Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | | | | | | | |
|---|---|---|--|-------------------------------|--|-------------|--|--|--|--|--|--|
| | | FCL011264 | B. WING | | 01/2 | R 4/2024 | | | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET ADI | DRESS. CITY. S | STATE, ZIP CODE | · | - | | | | | | |
| 60-B HORNOT CIRCLE | | | | | | | | | | | | |
| ANGEL HOUSE IV 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 | (EACH CORRECTIVE ACTION SHOUL | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | | | | |
| {C 000} | Initial Comments | | {C 000} | | | | | | | | | |
| | Report by Kelly Myers | | | | | | | | | | | |
| | Follow-up Survey of PM to 2:55 PM at the time of the survey corrected therefore NOTES: 1.) At the time of out that require an accedeficiencies listed w staff during the exit previous deficiencies from an open bienn were brought forward.) Take actions to conce completed process. | a Section conducted a Biennial in January24, 2024 from 2:40 ne above referenced facility. At ey not all deficiencies were further action is required. It visit, we cited deficiencies eptable plan of correction. All were discussed with onsite interview. There were est hat were not closed out ial survey, these deficiencies rd from previous survey. Correct all listed deficiencies, ovide verification in the form of voices, etc. for all work | | | | | | | | | | |
| | The cited deficienci | es are as follows: | | | | | | | | | | |
| {C 169} | Fire Safety-Smoke | Detectors | {C 169} | | | | | | | | | |
| | DISASTER PLAN (b) The building shadetectors as require Building Code and I connected to a dedi located in the attic a detectors shall be in provided with batter Note: Smoke detectinterconnected by the | nall be provided with smoke ed by the North Carolina State U.L. listed heat detectors icated sounding device and basement. These oterconnected and be | | | | | | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 | | (X3) DATE SURVEY COMPLETED | | | | | | | |
|--|---|--|--|--|-------------------------------|--------------------------|--|--|--|--|--|--|
| | | | | | F | | | | | | | |
| | FCL011264 | | B. WING | | 01/24/2024 | | | | | | | |
| 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 | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | | | | | | |
| {C 169} | Continued From page 1 | | {C 169} | | | | | | | | | |
| | interconnected with not require it. | smoke detectors, but does | | | | | | | | | | |
| | the egress hallway interconnected. Thi for routine interior n necessary steps to hallway smoke dete *This deficiency | e survey it was observed that smoke detectors were not s is not compliant with the rule naintenance. Take the interconnect the egress ectors. y was previously cited during biennial survey, take action to | | | | | | | | | | |

Division of Health Service Regulation STATE FORM