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	MHL0411146	A. BUILDING: _____ B. WING _____	R-C 03/16/2026

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AGAPE HOME LIVING CARE LLC	2708 16TH STREET GREENSBORO, NC 27405

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 3/16/26. The complaint was unsubstantiated (intake #NC00235592). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 4 and has a current census of 3. The survey sample consisted of audits of 1 former client.	V 000		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.	V 366		

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V 366	Continued From page 1	V 366		

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

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V 366	Continued From page 2 if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written policies governing their responses to level II incidents. The findings	V 366	**1. Corrective Action (Health & Safety)** **The facility has reviewed the incident involving FC #1 to ensure**	**4/30/2026**

			understanding of safety risks related to elopement. **Staff have been re-educated to prioritize supervision and verbal de-escalation techniques when multiple clients are in distress.** **Interventions emphasized include:** • **Increased visual supervision** • **Use of verbal redirection and calming strategies** • **Engagement in preferred activities to reduce escalation** **Physical or restrictive interventions will only be used as a last resort, consistent with policy and client rights.** **2. Incident Reporting & IRIS Compliance** **The facility has implemented a policy requiring mandatory IRIS reporting for all Level II incidents, including:** • **Elopement with police involvement** **All staff and supervisors have been retrained on:** • **Incident level determination** • **IRIS reporting timelines (within 72 hours)** **3. Corrective Measures** **To address identified issues, the facility will:** • **Implement enhanced observation during periods of**	

			behavioral escalation • **Ensure staff maintain line-of-sight supervision when indicated** • **Utilize behavior support strategies including verbal de-escalation, redirection, and coping skill prompts** • **Ensure shift-to-shift communication (pass downs) includes client behaviors, risks, and supervision needs** **4. Preventative Measures** **To prevent recurrence:** • **Weekly review of all incidents by the QP and Director** • **Monthly staff training on incident response procedures and IRIS reporting requirements** • **Random audits of incident reports to ensure compliance** • **Implementation of individualized supervision plans based on assessed risk** **5. Assignment of Responsibility** • **Director/Licensee: Oversight of policy implementation and compliance** **Qualified Professional (QP): Review incidents, ensure IRIS submission, and monitor corrective and preventative measures** • **Direct Care Staff: Respond to incidents and complete required documentation and reporting**	

			6. Monitoring & Compliance **The facility will conduct weekly audits of incident reports and IRIS submissions for 90 days, followed by ongoing quarterly reviews. Any deficiencies identified will result in retraining**	

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V 366	Continued From page 3 are: Review on 3/10/26 of FC #1's record revealed: -An admission date of 11/10/25 -Diagnoses of Intellectual Disability Disorder and Schizophrenia -A discharge date of 1/18/26 Attempted interviews on 3/11/26 and 3/13/25 with FC #1 were not successful as telephone calls to FC #1's new placement were not returned. Interview on 3/13/26 with FC #1's Legal Guardian revealed: -Had a difficult time locating FC #1. -Had attempted to track him down to no avail. Review on 3/10/26 of the facility's incident I incident reports revealed: -1/18/26 "Consumer (FC #1) was in his room. I had just checked on him after dealing with two other clients. While I was still calming (client #2) down, he (FC #1) jumped out of the window. Later was a knock on the door the police bring him back." Review on 3/10/26 of the NC Incident Response Improvement System (IRIS) revealed: -No level II incident report was submitted for police involvement after FC #1 eloped from the facility on 1/18/26 Interview on 3/10/25 with staff #1 revealed: -Client #2 had a behavior. -While client #1 had a behavior, FC #1 eloped from the window -This was the first time FC #1 had left the facility -Was unaware FC #1 had left the facility until the police returned him. -Had called the Director/License to inform her of this information.	V 366		

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V 366	Continued From page 4 Interview on 3/12/25 with the Qualified Professional revealed: -Was not aware of the incident with police involvement when FC #1 eloped from the facility on 1/18/26 Interview on 3/10/25 with the Director/Licensee revealed: -Was called by staff #1 when the police returned FC #1 to the facility on 1/18/26 when he eloped. -There was no documentation of how the facility had attended to the health and safety needs of the individuals involved in the incident; determined the cause of the incident; if the facility had developed and implemented any corrective measures; if any measures had been developed to prevent similar incidents and had they assigned person(s) to be responsible for implementation of any corrective/preventative measures.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail,	V 367		

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V 367	Continued From page 5 in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of 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	V 367		

