continued From page 19 affecting 1 of 3 audited clients (client #5). The findings are: - Reviews on 4/16/25 and 4/23/25 of Client #5's record revealed: - Admission Date: 10/12/23 - Diagnoses: Intellectual Developmental Disability, Mild; Paranoid Schizophrenia; Hypertension; Diabetes Mellitus, Type II; Gastroesophageal Reflux; Seizure Disorder and Hyperlipidemia Review on 4/23/25 of an email from the Licensee/staff #3 to client #5's Care Manager dated 4/23/25 revealed: - "Good morning, Please accept this as a 30 day discharge notice for [client #5]... Please note that the last day will be May 23, 2025 for my services." Interview on 4/23/25 with the Licensee/staff #3 revealed: - She had sent a discharge notice on 4/23/25 to client #5's care manager. - When client #5 was hospitalized (3/3/25-3/13/25) she tried to get the hospital to find him a "higher level of care such as a nursing home or ICF (Intermediate Care Facility) or at least get him 20 days in rehab." - She had not provided a discharge notice when client #5 was in the hospital (3/3/25-3/13/25). Interview on 4/23/25 with client #5's care manager revealed: - The first time the licensee/staff #3 had asked her to move client #5 out of the facility "was today (4/23/25)."	V 368	Effective 4/25/2025, all staff will undergo NCI training and training certifications will be included in staff files. This training will be completed annually but a refresher training will be given every 6 months by NCI instructor. The Director will keep a record of who attended the training, pass/fail results and an updated file on the trainer. The trainer file should include their name, training certification and completion of coaching or train the trainer instruction.	
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.	V 536		

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 _____	04/24/2025

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 536	Continued From page 20 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior;	V 536		

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 _____	04/24/2025

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 536	Continued From page 21 (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.	V 536		

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 _____	04/24/2025

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 536	Continued From page 22 (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time.	V 536		

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 _____	04/24/2025

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 536	Continued From page 23 (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff completed training on alternatives to restrictive interventions at least annually affecting 1 of 3 audited staff (staff #7). The findings are: Review on 4/16/25 of staff #7's personnel file revealed: - Hire date: 4/1/24 - No training certificate in alternatives to restrictive intervention Interview on 4/16/25 with staff #7 revealed: - "I am maintenance staff. I just clean up that is all." - He had not completed any staff trainings. Interview on 4/23/25 with staff #5 revealed: - "Sometimes [staff #7] is in the living room at night and I stay in front (of the facility). This is due	V 536		

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 _____	04/24/2025

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 536	Continued From page 24 to [client #3] is a runner." - Staff #7 is "periodically" staff. Staff #7 is there "as an extra pair of eyes." Interview on 4/23/25 with staff #4 revealed: - On 4/5/25 when there was an incident where client #5 punched client #1, she called staff #7 "when it first started because [staff #7] lives up the street." - Staff #7 intervened during the 4/5/25 incident and asked client #5 "to calm down or he was going to call the [licensee/staff #3]." Interviews on 4/15/25, 4/23/25 and 4/24/25 with the Licensee/staff #3 revealed: - Staff #7 worked "just daytime" for "two hours" each day. - Staff #7 had no other responsibilities "besides cleaning." - On 4/5/25 when there was an incident and "[client #5] hit [client #1]. I asked [staff #7] to come over when it was going on and help [staff #4] get things under control." - "[Staff #7] only started helping out since [staff #4] has been working."	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated	V 537	Continuation from V536.. No staff maintenance or one on one staff will be able to work with any members without appropriate training by a certified NCI instructor. No members will be secluded, isolated or put in restraint in an inappropriate manner	

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 _____	04/24/2025

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 537	Continued From page 25 competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation	V 537	All training will be within the approved guidelines of MH/DD/SAS. NCI training staff for Agape Home Living Care completes Annual refresher training and documentation will be kept on file by the Director.	

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 _____	04/24/2025

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 537	Continued From page 26 of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or	V 537		

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 _____	04/24/2025

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 537	Continued From page 27 failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time.	V 537		

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 _____	04/24/2025

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 537	Continued From page 28 (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff completed training in restrictive interventions for 1 of 3 audited staff (staff #7). The findings are: Review on 4/16/25 of staff #7's personnel file revealed: - Hire date: 4/1/24 - No training certificate in alternatives to restrictive intervention Interview on 4/16/25 with staff #7 revealed: - "I am maintenance staff. I just clean up that is all." - He had not completed any staff trainings. Interview on 4/23/25 with staff #5 revealed: - "Sometimes [staff #7] is in the living room at night and I stay in front (of the facility). This is due to [client #3] is a runner." - Staff #7 is "periodically" staff. Staff #7 is there "as an extra pair of eyes."	V 537	Effective immediately, all staff training including certifications will be in each staff members file the file will include the name of the certification, dates taken, and results. NCI training is the only authorized training at this time. Emergency / Planned seclusions, physical restraints, protective devices, and isolation time-outs or any combination are not authorized.	

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 _____	04/24/2025

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 537	Continued From page 29 Interview on 4/23/25 with staff #4 revealed: - On 4/5/25 when there was an incident where client #5 punched client #1, she called staff #7 "when it first started because [staff #7] lives up the street." - Staff #7 intervened during the 4/5/25 incident and asked client #5 "to calm down or he was going to call the [licensee/staff #3]." Interviews on 4/15/25, 4/23/25 and 4/24/25 with the Licensee/staff #3 revealed: - Staff #7 worked "just daytime" for "two hours" each day. - Staff #7 had no other responsibilities "besides cleaning." - On 4/5/25 when there was an incident and "[client #5] hit [client #1]. I asked [staff #7] to come over when it was going on and help [staff #4] get things under control." - "[Staff #7] only started helping out since [staff #4] has been working."	V 537		