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BROOKDALE ASHEVILLE OVERLOOK	308 OVERLOOK ROAD ASHEVILLE, NC 28803

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D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual survey and a follow-up survey on February 1-3, 2017.	D 000		
D 206	10A NCAC 13F .0604 (2--b) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staff The following describes the nature of the aide's duties, including allowances and limitations: (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure housekeeping performed by aides on second shift before 9:00pm was limited to occasional, non-routine tasks. The findings are: Interview with the business office manager on 2/3/16 at 3:45pm revealed a census of 45 from 1/22/17 through 1/28/17 and a census of 44 on 1/29/17. Review of the staffing schedule for the week of 1/22/17 through 1/29/17 revealed: -One supervisor/medication aide, 1 medication aide, and 1 personal care aide had beenroutinely	D 206		

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D 206	Continued From page 1 scheduled for second shift. -No staff was designated for laundry duty. Review of time sheets for second shift from 1/22/16 through 1/29/16 revealed the facility did not have above minimum personal care staffing to justify the personal care staff performing housekeeping duties. Review of the second shift assignment sheets for the medication aide and the personal care aide revealed their tasks included laundry and clearing the dining room. Confidential interviews with four staff revealed: -Personal care aides on first and second shift were responsible for washing, drying, folding, and distributing all resident clothing for those residents on their shower schedule which varied from 3 to 5 per personal care aide per shift. -Personal care aides on first and second shift were responsible for washing, drying, folding, and storing all linen, towels and wash cloths for residents who were on their shower schedule. -Personal care aides on first and second shift were responsible for washing, drying, and folding the table cloths. -After the meals, the medication aides and the personal care aides took dirty dishes, beverage containers, and flatware to the kitchen, and cleaned the tables. -The personal care aides sometimes swept the dining room floor. -The personal care aides assured all trash was out of the resident rooms and bathrooms at end of shifts. -The personal care aides cleaned any incidental areas during their shifts. -"Too much for 1 personal care aide." -They "do not have enough personal care aides	D 206		

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D 206	Continued From page 2 on second shift." -Forty four residents were too many residents for one personal care aide on the second shift. -The personal care aides did laundry, "not the medication aide." -"Facility needs more staff." -"Staff is very pressured." -"On Saturday's they are very short of staff." -"Facility needs more help." Interview with the Business Office Manager on 2/3/16 at 3:45pm revealed: -They did not have a designated laundry person. -They had one food service staff from 5:30am to 11:00am and one from 2:00pm to 7:00pm. Confidential interview with two dietary staff revealed: -They had one food service staff on duty from 5:30am to 11:00am and from 2:00pm to 7:00pm. -They had two food service staff on duty from 11:00am to 2:00pm. -The food service director was the second staff in the kitchen from 11:00am to 2:00pm but he was responsible for ordering food and the total food service operation. -With the limited staffing allowed for dietary, dietary staff did not have time to set and clear the tables. Telephone interview with the Administrator on 2/3/17 at revealed their staff were considered "universal workers" and therefore worked in the dining room and anywhere as needed.	D 206		
D 209	10A NCAC 13F .0604 (2-e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care Other	D 209		

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D 209	Continued From page 3 Staffing The following describes the nature of the aide's duties, including allowances and limitations (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure personal care staff food service duties were limited to assisting residents with eating and carrying plates and beverages to the residents. The findings are: Interview with the business office manager on 2/3/16 at 3:45pm revealed a census of 45 from 1/22/17 through 1/28/17 and a census of 44 on 1/29/17. Review of the assignment sheet for the second shift medication aide and the personal care aide revealed theirs tasks included setting up the dining room, serving, and clearing the dining room. Review of time sheets for second shift from 1/22/16 through 1/29/16 revealed the facility did not have above minimum personal care staff to justify the personal care staff performing food service duties. Confidential interviews with four staff revealed: -"Too much for 1 personal care aide."	D 209		

