STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092-236	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTONWOOD LEAD MINE	4510 LEADMINE ROAD RALEIGH, NC 27612

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D 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted an initial survey and complaint investigation on April 15 - 16, 2026. The complaint investigation was initiated by the Wake County Department of Social Services on March 25, 2026.	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 for 1 of 5 sampled resident (#2) as evidenced by a resident with a diagnosis of dementia who eloped from the facility's locked special care unit (SCU). The findings are: Review of the facility's Resident Elopement Policy dated 12/25 revealed: -Risk for elopement can be determined in the Health and Service assessment in the electronic	D 270		

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medication administration record.
-An individual care plan will be developed and implemented based on the elopement assessment.
-Elopement drills and procedures are performed quarterly by the community.
-Routine checks of alarmed doors will be performed weekly in the Special Care Unit (SCU) by maintenance staff to ensure resident safety and documented.

Review of the facility's Elopement Drill Policy dated 12/25 revealed:
-The Supervisor in Charge (SIC) will immediately be notified when a resident is missing.
-The SIC or designee will assign staff members to begin an immediate systematic search of the building and outside grounds.
-Search will include bathrooms, shower stalls, spa rooms, under and in beds, behind and inside furniture, behind and in boxes, in closets and behind doors regardless of if they are locked.
-Once a room is checked, staff are to close the door and place an object in front, so all know it has been searched.
-Staff outside should search behind shrubs, trees, outside furniture.
-Each staff will be assigned a sector to search to minimize overlap.
-This search should only last 15 minutes.
-If the resident is not discovered the SIC will immediately notify the Administrator, Resident Care Coordinator (RCC) or the designee.
-A search leader will be determined to leave the community in a car and look for, check with, and assist those searching on foot.
-The search on foot will take place in the immediate vicinity outside of the community.
-Search obvious routes to former home, or nearby shopping areas.

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D 270	Continued From page 2 Review of Resident #2's current FL-2 dated 01/08/26 revealed: -Diagnoses included dementia, hyperlipidemia, gastroesophageal reflux disease, Barrett's esophagus, history of colitis, and osteoarthritis. -The resident was constantly disoriented. -The resident was ambulatory. -The resident's current level of care was SCU. Review of the Resident Register for Resident #2 revealed she was admitted to the facility on 01/28/26. Review of the Resident #2's care plan dated 01/28/26 revealed: -The resident was occasionally disoriented to people, place, time or situation even in familiar surroundings. -The resident required supervision from staff for safety. -The resident looked for her husband who did not live in the facility. Review of the Resident #2's incident and accident (I/A) report dated 03/14/26 revealed: -On 03/14/26 at 4:20pm Resident #2 was seen on the facility's camera exiting her apartment in the SCU. -At 4:26pm Resident #2 exited the facility. -The resident then walked off the property and towards a nearby road. -Resident #2 went out of the view of the staff. -At 4:59pm Resident #2 returned to the facility and was escorted by staff back to the SCU. -The primary care provided (PCP) was notified by the RCC. -Resident #2's family was notified by the RCC. -The resident was placed on a 30-minute check watch.	D 270		

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D 270	Continued From page 3 Review of google maps on 04/16/26 revealed the facility was a 9-minute walk away from a nearby road where Resident #2's was witnessed by staff. Observation of the outside of the facility on 04/16/26 at 1:35pm revealed: -There was one bus stop located directly in front of the facility to the left side. -There was a crosswalk in front of the facility without pedestrian signals. -There was a sidewalk located to the right of the facility that crossed over to a nearby road. Second observation of the outside of the facility on 04/16/26 at 4:20pm revealed: -The facility was located on a 4-lane street with a median. -The street had 2 lanes on each side of the median traveling in opposite directions. -The parking lot entrance of the facility was connected to the 4-lane road. -There were no crossing signals located at the entrance of the facility which led to the road. -On 04/16/26 for 1 minute, there were 33 cars, 2 transfer trucks and 1 bus observed traveling the four-lane street. -The speed limit of the road directly in front of the facility was 35 miles per hour. Review of the local online weather report on 04/16/26 revealed the weather on 03/14/26 at 4:20pm was warm, with above average temperatures of 80 degrees. Review of Resident #2's PCP notes dated 03/16/26 revealed: -Resident #2 walked away from the SCU and onto the elevator. -Resident #2 entered the assisted living unit and	D 270		

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walked outside.
-Resident #2 returned with no injuries.
-Resident #2 had advanced dementia.

Interview with a personal care aide (PCA) on 04/15/26 at 9:26am revealed:
-She was not working on the morning of 03/14/26 when the elopement occurred.
-She was unsure how Resident #2 was able to elope.
-She was trained upon hire that no resident could be on the elevator alone.
-She was trained upon hire that the elevator would only work using a key fob.
-She was trained upon hire that staff could not walk away from the elevator without watching it close completely.

Interview with the second PCA on 04/16/26 at 1:36pm revealed:
-On 03/14/26 she used her key fob to get onto the elevator.
-She heard a resident call out her name.
-She turned around and went toward the resident that was calling out for help to offer assistance.
-She did not see any other residents at the elevator or around her.
-She did not wait for the elevator to close completely before walking off.
-She was trained when hired that she must wait for the elevator to close completely before walking off.
-She did not know that she was the staff who allowed Resident #2 to onto the elevator who then eloped until the Administrator told her.
-She knew she had to wait for the elevator to close completely but she walked away anyway.

