Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011264	A. BUILDING: ______ B. WING ______	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE IV	**60-B HORNOT CIRCLE ASHEVILLE, NC 28806**

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/15/15 with an exit conference via telephone on 09/16/15.	C 000		
C 115	10A NCAC 13G .0401 (1) Qualifications Of Administrator 10A NCAC 13G .0401 Qualification Of Administrator The administrator must meet certain requirements before and after being approved to manage a licensed home. The administrator is responsible for the home, including the development and management of services and accommodations and the hiring and training of qualified staff so that the home meets the rules of this Subchapter even in his absence. All of the following requirements must be met: (1) The potential administrator must apply on the License Application (DSS-1860). The Recommendation for a License (DSS-1861) is to be completed by the county department of social services and forwarded along with references and other appropriate forms to the Division of Facility Services for approval or disapproval; This Rule is not met as evidenced by: Based on interview and record review, the facility failed to submit to the Division of Health Service Regulation documentation of a new Administrator. The findings are: Review of the most current facility license application on file with the Division of Health	C 115		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011264	A. BUILDING: ______ B. WING ______	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE IV	**60-B HORNOT CIRCLE ASHEVILLE, NC 28806**

(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
C 115	Continued From page 1	C 115		

Service Regulation (DHSR), effective 01/01/15, revealed Staff A as Administrator and full Owner.

Further review of state agency facility files revealed no documents acknowledging a new administrator since the current license went into effect on 01/01/15.

Interview with the Supervisor in Charge on 09/15/15 at 8:05AM revealed Staff B as the Administrator, but she was not aware of any documentation to verify this.

Interview with Staff B on 09/15/15 at 8:50AM revealed:
- Staff C was the Administrator.
- He (Staff B) was a "Co-Administrator" over the facility.
- Staff C had been the Administrator since February, 2015.

Phone interview with Staff A on 09/15/15 at 9:00AM revealed:
- She submitted paperwork to the state agency between January and February, 2015 notifying that Staff C was the new Administrator .
- She did not follow up to make sure the paperwork was received by the state agency.
- She was not sure if Staff C submitted any paperwork to the state agency.
- The county Adult Home Specialist was sending to Staff C all Complaint Action Reports.
- Staff B was an Administrator-in-Training (AIT), with Staff C providing his training and oversight, and Staff B's paperwork would be mailed to the state agency sometime before October 1, 2015.

Phone interview with state agency staff on 09/15/15 at 9:59AM revealed:
- There was no documentation on file that Staff C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011264	A. BUILDING: ______ B. WING ______	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE IV	**60-B HORNOT CIRCLE ASHEVILLE, NC 28806**

(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
C 115	Continued From page 2	C 115		

was the Administrator of the facility.
- Staff A was no longer the Administrator.

Interview with Staff C on 09/15/15 at 10:10AM revealed:
- He was made interim Administrator of the facility effective January 15, 2015.
- An application was sent to the state agency but he did not recall receiving a reply.
- He assumed Staff A sent documentation to the state agency regarding his interim Administrator status.
- Staff B was on staff as a Property Manager and as an AIT, but he was not an Administrator-in-Charge.

Phone interview with Staff A on 09/15/15 at 11:05AM revealed:
- She had done nothing in an Administrator capacity since January, 2015.
- She was not the Administrator.
- Staff C was the person handing all resident care issues such as admissions, discharges, assessments, direct care issues, FL-2s and care plans.

C 311 | 10A NCAC 13G .0909 Residents' Rights | C 311

10A NCAC 13G .0909 Resident Rights
A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011264	A. BUILDING: ______ B. WING ______	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE IV	60-B HORNOT CIRCLE ASHEVILLE, NC 28806

(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
C 311	Continued From page 3 Based on observation, interview and record review, the facility failed to assure the maintenance of equipment (a rolling walker) essential for the safety of 1 of 2 sampled residents (#1) with a history of falls. The findings are: Review of Resident #1's current FL2 dated 2/11/15 revealed: -She had been admitted to the facility on 10/28/10. -She was noted to be ambulatory with a rolling walker. -Diagnoses included dementia, anemia, Parkinson's Disease, bipolar disorder and Kyphosis-an abnormal increase in the curvature of the thoracic spine. -Medications included Zyprexa: an antipsychotic,Vesicare: a treatment for overactive bladder, pramipexole: decreases the involuntary movements of Parkinson's Disease and may cause dizziness and confusion, gabapentin: used to treat tremors, trazadone: an antidepressant, divalproex: used to decrease symptoms of bipolar disorder and Tramadol: used for pain relief. Review of Resident #1's Assessment and Care Plan dated 2/10/15 revealed: -She was noted to be independent with transfers and toileting. -She required supervision with ambulation and eating. -She required limited assistance with bathing, dressing and grooming. Review of Resident #1's record revealed: -On 2/3/15 at 8:00am, the resident had been found on the front porch, down on her knees bent over with her face on the porch. She reported she	C 311		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011264	A. BUILDING: ______ B. WING ______	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE IV	60-B HORNOT CIRCLE ASHEVILLE, NC 28806