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V 367	Continued From page 6 client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the provider failed to report all level II incidents to the Local Management Entity (LME) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:	V 367	**1. Corrective Action** **The facility has reviewed the incident involving FC #1. Staff have been re-educated on requirements for timely reporting of Level II incidents, including elopement with police involvement. The importance of timely communication to supervisory staff and/or the Qualified Professional (QP) was reinforced.** **2. Corrective Measures** **Staff are required to notify the Director and/or QP of all incidents prior to the end of shift** **All Level II incidents will be entered into IRIS within 72 hours of**	**4/30/2026**

			awareness **A communication protocol has been implemented to ensure timely reporting to the QP and/or Supervisory review of all incidents will occur to confirm proper classification and reporting** **3. Assignment of Responsibility** **Director/Licensee: Oversight of reporting compliance** **Qualified Professional (QP) and/or supervisory staff: Ensure all Level II incidents are reported in IRIS** **Direct Care Staff: Report incidents to supervisory staff** **4. Monitoring & Compliance** **The facility will conduct weekly audits of incident reports and IRIS submissions for 90 days, followed by ongoing quarterly reviews. Any deficiencies identified will result in retraining.**	

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V 367	Continued From page 7 Review on 3/10/26 of FC #1's record revealed: -An admission date of 11/10/25 -Diagnoses of Intellectual Disability Disorder and Schizophrenia -A discharge date of 1/18/26 Attempted interviews on 3/11/26 and 3/13/25 with FC #1 were not successful as telephone calls to FC #1's new placement were not returned. Interview on 3/13/26 with FC #1's Legal Guardian revealed: -Had a difficult time locating FC #1. -Had attempted to track him down to no avail. Review on 3/10/26 of the facility's incident I incident reports revealed: -1/18/26 "Consumer (FC #1) was in his room. I had just checked on him after dealing with two other clients. While I was still calming (client #2) down, he (FC #1) jumped out of the window. Later was a knock on the door the police bring him back." Review on 3/10/26 of the NC Incident Response Improvement System (IRIS) revealed: -No level II incident report was submitted for police involvement after FC #1 eloped from the facility on 1/18/26 Interview on 3/10/25 with staff #1 revealed: -Client #2 had a behavior. -While client #1 had a behavior, FC #1 eloped from the window -This was the first time FC #1 had left the facility -Was unaware FC #1 had left the facility until the police returned him. -Had called the Director/License to inform her of this information. Interview on 3/12/25 with the Qualified	V 367		

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V 367	Continued From page 8 Professional revealed: -Was not aware of the incident with police involvement when FC #1 eloped from the facility on 1/18/26 Interview on 3/10/25 with the Director/Licensee revealed: -Was called by staff #1 when the police returned FC #1 to the facility on 1/18/26 when he eloped. -The Qualified Professional was responsible for submitting level II incident reports into IRIS -Was aware level II incidents were to be submitted into IRIS -Admitted she failed to notify the QP of the incident on 1/18/26 -"I take full responsibility that the incident report was not put in IRIS."	V 367		
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 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	V 537		

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V 537	Continued From page 9 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 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;	V 537		

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V 537	Continued From page 10 (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 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:	V 537		

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V 537	Continued From page 11 (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. (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.	V 537		

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AGAPE HOME LIVING CARE LLC	2708 16TH 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 12 (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on interview and record review, facility staff failed to display competency while implementing physical restraints affecting 1 of 3 audited staff members (Staff #2). The findings are: Review on 3/10/26 of Client #2's record revealed: -Admission date 6/5/23. -Diagnoses of Intellectual Developmental Disability-Mild, Post Traumatic Stress Disorder, Intermittent Explosive Disorder, Legal Blindness. Review on 3/10/26 of Staff #2's record revealed: -Hire date 11/5/25. -Employed as Paraprofessional. -Completed training in Nonviolient Crisis Intervention (NCI)-+ Restrictive Training on 8/27/25. Interview on 3/12/26 with Staff #2 revealed: -Identified job responsibilities to include: when they (clients) are having negative behaviors... "I talked to them to try to calm them down, I try to remind them of counting to 10.." -Client #2 was having behaviors and hit me, "I held his arms by his wrist area for 5 minutes" to avoid him from striking. -Had been trained in NCI,....."had not been trained to do a restraint like that."	V 537	**1. Corrective Action** **The facility reviewed the incident involving Staff #2. Staff were re-educated that only approved techniques taught in formal training may be used. Staff are not permitted to implement any physical intervention for which they have not been trained and demonstrated competency.** **Staff #2 will not implement physical restraints until competency has been re-evaluated and demonstrated through approved training.** **2. Corrective Measures** **All staff will follow only approved intervention techniques as trained** **Staff must complete competency-based training prior to implementing any restrictive intervention** **Staff will be retrained on proper implementation of approved techniques** **3. Assignment of Responsibility** **Director/Licensee: Ensure staff training compliance** **Qualified Professional (QP): Monitor staff competency** **Direct Care Staff: Follow approved trained techniques** **4. Monitoring & Compliance** **The facility will review incidents involving restrictive interventions to ensure staff are using approved techniques. Any deficiencies**	**4/30/2026**

			identified will result in retraining.	