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	HAL014014	A. BUILDING: _____ B. WING _____	R-C 05/13/2026

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BROCKFORD INN	56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 05/12/26-05/13/26. The complaint investigation was initiated by the Caldwell County Department of Social Services on 05/01/26.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on interviews and record reviews the facility failed to ensure 1 of 5 sampled residents (Resident #2) was free from neglect related to the resident who resided in a Special Care Unit (SCU) being immediately discharged from the SCU and transported to a local hospital emergency department (ED) where he was left alone in the waiting area with a bag containing his medications. The findings are: Review of Resident #2's current FL2 dated 06/10/25 revealed: -Diagnoses included Alzheimer's dementia (a progressive brain disorder that causes severe memory loss, cognitive decline, and behavioral changes), delirium (sudden change in mental	D 338		

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function that causes acute confusion and disorientation), and high blood pressure.
-The recommended level of care was SCU.
-Resident #2 was ambulatory, intermittently disoriented, incontinent of bowel and bladder, and required assistance with bathing and dressing.

Review of Resident #2's Resident Register revealed:
-An admission date of 07/16/15.
-Resident #2's responsible person was self.
-A family member was the contact person.
-There was no documentation that Resident #2 had a guardian or power of attorney (POA).
-Resident #2 and a staff member both signed the last page on 07/16/15.
-A notice of discharge was initiated by the Administrator of the facility on 05/09/26 and "danger to others immediate discharge" was the reason.
-The date of discharge was 05/09/26 and the resident was discharged to "patient's choice".
-Resident #2 signed the notice on 05/09/26 indicating he acknowledged the information in the discharge was complete and accurate.

Review of Resident #2's Care Plan dated 09/16/25 revealed:
-Resident #2 resided in the SCU and was alert and oriented to person and place, confused, had wandering behaviors and resisted care.
-He was incontinent of bowel and bladder, was forgetful and needed reminders, required supervision with eating, transfers, ambulation, and required extensive assistance with toileting, bathing, dressing, and required limited assistance with grooming.
-He ambulated with a walker and/or wheelchair.

Review of Resident #2's facility Resident

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Agreement Admission Policy dated 07/15/15 revealed:
-The touching of another person without his/her consent for the purpose of harassment, abuse, exploitation is unlawful and would not be permitted.
-The resident, family member, responsible party, guardian, or agency would be requested to make other immediate placement when it is believed that a delay would jeopardize the resident or others health or safety.
-It was signed by Resident #2 and a nursing supervisor and there was not a date it was signed.

Review of a physician's progress note for Resident #2 dated 03/09/26 revealed the resident required treatment in the "Alzheimer's unit" (SCU) for chronic progressive dementia and chronic anxiety.

Review of a a physician's progress note for Resident #2 dated 03/17/26 revealed:
-Resident #2 was unable to provide a family history due to dementia.
-The resident was pleasant, alert and oriented to name.

Review of an Incident Report for Resident #2 dated 05/08/26 revealed:
-Resident #2 reported to the medication aide (MA) that at 8:30pm another resident entered his room and urinated in his trash can.
-Resident #2 shoved the other resident who then slapped Resident #2 in his face and Resident #2 then hit the other resident in the head with a shoe.
-Resident #2's primary care provider (PCP) and the facility Manager were both notified by telephone.

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-A voicemail was left for Resident #2's contact person, documented on the FL2, about the incident.
-Resident #2 was discharged due to fighting.

Review of Nursing Notes for Resident #2 dated 05/08/26 revealed:
-Resident #2 reported that another resident entered his room and urinated in his trashcan.
-Resident #2 shoved the other resident who then slapped Resident #2 in his face and Resident #2 then hit the other resident in the head with a shoe.

Review of a second Nursing Note for Resident #2 dated 05/08/26 revealed:
-Staff reported a resident was hit in the head by Resident #2 with a shoe after the other resident slapped Resident #2 in the face.
-Emergency Medical Services (EMS) were contacted to come on site to evaluate the situation.
-Resident #2 was put on 15-minute checks.
-The local police came to the facility at 9:14pm to investigate and found no cause to charge Resident #2 and left the facility.
-The facility Manager spoke with Resident #2 on 05/09/26 at 1:00pm and Resident #2 recounted the events on 05/08/26. Resident #2 was his own responsible party, and it was discussed with the resident that he must leave the facility as per facility protocol.
-The Manager asked Resident #2 where he would like to be discharged to and Resident #2 stated the hospital in a town close by.
-Multiple attempts to reach a family member were made without success.
-Resident #2 signed the discharge paperwork and apologized for his actions.
-The transportation staff arrived on 05/09/26 at

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2:50pm to escort Resident #2 to his requested location and discharge paperwork and medications were given to the resident.

