

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 05/28/25.	C 000		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations, interviews and and record reviews, the facility failed to ensure activities were provided to promote the residents' involvement and engage the six residents who resided in the facility. The findings are: Interview with a resident on 05/28/25 at 8:52am revealed: -He was not offered activities during the day. -The only time they had activities during the day was for holidays. Interview with a second resident on 05/28/25 at 8:55am revealed: -The only time there was an activity was when there was a holiday. -He stayed busy by walking around outside. Interview with a third resident on 05/28/25 at 9:02am revealed there was not much to do at the facility except when they had a cookout at holidays. Observation made on 05/28/25 at 9:00am	C 288	SEE Attached	

Division of Health Service Regulation

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

TITLE

(X6) DATE

Bruce Gray administrator

6/23/25

STATE FORM

6899

ZYHL11

If continuation sheet 1 of 18

LSB Reviewed and acknowledged
06/23/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANGEL HOUSE 1

**60 D 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 288	Continued From page 1 revealed there was no activity calendar posted in the facility for residents to view. Observations of residents on 05/28/25 from 8:45am-4:00pm revealed activities were not offered to the residents. Interview with the Administrator on 05/28/25 at 2:12pm revealed: -The supervisor in charge (SIC) and medication aides (MAs) were supposed to meet with residents monthly to find out their interests and coordinate activities based on interests. -The staff were trained to provide 14 hours a week of activities. -She was not sure why the activities were not taking place.	C 288	See Attached	
C 291	10A NCAC 13G .0905 (c) Activities Program 10A NCAC 13G .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall	C 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 291	<p>Continued From page 2</p> <p>effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;</p> <p>(5) encourage residents to participate in activities; and</p> <p>(6) assure there are supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to post an updated activity calendar for the 6 residents residing at the facility to have the opportunity to view upcoming activity events.</p> <p>The findings are:</p> <p>Observation made on 05/28/25 at 9:00am revealed there was no activity calendar posted in the facility for residents to view.</p> <p>Observation in the facility office on 05/28/25 at 12:13pm revealed:</p> <ul style="list-style-type: none"> -There was an activity calendar leaning against the wall. -The calendar was dated May 2025. -There was one activity documented on each day of the week but it did not include a start or stop time indicating how long the activity would last. <p>Interview with a medication aide (MA) on 05/28/25 at 2:30pm revealed:</p>	C 291	<p>SEE</p> <p>Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 291	Continued From page 3 -The MAs were responsible for making the calendar. -The calendar should include a total of 14 hours of activities each week. -She did not know why it was in the office and not posted where residents could view it. Interview with the Administrator on 05/28/25 at 2:12pm revealed: -She was not sure why the calendar was in the office and not posted for the residents to see. -She expected the supervisor in charge (SIC) or the MAs to plan 14 hours a week of activities and post the calendar by the 5th day of each month and it should be visible for the residents to see. -The calendar should include start and stop times for each activity.	C 291	SEE Attached	
C 331	10A NCAC 13G .1004(b) Medication Administration 10A NCAC 13G .1004 Medication Administration (b) The facility shall assure that only staff meeting the requirements in Rule .0403 of this Subchapter shall administer medications, including the preparation of medications for administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure Staff A met the requirements to administer medications to the residents. The findings are:	C 331		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 331	<p>Continued From page 4</p> <p>Interview with Staff A upon entry to the facility on 05/28/25 at 8:45am revealed she was not a medication aide (MA).</p> <p>Review of Staff A's employee record revealed: -She was hired 11/24/24 as Supervisor-in-Charge (SIC). -There was documentation she completed her 15-hour medication training on 01/17/25. -There was documentation she completed her medication clinical skills on 01/17/25. -There was no documentation she completed her written medication aide test.