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
	HAL014014	A. BUILDING: _____ B. WING _____	R-C 06/10/2026

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 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 05/12/26-05/13/26 and 06/10/26. The complaint investigation was initiated by the Caldwell County Department of Social Services on 05/01/26.	D 000		
D 229	10A NCAC 13F .0702 (g) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (g) The facility administrator or their designee shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary; (2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination that is capable of meeting the needs of the resident; and (A) If at the time of the discharge notice the discharge destination is unknown or is not capable of meeting the needs of the resident, the facility administrator or their designee shall contact the local adult care home resident discharge team as defined in G.S. 131D 4.8(e) to assist with placement; and (B) The facility, at the direction of the administrator or their designee, shall inform the resident, the resident's legal representative, the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident, and the responsible person of their right to request the Regional	D 229	D229 10 NCAC 13F .0702(g) Discharge of residents - A discharge packet was created to include all needed information for a safe and orderly dishage 06/15/26 - Implementation of newly created discharge packet 06/15/26 - Administrative team to consult and invoke assistance from DSS for a safe and orderly discharge, Should a resident become aggressive towards another resident and 911 services are unable to assist. 06/11/26 - Administrative team will seek assistance from DSS discharge team whenever there is a resident who endangers others and the RP cant be located and 911 services cant assist. 06/11/26	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Administrator — (X6) DATE 07/10/26

Reviewed and acknowledged 7/13/26

RP

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D 229	Continued From page 1 Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team; and (3) offering the following material to the resident, the resident's legal representative, or the facility where the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter; (B) a copy of the resident's most current assessment and care plan; (C) a list of referrals to licensed health professionals, including mental health; (D) a copy of the resident's current physician orders; (E) a list of the resident's current medications; (F) the resident's current medications; and (G) a record of the resident's vaccinations and TB screening; (4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule: (A) the regional long-term care ombudsman; and (B) Disability Rights North Carolina, the protection and advocacy agency established under federal law for persons with disabilities; (5) providing the resident, responsible person, or legal representative, and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility.	D 229	- Documentation procedure is modified to include a copy of Current FL2, care plan current meds and medications list, TB screening, hearing request form and notice, and notation on the resident register. - The discharge packet will be copied, maintained, and discussed in monthly QA meetings, by Administrator and manager.	07/07/26 07/10/26

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D 229	Continued From page 2 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure a safe and orderly discharge for one resident who resided in the Special Care Unit (SCU) by failing to converge the Department of Social Services (DSS) discharge team to determine a discharge destination capable of meeting the resident's needs, failing to provide the resident's current FL2, care plan, and record of vaccinations and tuberculosis (TB) screenings (Resident #2). 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 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 admission FL2 dated 07/15/25 revealed: -Diagnoses included dementia with behavior disturbance and anxiety. -The recommended level of care was SCU. Review of Resident #2's Resident Register revealed: -An admission date of 07/16/15. -Resident #2's responsible person was self.	D 229		

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D 229	Continued From page 3 -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 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.	D 229		

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D 229	Continued From page 4 -It was signed by Resident #2 and a nursing supervisor and it was not dated. 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. -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	D 229		

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D 229	Continued From page 5 shoe. Review of a second Nursing Note for Resident #2 dated 05/08/26 - 05/09/26 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 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	D 229		

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D 229	Continued From page 6	D 229		

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.
-There were no directions provided to indicate the frequency or dose of administration for any of the medications.

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 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 medication aide (MA) on 05/12/26 at 12:21pm revealed:
-She was handing out snacks the evening of the

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D 229	Continued From page 7	D 229		

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.

Interview with the MA on 06/10/26 at 11:28am revealed:
-She made a copy of Resident #2's electronic administration record (eMAR), completed the medications released form, and gathered his bubble packs of medications and gave all of it to the Manager before Resident #2 was discharged to the hospital.
-She did not copy Resident #2's FL2, care plan, record of vaccinations, and TB screenings because she was not instructed to and did not know copies of those documents should have been sent with Resident #2 when he was discharged.
-She did not instruct anyone to transport Resident

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D 229	Continued From page 8 #2 to the hospital. 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 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 intermittently disoriented. -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 contact 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	D 229		

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D 229	Continued From page 9 of dementia. Interview with the Maintenance Supervisor on 05/12/26 at 3:04pm, 05/13/26 at 9:30am, and 06/10/26 at 8:58am revealed: -The MA called to inform him Resident #2 signed himself out of the facility and wanted to go to the hospital. -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 brought discharge paperwork to the ED and gave the paperwork to the receptionist. -He did not look at the discharge paperwork and did not know if the FL2, care plan, record of vaccinations, and TB screenings were included in the paperwork. -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. -He was not instructed by facility staff to stay with the resident in the waiting room. 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	D 229		

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D 229	Continued From page 10	D 229		

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 and "not in his right mind".

