

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 000	<p>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on February 10, 2026. The complaint was unsubstantiated (Intake #NC00234806). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for 5 and has a current census of 4. The survey sample consisted of audits of 2 current clients and 1 deceased client.</p>	V 000		
V 105	<p>27G .0201 (A) (1-7) Governing Body Policies</p> <p>10A NCAC 27G .0201 GOVERNING BODY POLICIES</p> <p>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:</p> <p>(1) delegation of management authority for the operation of the facility and services;</p> <p>(2) criteria for admission;</p> <p>(3) criteria for discharge;</p> <p>(4) admission assessments, including:</p> <p>(A) who will perform the assessment; and</p> <p>(B) time frames for completing assessment.</p> <p>(5) client record management, including:</p> <p>(A) persons authorized to document;</p> <p>(B) transporting records;</p> <p>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;</p> <p>(D) assurance of record accessibility to authorized users at all times; and</p> <p>(E) assurance of confidentiality of records.</p> <p>(6) screenings, which shall include:</p> <p>(A) an assessment of the individual's presenting problem or need;</p> <p>(B) an assessment of whether or not the facility</p>	V 105		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

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

Division of Health Service Regulation

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V 105	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement its written policies regarding A. client screening and B. client death. The findings are:</p> <p>Finding A.</p> <p>Review on 1/30/26 of the facility's records revealed:</p> <ul style="list-style-type: none"> - A Client Screening policy-"A prospective client is referred for a pre-admission screening assessment by the Area Authority (The Agape House). A designated QP (Qualified Professional) employed/retained by TAH,LLC (The Agape House, LLC)(Licensee). conducts a screening assessment to determine needs for services. The results of the screening assessment are documented and address the following areas: 1. complaint or presenting problems of individual as well as complaint or needs of others, if any regarding individual 2. assessment of presenting problems(s) or need(s) 3. disposition (referrals and/or recommendations) ..." <p>Review on 1/23/26 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted 2/10/25 - Diagnoses of Schizophrenia-Disorganized, Mood and Anxiety Disorder, Fall and Muscle Weakness, Peripheral Vascular Disease, Autism Disorder, Hypertension and Chronic Anemia - No documentation of a pre-admission screening assessment <p>Interview on 1/30/26 the Director/QP/Registered</p>	V 105		

Division of Health Service Regulation

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V 105	<p>Continued From page 3</p> <p>Nurse (RN) reported:</p> <ul style="list-style-type: none"> - Was responsible for completing the clients' pre-admission screening assessment - Ignored the Surveyor's question and didn't respond when asked if client #4's pre-admission screening assessment had been completed <p>Interview on 2/6/26 the Director/QP/RN reported:</p> <ul style="list-style-type: none"> - Pre-admissions screenings were completed once he was notified of a client's admission - He completed client #4's pre-admission screening assessment prior to client #4's admission into the facility, but "I couldn't put my hands on it" <p>The Director/QP/RN failed to provide client #4's pre-admission screening prior to the exit of the survey.</p> <p>Finding B.</p> <p>Review on 1/30/26 of the facility's records revealed:</p> <ul style="list-style-type: none"> - A Client Death policy-"As soon after the death as possible, the QP (Director/QP/RN) shall meet with staff present/on duty when the death occurred, with the following purposes:...e) to get staff who were present to record their account of the events surrounding the death; and to sign and date the account..." - No documentation of a written statement with the accounts of events surrounding deceased client (DC) #5's death from the Chief Executive Officer (CEO)/Licensee <p>Interview on 1/22/26 the Director/QP/RN reported:</p> <ul style="list-style-type: none"> - The CEO/Licensee was working in the facility and found DC #5 unresponsive on 1/11/26 - When the CEO/Licensee found DC #5 	V 105		

Division of Health Service Regulation

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V 105	Continued From page 4 unresponsive, she called 911 and performed CPR Interview on 2/6/26 the Director/QP/RN reported: - Was responsible for conducting investigations and obtaining statements - He had a written statement from the CEO/Licensee, but he needed to type the statement Interview on 2/10/26 the Director/QP/RN reported: - He forgot to provide the written statement from the CEO/Licensee The Director/QP/RN failed to provide a signed written statement from the CEO/Licensee recording the events surrounding DC #5's death prior to the exit of the survey.	V 105		
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	V 111		