</p> <p>Review of Staff B's employee record on 05/28/25 revealed: -She was hired 02/01/16 as a medication aide. -There was documentation she completed her 15-hour medication training on 01/15/15. -There was documentation she completed her medication clinical skills on 01/30/15. -There was documentation she completed her written medication aide test on 01/08/15.</p> <p>Interview with a resident on 05/28/25 at 8:52am revealed Staff A administered medications when she worked.</p> <p>Interview with a second resident on 05/28/25 at 8:55am revealed Staff A administered medications when she worked.</p> <p>Interview with a third resident on 05/28/25 at 9:02am and 10:24am revealed: -Staff A started administering medications to him about four weeks ago. -There was another SIC on campus who worked with Staff A for about a week when she first started but since then Staff A administered medications by herself when she worked.</p>	C 331	<p>SEE</p> <p>Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 331	<p>Continued From page 5</p> <p>Interview with a fourth resident on 05/28/25 at 9:12am revealed Staff A administered medications when she worked.</p> <p>Interview with a fifth resident on 05/28/25 at 9:15am revealed Staff A administered medications when she worked.</p> <p>Interview with Staff A on 05/28/25 at 8:45am and 1:58pm revealed:</p> <ul style="list-style-type: none"> -She was a SIC but she was not a MA. -She took the medication aide class but did not take the medication aide written exam. -Since she did not take the medication aide written examination within 60 days of taking the class she no longer had a log-in to document on the electronic medication administration record (eMAR). -Staff B pre-poured medications and left them in the medication cart for her to administer. -When medications needed to be administered she used the pre-poured cups that had been left in the medication cart and then called Staff B who then documented administration. -Staff B had the ability to sign the eMAR remotely from the sister facility she was assigned to. -She knew this was not the correct way to administer medications. <p>Interview with Staff B on 05/28/25 at 2:06pm revealed:</p> <ul style="list-style-type: none"> -She was a MA and a SIC in a sister facility. -She knew Staff A was not a MA. -She pre-poured medications and left them in the medication cart so Staff A could administer the medications while she was administering medications in her own facility. -Staff A called her after medications were administered and she signed into the eMAR 	C 331	<p>SEE Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 331	Continued From page 6 system and documented she administered the medications. -She was not trained to administered medications in that manner and knew staff who were not MAs should not administer medications. -She had not informed the Administrator she pre-poured medications for Staff A to administer and she signed the eMAR remotely from her assigned facility to document her initials as the MA who administered medications. Interview with the Administrator on 05/28/25 at 2:12pm revealed: -Staff A completed her MA training in February 2025, but did not take the written medication aide exam. -Since Staff A did not pass the exam within 60 days of her training and she was removed from administering medications and should not have been administering any medications. -She did not know Staff B, who was also a MA, pre-poured medications for Staff A to administer. -Staff B was not trained to administer medications in that manner.	C 331	SEE Attached		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	C 341			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	<p>Continued From page 7</p> <p>This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure medications were recorded by the staff person who administered the medications for 3 of 3 sampled residents (#1, #2, and #3).</p> <p>The findings are:</p> <p>Interview with Supervisor-in-Charge (SIC) on 05/28/25 at 8:45am revealed she was the SIC at the facility but not a MA.</p> <p>Interview with 5 residents on 05/28/25 during initial tour revealed the SIC who was working that morning administered medications when she worked.</p> <p>Interview with the SIC on 05/28/25 at 1:58pm revealed:</p> <ul style="list-style-type: none"> -She was the SIC assigned to the building but she was not a MA. -She administered medications to residents but did not document in the electronic medication administration record (eMAR) system because she was not a MA. -A Senior SIC, who was assigned to a sister facility, and was also a MA, documented administration of medications. -She did not have a log-in for the eMAR since she did not take the written medication aide exam within 60 days of the training. -A Senior SIC had the ability to sign the eMAR remotely from the sister facility she worked at. -She knew she was not supposed to document medication administration in that manner. 	C 341	<p>SEE</p> <p>Attached</p>		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANGEL HOUSE 1