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 05/12/26 at 5:30pm and 06/10/26 at 9:13am revealed:
-Resident #2 had a diagnosis of Alzheimer's Disease.
-She did not know that Resident #2 did not have a guardian or POA.
-She received a text message from the facility Manager that Resident #2 needed to be discharged because he assaulted another resident and the facility would take Resident #2 to a hospital of his choice.
-She was informed by the Manager that the local DSS instructed the Manager to discharge Resident #2 to a hospital of his choice.
-Since the last Division of Health Service Regulation state survey, any resident in the facility that displayed aggression would be "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 disoriented and confused.
-Staff should have stayed with Resident #2 until it was determined if he would be admitted to the hospital or not.
-She would have contacted her Medical Director for guidance if the Manager informed her at that time that Resident #2 did not have a POA or guardian.

Telephone interview with the local DSS Adult Home Specialist Supervisor on 05/13/26 at 9:50am and on 06/10/26 at 9:26am revealed:
-The facility Manager informed her on 05/09/26

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D 229	Continued From page 11	D 229		

about the incident with Resident #2 on 05/08/26 and that he signed himself out of the facility.
-The Manager wanted to "immediately discharge" Resident #2 to the hospital.
-She informed the Manager that if Resident #2 was a danger to himself or others he should be discharged and to send all paperwork with him including his FL2, care plan, record of vaccinations, and TB screenings.
-She was not asked to facilitate this discharge or assist with finding a safe discharge location.
-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.
-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

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D 229	Continued From page 12	D 229		

he was first admitted (07/16/15) and had been compliant but 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 Manager on 06/01/26 at 10:05am and 11:17am revealed:
-The discharge criteria for a resident that resided in the SCU would be to a different level of care determined by the PCP or an "immediate discharge" if the resident was a danger to themselves or others.
-The resident that Resident #2 hit in the head with a shoe sustained a brain hemorrhage (bleeding in the brain) and was discharged from the hospital to a skilled nursing facility.
-The facility did not have an admission or discharge policy except for DHSR regulatory guidelines.
-He did not ask DSS for assistance with placement for Resident #2 because DSS concurred he needed to be "immediately discharged".
-He informed DSS on 05/09/26 that Resident #2 resided in the SCU and did not have a POA or guardian.
-Residents at the facility were not always discharged to the hospital and it depended on each situation.

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 06/10/2026

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D 229	Continued From page 13 -Resident #2's eMAR, with the PCP name and telephone number, medications, and medication list were sent to the ED. -He did not sent Resident #2's FL2, current care plan, vaccination record, and TB screenings to the ED because the resident chose where he wanted to go and if the ED wanted those documents they could have asked for them. -He spoke with an ED case manager on 05/10/26 and they did not request those documents. -Resident #2 "knew right from wrong". -He was not a physician and could not determine if Resident #2 was competent. -He did not know the answer as to why DSS was not contacted regarding guardianship. -He was not at the ED with Resident #2 and did not make the decision to leave him alone in the ED waiting room. -He could not recall who instructed the maintenance staff to transport Resident #2 to the hospital. -The maintenance staff was not instructed to stay with the resident. 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. Attempted telephone interview with the Administrator on 06/10/26 was unsuccessful.	D 229		

Division of Health Service Regulation

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D 229	Continued From page 14 Based on interviews and record reviews Resident #2 was not interviewable. Refer to Tag D 0338 10A NCAC 13 F .0909 Resident Rights (Type A1 Violation). The facility failed to ensure Resident #2, who had a diagnosis of Alzheimer's Disease was confused, oriented to person only, and unable to make appropriate decisions for himself and resided in a locked Special Care Unit (SCU), received a safe an orderly discharge when the facility failed to converge the DSS discharge team to assist with an appropriate placement to a SCU and issued an "immediate discharge" to the local emergency department without the resident's FL2, current care plan, record of vaccinations, and TB screenings. This failure resulted in substantial risk for serious physical harm and constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/26 for this violation. CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED JULY 10, 2026	D 229		
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:	D 338	D338 10A NCAC 13F .0909 Residents Rights - The Administrative team will alter the discharge procedure to include assistance from county DSS whenever 911 services cant assist, if needed, whenever the RP cant be reached, and immediate discharge is needed.	07/07/26

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	HAL014014	A. BUILDING: _____ B. WING _____	R-C 06/10/2026

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D 338	Continued From page 15 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 one resident who resided in a Special Care Unit (SCU) being 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 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 admission FL2 dated 07/15/25 revealed: -Diagnoses included dementia with behavior disturbance and anxiety. -The recommended level of care was SCU. Review of Resident #2's Resident Register revealed: -An admission date of 07/16/15. -Resident #2's responsible person was self.	D 338	- Resident rights will be discussed in staff trainings for 3 months and stored with HR. - A training on neglect will also be held at these staff meetings for 3 months and stored along side HR. - An RP, besides the resident, will be required for admissions that take place on the ~~restricted~~ memory care unit, prior to admission.	07/30/26 07/30/26 06/11/26

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D 338	Continued From page 16 -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 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.	D 338		

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D 338	Continued From page 17	D 338		

-It was signed by Resident #2 and a nursing supervisor and it was not dated.

