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 _____	R 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE HOME LIVING CARE, LLC	310 FIELDS STREET GREENSBORO, NC 27405

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 3/16/26. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600 Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 4 current clients.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND 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.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to schedule a review of a plan at least annually affecting three of three audited clients (#1, #2, #3 and #4). The findings are:

Review on 3/12/26 of client #1's record revealed:
-Admission date of 6/4/24.
-Diagnoses of Intermittent Explosive Disorder, Moderate Intellectual Developmental Disability, Schizophrenia and Mental Disorder.
-Person Centered Plan (PCP) dated 2/1/25.
-There was no documentation of a current plan.

Review on 3/12/26 of client #2's record revealed:
-Admission date of 5/17/23.
-Diagnoses of Epilepsy, Klinefelter's Syndrome, Moderate Intellectual Developmental Disability, Vitamin D Deficiency, Nocturnal Enuresis, Constipation, Abnormal EKG and Unstable Housing.
-There was no documentation of a current plan.

Review on 3/12/26 of client #3's record revealed:
-Admission date of 6/8/22.
-Diagnoses of Schizophrenia and Mild Intellectual Disability.
-PCP dated 12/21/24.
-There was no documentation of a current plan.

Interview on 3/13/26 with the Qualified Professional (QP) revealed:

1. Corrective Action **4/30/2026**

The facility reviewed all client records. Updated Person-Centered Plans (PCPs) will be completed for all affected clients.

2. Corrective Measures
The Qualified Professional (QP) will ensure PCPs are reviewed and updated at least annually
A tracking system will be used to monitor PCP due dates

3. Assignment of Responsibility
Qualified Professional (QP): Ensure PCPs are current
Director/Licensee: Oversight

4. Monitoring & Compliance

The facility will review client records to ensure PCPs are current. Any deficiencies will be corrected.

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V 112	Continued From page 2 -She was responsible for completing the clients PCPs. -She reported the treatment plans are the most current.	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. 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 3/13/26 of the facility's fire drill log from December 2025 to February 2026 revealed: - There were only one documented fire drills and disaster drills conducted during the second quarter (April 2025 to June 2025). - There were only two documented fire drills and	V 114	**1. Corrective Action** **The facility reviewed fire and disaster drill requirements. Staff were re-educated on completing and documenting drills for each shift.** **2. Corrective Measures** • **Fire and disaster drills will be conducted at least quarterly on each shift** • **All drills will be documented at the time of completion** • **The Director will review drill logs for completeness** **3. Assignment of Responsibility** • **Director/Licensee: Oversight of drill completion and documentation** • **Direct Care Staff: Conduct and document drills** **4. Monitoring & Compliance** **The facility will review drill logs quarterly to ensure compliance. Any deficiencies will be corrected.**	**4/30/2026**

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V 114	Continued From page 3 disaster drills conducted during the third quarter (July 2025 to September 2025). - There were only two documented fire drills and disaster drills conducted during the fourth quarter (October 2025 to December 2025). Interviews on 3/12/26 with clients #1, #2, #4 revealed: - Indicated the facility did not practice fire and disaster drills. -They were unable to provide information on how often the facility practiced fire and disaster drills. Interview on 3/13/26 with staff #4 revealed: -Had been working at the facility since August 2025. -Every shift completes the fire and disaster drills monthly. -He did not know why other staff did not complete the documentation of the fire and disaster drills. Interview on 3/13/26 with the Licensee/staff #3 revealed: - Due to medical leave interview unsuccessful.	V 114		

V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities	V 513	**1. Corrective Action** **The facility reviewed the practice of locking access to food. Access to the refrigerator and pantry has been restored.** **2. Corrective Measures** • **Food will remain accessible to clients** • **Any concerns related to food hoarding will be addressed through individualized interventions** • **Staff will follow the Person-Centered Plan (PCP) and not implement general restrictions** **3. Assignment of Responsibility** • **Qualified Professional (QP): Ensure interventions are individualized** • **Director/Licensee: Oversight of compliance** • **Direct Care Staff: Follow PCP and maintain access** **4. Monitoring & Compliance** **The facility will review practices to ensure clients have access to food and that interventions are individualized and documented. Any deficiencies will be corrected.**	**4/30/2026**

