hand delivered 2-4-16

PRINTED: 01/15/2016
FORM APPROVED

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 _____	R 01/04/2016

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 and Buncombe County DSS conducted a follow-up survey on site December 30 and 31, 2015 with a telephone exit on January 4, 2016	{C 000}		
C 311	10A NCAC 13G .0909 Residents' Rights 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 A2 VIOLATION Based on observation, interview, and record review, the facility failed to assure every resident was free from mental and physical abuse as related to Resident #1 grabbing other residents' cigarettes and lighters, placing hands on other residents, and frequently requesting cigarettes and lighters from other residents, resulting in at least 4 residents (#4, #5, #6, and #8) expressing fear of Resident #1 and two residents (#9 and #10) who were touched inappropriately by Resident #1. The findings are: Review of Resident #1's FL-2 dated 11/16/15 revealed diagnoses which included: -History of traumatic brain injury (TBI) -Mood disorder due to TBI -Impulse control due to TBI -Major neurological disorder due to TBI -Epilepsy due to TBI	C 311	See Attached	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Tracy Gray

TITLE: Administrator

(X6) DATE: 2-3-16

accepted PCCJ Brenda Boggs 2-4-16

STATE FORM 6899 S88M12 If continuation sheet 1 of 19

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C 311	Continued From page 1 Review of Resident #1's Resident Register revealed an admission date of 11/16/15. Review of the current FL2, dated 11/16/15, for Resident #1 included the following orders: -Carbamazepine 300 mg BID (an anticonvulsant). -Fluphenazine 5 mg every 12 hours, give at 8:00am and 8:00pm (used to treat psychotic disorders). -Lamotrigine 250 mg every AM (an anti-epileptic medication). -Lamotrigine 300 mg at bedtime. -Lorazepam 0.5 mg three times per day, at 8:00am, at 2:00pm and at 8:00pm (used to treat anxiety disorders). -Sertraline 100 mg daily (an antidepressant). -Topiramate 100 mg at bed time (an anticonvulsant). -Topiramate 50 mg every AM. Interview with Staff A, the Supervisor-in-Charge (SIC) in this facility on 12/30/15 at 10:15am revealed: -Staff A had just received a call from the SIC in House E (another family care home on the property). -Resident #1 had gone up to the porch of House E, grabbed at the cigarettes and lighter in Resident #9's hand and knocked that resident's glasses off her head. -Staff A said she would ask the Administrator if she should call 911 because the Mental Health (MH) Provider had instructed her to call 911 if Resident #1 exhibited aggressive behaviors again to other residents. Observation on 12/30/15 at 10:25am revealed: -Two law enforcement officers came to the facility and talked with Resident #1 and she agreed to go	C 311		

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C 311	Continued From page 2	C 311		

to the the emergency room (ER).
-The officers left with Resident #1 in their law enforcement vehicle.

Review of Resident #1's hospital's Progress Notes from a hospital admission from 10/27/15 to 11/12/15 revealed:
-Resident #1 was admitted to the hospital because "she punched another resident" while residing in an another assisted living home.
-Resident #1 had repeated crisis hospitalizations, ALF (assisted living facility) placements and ER visits for aggression, and SI (suicidal ideations).
-A facility which cares for residents with TBI and a State mental hospital were discussed as appropriate placements for Resident #1.
-"However, if [name of State mental hospital] refuses her admission and she establishes stability while in the ER, we may proceed to seeking ALF/FCH (family care home) placement."

Review of Resident #1's hospital's Progress Notes dated 11/9/15, from a hospital admission for the period of 10/27/15 to 11/12/15, revealed:
-When Resident #1 was asked what happened that led her being brought to the ER, it was documented "that she became frustrated with another client and hit her."
-When Resident #1 was asked if she had struck people in the past, she replied "she has."

Review of Resident #1's hospital's Progress Notes, dated 11/11/15, from a hospital admission for the period of 10/27/15 to 11/12/15, revealed Resident #1 "has had no behavior problems at all and truly is ready for disposition."