**60 D 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 341	<p>Continued From page 8</p> <p>Review of the SIC's schedule revealed she was scheduled to work on 04/30/25 from 2:00pm through 05/09/25 at 2:00pm and 05/12/25 at 2:00pm through 05/28/25.</p> <p>Interview with the Senior SIC on 05/28/25 at 2:06pm revealed:</p> <ul style="list-style-type: none"> -She was a MA and a SIC in a sister facility. -The SIC assigned to the building administered medications but she did not document she administered them on the eMAR. -She knew the SIC was not a MA and not supposed to administer medications. -She did not administer medications in the facility when the SIC was working but she did document in the eMAR that the medications were administered. -She knew the person who administered medications was supposed to be the person who documented the administration in the eMAR. -She had not informed the Administrator she signed in remotely from her assigned facility to document she administered medications in this facility. <p>1. Review of Resident #1's current FL2 dated 01/16/25 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included schizoaffective disorder, substance use disorder, diabetes, and generalized anxiety disorder. -There was an order for chlorhexidine (used to clean wounds, treat gum disease, and prevent dental plaque) 0.12% twice daily. -There was an order for clonazepam (used to treat panic disorders) 0.5mg twice daily. -There was an order for clozapine (used to treat schizophrenia) 100mg take 2 tablets daily. -There was an order for clozapine 25mg take nine tablets at bedtime. -There was an order for gabapentin (used to treat 	C 341	<p>SEE Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	Continued From page 9 nerve pain) 100mg three times daily. -There was an order for glimepiride (used to treat high blood sugar levels caused by type 2 diabetes) 2 mg daily. -There was an order for lamotrigine (used to treat bipolar disorder) 200mg daily. -There was an order for losartan (used to treat high blood pressure) 25mg one tablet every 12 hours. -There was an order for mag oxide (treating low magnesium levels in the body) 400mg daily. -There was an order for metformin (used to treat type 2 diabetes) 500mg twice daily. -There was an order for potassium ER (used to treat low potassium levels in the blood) 10 meq three times daily. -There was an order for pravastatin (used to treat cholesterol and triglycerides in the blood) 20mg one tablet at bedtime. -There was an order for propranolol (used to treat neurological conditions) 10mg take ½ tablet three times a day. -There was an order for sertraline (used to treat mental health conditions) 100mg take one tablet every morning. -There was an order for acetaminophen (used to treat pain) 325mg take two tablets every 6 hours as needed. -There was an order for albuterol HFA (used to treat difficulty breathing, wheezing, chest tightness, and coughing caused by lung disease such as asthma) 90mcg inhale two puffs every 6 hours as needed. -There was an order for APAP EX-STR (used to treat pain) 500mg two tablets every 8 hours as needed. -There was an order for diphenhydramine (used to treat allergies) 25 mg one tablet every 6 hours as needed. -There was an order for haloperidol (used to treat	C 341	SEE Attached	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ANGEL HOUSE 1

