/ision of Health Service Regulation

ITEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	R-C 07/22/2026

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LDSBORO ASSISTED LIVING & ALZHEIMER'S CAI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

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D 000	Initial Comments The Adult Care Licensure Section and the Wayne County Department of Social Services conducted a follow-up survey and complaint investigation from 07/21/26 to 07/22/26. The complaint investigation was initiated by the Wayne County Department of Social Services on 06/25/26.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the assessed needs for 1 of 5 sampled residents (#2) who resided in the special care unit (SCU) as evidenced by the resident walking away from her primary care provider's office without staff knowledge. The findings are: Review of the facility's missing resident policy (no date) revealed: -If the whereabouts of a resident are unknown	D 270	Facility staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Since the day of the incident, May 18,2026, all residents going to doctor's appointments transported by facility staff have had 1:1 supervision. If the RCC takes more than 1 resident, a staff member goes with him so each resident is supervised. The RCC will make note on the resident appointment book if an extra employee goes on any appointment in order to have documentation to show supervision in accordance with each resident's needs, care plan and current symptoms. RCC will monitor each appointment to insure appropriate supervision. Administrator will monitor appointments weekly to insure appropriate supervision.	7/23/

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D 270	Continued From page 1	D 270		

and there is reason to be concerned about his safety, the person in charge in the home shall immediately do the following: contact the RCC.
-The RCC will determine if the resident's safety is at risk.
-If determined that the resident's safety is at risk, the RCC will instruct the SIC to contact the resident's responsible person, the appropriate law enforcement agency and the county department of social services.
-The RCC will then notify the Administrator.

Review of Resident #2's current FL-2 dated 10/06/25 revealed:
-Diagnoses included dementia, hypertension, diabetes, and stage 3 chronic kidney disease.
-She was semi-ambulatory.
-She used a walker as an assistive device.
-She was intermittently disoriented.
-The recommended level of care was the special care unit.

Review of Resident #2's Resident Register revealed she was admitted to the facility on 10/08/25.

Review of Resident #2's assessment and care plan dated 12/31/25 revealed:
-She was ambulatory with the use of a walker.
-She was sometimes disoriented.
-She needed supervision with ambulation.

Review of Resident #2's incident/accident report dated 05/18/26 revealed:
-She walked away from her doctor's office.
-There were no injuries at the time.
-Staff called 911 and the facility.

Review of the county's 911 event report dated 05/18/26 revealed:

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D 270	Continued From page 2 -The call was received at 11:31am. -The nature of the report was a missing person at risk. -Resident #2 left on foot. -It was unknown where Resident #2 might go. -Resident #2 was at risk. -Resident #2 was at the doctor's office to be seen and had wandered off. -Resident #2 had a medical/ mental condition. -A call was received at 11:47am Resident #2 was found at a local grocery store. -The call was cleared at 11:52am. Review of the county's 911 call from Resident #2's primary care provider's (PCP) office dated 05/18/26 revealed: -A representative from the PCP's office called 911. -The representative reported that Resident #2, who had a diagnosis of dementia, had wandered away from the PCP's office Review of the local weather report revealed that the temperature in the area on 05/18/26 at 11:31am was 86 degrees and partly sunny. Observation on 07/22/26 at 7:29am of the location Resident #2 was found revealed: -The local grocery store was 0.6 miles from the PCP's office -There was a sidewalk on the opposite side of the street from Resident #2's PCP's office. -There was not a sidewalk on the same side as the PCP's office. -There were 4 traffic lights from the PCP's office to the local grocery store. Interview with Resident #2 on 07/21/26 at 9:04am revealed: -She did not remember leaving her PCP's office. -Her daughter went with her to her appointments	D 270		