Review of the facility "Progress Notes" revealed:
-Resident #1 was admitted to the facility on 11/16/15.

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C 311	Continued From page 3 -On 11/17/15, Resident #1 went into another resident's room (Resident #4) and asked that resident to buy her a drink, but Resident #4 became very upset and said she did not want Resident #1 in her room and did not want Resident #1 asking her for money. -On 11/17/15, after Resident #1 went into Resident #4's room and was refused money, she then went to two other family care homes on the property asking for money. -On 11/17/15, Staff A, the SIC, called the local Crisis Team and was instructed to call the police if aggression started and then to call the Crisis Center. -On 11/18/15, Resident #1 went into Resident #4's room and Resident #4 "was very upset." -On 11/18/15 at 7:05pm, Resident #1 went (to another family care home) "next door and went into the rooms and was begging for money." -On 11/25/15 Resident #1 was picked up by family member for home visit, but while in transport Resident #1 had seizures and family member took Resident #1 to the local ER. -On 11/26/15 at 5:45am, the ambulance transported Resident #1 back to the facility. -On 11/26/15 at 6:30pm, "Resident has asked for cigarettes all day. She has left off porch too many times to count, finds another resident on property giving her cigarettes." -On 11/27/15, "Resident #1 has asked staff for cigarettes all day." -On 11/27/14 at 4pm, Resident #1 went into another facility, "got nasty cigarette butts." -On 11/27/15 at 6:20pm, Resident #1 went to another house and got cigarette from a female resident and was asked to leave that house because of begging cigarettes and getting dirty butts out of ashtray. -On 11/27/15 at 7:15pm, Resident #1 left house again and "went got cigarettes from another	C 311		

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C 311	Continued From page 4 resident." -On 11/28/15, Resident #1's family member came to visit and told the SIC that Resident #1's behavior of "stealing, lying, begging for money, drinks, and cigarettes, taking butts of cig[arette]s....is what got her put out 5 different places and that all the 5 places, she abusively hit many residents and one nurse." -On 11/29/15, Resident #1 went to another facility, "begging for cigs." The SIC at that home told Resident #1 to go home. -On 11/29/15 at 7:05pm, "All ladies are in an uproar -no one will stay in living room with her nor talk with" Resident #1. -On 12/2/15, Staff A applied the nicotine patch on Resident #1. -On 12/2/15 at 2:00pm, Resident #1 went to House A and went "into a man's bedroom, woke him up, and wanted a cigarette." The male resident got angry and said he never wanted her in his room again. -On 12/2/15 at 4:30pm, Resident #1 stole cigarettes from a staff car and when Staff B (another SIC who works in this facility), tried to get them back, Resident #1 grabbed Staff B by the arms and "got in the Administrator's face." The Mental Health (MH) Crisis team was called but it was the wrong crisis team and they could not help. -On 12/3/15 at 7:50pm, the resident "smoked all day long, went house to house getting butts out of ash trays and bumming cigarettes." Called MH Provider. -On 12/4/15 at 10:30am, Resident #1 has "started running for the cigarettes." Staff left message for MH provider and Resident #1's primary care physician to discontinue the nicotine patches. -On 12/9/15 4:30pm, Resident #1 has been on property all day getting cigarette butts and trying to bum them off other people.	C 311		

