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| BROCKFORD INN | 56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted an annual and follow-up survey and a complaint investigation on December 29-31, 2015. The Caldwell County DSS initiated the complaint investigation on November 6, 2015. | D 000 | | |
| D 083 | 10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(a) Adult care home shall:<br>(9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to have window coverings to provide for resident privacy in 5 of 15 resident rooms (Room #'s 303, 304, 306, 309, and 316) on the Special Care Unit (SCU).<br><br>The findings are:<br><br>Observations in the SCU on December 29, 2015 from 10:45am through 11:30am revealed:<br>-Residents were residing in all rooms.<br>-All windows panes in the SCU had a tinted colored coating over them.<br>-There were no window coverings in resident rooms 303, 304, 309, and 316.<br>-Resident room 306 had a set of see through sheer curtains over the windows.<br><br>Interview with the Administrator in Charge (AIC) | D 083 | Facility on 1-4-16 installed blackout curtains on all resident's rooms on the SCU. On 1-25-16 facility changed curtains to blinds on 1-25-16 and completed all on 1-27-16 for the SCU room's. | 1-27-16 |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Denise Coffey TITLE administrator (X6) DATE 1-27-16



Approved and Accepted by Joseph Cline on 2/3/16

Joseph Cline

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| D 083 | Continued From page 1<br>on December 31, 2015 at 11:00am revealed:<br>-It was difficult to keep curtains on the windows in the SCU because residents pulled them down.<br>-The former Administrator had the windows in the SCU tinted "a long time ago" (unsure of exact date).<br>-She was not aware anyone could see inside the rooms with tinted windows from the outside.<br><br>Maintenance staff attended the surveyor during observations (from the exterior of the facility, looking inside the windows) on December 31, 2015 at 11:30am. The furnishings and/or residents in all five rooms were clearly visible.<br><br>Confidential interviews with family members revealed they were concerned about the windows not having curtains and had been told (by management) the facility would not buy curtains for the SCU rooms. | D 083 | Administrator and Resident Care Director or supervisor will do daily rounds, checking rooms to ensure and monitor cleanliness and assure window coverings are still properly in place. 1-27-16 | |
| D 176 | 10A NCAC 13F .0601 (a) Management Of Facilities<br><br>10A NCAC 13F .0601Management Of Facilites<br><br>(a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. | D 176 | | |

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| D 176 | Continued From page 2<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A2 VIOLATION<br><br>Based on these findings, the previous Type A2 Violation was abated, non-compliance continues.<br><br>THIS IS A TYPE B VIOLATION<br><br>Based on observations, interviews, and record review, the Administrator failed to ensure the total operation of the facility met and maintained rules related to management of the facility, health care personnel registry, and resident rights.<br><br>The findings are:<br><br>Interview with the Administrator-in-charge on 12/31/15 at 3:30pm revealed the Administrator checked in regularly with the facility and attended the montly staff meetings.<br><br>The Administrator was present at the facility on 12/29/31 for a staff meeting when the surveyors entered the facility. The staff meeting was then canceled due to the survey. The Administrator was not present during the survey.<br><br>Areas of non-compliance identified during the survey were:<br><br>A. Based on observations and interviews, the facility failed to have window coverings to provide for resident privacy in five resident rooms on the Special Care Unit (SCU). [Refer to Tag D083 10A NCAC 13F .0306(a)(9) Housekeeping and Furnishings.]<br><br>B. Based on observations, record reviews, and | D 176 | Administrator in charge received administrator certification and informed DHHS and AHS of facility change in administrators as of 1-4-16.<br>A. Facility on 1-4-16 installed black out curtains on all resident's rooms in the SCU. On 1-25-16 facility changed curtains to blinds on the SCU with completion on 1-27-16 | 1-27-16 |