**60 D 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 341	<p>Continued From page 10</p> <p>nervous, emotional and mental conditions) 0.5mg daily as needed.</p> <p>-There was an order for haloperidol 2mg daily as needed.</p> <p>-There was an order for ibuprofen (used to treat pain and reduce inflammation) 200mg three tablets every 6 hours as needed.</p> <p>-There was an order for nicotine lozenges (used to help people stop smoking by alleviating cravings) 4 mg one lozenge every 2 hours as needed.</p> <p>-There was an order for trihexyphenidyl (used to treat dystonia, muscle spasms and contractions) 2 mg take one tablet as directed, take ½ tablet everyday for 2 days, then one tablet daily.</p> <p>Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for clonazepam 0.5mg one tablet three times daily with a scheduled administration time of 8:00am, 12:00pm, and 8:00pm.</p> <p>-There was an entry for clozapine 25mg nine tablets at bedtime with a scheduled administration time at 8:00pm.</p> <p>-There was an entry for gabapentin 100mg take three times daily with a scheduled administration time of 8:00am, 12:00pm, and 8:00pm.</p> <p>-There was an entry for gabapentin 300mg take three time daily with a scheduled administration time of 8:00am, 12:00pm, and 8:00pm.</p> <p>-There was an entry for losartan 25mg twice daily with a scheduled administration time of 8:00am and 8:00pm.</p> <p>-There was an entry for metformin 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm.</p> <p>-There was an entry for potassium ER 10meq three times daily with a scheduled administration</p>	C 341	<p>SEE</p> <p>Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	<p>Continued From page 11</p> <p>time of 8:00am, 12:00pm and 8:00pm.</p> <p>-There was an entry for pravastatin 20mg one at bedtime with a scheduled administration time of 8:00pm.</p> <p>-There was an entry for propranolol 10mg one tablet three times daily with a scheduled administration time of 8:00am, 12:00pm, and 8:00pm.</p> <p>-There was an entry for haloperidol 0.5mg take one daily as needed with a scheduled administration time as needed.</p> <p>-There was an entry for haloperidol 2mg take one as needed with a scheduled administration time as needed.</p> <p>-There was documentation the Senior SIC administered medications on 04/30/25 at 8:00pm when the SIC was working.</p> <p>-There was no documentation the SIC administered medications when she worked on 04/30/25 at 8:00pm.</p> <p>Review of Resident #1's May 2025 eMAR from 05/12/25-05/28/25 revealed:</p> <p>-There was an entry for chlorhexidine 0.12% rinse swish and spit 20ml twice daily with a scheduled administration time as 9:00am and 8:00pm.</p> <p>-There was an entry for clonazepam 0.5mg three times daily with a scheduled administration time as 9:00am, 12:00pm and 8:00pm.</p> <p>-There was an entry for clonazepam 100mg every morning scheduled administration time as 8:00am.</p> <p>-There was an entry for clozapine 25mg at bedtime scheduled administration time as 8:00pm.</p> <p>-There was an entry for gabapentin 100mg three times daily with a scheduled administration time as 8:00am, 12:00pm and 8:00pm.</p> <p>-There was an entry for glimepiride 2mg daily scheduled administration time as 8:00am.</p>	C 341	<p>SEE</p> <p>Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	<p>Continued From page 12</p> <ul style="list-style-type: none"> -There was an entry for lamotrigine 200mg daily scheduled administration time as 8:00am. -There was an entry for losartan 25mg twice daily scheduled administration time as 8:00am and 8:00pm. -There was an entry for mag oxide 400mg take daily with administration time at 8:00am. -There was an entry for metformin 500mg twice daily scheduled administration time as 8:00am and 8:00pm. -There was an entry for potassium ER 10 meq three times daily with a scheduled administration time as 8:00am, 12:00pm and 8:00pm. -There was an entry pravastatin 20mg take daily with administration time at 8:00am. -There was an entry for propranolol 10mg take ½ tablet three times daily with administration time of 8:00am, 12:00pm, and 8:00pm. -There was an entry sertraline 100mg take daily with administration time at 8:00am. -There was an entry trihexyphenidyl 2mg take daily with administration time at 8:00am. -There was an entry for haloperidol 0.5mg take everyday as needed with an administration time as needed. -There was an entry for haloperidol 2mg take every day as needed with an administration time as needed. -There was documentation the Senior SIC administered medications when the SIC was working. -There was no documentation the SIC administered medications when she worked in May 2025. <p>Refer to interview with the Administrator on 05/28/25 at 2:12pm.