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C 311	Continued From page 5 -On 12/9/15 at 6:30pm, Resident #1 went to the back porch of another house on the property and asked a resident to give her the cigarette he was smoking, which he threw into an ashtray and went inside his house. -On 12/9/15 at 6:56pm, received a call from the SIC (Staff C) in House E on the property. Resident #1 was on the porch trying to get cigarettes from Resident #9, a female resident. When Staff C asked Resident #1 to leave, Resident #1 swung at the SIC hitting them on the arm. Administrator notified. Staff A called the MH provider and they advised staff to call 911. An officer came and talked to Resident #1 and then the officer left. -On 12/9/15, Staff A called Resident #1's family member, who told Staff A that Resident #1 had abused so many residents and a nurse at 5 facilities that it will continually get worse and he did not want "no one" hurt. -On 12/11/15 at 5pm, Resident #1 tried to stab herself in left side of neck with a fork and then tried to stab herself in left ear. Staff A intervened and Resident #1 was not hurt. Staff A noted although it appeared Resident #1 may have tried to stab herself, upon further observation, Staff A noted that Resident #1 was "in a seizure." -On 12/11/15, Resident #1 had been all over the property every 20 to 30 minutes, all day bumming cigarettes and cigarette butts out of ashtray. -On 12/14/15 at 3:38pm, Resident #1 "has done usual on property smoking nasty cig[arette]s butts and bummin[g]." -On 12/14/15 at 8:00pm, Resident #1 was "trying to pickup cig[arette] butts out of dirty ashtrays and smoking them." -On 12/15/15 at 1:30pm to 2:45pm, Resident #1 was "caught twice trying to climb up our back deck coming into our kitchen-deck very high off ground." Staff A asked Resident #1 to not attempt	C 311		

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C 311	Continued From page 6 to climb the deck. -On 12/17/15 at 6:00pm, Resident #1 asked for a drink (but had already had her allotted 2 drinks for the day), getting into Staff A's face. The Administrator instructed Staff A per telephone at that time to temporarily remove herself away from Resident #1, go to her office, and lock the door. -On 12/18/15, Resident #1 was on property all day looking for cigarette butts. -On 12/28/15 at 3:50pm, Resident #1 was at House A and Staff A heard the SIC at House A (Staff D) call for the resident. When Staff A got to House A, Resident #1 had both her hands on Staff D trying to take an ashtray and nasty butts away from her. Staff A intervened and Resident #1 walked off. -On 12/28/15 at 5:30pm, Staff A was notified by an SIC in another home that Resident #1 grabbed a male resident by his shirt trying to get a cigarette, but the male resident pushed Resident #1 away. -On 12/28/15 at 6:30pm, Resident #1 went to House E and tried to get a cigarette from a resident. The SIC at House E asked Resident #1 to leave and Resident #1 shoved the SIC into a resident sitting on the porch. -On 12/28/15, a member of the Crisis Team came at 7:30pm and talked to Resident #1 and staff. Review of the electronic Medication Administration Records (e-MAR) for Resident #1 for November and December, 2015 revealed: -Staff wrote on the e-MAR Progress Notes Resident #1's behavior from 11/16/15 to 12/29/15. -The Administrator noted on the EMAR on 11/29/15, 12/8/15, 12/14/15, and 12/26/15 that he "read and reviewed Progress Notes." Interview with Staff A, the SIC in this facility, on 12/31/15 at 11:00am revealed:	C 311		

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C 311	Continued From page 7 -Staff A said if a staff member had been assigned to supervise Resident #1 at all times, it would have made Resident #1 more aggressive because she did not want anyone to follow her around and tell her what to do. -She gave Resident #1 her 2 drinks per day and allotted cigarettes per day on a routine basis, but Resident #1 always wanted more. -Resident #1 was always begging for cigarettes and soda drinks and went around the facility property collecting cigarette butts and begging other staff and residents for cigarettes. -On 12/9/15, when Resident #1 had hold of Staff B's arm, the Administrator kept telling Resident #1 to let go. Staff called 911 and officers came out and talked to Resident #1 and then the officers left the property. -On 12/28/15, the incident in the Progress Note related to Resident #1 grabbing a resident's shirt happened in House F with Resident #10. -The only activity that Resident #1 would participate in was puzzle books, which were always available. -She learned (from the physician at Resident #1's neurologist) that Resident #1 was having a seizure when she raised her hand over her head which explained the 12/11/15 fork incident. -Staff A said that whenever Resident #1 went to other homes on the property, the SICs would immediately ask her to leave and go back to her facility. -When Resident #1 tried to climb up the back patio, she would ask Resident #1 to quit. -Staff A and all staff on the property redirected Resident #1 whenever inappropriate behaviors were observed. Interview with the Licensee on 12/30/15 at 3:30pm revealed: -The facility had admitted Resident #1 under a	C 311		

