STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G119	A. BUILDING _____ B. WING _____	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WENDOVER HOME	631 OLD PARK ROAD MAIDEN, NC 28650

(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) COMPLETION DATE
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004	E 004 Emergency Preparedness Book has been updated and completed on July 18, 2023 DHSR - Mental Health JUL 27 2023 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dr. Kimella Pryor *Kimella Pryor* | Executive Director | 7/24/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the emergency preparedness plan (EPP) was reviewed and updated at least every two years. The finding is: Review of the facility EPP manual on 7/10/23 revealed a facility EPP manual dated 10/2017. Continued review of the facility EPP manual revealed outdated client specific information for 3 of 3 clients (#2, #3, #5) and missing information for client #4. Client #6 was admitted 7/10/23. Further review of the EPP manual also revealed expired client specific plans ranging from 1/20/22-4/13/22. Additional review of the EPP manual did not reveal client specific information for client (#4). Subsequent review of the facility EPP manual did not reveal evidence of updated in-service training, mock drills, or tabletop exercises. Continued review of the EPP manual revealed a facility tabletop drill dated 10/5/18 containing the following: 4 staff attendance signatures, no topic top drill name, no summary of the drill of pros or conc, and, no documentation of who lead/facilitated the drill. Interview with the qualified intellectual disabilities professional (QIDP) on 7/11/23 revealed that staff were provided in-service training during staff meetings however evidence of the in-service	E 004	E 004 Residents 2, 3, 5 specific plans were updated in the EOP. Resident 4 information was inserted and updated into the EOP. Resident 6 was added to the EOP. E 004 IDT Safety Committee Person, Behavioral Analysis Specialist with the assistance of the Qualified Professional will conduct Mock Drills & Tabletop In-Services monthly for the next three months	

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E 004	Continued From page 2 training was not available during the survey. Continued interview with the QIDP also revealed that evidence of current facility mock drills and tabletop exercises could not be located during the survey. Further interview with the QIDP revealed that client specific information in the EPP manual should be updated every two years or as needed.	E 004		