</p> <p>2. Review of Resident #2's current FL2 dated 06/04/24 revealed diagnoses included</p>	C 341	<p>SEE Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	<p>Continued From page 13</p> <p>schizophrenia, anxiety, hypertension and irritable bowel syndrome.</p> <p>Review of Resident #2's physician's orders revealed:</p> <ul style="list-style-type: none"> -There was an order dated 11/07/24 for aripiprazole (used to treat) 2.5mg daily. -There was an order dated 02/13/25 for lorazepam (used to treat anxiety) 1mg at bedtime . -There was an order dated 06/04/24 for risedronate sodium (used to treat) 35mg every other week. -There was an order dated 06/04/24 for tamsulosin (used to treat urinary retention) 0.4mg every evening. -There was an order dated 10/29/24 for Vitamin D2 (used to treat low calcium levels) 1.25mg every 2 weeks. -There was an order dated 06/04/24 for Tylenol (used to treat fever and pain) 500mg, 2 tablets every 8 hours as needed. -There was an order dated 06/04/24 for lorazepam (used to treat anxiety) 0.5mg daily as needed . -There was an order dated 06/04/24 for Miralax (used to treat constipation) 17g daily as needed. -There was an order dated 05/27/25 for fluticasone (used to treat seasonal allergies) 50mcg spray to each nostril every 12 hours as needed. <p>Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for aripiprazole 2.5mg daily at 8:00am. -There was an entry for lorazepam 1mg at 8:00pm. -There was an entry for risedronate sodium 35mg 	C 341	<p>SEE Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	<p>Continued From page 14</p> <p>every other week at 8:00am.</p> <p>-There was an entry for tamsulosin 0.4mg every evening.</p> <p>-There was an entry for vitamin D2 1.25mg every 2 weeks at 8:00am.</p> <p>-There was an entry for tylenol 500mg, 2 tablets every 8 hours as needed.</p> <p>-There was an entry for lorazepam 0.5mg daily as needed.</p> <p>-There was an entry for miralax 17g daily as needed.</p> <p>-There was documentation the Senior SIC administered medications on 04/30/25 at 8:00pm.</p> <p>-There was no documentation the SIC administered medications on 04/30/25 at 8:00pm.</p> <p>Review of Resident #2's May 2025 eMAR revealed:</p> <p>-There was an entry for aripiprazole 2.5mg daily at 8:00am.</p> <p>-There was an entry for lorazepam 1mg at 8:00pm.</p> <p>-There was an entry for risedronate sodium 35mg every other week at 8:00am.</p> <p>-There was an entry for tamsulosin 0.4mg every evening.</p> <p>-There was an entry for vitamin D2 1.25mg every 2 weeks at 8:00am.</p> <p>-There was an entry for Tylenol 500mg, 2 tablets every 8 hours as needed.</p> <p>-There was an entry for lorazepam 0.5mg daily as needed.</p> <p>-There was an entry for Miralax 17g daily as needed.</p> <p>-There was an entry for fluticasone 50mcg spray to each nostril every 12 hours as needed.</p> <p>-There was documentation the Senior SIC administered medications when the SIC was working.</p> <p>-There was no documentation the SIC</p>	C 341	<p>SEE</p> <p>Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	<p>Continued From page 15</p> <p>administered medications when she worked in May 2025.</p> <p>Refer to interview with the Administrator on 05/28/25 at 2:12pm.</p> <p>3. Review of Resident #3's current FL2 dated 11/26/24 revealed diagnoses included schizophrenia and bipolar disorder.</p> <p>Review of Resident #3's physician's orders revealed:</p> <ul style="list-style-type: none"> -There was an order dated 11/26/24 for Invega (used to treat schizophrenia), 156mg/ml, inject 1ml monthly by home health. -There was an order dated 11/26/24 for lithium carbonate (used to treat bipolar disorder), 300mg, 2 tablets twice daily. -There was an order dated 01/28/25 for nicotine lozenges (used to treat nicotine dependency), 2 mg lozenge every 2 hours as needed. -There was an order dated 03/13/25 for triple antibiotic ointment (a topical skin ointment), apply 3 times daily. -There was an order dated 03/13/25 for seroquel (used to treat insomnia), 50mg at bedtime as needed. -There was an order dated 05/14/25 for Tylenol (used to treat pain), 500mg, 2 tablets every 8 hours as needed. <p>Review of Resident #3's April 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for lithium ER 300mg, 2 tablets at 8:00am and 8:00pm. -There was an entry for triple antibiotic ointment, apply to affected area at 8:00am 12:00pm and 8:00pm. -There was documentation the Senior SIC 	C 341	<p>SEE Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	<p>Continued From page 16</p> <p>administered medications on 04/30/25 at 8:00pm. -There was no documentation the SIC administered medications on 04/30/25 at 8:00pm.