Review of a physician's order for Resident #2 dated 05/09/26 revealed "discharge patient".

Review of Resident #2's Discharge Notice dated 05/09/26 revealed:
-The reason for the discharge was due to "the safety of others is endangered".
-Resident #2 was "self-responsible" and there was not a responsible person and contact person notified.
-The discharge location was "location of patient's choice".
-The local long term care Ombudsman was notified.

Review of a Medications Released Form for Resident #2 dated 05/09/26 revealed the following medications were giving to Resident #2:
-Invega Sustenna (used to treat psychosis) 234mg, 1 injectable.
-Lorazepam (used to treat anxiety) 0.5mg, 37 tablets.
-Sertraline (treats depression) 50mg, 4 tablets.
-Memantine (used to treat memory issues) 28mg, 29 tablets.
-Jardiance (treats high blood sugar) 25mg, 26 tablets.
-Metformin (treats high blood sugar) 500mg, 40 tablets.
-Vitamin D2 (supplement) 1.25mg, 1 tablet.

Telephone interview with a personal care aide (PCA) on 05/12/26 at 12:11pm revealed:
-She was in the dining room the evening of 05/08/26 when she was informed that another resident went into Resident #2's room and was hit

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by Resident #2.
-That was the first time Resident #2 assaulted anyone that she knew of.
-Resident #2 was never violent and would just go from his room to the dining room.

Telephone interview with the MA on 05/12/26 at 12:21pm revealed:
-She was handing out snacks the evening of the incident (05/08/26) in the SCU.
-Staff told her she was needed in Resident #2's room.
-As she walked back to Resident #2's room, staff were assisting the other resident down the hall in his wheelchair and he was bleeding from the left side of his forehead.
-She contacted EMS for assistance.
-The ambulance and the local police came to the facility.
-The other resident was taken by ambulance to the hospital.
-The police would not take Resident #2 to the hospital for an evaluation or try to involuntarily commit the resident because he had a diagnosis of dementia.
-She instructed staff to make sure Resident #2 was checked on every 15-minutes.
-Resident #2 had no previous aggressive behaviors that she knew of.
-She called the Manager and the Director of Nursing (DON) about the incident.
-She called the resident's contact person and left a voicemail.

Telephone interview with the Director of Nursing (DON) on 05/12/26 at 2:51pm revealed:
-She was notified on 05/08/26 by the MA that Resident #2 hit another resident on the head.
-She instructed the MA to send the injured resident to the hospital and have staff stay

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one-on-one with Resident #2 until the Administrator and Manager could determine the next steps.
-The police would not take Resident #2 to the hospital for an evaluation due to his diagnosis of dementia.
-Resident #2 was forgetful and not always oriented.
-Resident #2 was his own person and had not been deemed incompetent by a court because he was always compliant.

Interview with the Special Care Coordinator (SCC) on 05/12/26 at 11:30pm revealed:
-Resident #2 had a history of agitating other residents but did not have a history of assaulting other residents.
-Resident #2 had lived in the facility for a long time.

Telephone interview with Resident #2's family member on 05/12/26 at 11:17pm revealed:
-The person listed on Resident #2 's Resident Register was deceased.
-The family member was notified by the hospital that the facility dropped off Resident #2 at the hospital "like he was a dog".
-The facility just "let him go" because he got into a fight.
-Resident #2 was still at the ED.
-Resident #2 was unable to inform the facility where he should go because he had a diagnosis of dementia.

Interview with the Maintenance Supervisor on 05/12/26 at 3:04pm and 05/13/26 at 9:30am revealed:
-The MA called to inform him Resident #2 signed himself out of the facility and wanted to go to the hospital.

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-He transported Resident #2 with his medications in a plastic bag to the hospital on 05/09/26 at 4:30pm.
-He spoke with the receptionist in the ED waiting room and informed her that Resident #2 signed himself out of the facility because he got into a fight and wanted to come to the hospital.
-He attempted to give the bag of medications to the receptionist, but she informed him she could not take it, so he gave the bag of medications to Resident #2.
-He left Resident #2 in the ED waiting area, along with 3 or 4 dollars in case he wanted to buy a drink, and then he left the hospital.