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| D 176 | Continued From page 3<br>interviews, the facility failed to protect residents by not investigating allegations for injury of unknown source (shoulder dislocation) for 1 resident (#11), and upon investigation of verbal abuse of a resident (#8) by a staff member the facility did not report to the Health Care Personnel Registry. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry. UNABATED TYPE B VIOLATION].<br><br>C. Based observations, interviews and record reviews, the facility failed to ensure residents residing in the facility were free from mental abuse as evidenced by staff (Staff G) to resident (Residents #8, #9, and #10) verbal abuse. [Refer to Tag 038 10A NCAC 13F .0909 Resident Rights. TYPE B VIOLATION].<br><br>---<br>On December 31, 2015 the facility provided the following plan of protection:<br>-The Administrator and Resident Care Coordinator immediately made rounds and spoke with each staff member to address any resident, or staff concerns related to management of the facility.<br>-The Resident Care Coordinator will meet with each shift Monday through Friday at shift change to address any concerns and report to the Administrator.<br><br>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 14, 2016. | D 176 | Facility management done immediate rounds on 12/13/15, spoke with each staff member and resident of any concerns or reports of abuse, neglect, injury of unknown source, misappropriation of property or diversion of drugs. Any report/allegation immediately report to HCPR.<br><br>Facility held mandatory staff meeting for all staff on 1-15-16 and educated and trained on how and what to report. Educated staff on injury of unknown source, if a fall or incident is not witnessed, it is a | 1-15-16<br><br>1-15-16 |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of | D 338 | | |

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| D 338 | Continued From page 4<br>all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based observations, interviews and record reviews, the facility failed to ensure residents residing in the facility were free from mental abuse as evidenced by staff (Staff G) to resident (Residents #8, #9, and #10) verbal abuse.<br><br>The findings are:<br><br>A. Review of Resident #8's current FL2 dated 10/6/15 revealed:<br>-Diagnoses included Alzheimers's Dementia.<br>-Resident was ambulatory with cane as an assistive device.<br><br>Review of the Special Care Unit profile dated 11/16/15 revealed the degree of cognitive impairment was "moderate".<br><br>Interview on 12/9/15 at 9:22am with the Administrator-in-charge revealed:<br>-The 11/03/15 incident, where Staff G, Personal Care Aide (PCA) told Resident #8 he would push her down if she did not move, was not reported to the Health Care Personnel Registry within the required 24 hours.<br>-The Health Care Personnel Registry Report was completed on 12/9/15 in response to the Adult Home Specialist visit on 12/8/15.<br>-Staff G was suspended on 12/8/15 pending the outcome of the facility's Health Care Personnel Registry Investigation. | D 338 | injury of unknown source and must be reported.<br>Facility implented new incident forms with more details of reflecting, who witnessed incident, so can be investagated upon an incident. Attachment A.<br>Facility held mnadatory staff meeting on 1.15.16 reviewed and discussed residents rights. Educated staff on residents right. Facility also posted a larger print of residents rights on the SCU. Facility has scheduled inservice with the onbudsman to educate and ongoing training for the staff on | 1.15.16 |

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| D 338 | Continued From page 5<br><br>Interview on 12/30/15 at 9:15am with Staff I, Medication Aide / Supervisor in Charge (SIC) regarding the 11/3/15 incident revealed:<br>-They were working with Staff G, on the Special Care Unit when they heard Staff G make the statement to Resident #8 "If you don't move I'm gonna knock you down."<br>-"If this was heard out of context, you would have thought he was being mean to the resident."<br>-They reported the incident to the Administrator-in-charge.<br>-Staff G was sent home that night "probably for that and and incident with an employee."<br>-"His tone of voice is what got him in trouble that night."<br><br>Interview with Staff E, PCA on 12/4/15 at 12:40pm revealed Staff G did not like Resident #8, but could not give any specifics.<br><br>Interview with the Administrator-in-charge on 12/8/15 at 4:00pm and 5:15pm revealed:<br>-On 11/3/15 Staff I, was working with Staff G in the special care unit.<br>-While removing food trays, Staff I, heard Staff G say to Resident #8 "Move or I'm gonna knock you down."<br>-Staff I, reported the incident to the Administrator-in-charge.<br>-"I interviewed Staff G and suspended him for the rest of the shift because of his attitude."<br><br>Refer to interview with Staff E on 12/4/15 at 12:40pm.<br><br>Refer to interview with Staff D on 12/8/15 at 9:51am.<br><br>Refer to confidential interview with a family member on 12/8/15 at 3:15pm. | D 338 | resident's rights for 2.26.16. Facility plans to monitor and review residents rights with each staff meeting monthly. Also facility continues to make rounds and speak with residents on daily basis to assure resident rights are being met.<br>To monitor resident rights 1.15.16 and HCPR plans for supervisor to meet with staff at each shift change and give assignment and address any concerns or reports of allegation of abuse, neglect, injury of unknown source, misappropriation of property or diversion of drugs and supervisor to report to RCC and administrator | |