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C 311	Continued From page 8 new plan developed by the hospital called the "Red Phone." -The Red Phone was a plan to place "complicated" residents in homes with "wrap around" support services. -The placement for Resident #1 was to be a 30 day trial. -A MH Provider provided counseling and support for Resident #1. -Resident #1 was supposed to be placed in a day program for TBI residents. Interview with the Licensee on 12/31/15 at 3:30pm described the Red Phone agreement with the hospital as follows: -The hospital staff assisted the facility by putting services in place before the "Red Phone residents" were admitted. -If the arrangement (placement) wasn't working after 30 days, the resident could return to the hospital. -Red Phone residents were described as "hard to place" residents with "behavioral issues." -It was the facility's responsibility to contact the hospital after 30 days if the placement was not working. Interview with the Administrator on 12/30/15 at 1:45pm revealed: -He was aware Resident #1 had behavior problems before she was admitted, but since they had MH services in place, he was willing to give Resident #1 an opportunity to live there. -He was on the property "daily" and was aware of Resident #1's behavior. -Resident #1 had not had that many problems until recently and they continued to work with MH services to provide counseling in attempt to allow her to live there. -They made referrals to Resident #1's physicians	C 311		

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C 311	Continued From page 9 (primary care physician and the neurologist) and MH to assess if adjustments needed to be made to Resident #1's medication regime for behaviors and seizures. -Resident #1 had become more aggressive "just recently" and when the incident on 12/30/15 occurred, he knew they had to reassess the arrangement. -He was not aware any residents in other homes (other than the home Resident #1 resided in) was afraid of Resident #1. -He knew Resident #1 collected cigarette butts and he had instructed all the SICs to keep the ashtrays empty. -Resident #1 had never attempted to leave the property where the 6 family care homes were located. -When Resident #1 was admitted to the facility, she had no money for cigarettes or drinks. -The Administrator provided cigarettes for Resident #1 and the SICs were instructed to give her a limited quantity at certain times of the day because Resident #1 was a chain smoker and would smoke all allotted cigarettes in a short time. -Resident #1 was not allowed to have a lighter because she was a seizure risk and they knew she could be aggressive. -Resident #1's family provided sodas and requested the staff store the drinks and only give her two drinks per day because she would drink them all at once. -Resident #1's family member had been serving as the guardian for her, but the family member had requested DSS find her another guardian. -The only service the "Red Phone" agreement had provided after Resident #1 was admitted to the facility was assuring Resident #1 received MH services. Interview on 12/30/15 at 9:45am with Resident #4	C 311		

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C 311	Continued From page 10 who resided in this facility revealed: -She was afraid of Resident #1 because she (Resident #1) hit Staff C and the police was called. -"She did not hurt me," but "hugged me" and "I did not want her to." -"She is dangerous." Interview on 12/30/15 at 10:00am with Resident #5 who resided in this facility revealed: -She was afraid of Resident #1 but Resident #1 had never hurt her. -Resident #1 came into her room at least once uninvited and she did not like the way Resident #1 "walked by the room and looked at her." Interview on 12/30/15 at 4:00pm with Resident #6 who resided in this facility revealed: -She was afraid of Resident #1 but Resident #1 had never hurt her. -Resident #6 was afraid of her because of the way Resident #1 "walked by her room and looked at her." Interview on 12/30/15 at 3:10pm with Resident #10 , who resided at House F on the property, revealed: -He was a smoker and one time when Resident #1 asked for cigarettes, Resident #1 "grabbed my neck" and [name of Staff C] saw it." -When surveyor asked Resident #10 if he was hurt, he replied "yes," but would not explain anymore about what "hurt" meant. -An SIC intervened and told Resident #1 to go back to her house. -Resident #1 made Resident #10 "kind of nervous." -Staff told him to not give Resident #1 any cigarettes or lighter.	C 311		