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D 270	Continued From page 3 or she would go alone. -She did not need anyone to go with her to her appointments. Interview with Resident #2's family member on 07/21/26 at 9:42am revealed: -She received a call from the facility on 05/18/26 (not sure of time) that Resident #2 had walked away from her PCP's office. -Resident #2 was back in the facility when she received the call. -She went to the PCP's office when she found out Resident #2 left the office and they did not know what happened. -She went to the facility to check on Resident #2. -She was told Resident #2 walked away because she said she was going to a party. -She was concerned about Resident #2 because of the heat, she had on a sweater, she used a walker, and her right leg gave out sometimes. -Resident #2 could have gotten hit by a car or someone could have picked her up. Interview with the facility's Business Office Manager (BOM) on 07/21/26 at 11:57am and on 07/22/26 at 8:34am revealed: -The Resident Care Coordinator (RCC) called her to inform her and the Administrator that Resident #2 walked away from the PCP's office and that he had called law enforcement. -She and the Administrator left to go to the PCP's office. -When they arrived at the PCP's office, law enforcement were there and everyone decided to go in opposite directions to start looking for Resident #2. -She found Resident #2 across the street from a local restaurant, which was toward the local grocery store. -She took Resident #2 back to the PCP's office.	D 270		

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D 270	Continued From page 4 -She called the family as soon as she returned to the facility with Resident #2. -She informed the responsible person Resident #2 walked away while she was waiting at the PCP's office. -She informed the responsible person that law enforcement was called and Resident #2 was fine. -The family told her they were on their way to the facility. -She knew that law enforcement and the responsible person were supposed to be called while the incident was happening but there was so much going on and everyone was in panic mode. Interview with the RCC on 07/21/26 at 12:10pm revealed: -He took Resident #2 to her PCP's appointment along with another resident. -He took Resident #2 to the lobby and told her to sit there and she said okay. -Resident #2 had sat in the lobby at previous appointments and he did not have any issues. -He never had an issue with Resident #2 walking away. -Resident #2 always followed his directives. -He asked the receptionist to keep an eye on Resident #2. -When he came to check out the other resident he noticed Resident #2 was gone. -He went outside and looked around and did not see Resident #2. -He came back to the PCP's office and asked the receptionist to call 911. -He called the facility and spoke with the BOM and told her Resident #2 walked away. -The Administrator, the BOM and the Maintenance Director came and started looking for Resident #2.	D 270		

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D 270	Continued From page 5 -The BOM called and said she found Resident #2. -They came back to the PCP's office; the nurses checked her out to ensure there were no injuries or heat exhaustion. -Resident #2 never showed behaviors that she would walk off. -Resident #2 should have been kept in an eyes view. Interview with the Administrator on 07/21/26 at 1:50pm revealed: -The BOM received a call from the RCC on 05/18/26 that Resident #2 had walked away from the PCP's office. -She and the BOM got in separate cars and went there. -She called the Maintenance director to meet them there. -They decided to start looking for Resident #2. -The BOM called her to let her know she found Resident #2 and took her back to the PCP's office. -When she returned to the PCP's office, the staff from the PCP's office were outside talking to Resident #2. -Resident #2 returned to the facility with the BOM. -She informed the BOM to call the county Department of Social Services (DSS) and Resident #2's responsible person. -If a resident was a known wanderer staff should stay with them. -She thought residents in memory care needed to be supervised. Attempted telephone interview with Resident #2's PCP's office on 07/21/26 at 11:43am and 07/22/26 at 8:02am was unsuccessful. The facility failed to ensure 1 of 5 residents (#2)	D 270		

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D 270	Continued From page 6 who resided in the Special Care Unit with a diagnosis of dementia was properly supervised by the facility staff while attending a primary care provider's appointment resulting in the resident walking away unsupervised 0.6 miles from the PCP's office to a grocery store. The facility's failure to supervise the resident resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 21, 2026.	D 270		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to immediately notify the responsible person for 1 of 5 sampled residents (#2) who resided in the memory care unit when the resident's whereabouts where unknown due to	D 328	The facility shall notify the resident's responsible party, appropriate law enforcement agency and the county DSS if there is reason to be concerned about resident's safety. Immediately following the incident, the facility established a procedure to notify responsible parties immediately when there is a concern about a resident's safety. This has always been done when a resident is missing from the facility. The day of the incident, which did not happen at the facility, law enforcement was notified immediately. DSS and the family was notified immediately after the resident was found and returned to the facility. (The facility was notified of the situation by the RCC at the doctor's office at 11:32am.	7/23/2026