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| D 338 | Continued From page 6<br><br>Refer to confidential resident interview on 12/8/15 at 3:25pm.<br><br>Refer to interview on 12/8/15 at 3:38pm with Staff G.<br><br>Refer to interview on 12/8/15 at 4:10pm with Staff H.<br><br>B. Review of Resident #9's current FL2 dated 10/6/15 revealed diagnoses included Alzheimers's Dementia.<br><br>Review of Resident #9's Care Plan dated 7/6/15 revealed:<br>-The Resident required the use of a wheelchair for ambulation.<br>-The Resident was always disoriented.<br>-The Resident had significant loss of memory and must be redirected.<br>-The Resident required limited assistance with ambulation.<br>-The Resident required extensive assistance with transfers.<br><br>Review of the Special Care Unit profile dated 10/20/15 revealed the degree of cognitive impairment was "disoriented constantly".<br><br>Interview with Staff E, PCA on 12/4/15 at 12:40pm revealed on one occasion Staff G told Resident #9 "I'll break your legs".<br><br>Interview with Staff D, PCA on 12/8/15 at 9:51am revealed they heard Staff G tell Resident #9 "I'll Break your legs".<br><br>Interview on 12/8/15 at 4:10pm with Staff H, PCA revealed they heard Staff G tell Resident #9 "If | D 338 | immediately. Administrator will do 24hr HCPR report and suspend accused until investigation is completed. Then administrator will do 5 day HCPR report. Also as fax HCPR 24hr report, a copy will be faxed to AHS. | |

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| D 338 | Continued From page 7<br>you keep on, I'll break both of your legs."<br><br>Refer to interview with Staff E on 12/4/15 at 12:40pm.<br><br>Refer to interview with Staff D on 12/8/15 at 9:51am.<br><br>Refer to confidential interview with a family member on 12/8/15 at 3:15pm.<br><br>Refer to confidential resident interview on 12/8/15 at 3:25pm.<br><br>Refer to interview on 12/8/15 at 3:38pm with Staff G.<br><br>Refer to interview on 12/8/15 at 4:10pm with Staff H.<br><br>C. Review of Resident #10's current FL2 dated 9/3/15 revealed:<br>-Diagnoses included Alzheimers's Dementia.<br>-A history of wandering.<br>-The resident was ambulatory without assistive devices.<br>-The resident was always disoriented.<br><br>Review of the Special Care Unit profile dated 10/3/15 revealed the degree of cognitive impairment was "moderate".<br><br>Interview with Staff E, PCA on 12/4/15 at 12:40pm revealed Staff G called Resident #10 a derogatory name to her face.<br><br>Refer to interview with Staff E on 12/4/15 at 12:40pm.<br><br>Refer to interview with Staff D on 12/8/15 at | D 338 | | |