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.
-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

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	HAL014014	A. BUILDING: _____ B. WING _____	R-C 06/10/2026

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

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D 338	Continued From page 18 shoe. Review of a second Nursing Note for Resident #2 dated 05/08/26 - 05/09/26 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 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	D 338		

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D 338	Continued From page 19	D 338		

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.
-There were no directions provided to indicate the frequency or dose of administration for any of the medications.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BROCKFORD INN	56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630

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D 338	Continued From page 20	D 338		

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 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 intermittently disoriented.
-Resident #2 was his "own person" and had not

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D 338	Continued From page 21	D 338		

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 contact 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, 05/13/26 at 9:30am, and 06/10/26 at 8:58am revealed:
-On 05/09/26 the MA called to inform him Resident #2 signed himself out of the facility and wanted to go to the hospital.
-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 brought discharge paperwork to the ED and gave the paperwork to the receptionist.

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D 338	Continued From page 22 -He did not look at the paperwork and did not know what the documents were. -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. -He was not instructed by facility staff to stay with the resident in the waiting room. 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 and "not in his right mind". Telephone interview with the facility's contracted Nurse Practitioner (NP) on 05/12/26 at 5:30pm and 06/10/26 at 9:13am revealed: -Resident #2 had a diagnosis of Alzheimer's Disease. -She did not know that Resident #2 did not have a guardian or POA. -She received a text message from the facility Manager that Resident #2 needed to be discharged because he assaulted another resident and the facility would take Resident #2 to a hospital of his choice. -She was informed by the Manager that the local Department of Social Services instructed the	D 338		

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 06/10/2026

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D 338	Continued From page 23 Manager to discharge Resident #2 to a hospital of his choice. -Since the last Division of Health Service Regulation state survey, any resident in the facility that displayed aggression would be "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 disoriented and confused. -Staff should have stayed with Resident #2 until it was determined if he would be admitted to the hospital or not. -She would have contacted her Medical Director for guidance if the Manager informed her at that time that Resident #2 did not have a POA or guardian. Telephone interview with the local DSS Adult Home Specialist Supervisor on 05/13/26 at 9:50am and on 06/10/26 at 9:26am revealed: -The facility Manager informed her on 05/09/26 about the incident with Resident #2 on 05/08/26 and that he signed himself out of the facility. -The Manager wanted to "immediately discharge" Resident #2 to the hospital. -She informed the Manager that if Resident #2 was a danger to himself or others he should be discharged and to send all paperwork with him including his FL2, care plan, record of vaccinations, and TB screenings. -She was not asked to facilitate this discharge or assist with finding a safe discharge location. -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.	D 338		

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D 338	Continued From page 24 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. -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 or requested the discharge team to help secure a safe discharge destination. -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.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 25 Interview with the Manager on 06/01/26 at 10:05am and 11:17am revealed: -The discharge criteria for a resident from the SCU would be to a different level of care determined by the PCP or an immediate discharge if the resident was a danger to themselves or others. -The resident that Resident #2 hit in the head with a shoe sustained a brain hemorrhage (bleeding in the brain) and was discharged from the hospital to a skilled nursing facility. -The facility did not have an admission or discharge policy except for DHSR regulatory guidelines. -He did not ask DSS for assistance with placement for Resident #2 because DSS concurred he needed to be "immediately discharged". -He informed DSS on 05/09/26 that Resident #2 resided in the SCU and did not have a POA or guardian. -Residents at the facility were not always discharged to the hospital and it depended on each situation. -Resident #2's eMAR, with the PCP name and telephone number, medications, and medication list were sent to the ED. -He did not sent Resident #2's FL2, current care plan, vaccination record, and TB screenings to the ED because the resident chose where he wanted to go and if the ED wanted those documents they could have asked for them. -He spoke with an ED case manager on 05/10/26 and they did not request those documents. -Resident #2 "knew right from wrong". -He was not a physician and could not determine if Resident #2 was competent. -He did not know the answer as to why DSS was not contacted regarding guardianship.	D 338		

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 06/10/2026

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

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D 338	Continued From page 26 -He was not at the ED with Resident #2 and did not make the decision to leave him alone in the ED waiting room. -He could not recall who instructed the maintenance staff to transport Resident #2 to the hospital. -The maintenance staff was not instructed to stay with the resident. 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. Attempted telephone interview with the Administrator on 06/10/26 was unsuccessful. Based on interviews and record reviews Resident #2 was not interviewable. 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 (SCU)with a diagnosis of Alzheimer's Disease who was confused, oriented to person only, and unable to make safe decisions for himself, was free from	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page 27 neglect when the facility discharged him to a local emergency department. Resident #2 resided in the facility's SCU since 2015 without any documention of physically aggressive behavior and was in a physical altercation with another SCU resident. The facility took Resident #2 from a locked SCU, 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		