Telephone interview with the ED Clinical Leader on 05/13/26 at 8:49am revealed:
-She was informed that Resident #2 got into an argument with his roommate and the roommate threw a shoe at Resident #2 and so he wanted to leave the facility.
-Resident #2 had a diagnosis of Alzheimer's Disease and the facility let him sign himself out.
-Resident #2 did not know his date of birth or the year, and wanted to go back to the facility.
-He was admitted to the ED on 05/09/26 "due to safety issues" and was currently in the ED.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 05/12/26 at 5:30pm revealed:
-Resident #2 had a diagnosis of Alzheimer's Disease.
-She did not know that Resident #2 did not have a guardian.
-Any resident in the facility that displayed aggression were discharged immediately.
-The staff that transported Resident #2 to the ED should not have left him alone in the waiting room with his medications because the resident was

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disoriented and confused.
-Staff should have stayed with Resident #2 until it was determined if he would be admitted to the hospital or not.

Telephone interview with the local Department of Social Services (DSS) Adult Home Specialist Supervisor on 05/13/26 at 9:50am revealed:
-The facility Manager telephoned her on 05/09/26 to inform her about the incident with Resident #2 on 05/08/26 and that he signed himself out of the facility.
-She informed the Manager that if Resident #2 was a danger to himself or others he should be discharged.
-She was not informed that Resident #2 resided in the SCU or had a diagnosis of Alzheimer's Disease and if she had known she would have informed the Manager that Resident #2 could not sign himself out.
-She was never approached by the facility about guardianship issues for Resident #2.

Interview with the Manager on 05/12/26 at 12:00pm and 4:25pm revealed:
-He was notified on the evening of 05/08/26 that Resident #2 assaulted another resident.
-Another resident entered Resident #2's room and urinated in his trashcan, Resident #2 pushed the other resident and the other resident slapped Resident #2 in the face and Resident #2 hit the other resident in the head with a shoe.
-Staff sent the other resident out to the hospital for his injury and the police came out to the facility.
-Resident #2 was put on 15-minute checks and staff were instructed to remove all items in his room that he could throw.
-Staff tried to get in contact with Resident #2's family on 05/08/26 and 05/09/26.

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-The Manager came to the facility on 05/09/26 to finish his investigation and Resident #2 told him he "beat him down" with a shoe.
-Resident #2 signed himself into the SCU when he was first admitted (07/16/15) and has been compliant but has had some aggression in the past.
-The facility had not attempted to contact the local DSS about guardianship for Resident #2.
-He informed Resident #2 he should go somewhere safe because he assaulted the other resident and it should be somewhere safe.
-Resident #2 wanted to go with a family member but that person could not be reached.
-Resident #2 picked a hospital that was close to that family members residence.
-He thought it was ok to discharge Resident #2 to the ED because he was his own person and had not been deemed incompetent by a judge and signed himself out.

Interview with the Administrator on 05/12/26 at 4:17pm revealed:
-The police officer that responded to the assault on 05/08/26 would not transport Resident #2 to the ED for Involuntary Commitment due to a diagnosis of dementia.
-Resident #2 was upset about the incident and wanted to go to the hospital.
-Resident #2 signed himself out of the facility and discharged himself as he was his own person and did not have a guardian or POA.
-Resident #2's Care Plan was an accurate assessment of the resident.
-Resident #2's belongings were still at the facility and would be delivered to the resident when he was discharged from the ED.

Based on interviews and record reviews Resident #2 was not interviewable.

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D 338	Continued From page 10 Request for the 05/08/26 incident police report on 05/12/26 at 2:04pm was unsuccessful. _____ The facility failed to ensure Resident #2, who resided in a Special Care Unit with a diagnosis of Alzheimer's Disease who was confused, oriented to person only, and unable to make appropriate decisions for himself, was free from neglect when the facility provided an immediate discharge to a local emergency department due to Resident #2 responding to another resident who urinated in Resident #2's room and slapped Resident #2. Resident #2, who had no history of assault since his admission in 2015, then hit the other resident with a shoe. The facility took Resident #2 from a locked Special Care Unit, which was needed for his diagnoses, with all his medications in a bag, transported Resident #2 to the emergency department and left him alone in the the waiting room with the bag of medications. This failure resulted in serious neglect and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/13/26 for this violation.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by:	D 438		