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| D 338 | Continued From page 8<br>9:51am.<br><br>Refer to confidential interview with a family member on 12/8/15 at 3:15pm.<br><br>Refer to confidential resident interview on 12/8/15 at 3:25pm.<br><br>Refer to interview on 12/8/15 at 3:38pm with Staff G.<br><br>Refer to interview on 12/8/15 at 4:10pm with Staff H.<br><br>---<br><br>Interview with Staff E, PCA on 12/4/15 at 12:40pm revealed:<br>-Staff G was "rude to the residents and staff".<br>-"[Staff G] had been suspended for a couple of days".<br>-"[Staff G] had been suspended 3 times".<br><br>Interview with Staff D, PCA on 12/8/15 at 9:51am revealed:<br>-Staff G got aggravated with everyone but the residents who were "bed bound" because they were not up moving around.<br>-Staff G was "disrespectful and mocks the residents and makes fun of them".<br>-Staff G had "been in trouble before".<br><br>A confidential interview with a family member on 12/8/15 at 3:15pm revealed "[Staff G] has a tone of voice".<br><br>A confidential resident interview on 12/8/15 at 3:25pm revealed "I have witnessed him [Staff G] being rough", but could not give any specifics. | D 338 | | |

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| D 338 | Continued From page 9<br>Interview on 12/8/15 at 3:38pm with Staff G, PCA revealed:<br>-He was not aware of any allegations regarding talking disrespectful towards the residents.<br>-He stated "I get along with everybody".<br><br>Interview on 12/8/15 at 4:10pm with Staff H, PCA revealed:<br>-Staff G was not respectful to staff or residents.<br>-Staff G "gets in the residents faces".<br>-Staff G "Talks disrespectful to the residents".<br><br>---<br><br>The facility provided the following plan of protection on 12/8/15.<br>-Suspended accused employee.<br>-Immediately complete the HCPR 24 hour and 5 day report.<br>-Provide monthly training on resident rights.<br>-Supervisor will do rounds throughout the building to ensure resident rights are in compliance, and residents are being treated with dignity and respect.<br><br>THE PLAN OF CORRECTION DATE FOR THIS TYPE B VIOLATION IS FEBRUARY 14, 2016. | D 338 | | |
| D 438 | 10A NCAC 13F .1205 Health Care Personnel Registry<br><br>10A NCAC 13F .1205 Health Care Personnel Registry<br>The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. | D 438 | | |

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| D 438 | Continued From page 10<br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO A TYPE B VIOLATION.<br><br>Based on these findings, the Type B Violation was unabated.<br><br>Based on observations, record reviews, and interviews, the facility failed to protect residents by not investigating allegations for injury of unknown source (shoulder dislocation) for 1 resident (#11), and upon investigation of verbal abuse of a resident (#8) by a staff member the facility did not report to the Health Care Personnel Registry.<br><br>The findings are:<br><br>A. Review of Resident #8's current FL2 dated 10/6/15 revealed:<br>-Diagnoses included Alzheimer's Dementia.<br>-Resident was ambulatory with the assistance of a cane.<br><br>Review of the Special Care Unit Profile dated 11/16/15 revealed the degree of cognitive impairment was "moderate".<br><br>Interview on 12/4/15 at 12:40pm with Staff E, Personal Care Aide (PCA) revealed:<br>-Staff G was "Rude to the residents and staff".<br>-Staff G, did not like Resident #8.<br>-"I overheard, [Staff G, PCA] tell [Resident #8] that if she did not sit down he would push her down".<br><br>Interview with Staff D, PCA on 12/7/15 at 8:59am revealed another staff member reported Staff G to the Administrator in Charge because of what he said to one of the female residents. | D 438 | The facility held mandatory staff meeting on 1.15.16. Educated staff and trained on how and what to report. When reported to supervisor, supervisor is immediately to notify RCC and/or administrator, Administrator will do 24hr HCPR report and copy faxed also fax to AHS. Then administrator will | 1.15.16 |

