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
	FCL011269	A. BUILDING: _____ B. WING _____	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGEL HOUSE 6	60 F 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 the Buncombe County Department of Social Services conducted an annual survey on 05/29/25.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to ensure referral and follow-up for 1 of 3 sampled residents (#2) related to a CT scan, (computerized tomography; a type of imaging that uses X-ray techniques to create detailed images of the body), a urology follow-up and a cardiac event. The findings are: Review of Resident #2's current FL2 dated 05/31/24 revealed diagnoses included hypertension, diabetes and hearing impairment. a. Review of Resident #2's facility generated "consultation report" dated 03/28/25 revealed: -It was signed by his urologist (physician specializing in the urinary tract). -There was an order for a CT of his chest, abdomen and pelvis due to his history of renal cell cancer. -There was an order for a follow-up appointment after the CT was completed. -There was documentation the new order was noted by the Supervisor-in-charge (SIC) on	C 246	See Attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Bianka Gray | administrator | 6/23/25

AS Reviewed and Acknowledged 06/30/2025

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C 246	Continued From page 1 03/28/25. Review of Resident #2's record revealed: -There was no documentation the CT was completed. -There was no documentation of a follow-up appointment since 03/28/25 with the urologist. Interviews with the facility Site Manager on 05/29/25 at 10:42am and 1:41pm revealed: -She did not think the CT and follow-up appointment was completed. -The SIC was responsible for scheduling appoinments but there was a lot of turnover in staff in the past few months and she was not sure why the SIC did not schedule the CT and the follow-up. -She was responsible for conducting chart reviews but had not had time to do them recently because the facility was short staffed. -If she had time to review the charts she would have noticed the CT was not scheduled. Telephone interview with Resident #2's hearing interpreter on 05/29/25 at 2:45pm revealed: -She took Resident #2 to most of his medical appointments. -She did not think Resident #2 had a CT. Interview with the Administrator on 05/29/25 at 3:05pm revealed: -Resident #2 was diagnosed with kidney cancer in 2024 but she was not aware the urologist ordered a CT for follow-up. -The SIC was responsible for scheduling the CT and follow-up appoinments and she did not know why it was not completed. -Staff turnover resulted in missed appointments. Attempted telephone interview with Resident #2's	C 246	See Attached	

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C 246	Continued From page 2 urologist on 05/29/25 at 1:26pm was unsuccessful. b. Review of Resident #2's facility generated "consultation report" dated 12/11/24 revealed: -It was completed by his hearing interpreter. -There was a recommendation to have a check-up with a cardiologist due to irregular heart rate and dizzy spells. -There was documentation the consultation report was noted by the Supervisor-in-charge (SIC) on 12/11/24. Telephone interview with Resident #2's hearing interpreter on 05/29/25 at 2:45pm revealed: -She took Resident #2 to his medical appointments. -She took Resident #2 to church in December 2024 and while he was there she had to call 911 because he was "dizzy and his heart was going in and out of rhythm". -The emergency medical technicians that responded to the 911 call said it was not necessary to transport him to the hospital but recommended he see a cardiologist. -She informed the facility of the episode when she brought Resident #2 back to the facility and then completed the consultation form. -He was never seen by a cardiologist that she was aware of. Interviews with the facility's Site Manager on 05/29/25 at 10:42am and 1:41pm revealed: -She did not think the primary care provider (PCP) was informed about the EMS event. -The SIC was responsible for scheduling appoinments but there was a lot of turnover in staff in the past few months and she was not sure why the SIC did not schedule the appointment. -She was responsible for conducting chart	C 246	See Attached	

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C 246	Continued From page 3 reviews but had not had time to do them recently because the facility was short staffed. -If she had time to review the charts she would have noticed the note from the hearing interpreter. Interview with the Administrator on 05/29/25 at 3:05pm revealed: -The SIC was responsible for informing the PCP about the EMS event and recommendation for a cardiology evaluation and she did not know why it was not completed. -Staff turnover resulted in missed appointments. The facility failed to schedule a CT scan of the chest, abdomen and pelvis and schedule a follow-up appointment with urology for Resident #2 who had a history of renal cancer and failed to inform the PCP that 911 was called due to Resident #2 being dizzy and having an irregular heart rate. This failure was detrimental to Resident #2's health and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/25 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 13, 2025.	C 246	See Attached	
C 292	10A NCAC 13G .0905 (d) Activities Program 10A NCAC 13G .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative	C 292		

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C 292	Continued From page 4 expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on interviews and observations, the facility failed to ensure a minimum of 14 hours of planned group activities were planned each week that promoted socialization, physical interactions, group accomplishment, creative expression, increased knowledge, and learning new skills for the 4 residents living in the facility. The findings are: Observation of the activities calendar posted in the hallway on 05/29/25 at 9:30am revealed: -One activity was listed daily. -There were no beginning times or completion times. -On 05/03/25, the activity listed was "Barber." -On 05/10/25, the activity listed was "Nail Care." -On 05/17/25, the activity listed was "Oral Care." Interview with a resident on 05/29/25 at 9:09am revealed: -He was not sure how long the activities lasted each day. -He did not engage in activities much because he chose not to. Interview with the Administrator on 05/29/25 at 3:38pm revealed: -She did not realize the calendar did not have beginning times or completion times. -The supervisor in charge (SIC) and medication aides (MAs) were trained to make sure 14 hours a week of activities were completed.	C 292	SEE Attached	

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C 292	Continued From page 5 -She expected the calendars to be completed each month by the 5th day and expected the calendar to have beginning and completion times. -She was not sure why the calendar did not have beginning times or completion times. -The SICs and MAs were supposed to meet monthly with residents to find out their interests and make the monthly schedule accordingly. -She was not aware activities such as "barber", "nail care", and "oral care" were listed on the calendar and knew those activities would not enhance social, emotional, physical, and psychological functioning. -The SIC or MAs were responsible for completing the monthly calendars.	C 292	See Attached	

Angel House Family Care Homes

Angel House F6

In response to rule 10A NCAC 13G. 0902(b) Health Care

1. As stated in the plan-of-protection, facility administrator has revised the policy on the steps for staff to follow when residents have follow-up care instructions from medical providers as well as any referrals made for resident. All follow-up care plans/ referrals are to be faxed to the facility's main fax number. Staff are to also report this has been completed to administration that faxes are completed and document in residents' chart. This is to be documented in the interdisciplinary notes section of residents' chart. Administration will review faxed documents and assist staff with ensuring this is completed correctly. Administration will ensure that training for staff in this rule area is completed annually with documented proof of completion as well as the understanding of resident health care. Administration will complete weekly check-ins for six months to ensure to be within compliance. On June 1st 2025 resident 2 went to the hospital after having a incident at church, and with what the hospital found was the issue, facility had to send resident to a higher level of care. So resident no longer resides at the facility as of June 1st 2025.

Per telephone interview on 6/30/25 @ 2:11pm, the POC date is 06/01/25. Per telephone interview with Bianka Gray, Administrator.

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

1. 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. The activity calendar was posted with corrections on 5/30/2025.

Per telephone interview with Bianca Gray, Administrator on 6/30/25 at 2:11pm, the POC date is 05/30/25.