Division of Health Service Regulation

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V 111	<p>Continued From page 5</p> <p>(5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure admission assessments were completed for 1 of 4 clients (#4). The findings are:</p> <p>Review on 1/23/26 of client #4's record revealed:</p> <ul style="list-style-type: none"> - Admitted 2/10/25 - Diagnoses of Schizophrenia-Disorganized, Mood and Anxiety Disorder, Fall and Muscle Weakness, Peripheral Vascular Disease, Autism Disorder, Hypertension and Chronic Anemia - An admission assessment (no date) with only client #4's name written on the top of the first page <p>Interview on 1/30/26 the Direct/Qualified Professional (QP)/Registered Nurse (RN) reported:</p> <ul style="list-style-type: none"> - Was responsible for completing the clients' 	V 111		

Division of Health Service Regulation

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V 111	<p>Continued From page 6</p> <p>admission assessment</p> <ul style="list-style-type: none"> - Didn't respond when asked if client #4's admission assessment was completed <p>Interview on 2/6/26 the Director/QP/RN reported:</p> <ul style="list-style-type: none"> - An admission assessment was the "initial assessment" completed when the client moved into the facility - He completed "half of it (client #4's assessment)" prior to client #4's admission into the facility, but "I couldn't put my hands on it ...I don't know what happened to it" <p>The Director/QP/RN failed to provide client #4's admission assessment prior to the exit of the survey.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 111		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <ol style="list-style-type: none"> (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 	V 366		

Division of Health Service Regulation

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V 366	<p>Continued From page 7</p> <p>for implementation of the corrections and preventive measures;</p> <p>(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</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(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.</p> <p>(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:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(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:</p> <p>(A) review the copy of the client record to determine the facts and causes of the incident</p>	V 366		

Division of Health Service Regulation

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V 366	<p>Continued From page 8</p> <p>and make recommendations for minimizing the occurrence of future incidents;</p> <p>(B) gather other information needed;</p> <p>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</p> <p>(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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p>	V 366		

Division of Health Service Regulation

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V 366	<p>Continued From page 9</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement policies regarding documentation of Level II incidents. The findings are:</p> <p>Review on 1/26/26 of client #2's local hospital record dated 1/4/26 revealed:</p> <ul style="list-style-type: none"> - "Visit Diagnoses ...Fall, initial encounter (primary)" - "Trauma One (BIB (brought in by) EMS (Emergency Medical Services) from group home d/t (due to) multiple falls today (1/4/26) ..." <p>Review on 1/30/26 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - No IRIS report for client #2's falls <p>Interview on 1/21/26 the Director/Qualified Professional (QP)/Registered Nurse (RN) reported:</p> <ul style="list-style-type: none"> - Was responsible for reporting level II incidents in IRIS - Didn't report client #2's fall because the staff only called 911 to assist client #2 up from his fall - Client #2 was transported to the local hospital because he was experiencing weakness from an illness and not because of his falls - Was unaware client #1 had fractured his ribs that resulted from his falls <p>Interview on 2/6/26 the Director/QP/RN reported:</p> <ul style="list-style-type: none"> - Didn't consider client #2's falls as a level II incident because the staff called 911 because they needed help getting client #2 up from the 	V 366		

Division of Health Service Regulation

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V 366	Continued From page 10 floor - "He's (client #2) a big guy" - He was responsible for submitting the preliminary findings of fact within five working days of the incident - He was responsible for submitting the final report signed by the Chief Executive Officer (CEO)/Licensee - Was unaware he was supposed to submit the preliminary findings of fact to the Local Management Entity (LME)/Managed Care Organization (MCO) - Was unaware he was supposed to issue a final written report signed by the CEO/Licensee to the LME/MCO within three months of the incident	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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V 367	<p>Continued From page 11</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the</p>	V 367		