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D 209	Continued From page 4 -They "do not have enough personal care aides on second shift." -Personal care staff prepare the dining room tables for the each meal by placing tablecloths, glasses, and silverware on the tables. -After each meal, the personal care staff take dirty dishes, beverage containers, and flatware to the kitchen, and clean the tables. -"Facility needs more staff." -Staff are sometimes too busy to give medication. -"Staff is very pressured." -"On Saturday's they are very short of staff." -"At 5:30 care staff have to help out in the dining room." -"Facility needs more help." Confidential interviews with two dietary staff revealed: -They had one food service staff scheduled from 5:30 to 11:00am and from 2:00 to 7:00pm. -They had two food service staff scheduled from 11:00am to 2:00pm. -The food service director was the second staff in the kitchen from 11:00am to 2:00pm but he had the responsibility for ordering food and the total food service operation. -With the limited dietary staffing, dietary staff did not have time to set up the dining room with table cloths, beverage glasses, napkins, and flatware, and did not have time to clear the tables and clean the dining room after each meal. Interview with the Business Office Manager on 2/3/16 at 3:45pm revealed they had one food service staff from 5:30am to 11:00am and one from 2:00pm to 7:00pm. Telephone interview with the Administrator on 2/3/17 revealed their staff are considered "universal workers" and therefore work in the	D 209		

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D 209	Continued From page 5 dining room and anywhere as needed.	D 209		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .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: Based on interviews and record reviews, the facility failed to assure referral and follow-up for 2 of 5 residents sampled related to a recommendation for a urology appointment (Resident #1) and for elevated blood pressures (Resident #3). The findings are: A. Review of Resident #1's current FL2 dated 12/23/16 revealed diagnosis was pneumonia. Review of Resident #1's previous FL2 dated 4/1/16 revealed additional diagnoses included congestive heart failure, coronary artery disease, and anemia. Review of an emergency room (ER) report dated 10/26/16 revealed: -"Diagnoisis: Bilateral renal masses, diarrhea." -"Specific ED discharge instructions: You have cysts on both of your kidneys. You have as 9.2 cm lesion on your left kidney. We don't know if this a cyst or some other tumor. Please follow up with urology (see below). Please give this to your doctor. Perhaps they can consider weaning you off of your Benzodiazepines to minimize possible	D 273		

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withdrawal symptoms."
-Radiology completed CT (computerized tomography) abdominal/pelvis with contrast.

Review of Resident #1's record revealed no documentation of the referral for an appointment with the urologist.

Interview with the health and wellness director on 2/4/16 at revealed:
-She did not know who filed the ER report in the resident record, but she was not aware of the urology referral before the survey.
-Sometimes Resident #1 received medical documents and did not share the information with staff.
-Sometimes staff had found medical documents in Resident #1's room and requested his permission to file them in his medical record.
-After surveyor asked about the referral, the health and wellness director contacted Resident #1's primary care physician on 2/3/16 for a urologist referral order and made the appointment for 2/22/17.

Interview with Resident #1 on 2/4/16 at 11:15am revealed there was nothing wrong with his kidneys.

Attempted telephone interview to Resident #1's primary care physician on 2/3/17 at 3:13pm was not successful.

B. Review of Resident #3's FL2 dated 5/21/16 revealed:
-Diagnoses included hypertension.
-Medications included Hydrochlorothiazide (a fluid pill) and Cozaar (for high blood pressure).
-An order to check blood pressures daily.

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D 273	Continued From page 7 Review of Resident #3's Resident Register revealed an admission date of 11/28/2013. Review of physician orders dated 1/09/17 for Resident #3 revealed order to check blood pressure every day and to call the physician if over 150/95 or below 100/50. Review of Resident #3's Blood Pressure Monitoring Form for January 2017 revealed: -On 1/1/2017, a blood pressure reading of 152/60. -On 1/2/2017, a blood pressure reading of 158/62. -On 1/5/2017, a blood pressure reading of 162/58. -On 1/11/2017, a blood pressure reading of 158/70. -On 1/12/2017, a blood pressure reading of 162/70. Review of Resident #3's record revealed no documentation the physician had been notified when blood pressures were above 150 on 1/1/17; 1/2/17; 1/5/17; 1/11/17 and 1/12/17. Telephone interview on 2/3/17 at 3:15pm with the physician's office regarding Resident #3 revealed: -The facility had contacted the physician twice in January. -Neither of the calls had been to report high blood pressure readings. -During the last appointment, her blood pressure reading had been low. -The physician did not like readings to be over 150 and would be concerned if they continued for a several days. -If a resident had blood pressure readings over 150, and was symptomatic, the physician would want the facility to bring the resident in to be	D 273		