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C 311	Continued From page 11 Interview with Resident #7 in House A on 12/31/15 at 2:30pm revealed: -"I was afraid of her." -"I did not know what to expect, I always thought she was going to jerk" my cigarette out of my hand. -Resident #1 "did not know how to take no for an answer." -One time, Resident #1 asked for a light and "instead of getting a light off my cigarette, she grabbed my cigarette out of my hand." Interview with Resident #8 in House A on 12/31/15 at 2:40pm revealed: -"I had a problem with" Resident #1. -"I was not afraid of her but she aggravated me." -"I wanted to be left alone." Interview with Resident #9 who resided in House E on 12/30/15 at 3:55pm revealed: -Resident #9 was "not scared of" Resident #1. -Resident #1 "jerked glasses off, she was attempting to get the cigarettes in my lap." -I asked Resident #1 "not to bother me." -"When I saw her coming, I come inside." Interveiw with Resident #11 on 12/30/13 at 3:25 revealed she was not afraid of Resident #1. Interview on 12/31/15 at 10:00am with the SIC, Staff C, who worked at House E on the property revealed: -When Resident #1 first arrived, Resident #1 asked Resident #11 (who resided in House E) for a cigarette and light. When Resident #11 said no, Resident #1 grabbed the cigarette and lighter off the table. Resident #11 asked for them back and Resident #1 gave them back after she took one cigarette out of the pack. -Another time when Resident #11 was sitting on	C 311		

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(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 12 the porch of House E where she (Resident #11) lived, Resident #1 came onto the porch and headed toward Resident #11. Staff C, (the SIC at House E) got in between Resident #1 and Resident #11. Resident #1 pushed Staff C and Staff C stumbled into a chair. Then Resident #1 went to the other side of the table and grabbed Resident #11's cigarettes and lighter. When Resident #11 threatened to "whip her [explicative]." Resident #1 spit in Staff C's face and laid down the cigarettes and lighter. -When Resident #10 (who resided in House F) refused to give Resident #1 a light, Resident #1 "grabbed" Resident #10's "shoulder and started pushing him backwards." Staff C separated Resident #10 and Resident #1. Staff C explained this incident was probably the same one where Resident #10 described Resident #1 as "grabbed my neck." -On December 30, 2015, Resident #1 was on the porch of House F and put her hand in Resident #10's pocket. Resident #10 got Resident #1's hand out of his pocket and ran into his house. Review of record revealed MH staff were contacted or MH staff were on-site the following days after Resident #1's admission on 11/16/15: -11/18/15: Facility staff contacted the local MH Crisis team to establish service. -11/30/15: Staff contacted MH Services. -12/2/15: Staff contacted MH Services. -12/8/15: MH Staff came to the facility to see Resident #1 -12/9/15: MH Staff came to the facility to see Resident #1 after facility staff called MH about Resident #1's aggression -12/28/15: Mental Health Staff came to the facility to see Resident #1 after facility staff called about Resident #1's behavior	C 311		

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 _____	R 01/04/2016

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C 311	Continued From page 13 Telephone interview with the Supervisor at Resident #1's MH Provider on 12/31/15 at 2:10pm revealed: -Their office had more than one staff who provided support for Resident #1 at this facility. -MH staff did not leave visit notes with the facility unless they recommended significant changes to care. -He did not have a copy of all the visits their MH Services provided to Resident #1 but knew one Registered Nurse (RN) came out two times and another RN came out one time. -MH staff came out to the facility at least four times in November 2015 to counsel Resident #1. -MH staff completed a two part assessment on Resident #1 which was on 12/1/15 and 12/8/15 to determine if a referral should be made for other services such as the day program . -They were capable of providing "peer support" to residents but were not allowed to ever touch a resident who was aggressive. -They provided counseling and were working with Resident #1 on her "coping skills." -"Up until the last few weeks, [Resident #1] had been doing fine" with staff using redirection and on-going counseling such as working with Resident #1's impulse control. -"We know housing has been a problem" for Resident #1. -The TBI day program would not accept Resident #1 because Resident #1 had not been stable enough to attend the day program. These stipulations were in place by the day program, not the MH services. -There were no other day programs available for Resident #1. -The facility had been instructed to call 911 when Resident #1 was aggressive and could not be talked down. -When asked if Resident #1 was an appropriate	C 311		