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| D 438 | Continued From page 11<br>Interview on 12/8/15 at 3:38pm with Staff G revealed:<br>-He was not aware he was talking disrespectful to the residents.<br>-He stated "I get along with everybody."<br><br>Interview with the Administrator-in-Charge on 12/8/15 at 4:00pm and 5:15pm revealed:<br>-On 11/3/15 Staff I, was working with Staff G in the special care unit.<br>-While removing food trays, Staff I, heard Staff G say to Resident #8 "Move or I'm gonna knock you down."<br>-Staff I, reported the incident to the Administrator-in-Charge.<br>-"I interviewed Staff G and suspended him for the rest of the shift because of his attitude."<br><br>Interview with the Administrator-in-Charge on 12/9/15 at 9:22am revealed:<br>-The incident on 11/3/15 was not reported to the Health Care Personnel Registry within the required 24 hours.<br>-She did not report the incident to the Health Care Personnel Registry because after her investigation she determined Staff G did not directly mean to say anything negative to the resident "It was taken out of context".<br>-The Health Care Personnel Registry Report was completed on 12/9/15.<br>-Staff G was suspended on 12/8/15 pending outcome of the facility's investigation.<br><br>Interview on 12/30/15 at 9:15am with Staff I, Medication Aide / Supervisor in Charge (SIC) regarding the 11/3/15 incident revealed:<br>-They were working with Staff G, on the Special Care Unit when they heard Staff G make the statement to Resident #8 "If you don't move I'm gonna knock you down." | D 438 | do 5day investagation report. To monitor and assure all allegations are being report. Facility supervisor meets with staff a shift change and addresses any concerns and reports daily to administrator. Administrator will do rounds speaking with staff and residents to assure all concerns and allegations are being reported promptly. Facility has imperted ongoing training on how to report and manage at staff meetings throughout each month to review and continue to educate staff on | |

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|---|---|---|---|
| | HAL014014 | A. BUILDING: _____ B. WING _____ | R 12/31/2015 |

| 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 438 | Continued From page 12<br>-"If this was heard out of context, you would have thought he was being mean to the resident."<br>-They reported the incident to the Administrator-in-Charge.<br>-Staff G was sent home that night "probably for that and and incident with an employee."<br>-"His tone of voice is what got him in trouble that night."<br><br>Review of the facility's Health Care Personnel Registry Policy revealed: "Employee will be checked with Health Care Registry prior to employment. If employee is hired, employee is to report to supervisor in charge any complaint or allegation of any kind. Supervisor is to report to nursing supervisor and administration. Administration is to complete a 24-hour HCPR report and a 5-day investigation. If findings are found to be true the employee will be terminated and not eligible for rehire."<br><br>Review of the facility's Health Care Personnel Registry Investigation, received on 12/14/15 revealed the facility's Health Care Personnel Registry investigation was completed on 12/14/15 and, Staff G, was terminated on 12/11/15.<br><br>B. Review of Resident #11's current FL2 dated 8/21/15 revealed:<br>-Diagnoses of Alzheimers Disease, degenerative joint disease, chronic kidney disease and Azotemia (Elevated blood urea nitrogen and serum creatine levels.<br>-An admission date of 8/27/08.<br>-Resident was disoriented.<br>-A recommended placement of special care unit-assisted living.<br>-Assistive device: Cane.<br><br>Review of an incident report dated 12/24/15 at | D 438 | reporting and residents rights. | |

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| D 438 | Continued From page 13<br>12:01am provided by the facility revealed under "Describe Incident" Resident was getting up out of chair, went to turn around and tripped over cane and fell.<br><br>Interview with Staff A, Supervisor-in-Charge / Medication Aide on 12/30/15 at 2:50pm and 12/31/15 at 8:00am revealed:<br>-She completed the incident report on Resident #11 dated 12/24/15 at 12:01am.<br>-She notified the resident's responsible person before she got off work at 7:00am.<br>-She received a call around 12:00am from Staff B, Personal Care Aide that Resident #11 was found on the floor in her room.<br>-No one had seen Resident #11 fall.<br>-When she arrived at the resident's room the resident's chair was pushed to the side from where it normally was located, the resident's cane was laying to the side, and Resident #11 was laying in the floor.<br>-"It looked like she [Resident #11] was trying to go to the bathroom and fell."<br>-She checked the resident out and determined that she had no injuries.<br>-Resident #11 did not verbalize any complaints of pain or discomfort.<br>-She "Assumed" Resident #11 had fallen from the way the room looked and where she was located in the floor".<br>-She continued to check on the resident the remainder of the shift and reported to the oncoming shift.<br><br>Attempted Interview on 12/31/15 at 9:00am and 11:30am with Staff B, PCA during the survey was unsuccessful.<br><br>Continued review of the same incident report dated 12/24/15 revealed: | D 438 | | |