Observation of the elevator on the SCU on 04/15/26 at 8:13am revealed:

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D 270	Continued From page 5 -The elevator could only be operated by a staff member with an activated key fob. -There was an electronic pad inside the elevator to the left to scan the key fob. -The elevator needed a key fob to go to the 3rd SCU floor. -The elevator needed a key fob to go to the ground level floor. -The elevator needed a key fob to access all three floors of the facility. Interview with a concierge on 04/15/26 at 2:26pm revealed: -Resident #2 walked up to her on 03/14/26 around 4:20pm and said that she was going out for a walk. -The concierge let Resident #2 out the front door of the facility by pushing the release button at the desk. -She did not recognize Resident #2 as a resident and did not realize that Resident #2 resided in the SCU. -After she allowed Resident #2 to go out the front doors, she then had a gut feeling something was off and she looked at the face sheets at her desk to see if she could find Resident #2 as a resident. -She quickly spoke with a medication aide (MA) and asked her should she have allowed a resident out of the building and the MA said no she should not have let her out of the building. -The MA walked out and saw Resident #2 walking back towards the building. -The MA was able to get Resident #2 back inside the building. -She notified the Health and Wellness Director (HWD) of Resident #2 walking out the front door. -The HWD notified the Special Care Coordinator (SCC) who notified the Administrator about the incident.	D 270		

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D 270	Continued From page 6 Interview with the HWD on 04/16/26 at 8:01am revealed: -She received a phone call from the MA a little after 5:00pm on 03/14/26 stating that a SCU resident had eloped from the facility. -The PCA did not follow the training that was provided when she was initially hired. -Staff were trained upon hire to always make sure the elevator doors closed completely and no residents were on the elevator before walking away. -The PCA was supposed to wait until the elevator door closed completely before walking away. -There was a resident's book with residents' names and pictures at the front desk to alert the concierge who was on the SCU. -The concierge did not look in the resident's book before letting the resident go outside. Interview with the SCC on 04/15/26 at 9:00am revealed: -The elevator doors did not open unless a staff member used their key fob. -He was not working the day Resident #2 eloped from the facility. -He was told that the PCA used their key fob at the elevator to get on but then walked away. -This incident was on video footage, but the footage was erased after two weeks. -The video footage showed the PCA using her key fob to open the elevator and then walking off before it closed completely. -The concierge allowed Resident #2 to walk outside. -All staff were trained upon hire and no one should walk away from the elevator until it closed completely. -All staff had been retrained on the facility's elopement procedure.	D 270		

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D 270	Continued From page 7 Second interview with the SCC on 04/16/26 at 8:18am revealed: -All staff upon hire had to go through the elopement training. -The elopement training consisted of explaining that the staff must watch the elevator door close completely before walking away. -All SCU residents must be escorted on and off the elevator. -SCU residents were not allowed to use the elevator without a staff member riding up or down with them. -The elevator doors would not work unless a staff member used their key fob to operate the elevator. Telephone interview with Resident #2's PCP on 04/16/26 at 2:28pm revealed: -Resident #2's diagnosis included dementia per her FL-2 and her initial encounter with Resident #2 was she did have short term memory loss. -Resident #2's baseline was she was alert and oriented to self but not to time or place, and she recognized her family members. -She was made aware that Resident #2 walked out of the facility on 03/14/26. -The facility notified her assistant regarding the incident and wrote an incident report. -She saw Resident #2 on the following Monday, 03/16/26 for a well check after the incident. -She noted no concerns during her follow up visit. -She was concerned about Resident #2 possibly attempting to cross the busy street and that she could have gotten lost during this incident. -She expected the SCU staff to keep an eye on Resident #2 so that she did not get out of the building without someone's knowledge. -Resident #2 was dealing with the recent loss of her spouse so the PCP increased Resident #2's Zoloft to treat her insomnia from 50mg to 75mg.	D 270		

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D 270	Continued From page 8 Interview with the Administrator on 04/15/26 at 1:44pm revealed: -The PCA went to assist another resident when the Resident #2 walked onto the elevator without the PCA's supervision. -The concierge did not recognize Resident #2 because she was a part-time weekend only staff member. -The concierge was the staff that allowed Resident #2 to walk outside. -Staff did not follow the elopement training provided upon hire. -He discovered how Resident #2 was able to elope by watching the facility's video footage. -He no longer had the video footage because the video footage erased after two weeks. -Resident #2 told him that she was attempting to walk to see her husband. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable. Attempted telephone interview with Resident #2's family member on 04/15/26 at 8:33am, 2:17pm, 4:08pm, and on 04/16/26 at 1:35pm was unsuccessful. Attempted telephone interview with a second MA on 4/15/26 at 9:22am and 2:49am was unsuccessful. _____ The facility failed to ensure a resident (#2) who had diagnosis of dementia and resided in a special care unit (SCU) was supervised resulting in the resident eloping from the facility and was outside for 33 minutes and was witnessed by staff walking from a nearby street 0.9 miles away from	D 270		

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D 270	Continued From page 9 the facility. This failure resulted in serious neglect of the resident and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 03/25/26. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED May 16, 2026. TYPE A1 VIOLATION	D 270		