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C 311	Continued From page 14 fit for this facility, he replied that he did not know, but he had always been pleased with the care this facility group provided to residents and "had lots of successes in the past." Review of Resident #1's record revealed the facility made contacts with the Primary Care Physician as follows: -Facility staff contacted a local Primary Care Physician on 11/18/15 and made an appointment for Resident #1 with that provider for 11/20/15 to establish services. -Facility staff took Resident #1 to the appointment with the Primary Care Physician on 11/20/15. -Facility staff took Resident #1 to the appointment with the Primary Care Physician on 12/1/15 and the physican ordered a Nicotine Patch. -The Primary Care Provider was contacted on 12/4/15 requesting the physician discontinue the Nicotine Patch because Resident #1 was continuing to smoke. Review of record revealed a physician order, dated 12/1/15, to apply 1 Nicotine Patch every day and remove old patch. Review of December, 2015 e-MAR for Resident #1 revealed the Nicotine patch was documented as applied on 12/2, on 12/3, and on 12/4. Review of record revealed Resident #1 was taken to the local ER on 11/25/26 because of frequent seizures, but returned to the facility with no medication changes. Review of record revealed the facility made contacts with a Neurologist for Resident #1 as follows: -Resident #1 went for a Neurologist appointment on 12/1/15 with no medication changes .	C 311		

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C 311	Continued From page 15 -On 12/14/15, facility staff called the Neurologist informing them Resident #1's seizures were worse. -Staff at the Neurologist office on 12/14/15 said Resident #1 may not be on a high enough dose of medication for the seizures and they were sending a dosage change to the pharmacy. Review of laboratory results, dated 12/4/15, revealed the Topamax level was 2.9 with the lab listing normal range as 5.0 to 20.0. Review of physician orders, dated 12/15/15, revealed to discontinue the Topiramate 50 mg in the AM and the 100 mg at bedtime and ordered Topiramate 50 mg twice daily for 1 week, then change to 75 mg twice daily after the 50 mg twice daily was complete. Review of physician orders, dated 12/7/15, revealed to discontinue the Fluphenazine 5 mg every 12 hours and to start Fluphenazine 10 mg at bedtime. Review of Resident #1's e-MARs for November and December, 2015 revealed all medications were documented as administered as ordered. Observation of medications on hand for Resident #1 on 12/30/15 at 12:30pm revealed all medications were on hand and available for administration, and all medication labels matched the current medication orders. Review of the facility's Standard Assessment Forms revealed facility staff had assessed Resident #1 as follows: -Bathing: "Requires extensive assistance due to seizures and history of safety unsteady gait." -Dressing and grooming: Requires assistance	C 311		

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C 311	Continued From page 16 with socks, pants, shoes, buttons -Toileting; Requires assistance to assure clean up after toileting and use of incontinent briefs, incontinent bladder. -Ambulation: Due to seizures history, resident requires assistance with ambulation for gait. -Cognition: due to seizures and TBI, cognitive impairment present -Mood: "When mood unstable and unmanageable, extensive assistance is required to help redirect. -Behavior: When behavior is out of control, extensive assistance needed. -"Resident is struggling with some of the smoking policy as she has no cigarettes. Family wishes for her not to have or buy any. She has no funds to get any. "Continues to dig in ashtrays and burn." -Memory to recall adequate: No -Decision making skills are reasonable and consistent: No -Resident is able to communicate the risks associated with smoking: Yes -Risk of Elopement: Not at risk. Observation of Resident #1 on 12/30/15 at 9:50am revealed she walked independently (with no assistance) and no gait problems noted. Observation of the facility property on 12/30/15 at 9:15am revealed: -Six family care homes (all managed by the same licensee) located adjacent to each other with connecting yards and parking spaces. -All 6 homes within a short walking distance of each other. -All 6 homes in visible sight when standing in the driveway in front of the homes. An attempted telephone call to Resident #1's family member on 1/4/15 at 9:00am was not	C 311		