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| D 438 | Continued From page 14<br><br>-X-ray of right shoulder (which was completed on 12/26/15).<br>-Intervention of "encourage proper use of cane".<br>-Physician and on-call facility staff notified.<br><br>Interview with the Resident Care Coordinator on 12/30/15 at 11:10am and 12/31/15 at 2:25pm revealed:<br>-She was on call for the facility over Christmas.<br>-She did remember getting a call in regards to Resident #11 from Staff C, Supervisor in Charge / Medication Aide, but could not recall the exact time she received the call, but the date was 12/26/15.<br>-Staff C told her that Resident #11 was complaining about pain in her right arm and her right hand was swollen.<br>-She told Staff C to call the on-call physician.<br><br>Review of a physician order from the on-call physician for the facility dated 12/26/15 revealed a verbal order for Resident #11 to have an x-ray of her right shoulder.<br><br>Review of a Radiology Report from the company who provided the facility x-ray revealed:<br>-They were notified of the x-ray on 12/26/15 at 5:09am.<br>-The x-ray was completed at the facility on 12/26/15 at 6:30am.<br>-The Radiologist read the x-ray on 12/26/15 at 8:20am.<br>-Conclusion: Anterior shoulder dislocation.<br><br>Continued review of the same Radiology Report revealed hand written documentation of a follow-up appointment with "Orthopedics" on 12/28/15 related to the x-ray results, and an appointment with "Orthopedics" on 12/31/15 at 11:30am. | D 438 | | |

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|---|---|---|---|---|
| D 438 | Continued From page 15<br><br>Attempted interview on 12/31/15 at 11:15am with the on-call physician who ordered the x-ray was unsuccessful.<br><br>Review of documentation of the orthopaedic consult dated 12/31/15 revealed under findings "Anterior inferior dislocation of humeral head without fx in osteopenic bone (A condition which the bone has a mineral density that is lower than normal) with metallic clothing fasteners."<br><br>---<br><br>On December 31, 2015 the facility provided the following plan of protection:<br>-The Administrator in Charge and Resident Care Coordinator immediately made rounds and spoke with each staff member to address any resident, or staff concerns related to abuse, neglect, or injury of unknown source.<br>-The Administrator will investigate and report all incidents of injury of unknown origin, abuse, or neglect.<br>-The Administrator will be scheduling a meeting with all staff to discuss resident rights, and the importance of reporting any injuries, abuse (physical and verbal) to their supervisors.<br>-Reexamine shift change procedures and assure all injuries or abuse allegations are properly reported.<br><br>THE FACILITY PROVIDED THE PLAN OF CORRECTION DATE FOR THE UNABATED B VIOLATION OF JANUARY 15, 2015. | D 438 | | |
| D911 | G.S. 131D-21(1) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights | D911 | | |

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| D911 | Continued From page 16<br>Every resident shall have the following rights:<br>1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility to treat residents in the Special Care Unit (SCU) with the right to privacy by not providing window coverings in 5 of 15 rooms.<br><br>The findings are:<br><br>Based on observations and interviews, the facility failed to have window coverings to provide for resident privacy in 5 of 15 resident rooms (Room #'s 303, 304, 306, 309, and 316) on the Special Care Unit (SCU).<br>[(Refer to tag D083 10A NCAC 13F .0306(a)(9) Housekeeping and Furnishings.)] | D911 | Facility on 1-4-16 hung black out curtains on all residents rooms on the scu on 1-26-25.16 changed curtains to blinds with completion on 1-27-16 | 1-27-16 |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure residents were free from neglect related to failure to investigate allegations of injury of and unknown source, dislocated shoulder, and verbal abuse of | D912 | Resident right training on 1-15-16. Facility plans to continue on going training on resident's rights. Facility has scheduled inservice with onbudsman on residents rights, mandatory for all staff. Facility plans to continue monthly | 1-15-16 |

