**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**BROOKSHIRE NURSING CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**300 MEADOWLAND DRIVE**

**HILLSBOROUGH, NC 27278**

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<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| F 552 | SS=D | Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) | | | | | §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:  
§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  
§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  
§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.  
This REQUIREMENT is not met as evidenced by:  
Based on record review, family, physician assistant, and staff interviews, the facility failed to inform a resident's responsible party of abnormal laboratory results for one out of four sampled residents (Resident #10) reviewed for laboratory results.  
Findings include:  
Resident #10 was admitted to the facility on 4/26/18 with diagnoses that included Urinary Tract Infection, Urine Retention requiring Catherization, Cystitis without Hematuria, Dementia, and Sepsis.  
A review of Resident #10's most recent MDS (Minimum Data Set) was coded as an admission assessment and was dated 5/1/18. The resident was coded as cognitively impaired and needed | F 552 | | | | 11/7/18 |

This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan of correction does not constitute an agreement by the facility that the surveyors findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.  
1. Corrective action for the resident

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

Electronically Signed

10/26/2018
extensive one-person assistance with ADLs (Activities of Daily Living). A review of Resident #10's medical record revealed a physician's order dated 5/23/18 for an abdominal ultrasound and a CMP (comprehensive metabolic panel) to be obtained. A review of Resident #10's medical record revealed the results of the abdominal ultrasound and the CMP were sent to the facility on 5/24/18. The CMP revealed Resident's BUN (Blood Urea Nitrogen) was elevated at 38 (normal range: 8-27) and her Creatinine was 5.37 (normal range: 0.57-1). A review of Resident #10's medical record revealed a note from the PA (Physician Assistant) dated 5/25/18 that read in part: "Patient seen in evaluation after it was noted that on lab work that was ordered on Wednesday after she had vomited revealed a Creatinine of 5.37 which was considerably up from her previous labs two weeks ago with a Creatinine of 1.32. Of note her family has decided to take the patient home." A review of Resident #10's discharge summary from the facility dated 5/26/18 did not reveal any abnormal lab results. A review of Resident #10's medical record revealed a note from the PA (Physician Assistant) dated 5/25/18 that read in part: "Patient seen in evaluation after it was noted that on lab work that was ordered on Wednesday after she had vomited revealed a Creatinine of 5.37 which was considerably up from her previous labs two weeks ago with a Creatinine of 1.32. Of note her family has decided to take the patient home." A review of Resident #10's medical record revealed a note from the PA (Physician Assistant) dated 5/25/18 that read in part: "Patient seen in evaluation after it was noted that on lab work that was ordered on Wednesday after she had vomited revealed a Creatinine of 5.37 which was considerably up from her previous labs two weeks ago with a Creatinine of 1.32. Of note her family has decided to take the patient home."
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him that the resident needed to be seen at urgent care due to Creatinine being elevated. An attempt to contact the Physician Assistant was unsuccessful. 

An interview was conducted on 10/10/18 with the Administrator and DON (Director of Nursing) at 3:15pm. The Administrator reported it was his expectation that residents or their responsible parties be notified of critical laboratory results after being reviewed by the provider. He reported it was his expectation that any resident being discharged, or his/her responsible party, be informed of abnormal laboratory results prior to discharge.

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labs, and discharge summaries 5 times a week in clinical meeting. DON will audit 2 times a week X 4 weeks. Audits then will continue 1 time a week X 3 months, and then DON will spot audit 10 lab results, notification, and discharge summaries quarterly as needed to ensure 100% compliance is maintained. Audit results will be reported monthly in QAPI for further review and recommendations.