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C 311	Continued From page 17 successful. The facility provided a Plan of Protection on 12/30/15 as follows: -The Administration will assure that all residents at [Name of facility group] will be safe from harm from staff and other residents. -The Administrator will do daily check-in with staff and residents to make sure that all safety measures are being done to protect all. -The Administration will check all referrals before admitting any residents to [Name of facility group] that has aggressive behaviors to any other staff and residents. -The facility will not tolerate any aggressive behavior and will check daily with staff. -To protect all other residents and staff and because other residents are feeling afraid, Resident #1 will no longer be admitted back to the facility. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 3, 2015.	C 311		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents were free of mental and physical abuse related to agressive and inappropriate behaviors by a resident. The findings are:	C 914		

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C 914	Continued From page 18 Based on observation, interview, and record review, the facility failed to assure every resident was free from mental and physical abuse as related to Resident #1 grabbing other residents' cigarettes and lighters, placing hands on other residents, and frequently requesting cigarettes and lighters from other residents, resulting in at least 4 residents (#4, #5, #6, and #8) expressing fear of Resident #1 and two residents (#9 and #10) who were touched inappropriately by Resident #1. [Refer to Tag 311 10A NCAC 13G .0909 Resident Rights (Type A2 Violation).]	C 914		

Angel House Family Care Homes

PLAN OF CORRECTION: DATE 2/3/2016

In response to rule 10A NCAC 13G .0909 (Resident Rights) In violation, Facility admin. Tried with due diligence to Assist resident #1 with adjusting to the Facility. Admin. Had agreed to admit resident #1 though there was a Questionable history. History did include aggression, Some violent impulsive behavior. Admin. agreed to Give resident #1 a chance at the facility, with the Understanding that certain specific services would Be in place. This was agreed upon with Admin., and The hospitals new Red Phone Team that helps Find placement for difficult patients. There was a gap in Communication between the hospital staff, and the Facility admin. Admin. was not aware that an Assessment from a MHP was to be completed for The resident prior to her being placed with the facility. Admin. followed through with placement as the LME (Smokey Mountain), had called admin. to inform that They were expediting services for the resident with a MHP (Family Preservation) at discharge. The issue

That caused the violation was the services needed
For resident #1 was at a delay, and not enough to
Allow the facility staff to have more help from MHP
During times of aggression as documented. Resident
#1 was having behaviors on a consistent basis. Admin.
Felt as If the MHP was of adequate assistance to the facility
Staff as they were always available when called upon,
As well as admin. being present during these times
Of the behavior, and the behavior was easily defused
Without incident. On the date of follow up visit from
State, 12/30/2015 Admin. with MHP was in the process
Of having resident #1 taken to the hospital as also
Agreed upon when being admitted to facility. As it
Had come to the level that admin. could no longer
Meet resident #1's need. The aggression had slowly
Escalated beginning on 12/28/2015. After being
Taken to the hospital resident did not return to the
Facility. Admin. has staffed with hospital Red Phone
Team to discuss the services that would need to be
In place when referring a patient form their team.
This meeting took place on 1/6/2016. Admin. is
Now going to have a more detailed pre-screening

Process when admitting residents. Admin. will now Have documentation of all services that need to be In place for the resident before placement is made. Admin. will be sure to thoroughly evaluate all Possible residents for admission, for any history Of aggression, violent behaviors. If there is a recent Behavior of such within the past 12months resident Will not be admitted. The behaviors will need to be Stabilized, and controlled to be admitted. There Will also be a plan already in place. This process Will be in place to ensure facility remains in Compliance, and to keep all residents within The facility and other adjacent facilities safe and Free from any type of abuse.

Markey Gray

Markey Gray