</p> <p>Review of Resident #3's May 2025 eMAR revealed:</p> <p>-There was an entry for Invega, 156mg/ml, inject 1ml monthly.</p> <p>-There was documentation the Senior SIC observed a home health nurse administer invega on 05/22/25.</p> <p>-There was an entry for lithium ER 300mg, 2 tablets at 8:00am and 8:00pm.</p> <p>-There was documentation the Senior SIC administered lithium ER on 05/01/25 through 05/08/25, at 8:00am on 05/09/25, at 8:00pm on 05/12/25 and on 05/13/25 through 05/28/25.</p> <p>-There was an entry for triple antibiotic ointment, apply to affected area at 8:00am 12:00pm and 8:00pm.</p> <p>-There was documentation the Senior SIC administered triple antibiotic ointment on 05/01/25 through 05/08/25, at 8:00am on 05/09/25, at 8:00pm on 05/12/25 and on 05/13/25 through 05/28/25.</p> <p>-There was an entry for nicotine lozenges 2 mg, 1 lozenge every 2 hours as needed.</p> <p>-There was documentation the Senior SIC administered the nicotine lozenge on 05/04/25, 05/14/25, 05/16/25, 05/17/25, 05/19/25 and 05/26/25.</p> <p>-There was an entry for seroquel, 50mg at bedtime as needed.</p> <p>-There was documentation the Senior SIC administered seroquel on 05/14/25 and 05/16/25.</p> <p>-There was an entry for Tylenol 500mg, 2 tablets every 8 hours as needed.</p> <p>-There was documentation the Senior SIC administered tylenol on 05/14/25 through 05/16/25 and 05/19/25 through 05/21/25.</p>	C 341	<p>SEE Attached</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE 1			STREET ADDRESS, CITY, STATE, ZIP CODE 60 D 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 341	<p>Continued From page 17</p> <p>-There was no documentation the SIC administered medications when she worked in May 2025.</p> <p>Refer to interview with the Administrator on 05/28/25 at 2:12pm.</p> <p>Interview with the Administrator on 05/28/25 at 2:12pm revealed:</p> <p>-The Senior SIC was supposed to be administering medications in the facility.</p> <p>-She did not know the Senior SIC was documenting administration of medications but Staff A was actually the one administering the medications.</p> <p>-The Senior SIC and the SIC were trained the proper way to document and she did not know why they were doing it wrong.</p>	C 341	<p>SEE Attached</p>		



Angel House Family Care Homes

Angel House D1

In response to rule 10A NCAC 13G. 1004 Medication Administration

1. Administrator will ensure that Staff B has training in medication administration in addition to the annual six CEUs in medication. This will be completed by date June 28, 2025, through our online training system that is utilized for our facility. Staff A is no longer employed by Angel House. Administration will monitor medication administration weekly and document each check-in for six months to ensure staff are abiding by proper medication administration to maintain compliance. Administration will also ensure all staff are aware of rule area on medication administration by providing a posted document beside the medication cart. Administration always ensures that qualified Med Aides are on duty and administering medications during the interim of staff that are past their sixty-day window to train on passing medications and are awaiting to take their medication aide exam.

In response to rule 10A NCAC 13G. 0905(a) Activities Program

2. Administrator will provide assistance along with hands-on training to staff monthly according to the activities posted for residents. Staff will conduct monthly house meetings to receive input from residents regarding what activities they would like to participate in. This will be considered a social activity. Administration will ensure staff complete activity assessments and will provide hands-on assistance for three months (with weekly documentation) to ensure staff are aware of state regulations and rules in the area of activities. Administration will ensure staff complete the activities calendar to be in compliance of facility policy no later than the fifth day of the month for six months to maintain compliance.