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| D912 | Continued From page 17<br>a resident by a former staff member, and report to Health Care Personnel Registry.<br><br>The findings are:<br><br>A. Based on observations and interviews, the facility failed to have window coverings to provide for resident privacy in 5 of 15 resident rooms (Room #'s 303, 304, 306, 309, and 316) on the Special Care Unit (SCU). [Refer to Tag D083 10A NCAC 13F .0306(a)(9) Housekeeping and Furnishings.]<br><br>B. Based on observations, interviews, and record review, the Administrator failed to assure the total operation of the facility met and maintained rules related to management of the facility, Health Care Personnel Registry, and resident rights. [Refer to Tag D176 10A NCAC 13F .0601(a) Management of Facilities TYPE B VIOLATION].<br><br>C. Based on observations, record reviews, and interviews, the facility failed to protect residents by not investigating allegations for injury of unknown source (shoulder dislocation) for 1 resident (#11), and upon investigation of verbal abuse of a resident (#8) by a staff member the facility did not report to the Health Care Personnel Registry. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry UNABATED TYPE B VIOLATION].<br><br>D. Based observations, interviews and record reviews, the facility failed to ensure residents residing in the facility were free from mental abuse as evidenced by staff (Staff G) to resident (Residents #8, #9, and #10) verbal abuse. [Refer to Tag 038 10A NCAC 13F .0909 Resident Rights TYPE B VIOLATION]. | D912 | inservice for ongoing training and review residents rights at each training. Facility plans to monitor by management making daily rounds and speaking with each resident to assure residents rights are being met and address any concerns immediately. | |

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|---|---|---|---|---|
| D914 | Continued From page 18 | D914 | | |
| D914 | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to assure residents were free of mental abuse, from staff (Staff G) to resident verbal abuse (Residents #8, #9 and #10).<br><br>The findings are:<br><br>Based observations, interviews and record reviews, the facility failed to ensure residents residing in the facility were free from mental abuse as evidenced by staff (Staff G) to resident (Residents #8, #9, and #10) verbal abuse. [Refer to Tag 038 10A NCAC 13F .0909 Resident Rights TYPE B VIOLATION]. | D914 | | |

Attachment A

**Brockford Inn Assisted Living**
**56 N. Highland Ave.**
**Granite Falls,N.C. 28630**
**Phone 828-396-3111**
**Fax 828-396-5822**

Administrator-Denise Coffey — Admin. Assist – Lora Mitchum
Nursing Supervisor-Rhonda Piercy — Activities Director- Shelby Ribbe

# Incident Report

Resident Name:_____
Date Of Incident:_____
Person Reporting:_____
Any Injury:_____Time:_____
Any Treatment:_____Describe:_____
_____By Whom:_____
Family Notified:_____Name:_____Phone:_____By who_____
Doctor Notified:_____Name:_____Phone:_____By who_____
DSS Notified:_____Date:_____
On Call Personnel Notified:_yes_no Who_____By who_____
Date of last fall:_____how many falls past three months:_____
Is incident from unknown source: yes or no HCPR done: yes or n/a
Describe Incident_____
_____
_____
_____
_____
Was incident witnessed?____Yes___No Witnessed by who_____
Immediate Intervention_____
_____

**Give resident horn and instruct how to call for help**
**Place resident on every two hour checks for 24 hours after a fall for any changes**
Follow up and follow up report from MD _____
_____
_____
#1 intervention_____
_____
follow up #1 intervention_____
_____
#2 intervention_____
_____
follow up #2 intervention_____
_____
#3 intervention_____
MD reassessment_____
_____