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D 273	Continued From page 8 seen. Interview with the Resident Care Coordinator and Health and Wellness Director on 2/3/17 at 3:30pm revealed the Medication Aide was responsible for calling the physician when blood pressures were outside the listed parameters. Interview with Resident #3 on 2/3/17 at 3:50pm revealed: -She was not aware her blood pressure had been over 150 for several days. -She had not felt any differently when her blood pressure had been high.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure medications were administered in accordance with orders written by a licensed prescribing practioner for 2 of 5 sampled residents (Residents #3 and # 5) related to pain medication. The findings are:	D 358		

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D 358	Continued From page 9 Review of Resident #5's current FL2 dated 6/22/16 revealed: -Diagnoses included arthritis. -Medications included oxycodone (for pain) and Tylenol Extra Strength (for pain). -He was ambulatory without assistive devices. Review of the Resident #5's Resident Register revealed an admission date of 6/21/16. Review of Resident #5's record revealed: -Notes written by the physician's assistant (PA) included additional diagnoses of fibromyalgia, Parkinson's Disease and chronic pain. -He was being treated at a local pain clinic. -An order written by the PA on 8/15/16 for methotrexate 2.5mg, give 5 tablets every Monday (reduces pain and swelling caused by arthritis). -A order written on 9/20/16, by the PA to give oxycodone 15mg, one tablet, at 6:00am, 10:00am, 2:00pm, 6:00pm and 10:00pm and to give two tablets at 2:00pm on Tuesdays and Saturdays (the days the resident's showers were scheduled for 3:00pm). -A Physician/Healthcare Provider Visit Form, completed on 10/5/16 by the Pain Clinic, instructed the facility to continue the oxycodone (as ordered by the PA on 9/20/16), the resident was to return for a strict 25 day follow-up appointment and "Do not let patient run out of pain medications." Review of Resident #5's October 2016 through December 2016 Medication Administration Record (MARs) revealed: -Each MAR with an order to administer oxycodone 15mg, one tablet, at 6:00am, 10:00am, 2:00pm, 6:00pm and 10:00pm and to give two tablets at 2:00pm on Tuesdays and Saturdays (the days the resident's showers were	D 358		

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D 358	Continued From page 10 scheduled for 3:00pm). -In October 2016, the resident did not receive 2 oxycodone tablets on 5 of 9 shower days. -On 10/2/16, the 2:00pm routine (non-shower day) dose of 1 oxycodone had not been administered. Reason: "enroute from pharmacy". -In November 2016, the resident did not receive 2 oxycodone tablets on 3 of 9 shower days. -In December 2016, the resident did not receive 2 oxycodone tablets on 4 of 9 shower days. Interview on 2/1/17 at 10:05am with Resident #5 revealed: -He had fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue and tenderness in localized area) and the pain never went away. -In August 2016, he had been seen by a rheumatologist who diagnosed osteo-arthritis (inflammation, breakdown and the eventual loss of cartilage in the joints) and rheumatoid arthritis (chronic inflammation affecting joint linings causing painful swelling and eventual bone loss and deformity). -He had received an intravenous infusion of Remicade (reduces inflammation) to help treat his pain. -He would be returning to the rheumatologist for another infusion after he had necessary dental work completed. -He was being seen at a pain clinic on a regular basis. -He needed assistance with his showers because of his pain, especially in his joints. -Several Medication Aides (MA) had started asking him around 1:00pm if he was going to take a shower that day. -He had told them he didn't know, he would have to see what time the PCA would be able to help him.	D 358		