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V 513	Continued From page 4 meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the least restrictive and most appropriate settings and methods were used. The findings are: Observation on 3/13/26 at 1:19pm revealed: -The refrigerator and pantry stock locked behind a storage room door. Review on 3/12/26 of client #1's record revealed: -Admission date of 6/4/24. -Diagnoses of Intermittent Explosive Disorder, Moderate Intellectual Developmental Disability, Schizophrenia and Mental Disorder. -Person Centered Plan (PCP) dated 2/1/25. Interview on 3/13/26 with Staff #2 revealed: -Locked the door where the refrigerator was located every time after he used it. -Client #1 had been taking food from the refrigerator and pantry and hoarding it under his bed.	V 513		

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V 513	Continued From page 5 -The food had ben locked up away from client access for the past few months. Interview on 3/13/26 with staff #3 revealed: -She was aware that the food was locked up because client #1 had been hoarding the food.	V 513		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a safe, clean, attractive and orderly manner and free from offensive odors. The findings are: Observation on 3/12/26 between 10:37am to 10:52am arriving at the facility revealed: -The front door had been open. -The smell of feces was observed at the front of front of the facility at. -The kitchen wall to the left had multicolor stains on the wall, in several directions. -Staff #2 spraying air freshener around the facility due to the back up sewage smell. Observation on 3/13/26 between 1:15pm to 2:25pm of the facility revealed. -Client #2 bedroom had more then 12 broken window blind slates. -A full size box spring, mattress, headboard and footboard leaning upright against the hallway wall. -Bathroom #1 tub filled front to back with	V 736	**1. Corrective Action** **The facility reviewed the condition of the home. Cleaning and repairs have been initiated to address sanitation concerns, odors, and maintenance issues.** **2. Corrective Measures** • **The facility will be maintained in a clean and sanitary condition** • **All identified maintenance issues (damaged items, broken fixtures, and cleanliness concerns) will be repaired or replaced** • **Staff will ensure prompt cleaning and reporting of maintenance concerns** • **Staff will provide supervision and prompting to support proper hygiene and use of facilities** **3. Assignment of Responsibility** • **Director/Licensee: Ensure maintenance and cleanliness are addressed** • **Direct Care Staff: Maintain cleanliness and report concerns** **4. Monitoring & Compliance** **The facility will conduct routine checks of the home to ensure it remains clean, safe, and in good repair. Any deficiencies will be corrected.**	**4/30/2026**

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V 736	Continued From page 6	V 736		

grey/blackish dust/debris that coated the entire bottom.
-Missing cabinet door on top of the sink area in the kitchen.
-Chipped paint alongside the sink base.
-Bathroom #2 torn shower curtain, shredded at the top and on both sides.
-Cracked 13x49 mirror which was propped on the backside of the toilet.
-Orange Play-Doh stains smeared on the countertop.
-White splashes along side the middle of the wall from sink to wall approximately 5ft in length.
-Top of dryer brown/blackish stains along side of the length of the dryer, and missing strength knob.
-Client #5 bedroom window dressing hanging sideways not covering the entire window.
-Side of closet door propped against the wall by the window.
-Air Condition window unit stuffed with miscellaneous items on either side.
-The back of folding camp chair not attached.

Interview on 3/12/26 with client #4 revealed:
-The toilet had been broken since yesterday.
-They (clients) can use another toilet in the facility.

Interview on 3/12/26 with staff #2 revealed:
-Had reported that the front door was open because one of the clients in the facility attempted to flush underwear down the toilet and stopped it up, "now it smells like poop in here."
-The toilet had been broken for one day.
-The clients do not flush the toilets they need staff to prompt them to do so.

Attempted interview on 3/13/26 the Licensee revealed:

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V 736	Continued From page 7 -Duet to medical leave interview unsuccessful.	V 736		