

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011295	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2018
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE VII		STREET ADDRESS, CITY, STATE, ZIP CODE 60-C 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 Report by Greg Williams DHSR Construction Section conducted a Biennial Survey on March 13, 2013 from 3:30 PM to 4:30 PM at the above referenced facility. DHSR records indicate the home was first licensed on April 6, 1994 as a Family Care Home for six Residents where no more than three are non-ambulatory (who are unable to evacuate and respond without any physical or verbal assistance during a fire or other emergency) Based on this information, we are requiring the home to maintain compliance with the following; the 1992 "Rules for Family Care Homes Minimum Standards and Regulations" and the applicable portions of the 2005 Rules 10A NCAC 13G for Family Care Homes and the 1991 Edition of the North Carolina State Building Code - Section 514.2 Residential Care Facilities. 1.) At the time of our visit, we cited deficiencies that require an acceptable plan of correction. All deficiencies listed were discussed with on -site staff during the exit interview. 2.) Take actions to correct all listed deficiencies, once completed provide verification in the form of photos, receipts, invoices, etc. for all work performed.	C 000		
C 117	Have Current San. And Fire Safety Approvals SECTION .0300 - THE BUILDING 10A NCAC 13G .0302 DESIGN AND CONSTRUCTION (n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review.	C 117		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL011295	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2018
NAME OF PROVIDER OR SUPPLIER ANGEL HOUSE VII		STREET ADDRESS, CITY, STATE, ZIP CODE 60-C 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 117	Continued From page 1 This Rule is not met as evidenced by: 1.) At the time of the survey there was not a copy of the latest Sanitation and Fire Inspection report at the facility. Provide a copy of the Inspection reports. This is not compliant with the rule.	C 117		
C 135	Bathroom-Hand Grips SECTION .0300 - THE BUILDING 10A NCAC 13G .0309 BATHROOM (e) Hand grips shall be installed at all commodes, tubs and showers used by the residents. This Rule is not met as evidenced by: 1.) At the time of the survey it was observed that the toilets in the residents bathrooms did not have hand grips at the toilets. This is not compliant with the rule.	C 135		