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V 367	<p>Continued From page 12</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 and updated with missing or incomplete information within 24 hours as required. The findings are:</p> <p>Review on 1/30/26 of the Incident Response Improvement System (IRIS) revealed:</p> <ul style="list-style-type: none"> - No IRIS report for client #2's falls - An IRIS report dated 1/11/26 for deceased client (DC) #5 revealed the following: 	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 367	<p>Continued From page 13</p> <ul style="list-style-type: none"> - "Last date submitted: 1/12/26" - "Host LME: ...[Local Insurance Company]" - "Home LME: ...[Local Insurance Company]" - Deceased client #5's death was not reported to the LME/MCO - The Incident Comments Section had the following request: <ul style="list-style-type: none"> - 1/15/26-"Request to Update Health Plan ...Provider - [Local Insurance Company] does have a record of this consumer being a member of the health plan. Please update the case with the correct health plan. An email was also sent with the same request." <p>Interview on 1/21/26 the Director/Qualified Professional (QP)/Registered Nurse (RN) reported:</p> <ul style="list-style-type: none"> - Was responsible for reporting level II incidents - Didn't report client #2's fall because the staff only called 911 to assist client #2 up from his fall - Client #2 was transported to the local hospital because he was experiencing weakness from an illness and not because of his falls - Was unaware client #1 had fractured his ribs that resulted from his falls <p>Interview on 2/6/26 the Director/QP/RN reported:</p> <ul style="list-style-type: none"> - Didn't consider client #2's falls as a level II incident because the staff called 911 for assistance in getting client #2 up from the floor - Was unaware he needed to update DC #5's IRIS report as requested - Was unaware he made an error on DC #5's IRIS report and the report wasn't submitted to the LME/MCO because he believed he was supposed to provide DC #5's Health Plan instead of the LME/MCO 	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 512	<p>27D .0304 Client Rights - Harm, Abuse, Neglect</p> <p>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION</p> <p>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.</p> <p>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.</p> <p>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.</p> <p>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.</p> <p>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, 1 of 3 audited paraprofessional staff (#1) neglected 1 of 1 deceased client (DC #5). The findings are:</p> <p>Review on 1/23/26 of staff #1's record revealed:</p> <ul style="list-style-type: none"> - Hired 6/26/25 - Title: Habilitation Technician I - Cardiopulmonary Resuscitation (CPR) 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 512	<p>Continued From page 15</p> <p>training certificate dated 6/8/25</p> <ul style="list-style-type: none"> - A client rights training certificate dated 6/11/25 <p>Review on 1/21/26 of DC #5's record revealed:</p> <ul style="list-style-type: none"> - Admitted 6/5/09 - Diagnoses of Schizophrenia-Chronic Type and Hyperlipidemia - Discharge summaries from a local hospital dated 1/6/26 and 1/8/26 revealed DC #5 was diagnosed with influenza <p>Interview on 1/21/26 the Director/Qualified Professional (QP)/Registered Nurse (RN) reported:</p> <ul style="list-style-type: none"> - DC #5 died on 1/11/26 <p>Review on 1/30/26 of the facility's records revealed:</p> <ul style="list-style-type: none"> - The facility's client rights training outline contained information about preventing abuse, neglect and exploitation <p>Review on 1/29/26 of the police report dated 1/11/26 from the local Police Department (PD) revealed:</p> <ul style="list-style-type: none"> - "Incident Summary...This report contains information about a deceased male (DC #5) subject of non-suspicious circumstances. The deceased male was a resident (client) of a group home where his co-inhabitants (clients) found him not breathing this morning. CPR was performed by co-inhabitants before 911 was called. EMS (Emergency Medical Services) personnel attempted CPR upon arrival before confirming the male was deceased." - "Officer Narrative...I, [local Police Officer], responded to 7320 Bentley Wood Lane, part of Agape Group Home, on January, 11th, 2026 for a report of a deceased male subject, [DC #5]. Just 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 512	<p>Continued From page 16</p> <p>prior to my arrival, EMS paramedic [Responding Paramedic] called the time of death as 08:18 (8:18 am) after CPR was attempted but failed...After EMS left the scene, I spoke to [Chief Executive Officer (CEO)/Licensee] who worked for the the group home and [staff #1], a resident of the group home...This morning, [staff #1] and [CEO/Licensee] attempted to wake [DC #5] for breakfast when they found he was not breathing. According to [CEO/Licensee], they attempted CPR on [DC #5] before calling 911..."