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D 358	Continued From page 11 -"If I didn't say I was definitely going to take a shower, they would write down I refused, but I really hadn't." -He had been told if he wasn't going to shower, they would just give him one of the oxycodone at 2:00pm and not have to waste the other one. -He felt there was not enough staff on second shift to get everything done, including his shower. -He decided to have a former caregiver come in and help with showers. -He felt his pain was not adequately controlled at the present time. Confidential interviews with four MAs revealed: -They were aware Resident #5 had an order to receive two oxycodone 15mg tablets. at 2:00pm on his shower days. -The order had been written to make him more comfortable and better able to help with his shower. -Several MAs knew he had been refusing his showers but had not asked him why. -They would ask him around 1:00pm or 1:30pm, before they started their 2:00pm medication pass, if he was going to shower that day. -If he said he wasn't, only one oxycodone would be signed out and administered saving them from having to waste one if they had signed out two. -They would document he had refused the shower. -They had not notified the PA the resident had been "refusing" his shower. -They had not notified the PA, or the pain clinic, of the change they had made to the order by giving 2 oxycodone only if the resident stated he was going to shower. Interview on 2/2/17 at 2:10pm with Resident #5's family member revealed: -The resident had been at the facility for about 6	D 358		

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months.
-He had adjusted fairly well to being there.
-He had been diagnosed with Parkinson's Disease about one year ago and his legs don't work very well for him.
-He had a walker in his room to use when/if he needed it.
-When he arrived at the facility, there had been a physician's order for physical therapy but he refused.
-The resident had seen a rheumatologist in August 2016 and diagnosed with arthritis.
-He had received an infusion of Remicade which the resident had initally told him (the family member) had been ineffective.
-The resident had decided to try it again (he thought it had been helpful) and made himself an appointment.
-He was aware of the medication order for additional medication prior to the resident being showered.
-He had not been told the additional medication had been given only when the resident said he would be showering that day.
-The resident had mentioned several times a staff member had come to get him for a shower, left his room and never returned.
-The resident also said the staff does not shower him at 3:00pm as he had been told they would because they are too busy.
-The family member was aware the resident had made arrangements for a former caregiver to give the showers.
-He was very picky about his bathing and did not like to be rushed.

Interview on 2/3/17 at 11:45am with the Health and Wellness Director (HWD) regarding Resident #5 revealed:
-She was aware of the PA's order for the resident

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D 358	Continued From page 13 to receive 2 oxycodone at 2:00pm on shower days. -It was his choice if he took showers and it depended on his level of pain and strength. -She was not aware the MAs had not been administering the oxycodone as ordered on his shower days. -She did not know why the resident had been refusing some of his showers. -If the resident had been refusing showers, the PA should be notified. -The order for the 2 oxycodone at 2:00pm on the resident's shower days should have been followed as written. -Any change to any order must be made by the PA or a physician caring for the resident. -She would make sure the PA was immediately notified regarding the resident refusing showers and the staff not administering the oxycodone as it had been ordered. Interview on 2/3/17 at 2:45pm with the Resident Care Coordinator (RCC) revealed: -Resident #5's shower days were Tuesdays and Saturdays at 3:00pm (on second shift). -"Showers before meals were the hardest ones to get done." -Several times the day shift had been able to shower him. -She had not considered changing the time of his showers. -He refused his showers "a whole lot". -He had told her he had been in too much pain to shower. -She had notified the PA and that had been when the 2:00pm oxycodone was increased to 2 tablets on his shower days. -He continued to refuse showers on a regular basis. -She had not spoken with him about the refusals.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011036	A. BUILDING: _____ B. WING _____	R 02/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ASHEVILLE OVERLOOK	308 OVERLOOK ROAD ASHEVILLE, NC 28803

(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
D 358	Continued From page 14 -She had not notified the PA the resident had continued to refuse his showers. -She had not notified the PA, or the pain clinic, the oxycodone had not been administered as prescribed. A telephone call on 2/3/17 at 3:20pm to the PA caring for Resident #5 was not successful.	D 358		