

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079076</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/08/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAWSON FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>704 WILLOW STREET REIDSVILLE, NC 27323</b>
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(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 conducted an annual survey on December 8, 2022. .	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: Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider (PCP) was notified for a resident (#1) who had five falls within nine days.  The findings are:  Review of Resident #1's current FL2 dated 06/02/22 revealed diagnoses included schizophrenia affective, mild mental retardation, acute renal failure, and head trauma (1971).  Review of Resident #1's progress note, dated 11/27/22, revealed: -At approximately 3:50pm, Resident #1 lost his balance and fell. -There was no documentation Resident #1's Primary Care Provider (PCP) was notified.  Review of Resident #1's progress note dated 12/02/22 revealed: -At approximately 11:30am, Resident #1 had a fall in his room. -At 3:40pm, Resident #1 had a fall in the hallway. -There was no documentation Resident #1's Primary Care Provider (PCP) was notified.  Review of Resident #1's progress note dated	C 246	<p><i>It has been put in place and discussed w/staff that in the event a resident is observed w/frequent falls that the Primary Care Provider is notified, by making the administrator aware and she will contact the PCP immediately and follow the directions of PCP. Have documentation that the PCP has been notified and his instructions.</i></p> <p>Addendum by telephone 12/28/22: If the resident has more than one fall in a day or if the resident has two or more falls in a week the PCP will be notified by the Administrator. The Administrator will document communication with the PCP.</p>	

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

*Mary K. Thomas*

TITLE: *Administrator* (X6) DATE: *12/15/22*

STATE FORM

6899 YTHP11

DEC 19 2022

If continuation sheet 1 of 4

Reviewed and acknowledged 12/28/22 with addendum. *kg*

ADULT CARE LICENSURE SECTION  
RALEIGH

Division of Health Service Regulation

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C 246	<p>Continued From page 1</p> <p>12/03/33 revealed: -At 9:30am, Resident #1 had a fall in front of the bathroom door. -There was no documentation Resident #1's Primary Care Provider (PCP) was notified.</p> <p>Review of Resident #1's progress note dated 12/04/33 revealed: -At approximately 9:30am, Resident #1 had a fall at the exit door of the facility. -There was no documentation Resident #1's Primary Care Provider (PCP) was notified.</p> <p>Interview with the Supervisor in Charge (SIC) on 12/08/22 at 11:23am revealed: -The Administrator said Resident #1 had fallen because his iron was low. -On Monday, 12/05/22, Resident #1 had a fall at a local restaurant. -Resident #1 had two falls in one day when she was working. -Resident #1 had an increase in his confusion. -It seemed like Resident #1 was dragging his feet more. -The Administrator told staff to keep an eye on Resident #1. -She did not notify Resident #1's PCP, the Administrator was responsible for contacting the PCP.</p> <p>Observation on 12/08/22 between 12:58pm and 2:16pm revealed: -Resident #1 stood in front of his chair, lost his balance, and fell. -After being assisted to his feet by staff, he was not able to stand on his legs. -It took two people to get Resident #1 into a chair. -At 2:16pm, Resident #1 stood, staff offered assistance, but he declined. -Resident #1 used his walker to ambulate to his</p>	C 246		

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C 246	<p>Continued From page 2 room.</p> <p>Interview with the Administrator on 12/08/22 at 1:10pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's iron was low, and he had received an infusion on 12/06/22.</li> <li>-She let Resident #1's PCP know about the falls.</li> <li>-Resident #1 was having more falls over the last few weeks.</li> <li>-She was concerned about Resident #1's falls and had instructed staff to keep a closer eye on him.</li> <li>-The last time Resident #1's iron was low, she could see an improvement after one infusion and then was fine after the second infusion.</li> <li>-She had not seen as much improvement after the first infusion this time.</li> <li>-Resident #1 had been discharged from physical therapy in November 2022.</li> <li>-She did not document when she notified Resident #1's PCP of the falls.</li> </ul> <p>Telephone interview with Resident #1's PCP on 12/08/22 at 3:40pm revealed:</p> <ul style="list-style-type: none"> <li>-He knew Resident #1 had fallen prior to a hospitalization in October 2022.</li> <li>-He was not aware Resident #1 had suffered any recent falls.</li> <li>-He asked a staff member in his office if any calls had been received related to Resident #1 falling, and they responded no.</li> <li>-If he had been called, he would have recommended Resident #1 be brought to the office for an evaluation.</li> <li>-He expected to be notified when Resident #1 had fallen.</li> <li>-Resident #1's iron being low could have been a contributing factor to the falls, but the resident needed to be evaluated to make sure nothing else was going on.</li> </ul>	C 246		

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C 246	Continued From page 3  Based on observations it was determined Resident #1 was not interviewable.	C 246		