</p> <p>Review on 1/26/26 of the local EMS report dated 1/11/26 revealed:</p> <ul style="list-style-type: none"> - "Chief Complaint obvious death" - On scene 8:16:11 (8:16 am) - Departed scene 8:34:46 (8:34 am) - "Dispatched for cardiac arrest...bystanders (unidentified clients and staff) reported they found PT (patient) (DC #5) unresponsive in bed stiff as a board, called 911, dispatcher instructed them to remove him from bed and place on floor and begin CPR...Time of death called at 0818 (8:18 am)..." <p>Review on 2/3/26 of a dispatch 911 audio recording revealed:</p> <ul style="list-style-type: none"> - Automated System: "January 11, 2026 8 hours 12 minutes 41 seconds" - Dispatch: "911, What's the location of your emergency?" - Client #1: "[Redacted] Bentley Wood Wood Lane. I think we got a guy client that's dead. He ain't moving, I don't feel no pulse or nothing." - Dispatch: "Okay, repeat the address for me to make sure I have it right." - Client #1: "[Redacted] Bentley Wood Lane" - Dispatch: "Okay, you said this is a client?" - Client #1: "Uh-huh" - Dispatch: "You said this is a client with no 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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V 512	<p>Continued From page 17</p> <p>pulse?"</p> <ul style="list-style-type: none"> - Client #1: "I don't feel no pulse. He ain't moving. His eyes open, but he ain't moving" - Dispatch: "Alright, we're going to get help on the way, what's your name and phone number real quick?" - Client #1: "[Redacted]" - Dispatch: "Are you with him right now?" - Client #1: "Yes, I'm in the room" - Dispatch: "How old is he?" - Client #1: "He's 71. I think he just turned 71" - Dispatch: "71, okay. Is-I have, I have to verify. Is he awake right now?" - Client #1: "His eyes open, but he ain't awake" - Dispatch: "Is he breathing?" - Client #1: "Naw he ain't breathing. Oh wait a minute. Wait a minute, oh. He's cold, wait a minute..." - Dispatch: "He's cold?" - Client #1: "His nose cold. (Inaudible) sound like he breathing. I looked at his chest but it ain't going up and, his stomach ain't going up and down." - Dispatch: "So he's not breathing?" - Client #1: "Naw" - Dispatch: "Okay, alright hold on one second, I'm going to page the paramedics. We got them on the way, okay?" - Client #1: "Alright" - Dispatch: "I know you said, I know you said that he's cold, do you think he's beyond any help?" - Client #1: "I don't know. I just came in here. We were getting ready, we we um we wanted to wake him up..." - Dispatch: "Okay" - Client #1: "...we just came in here and he was just laying here in the bed..." - Dispatch: "Okay" - Client #1: "...I bout slapped him on the..." 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 512	<p>Continued From page 18</p> <ul style="list-style-type: none"> - Dispatch: "Okay, If you're not sure..." - Client #1: "...I slapped him on the..." - Dispatch: "If you're not sure if he's beyond any help then I'm gonna tell you how to do CPR, okay. If there's a defibrillator available, send someone to get it now and tell me when you have it." - Dispatch: "Do you have a defibrillator available?" - Client #1: "(Inaudible) Naw, uh-uh" - Dispatch: "Okay, alright. (Inaudible)..." - Client #1: "I know a, I know a little CPR though" - Dispatch: "Say what?" - Client #1: "I know a little bit of CPR" - Dispatch: "Okay, put your phone on speaker so your hands are free to help him" - Client #1: "Okay, hold on. It's on speaker, hold on. Hold on let me turn it up. Okay" - Dispatch: "Lay him flat on his back, on the ground..." - Client #1: "He's on, he's on, he's on his back. He's on his back." - Dispatch: "Is he on the floor or is he on the bed?" - Client #1: "Naw, he on the bed" - Dispatch: "Okay, we need to get him off the bed, to to the floor" - Client #1: "I don't. I don't know if I can. Wow he's heavy" - Dispatch: "Okay..." - Client #1: "...I can't do it by myself..." - Dispatch: "Okay ..." - Client #1: "I can't do it by myself" - Dispatch: "If there's a sheet or a blanket under him, then loosen it from the mattress, stand at the side of the bed closest to him. Remove anything from under his head and then you'll pull..." - Client #1: "...Help me help me get him 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 512	<p>Continued From page 19</p> <p>(inaudible) the floor. Hold on hold on somebody here hold on. Help me get him on the floor..."