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D 328	Continued From page 7 the resident walking away from her primary care provider's office without staff knowledge. The findings are: Review of the facility's missing resident policy (not dated) revealed: -If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately do the following: contact the RCC. -The RCC will determine if the resident's safety is at risk. -If determined that the resident's safety is at risk, the RCC will instruct the SIC to contact the resident's responsible person, the appropriate law enforcement agency and the county department of social services. -The RCC will then notify the Administrator. Review of Resident #2's current FL-2 dated 10/06/25 revealed: -Diagnoses included dementia, hypertension, diabetes, and stage 3 chronic kidney disease. -She was semi-ambulatory. -She used a walker as an assistive device. -She was intermittently disoriented. -The recommended level of care was special care unit. Review of Resident #2's Resident Register revealed she was admitted to the facility on 10/08/25. Review of Resident #2's assessment and care plan dated 12/31/25 revealed: -She was ambulatory with the use of a walker. -She was sometimes disoriented. -She needed supervision with ambulation.	D 328	DSS was notified at 12:09pm and the family was notified at 12:12pm. The family did come to the facility and took the resident out to run errands until 7:15pm.) All sic's/med techs and supervisory staff have been in-serviced on contacting responsible parties when there is a concern about a resident's safety. Administration will be responsible for making sure all notifications have been made per regulations. After any such incident, Administrator will review procedures to insure all were followed and assess if any changes need to be made.	7/25/2026

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D 328	Continued From page 8 Review of Resident #2's incident/accident report dated 05/18/26 revealed: -She walked away from her doctor's office. -There were no injuries at the time. -Staff called 911 and the facility. Review of the county's 911 event report dated 05/18/26 revealed: -The call was received at 11:31am. -The nature of the report was a missing person at risk. -Resident #2 left on foot. -It was unknown where Resident #2 might go. -Resident #2 was at risk. -Resident #2 was at the doctor's office to be seen and had wandered off. -Resident #2 had a medical/ mental condition. -Resident #2 was a dementia resident and was there with an assisted living. -A call was received at 11:47am that Resident #2 was found at a local grocery store. -The call was cleared at 11:52am. Interview with Resident #2's family member on 07/21/26 at 9:42am revealed: -She received a call from the facility on 05/18/26 (not sure of time) that Resident #2 had walked away from her PCP's office. -Resident #2 was back in the facility when she received the call. -She was concerned because of the following: the heat, Resident #2 had on a sweater, Resident #2 used a walker, and Resident #2's right leg gave out sometimes. -Resident #2 could have gotten hit by a car or someone could have picked her up. Interview with the Business Office Manager (BOM) on 07/21/26 at 11:57am revealed: -The Resident Care Coordinator (RCC) called her	D 328		

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D 328	Continued From page 9 to inform her and the Administrator that Resident #2 walked away from the PCP's office and that he had called law enforcement. -She and the Administrator left to go to the PCP's office. -She called the family as soon as she returned to the facility with Resident #2. -She informed the responsible person Resident #2 walked away while she was waiting at the PCP's office. -She informed the responsible person that law enforcement was called and Resident #2 was fine. -The responsible person told her they were on their way to the facility. -She knew that law enforcement and the responsible person were supposed to be called while the incident was happening but there was so much going on and everyone was in panic mode. Interview with the RCC on 07/21/26 at 12:10pm and 4:06pm revealed: -He took Resident #2 to her PCP's appointment along with another resident on 05/18/26. -He took Resident #2 to the lobby and told her to sit there and she said okay. -When he came to check out the other resident he noticed Resident #2 was gone. -He went outside and looked around and did not see Resident #2. -He came back to the PCP's office and asked the receptionist to call 911. -He called the facility and spoke with the BOM and told her Resident #2 walked away. -His priority was to find Resident #2. -He did not want to notify the responsible person with no answers. -He preferred to notify the responsible person after they found Resident #2 so he could let them	D 328		

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D 328	Continued From page 10 know she was safe. Interview with the Administrator on 07/21/26 at 1:50pm revealed: -The BOM received a call from the RCC on 05/18/26 that Resident #2 had walked away from the PCP's office. -She and the BOM got in separate cars and went there. -She called the Maintenance Director to meet them there. -Her concern was to find Resident #2. -She was not going to stop and call the responsible person. -When they returned to the office, she informed the BOM to call the county department of social services and Resident #2's responsible party.	D 328		