(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
C 311	Continued From page 4 had lost her balance. -On 3/31/15, in the morning, the resident had been found sitting on the floor (unspecified location). Reported "her legs just gave out on her." -A Functional Assessment dated 6/2/15 revealed Resident #1 "uses a walker to prevent falls". -On 9/8/15, a Home Health Physical Therapy consultation reported the "caregiver reports no falls although several close calls and states the patient is not 100% consistent with use of assistive device (rolling walker). Will also need cues to stay close to the RW (rolling walker)." -On 9/11/15, a consultation by the Home Health Physical Therapist stated the resident's treatment included safety education. Plan of Care would be 2-3 times a week for 2 weeks. -On 9/12/15 at 12:15pm, the resident "fell on her butt (in the living room), didn't have her walker." Review of Resident #1's monthly Medication Administration Record revealed the notation: "Activity: Rolling Walker-use fall precautions." Interview on 9/15/15 at 8:15am with Resident #1 revealed: -She "falls all the time". -She had a rolling walker the facility and Home Health staff told her she needed to use it to keep from falling. -Her physician told her she needed to use the walker to keep from falling. -The (rolling) walker had been "broken for awhile" but she could not define "awhile". -She had put the part of the handle, when it fell off, in a bin on her bookshelf so she wouldn't lose it. -The brake on the right wheel didn't work. -She had not told anyone the walker was broken.	C 311		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011264	A. BUILDING: ______ B. WING ______	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE IV	**60-B HORNOT CIRCLE ASHEVILLE, NC 28806**

(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
C 311	Continued From page 5 Observation at 8:20am of Resident #1's using the rolling walker revealed: -The brake grip handle on the right side of the walker was missing. -The right brake cable ran from the connection at the brake handle down the leg of the walker and was laying under the walker seat. -The brake cable was not connected to the brake on the right wheel. -When both brake handles were squeezed, the left wheel of the walker stopped moving and the right wheel continued to move forward, causing the resident to be shifted off-balance. Interview on 9/15/15 at 8:40am with the Medication Aide (MA)/Supervisor-in-Charge(SIC) revealed: -Resident #1 appeared to walk on the sides of her feet which made her unsteady when she walked. -Resident #1's family were getting her different shoes which would increase her stability. -The resident was forgetful and needed to be reminded constantly to use her walker. -She had not observed anything out of the ordinary when she had looked at Resident #1's walker with the surveyor. Interview on 9/15/15 at 9:00am with the Physical Therapist working with Resident #1 revealed: -She thought the brakes had been working when she last visited on 9/10/15. -The resident definitely needed the walker for safety. -She would make telephone calls about getting the walker fixed. -The SIC had told her Resident #1 did not have an extra walker. -She had instructed Resident #1 to be especially cautious until the walker could be fixed.	C 311		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011264	A. BUILDING: ______ B. WING ______	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE IV	60-B HORNOT CIRCLE ASHEVILLE, NC 28806

(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
C 311	Continued From page 6 Interview on 9/15/15 at 1:35pm with the acting Administrator revealed: -He was not aware the brake on Resident #1's walker had not been working. -The walker brakes were like the brakes on a bicycle and he thought he could repair it. -If he couldn't fix the walker right then, he would immediately go and buy Resident #1 a new walker. ______________________ A Plan of Protection provided by the facility on 9/15/15 at 4:10pm revealed: -Resident #1's walker would be repaired or replaced immediately. -All assistive walking devices would be checked immediately to ensure they were in good working order. -All assistive walking devices would be checked on a monthly basis to ensure they remain in good working order. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 31, 2015.	C 311		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to assure all residents	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011264	A. BUILDING: ______ B. WING ______	09/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE IV	**60-B HORNOT CIRCLE ASHEVILLE, NC 28806**

(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
C 912	Continued From page 7 received care and services which were adequate, appropriate and in compliance with relevant federal and state laws, rules and regulations related to resident rights. The findings are: Based on observation, interview and record review, the facility failed to assure the maintenance of equipment (a rolling walker) essential for the safety of 1 of 2 sampled residents (#1) with a history of falls. [Refer to Tag 0311 10A NCAC 13G .0909 Resident Rights (Type B Violation)].	C 912		