</p> <ul style="list-style-type: none"> - Dispatch: "...Tell me when you get him on the floor." - Client #1: "...Get his legs. Wait a minute. Okay he's on the floor." - Dispatch: "Okay" - Client #1: "He's on the floor" - Dispatch: "Alright, lay him. Make sure he's flat on his back on the ground. Remove anything from up under his head and we are, you gotta do chest compressions okay. Place the heel of your..." - Client #1: "...Okay..." - Dispatch: "...On the breast bone, right between the nipples and put your other hand on top of that hand okay?" - Client #1: "Alright" - Dispatch: "Pump the chest hard and fast twice per second and two inches deep. Let the chest come all the way up between pumps. Where going to do this until help can take over, okay?" - Client #1: "Okay" - Dispatch: "I need you to count out loud so I can count with you okay?" - Client #1: "Okay...one..." - Dispatch: "...Go ahead start now. One.." - Client #1 and Dispatch: "Two..." - Client #1: "...Okay..." - Dispatch: "...Three. Four. Match my pace..." - Client #1: "...Three..." - Dispatch: "...One..." - Client #1: "...Four..." - Dispatch: "...Two. Three. Four." - Client #1 and Dispatch: "One. Two. Three. Four" - Client #1: "One. Two. Three. Four..." - Dispatch: "Yep. One. Two. Three. Four. Good just like that..." 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 512	<p>Continued From page 20</p> <ul style="list-style-type: none"> - Client #1: "...One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. He ain't doing nothing. One. Two. Three. Four. One..." - Dispatch: "Yep. Keep going..." - Client #1: "Two. Three..." - Dispatch: "...If there's..." - Client #1: "Four" - Dispatch: "...Somebody else there send them to go open the door. The medics are pulling up..." - Client #1: "...One..." - Dispatch: "...So send somebody else to go open the door..." - Client #1: "...Two. Three. Four" - Dispatch: "...and you keep doing the CPR." - Client #1: "One. Go to the door. See if the Medics pulling up..." - Dispatch: "Okay" - Client #1: "Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. Two. Three. Four. One. I can't do it no more. Four..." - Dispatch: "You have..." - Client #1: "...One. Two. Three. Four..." - Dispatch: "...You have someone there that can take over for you?" - Client #1: "Oh. Oh. There he is. Medic here." - Dispatch: "Alright, I'll let you go then" - Client #1: "Alright. Thanks." - Dispatch: "Bye-Bye" - Automated System: "January 11, 2026 8 hours 17 minutes 42 seconds" <p>Interview on 2/5/26 the local Emergency Communications Center Representative reported:</p> <ul style="list-style-type: none"> - Was the only dispatch 911 audio for the 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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V 512	<p>Continued From page 21</p> <p>1/11/26 event</p> <p>Interview on 1/27/26 the Responding Paramedic reported:</p> <ul style="list-style-type: none"> - Arrived at the facility on 1/11/26 and saw "one of them (a person in the facility)" performing CPR on DC #5 - "I think it was a patient giving CPR...He looked older, tall and thin" - "I don't believe he (person performing CPR) was an employee (staff)...he could have been another resident" - "No one clearly identified themselves as an employee" - He saw "three black men" in the facility and there was "no woman there" - He didn't know the names of the people he saw in the facility - DC #5 "was beyond help" <p>Attempted interviews on 2/4/26 and 2/6/26 with the Responding Police Officer were unsuccessful because the responding Police Officer didn't return any of the calls.