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D 438	Continued From page 11 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within 24 hour and 5 day requirements for 1 of 1 sampled staff (Staff A) who left a resident (#1) with a diagnosis of dementia and required extensive assistance with ambulation alone outside in his wheelchair. The findings are: Review of Resident #1's FL2 dated 11/26/25 revealed: -Diagnoses included dementia, atrial fibrillation, chronic obstructive pulmonary disease, edema, and hypertension. -Resident #1 was intermittently disoriented, semi-ambulatory, and had a history of wandering behaviors. -The recommended level of care was domiciliary. Review of Resident #1's Care Plan dated 03/21/26 revealed: -Resident #1 was alert and oriented with confusion. -Resident #1 was ambulatory with device, sometimes disoriented, and sometimes forgetful-needing reminders. -Resident #1 required extensive staff assistance with ambulation/locomotion. -Resident #1 was totally dependent on staff with transfers. Review of Resident #1's Incident Report dated 04/21/26 revealed: -Resident #1 resided on the assisted living side of the facility. -Resident #1 was found on the front entrance	D 438		

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steps of the facility with his wheelchair flipped over.
-Resident #1 was transferred to the hospital via emergency medical service (EMS) for evaluation.

Review of Resident #1's local emergency department (ED) note dated 04/21/26 revealed:
-He presented after an unwitnessed fall down stairs due to a tipped wheelchair.
-He sustained a 1.5-inch laceration over the right eyebrow and required six sutures.
-He sustained a small subdural hematoma (accumulation of blood between the brain's outer covering and the surface of the brain itself, typically resulting from head trauma).
-X-rays of the left knee showed possible fibular head fracture which could be related to the fall or gout (inflammatory arthritis caused by high levels of uric acid).
-He was admitted to hospital service for further observation.

Review of the facility camera footage dated 04/21/26 from 2:12pm to 2:54pm revealed:
-At 2:12pm, Staff A, personal care aide (PCA), pushed Resident #1, who was seated in a wheelchair, onto the facility's front porch.
-Staff A positioned Resident #1 on the right side of the front steps near a column leaving Resident #1 without applying the brake on the wheelchair.
-At 2:13pm, Staff A, PCA, returned to the porch, applied Resident #1's wheelchair brake, and then left leaving Resident #1 on the porch.
-At 2:31pm, Resident #1 released the brake on his wheelchair, moved his chair backwards and away from the porch column, then rolled to the top of the concrete stairs, failing to reapply the brake on the wheelchair.
-At 2:33pm, another PCA, passed by Resident #1 seated in his wheelchair at the top of the concrete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014014	A. BUILDING: _____ B. WING _____	R-C 05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROCKFORD INN	56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630

(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 438	Continued From page 13	D 438		

steps and entered the facility.
-At 2:36pm, Resident #1 was observed to roll over the ledge of the concrete steps in the wheelchair and was found by another resident who immediately alerted facility staff.
-From 2:36pm to 2:54pm, facility staff provided first aid to Resident #1 and remained with the resident until the EMS arrived to transport Resident #1 for evaluation and treatment at a local hospital.

Interview with a PCA on 05/12/26 at 3:40pm revealed:
-She worked on 04/21/26 during the time when Resident #1 fell down the front steps of the facility.
-Staff A took Resident #1 outside onto the front porch and went home.
-Staff A did not tell any of the other staff Resident #1 was on the porch before going home.

Interview with a medication aide (MA) on 05/12/26 at 4:13pm revealed:
-Resident #1 fell down the stairs during shift change on 04/21/26.
-She and the first shift MA were in the process of counting the medication cart when Resident #1 fell.
-Staff A did not tell her Resident #1 was on the front porch.
-She found out Resident #1 was on the porch when a resident came from outside and told her Resident #1 had fallen and needed assistance.

Interview with the Administrator on 05/13/26 at 3:45pm revealed:
-He did not complete a 24-hour or 5-Day HCPR reports on Staff A.
-The situation did not dictate making a HCPR report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014014	A. BUILDING: _____ B. WING _____	R-C 05/13/2026

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D 438	Continued From page 14 -Generally when he reported a person to HCPR, it was due to a form of abuse. -There was no requirement Staff A needed to let the MA know Resident #1 was on the porch. Attempted telephone interview with Staff A on 05/12/26 at 1:52pm was unsuccessful. The facility failed to complete a 24 hour and 5 day report to the HCPR for Staff A, who neglected to inform other staff that Resident #1, who had a diagnosis of dementia and required extensive assistance with ambulation, was left alone on the front porch. Resident #1 moved himself without assistance and flipped his wheelchair on concrete stairs sustaining injuries including 1.5-inch laceration over the right eyebrow requiring six sutures, a small subdural hematoma, and possible fibular head fracture. This failure was detrimental to the health, safety, and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/20/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 27, 2026.	D 438		