</p> <p>Interviews on 1/21/26 and 2/6/26 DC #5's Agency Guardian Representative reported:</p> <ul style="list-style-type: none"> - DC #5 died on 1/11/26 - DC #5's cause of death was influenza <p>Interview on 1/22/26 client #1 reported:</p> <ul style="list-style-type: none"> - He found DC #5 laying in his bed, unresponsive "early in the morning" around 7:30am-8am - When he found DC #5, he "was cold and hard" - Wasn't sure of the date, but "I think it was Friday (1/9/26)" - The CEO/Licensee wasn't working in the facility when he found DC #5 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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V 512	<p>Continued From page 22</p> <ul style="list-style-type: none"> - Staff #1 was working in the facility - Staff #1 worked in the facility for the past "5 or 6 months" - "I told [staff #1] [DC #5] was dead...he had died during the night" - Staff #1 "was in the other room calling someone...I think he (staff #1) called [CEO/Licensee] so I called 911" - He and staff #1 moved DC #5 from his bed to the floor - He performed chest compressions, but he didn't do any rescue breaths - He performed chest compressions on DC #5 for "at least a minute" until "my arms got tired...I couldn't do it anymore" - "He (staff #1) stayed in there (DC #5's bedroom), but he didn't do CPR" - Staff #1 watched him perform CPR on DC #5 - Staff #1 was on the phone while he performed CPR, but he didn't know who staff #1 was on the phone with - EMS arrived at the facility first, then the local Fire Department and the local PD arrived last - The CEO/Licensee arrived at the facility after EMS and the Fire Department arrived - The CEO/Licensee interrupted his interview with the local PD as if "she (CEO/Licensee) didn't want me talking to the police" - "She (CEO/Licensee) took over...like she didn't want me to say anything" - "I believe [CEO/Licensee] trying to protect somebody" <p>Observation and interview at 10:34am on 2/4/26 client #1 reported:</p> <ul style="list-style-type: none"> - Client #1 listened to the beginning of the dispatch 911 recording and verified he was the caller - DC #5 was "hard", "his face was blue" and "his eyes were open" 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 512	<p>Continued From page 23</p> <ul style="list-style-type: none"> - He "tapped" DC #5 on the jaw and "touched his nose to see if there was any air coming out" - He called staff #1 and said "I think [DC #5] dead" - He told staff #1 "to call the rescue squad or police...[staff #1] called someone...I just called 911" - Staff #1 "just stood there (in DC #5's bedroom) for a while...at the foot of the (DC #5's) bed" - Had "some" CPR training 33 years ago while he was in the military - The CEO/Licensee was not in the facility when he found DC #5 - The CEO/Licensee arrived at the facility after EMS arrived <p>Interview on 1/23/26 client #3 reported:</p> <ul style="list-style-type: none"> - Was in the facility when client #1 found DC #5 unresponsive in his bedroom on 1/11/26 and client #1 reported it to staff #1 - "[Client #1] called [DC #5] and he wasn't responding" - He saw when "[client #1] slapped him (DC #5)" and "checked his pulse" - He saw client #1 move DC #5 to the floor and client #1 started performing CPR - "[Staff #1] didn't help" - Staff #1 was standing beside him in the hallway while client #1 performed CPR on DC #5 - "[Client #1] said "1, 2, 3, 4; 1, 2, 3, 4; 1, 2, 3, 4; 1, 2, 3, 4...3 or 4 times" while client #1 was doing chest compressions on DC #5 - He left the hallway and walked into the facility's living room to sit down - He could still hear client #1 saying "1, 2, 3, 4" from the living room - Couldn't recall if he saw staff #1 leave the hallway - Didn't know who called 911 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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NAME OF PROVIDER OR SUPPLIER THE AGAPE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 7320 BENTLEY WOOD LANE RALEIGH, NC 27616
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V 512	<p>Continued From page 24</p> <ul style="list-style-type: none"> - "[Staff #1] may have called (911). I saw him call someone" - The local PD and EMS arrived at the facility and pronounced DC #5 dead - Staff #1 was working in the facility on 1/11/26 and not the CEO/Licensee - EMS arrived at the facility first, and it was just him, client #1 and staff #1 in the facility when they arrived - Couldn't recall when the CEO/Licensee arrived at the facility, but EMS was already in the facility when she arrived <p>Interview on 2/4/26 staff #1 reported:</p> <ul style="list-style-type: none"> - Worked overnight in the facility on 1/10/26 - The CEO/Licensee arrived to relieve him at 6:30am on 1/11/26 - When she came into the facility, she found DC #5 was unresponsive in his bedroom - The CEO/Licensee instructed him to call 911, but client #1 had already called 911 - He stayed in the facility's office and "let her (CEO/Licensee) take over" the emergency - "She (CEO/Licensee) had taken over the whole thing (emergency)" - There was no reason why anyone would say he helped client #1 move DC #5 to the floor because he didn't help move DC #5 - He stayed in the facility's office - There was no reason why anyone would say he helped perform CPR on DC #5 because "[CEO/Licensee] took over and [CEO/Licensee] did CPR" - Didn't see or speak to the Paramedic or the Police Officer because he was preparing to leave the facility - He left the facility around 6:30am or 7am - He wasn't at the facility at 8am <p>Interview on 1/21/26 the Director/QP/RN</p>	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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V 512	<p>Continued From page 25</p> <p>reported:</p> <ul style="list-style-type: none"> - The House Manager and the CEO/Licensee were the staff that worked in the facility over the past 3 months - The CEO/Licensee and the House Manager rotated shifts as needed - The CEO/Licensee was working in the facility on 1/11/26 - The CEO/Licensee reported the following: <ul style="list-style-type: none"> - The clients woke up, ate and went to the day program - She went to wake DC #5 up and he was unresponsive - She called 911 and performed CPR until EMS arrived and pronounced DC #5 deceased <p>Interview on 1/23/26 the Director/QP/RN reported:</p> <ul style="list-style-type: none"> - No other staff worked in the facility in the past 3 months besides the CEO/Licensee and the House Manager - Then he reported staff #1 was a fill-in staff for the facility and he worked in January 2026 - Couldn't recall the exact dates staff #1 worked, but he knew the last day staff #1 worked was on 1/8/26 - He didn't understand the request to identify all the staff that had worked in the facility in the past 3 months - The CEO/Licensee reported she found DC #5 unresponsive on 1/11/26, called 911 and performed CPR <p>Observation and interview at 12:52pm on 2/6/26 the Director/QP/RN reported:</p> <ul style="list-style-type: none"> - CEO/Licensee recently reported the following: <ul style="list-style-type: none"> - She arrived at the facility around 7am on 1/11/26 - She made breakfast and told client #1 to 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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V 512	<p>Continued From page 26</p> <p>wake up DC #5</p> <ul style="list-style-type: none"> - Client #1 came back into the kitchen upset saying DC #5 was unresponsive - She yelled for staff #1 to call 911, but client #1 had already called 911 - She went into DC #5's bedroom and started performing CPR until EMS arrived at the facility - The Director/QP/RN listened to the entire dispatch 911 recording - Only knew what the CEO/Licensee had reported to him and the recording "matched" what the CEO/Licensee reported - "[CEO/Licensee] called for someone to call 911" - Didn't hear the CEO/Licensee on the dispatch 911 recording performing CPR - Was unaware staff #1 didn't assess DC #5 when client #1 found him unresponsive - Was unaware neither staff #1 or the CEO/Licensee performed CPR on DC #5 - Was unaware the CEO/Licensee was not in the facility until after EMS arrived at the facility - Staff #1 didn't follow protocol because he didn't perform as he was trained to do in an emergency situation <p>Interview on 1/22/26 the CEO/Licensee reported:</p> <ul style="list-style-type: none"> - Worked as the CEO and Direct Care Professional in the facility - Was filling in for the for the House Manager on 1/11/26 - She found DC #5 unresponsive in his bedroom on 1/11/26 when she attempted to wake him up - She called 911 and started CPR on DC #5 <p>Interview on 2/5/26 the CEO/Licensee reported:</p> <ul style="list-style-type: none"> - She didn't relieve the House Manager on 1/11/26, she relieved staff #1 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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V 512	<p>Continued From page 27</p> <ul style="list-style-type: none"> - Staff #1 began working for the facility in September 2025 - Couldn't recall some details of what happened on 1/11/26 because "everything was so rowdy" - Recalled she arrived at the facility before 7am on 1/11/26 - She went into the facility's office to put her belongings down - Couldn't recall what staff #1 was doing when she arrived at the facility - She finished cooking breakfast, called the clients to eat, but DC #5 didn't come out of his bedroom - She told client #1 to go get DC #5, but client #1 came back and said "[DC #5] wasn't answering" - Recalled staff #1 was in the facility's office and she yelled for him to call 911 - She went into DC #5's bedroom and she "initiated" CPR until EMS arrived - Didn't know who opened the door for the Paramedics - The Paramedics went into DC #5's bedroom, she moved out the way and spoke with the Police Officers - She didn't go back into the facility's office, so she didn't know what time staff #1 left the facility - There was no reason why anyone would report she wasn't in the facility when EMS arrived - Then she reported that she went into the facility's office and that could be why the Responding Paramedic said he didn't see a woman in the facility - Then she reported client #1 "initiated" CPR and then she "took over" performing CPR - "He (client #1) called 911 without anyone asking...he started CPR without anyone asking...I told him to move. It wasn't his job to do CPR, so I took over" 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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V 512	<p>Continued From page 28</p> <p>Interview on 2/6/26 the CEO/Licensee reported:</p> <ul style="list-style-type: none"> - "I panicked!" - "I didn't do CPR" on DC #5 - "When I got there, EMS was already in the room (DC #5's bedroom)" - She saw client #1, staff #1 and the Paramedics in DC #5's bedroom when she went into the facility - She asked staff #1 what happened and "[staff #1] said 'we (he and client #1) did CPR'" - "I asked why you (staff #1) say 'we'?" - "He (staff #1) said he and [client #1] did CPR" on DC #5 - "I asked why he (staff #1) would allow [client #1] to do CPR?" on DC #5. "So I assumed the responsibility" - "I was scared...[staff #1] is the staff, [Client #1] is not supposed to do CPR on another client" - "I didn't know how the state (Division of Health Service Regulation) would take it if they found out" a client participated in performing CPR on another client - She didn't report staff #1 and client #1 performing CPR on DC #5 to the Director/QP/RN - "I didn't know what to think because I was so scared" - Was unaware staff #1 didn't assess DC #5 or perform CPR - Staff #1 should have performed CPR <p>Review on 2/6/26 of a Plan of Protection written by the Director/QP/RN on 2/6/26 revealed:</p> <ul style="list-style-type: none"> - "What immediate action will the facility take to ensure the safety of the consumers in your care?" - Every staff on duty MUST demonstrate CPR/FIRST AID - Training - All staff must return demonstration and show that they will perform CPR/First Aid. - Staff will be retrained on CPR/First aid. 	V 512		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-520	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/10/2026
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V 512	<p>Continued From page 29</p> <ul style="list-style-type: none"> - QP (Director/QP/RN) will ensure that client receive care - Only staff that demonstrate competence will work in the facility as of today (2/6/26) - [Staff #1] will not come back to the facility until he is retrained within 30 days - Describe your plans to make sure the above happens. - Staff will be retrained on CPR/First Aid and steps to take in emergency situations within the next 30 days from today. - QP will ensure training are completed. - [Staff #1] will not be rehired by Agape Family Care Homes as of today-2/6/26" <p>The facility served clients diagnosed with Schizophrenia, Mood and Anxiety Disorder, Autism Disorder, Hyperlipidemia, Diabetes Mellitus with Diabetic Chronic Kidney Disease, Hypertension, and Chronic Anemia. On January 11, 2026, client #1 discovered DC #5 unresponsive in his bed and immediately reported the situation to staff #1, instructing him to call 911. Staff #1, who was on duty and responsible for ensuring the health and safety of clients, did not assess DC #5, call 911 or render emergency aid as needed. Staff #1 later stated that he did not intervene because he believed the CEO/Licensee was managing the emergency; however, the CEO/Licensee was not present at the facility when client #1 discovered DC #5 and the CEO/Licensee did not arrive at the facility until after the Paramedics had arrived and pronounced DC #5 deceased.</p> <p>Client #1 independently contacted 911, assessed DC #5, and initiated CPR until emergency medical services arrived, while staff #1 remained nearby and observed client #1 perform CPR on DC #5.</p>	V 512		

Division of Health Service Regulation

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V 512	Continued From page 30 Staff #1 did not initiate emergency procedures, including calling 911 and providing CPR. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 512		