ERVICES			C	FORM APPROVED OMB NO. 0938-0391
SUPPLIER/CLIA (X2)				(X3) DATE SURVEY COMPLETED
34G119 B. W	ING			06/26/2024
ł		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
EDED BY FULL PI		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIA	
§441.184(b) 4483.73(b)(1), 85.625(b)(1) lities] must preparedness the emergency is section, risk this section, agraph (c) of edures must rears [annually ne policies and ving: eds for staff e or shelter in the following: aceutical naintain the health and v storage of hd alarm B(b)(6)(iii):] uirements for cilities only. address the	E 01			
	/SUPPLIER/CLIA (X2) TION NUMBER: A. BI 34G119 B. W	/SUPPLIER/CLIA       (X2) MULTIPL         TION NUMBER:       A. BUILDING         34G119       B. WING         34G119       B. WING         FICIENCIES       ID         FICIENCIES       ID         FICIENCIES       ID         FICIENCIES       ID         PREFIX       TAG         atients       E 015         §441.184(b)       \$483.73(b)(1), .85.625(b)(1)         illities] must       / preparedness         / preparedness       the emergency         is section, risk       this section, agraph (c) of         edures must       ////////////////////////////////////	ISUPPLIER/CLIA TION NUMBER: 34G119 (x2) MULTIPLE CONSTRUCTION A. BUILDING 34G119 B. WING STREET ADDRESS, CITY, STATE, ZIP COL 631 OLD PARK ROAD MAIDEN, NC 26650 PROVIDER'S PLAN OF CC 620 SREETER CONSTRUCTION INFORMATION) atients S441.184(b) 3483.73(b)(1), 85.625(b)(1) Ilities] must / preparedness the emergency is section, risk this section, agraph (c) of edures must / preparedness the emergency is section, risk this section, agraph (c) of edures must / preparedness the emergency is section, risk the senter in o the following: maceutical maintain the t health and / storage of md alarm 3(b)(6)(iii):] uirements for cilities only. address the	SUPPLIERCLA       (2) MULTIPLE CONSTRUCTION         A. BUILDING

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 06/28/2024

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.

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/28/2024 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE		
		34G119	B. WING			_	06/26/2024		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
WENDOV	ER HOME				631 OLD PARK ROAD MAIDEN, NC 28650				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 015	<ul> <li>hospice employees a evacuate or shelter in limited to the following (A) Food, water, medisupplies.</li> <li>(B) Alternate sources following:</li> <li>(1) Temperatures to p safety and for the safe provisions.</li> <li>(2) Emergency lightin (3) Fire detection, ext systems.</li> <li>(C) Sewage and wast This STANDARD is r Based on record revit failed to ensure the prineeds for clients and emergency food supp</li> <li>Observation of the fac supply on 6/25/24 revision of the fac supply on 6/25/24 revision of the face supply on 6/25/24 revision of the face</li></ul>	nd patients, whether they place, include, but are not g: ical, and pharmaceutical of energy to maintain the rotect patient health and e and sanitary storage of g. inguishing, and alarm e disposal. not met as evidenced by: ew and interview, the facility rovision of subsistence staff relative to the ly. The finding is: cilities emergency food ealed the emergency food ous food items which aby food, graham crackers, of mash potatoes, a box of bars, cereal bars, and d observations revealed the tion dates of 1/23, 8/23, 4. 3/24, and 5/24.		015	5				

Facility ID: 922856

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G119 B. WING 06/26/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD WENDOVER HOME **MAIDEN, NC 28650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 037 Continued From page 2 E 037 §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). \*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. \*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/28/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/28/2024 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	SURVEY
1		34G119	B. WING			06/2	26/2024
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT	ΓΕ, ZIP CODE		
WENDOVE	ER HOME			1 OLD PARK ROAD AIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
E 037	procedures. (iii) Provide emergence least every 2 years. (iv) Periodically review emergency preparedre employees (including special emphasis place procedures necessary others. (v) Maintain document proparedness training (vi) If the emergency I procedures are signifit must conduct training procedures. *[For PRTFs at §441. program. The PRTF r (i) Initial training in em- policies and procedure staff, individuals provia arrangement, and vol expected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document procedures. (iv) Maintain document procedures are signifit must conduct training procedures. *[For PACE at §460.8 organization must do (i) Initial training in em-	cy preparedness training at w and rehearse its ness plan with hospice nonemployee staff), with ced on carrying out the y to protect patients and nation of all emergency g. preparedness policies and icantly updated, the hospice on the updated policies and 184(d):] (1) Training must do all of the following: nergency preparedness res to all new and existing iding services under functeers, consistent with their g, provide emergency g every 2 years. f knowledge of emergency coreparedness policies and icantly updated, the PRTF on the updated policies and icantly updated, the PRTF on the updated policies and icantly updated policies and icantly updated policies and	E 037				

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If continuation sheet Page 4 of 19

	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/28/2024 APPROVED . 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	-	(X3) DATE : COMPI	
		34G119	B. WING			06/2	26/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WENDOVI	ER HOME			631 OLD PARK ROAD MAIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	staff, individuals provi arrangement, contract volunteers, consistent (ii) Provide emergence least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to g case of an emergency (iv) Maintain documer (v) If the emergency procedures are signifi must conduct training procedures. *[For LTC Facilities at Program. The LTC fact following: (i) Initial training in em policies and procedure staff, individuals provi arrangement, and volue expected role. (ii) Provide emergence least annually. (iii) Maintain documer preparedness training (iv) Demonstrate staff procedures. *[For CORFs at §485. CORF must do all of tt (i) Provide initial traini preparedness policies and existing staff, indi- under arrangement, a with their expected ro	iding on-site services under tors, participants, and t with their expected roles. by preparedness training at f knowledge of emergency informing participants of go, and whom to contact in y. nation of all training. preparedness policies and icantly updated, the PACE on the updated policies and f §483.73(d):] (1) Training cility must do all of the hergency preparedness res to all new and existing iding services under unteers, consistent with their by preparedness training at nation of all emergency g. f knowledge of emergency g. f knowledge of emergency g. f knowledge of emergency g. f knowledge of all new the following: ing in emergency s and procedures to all new ividuals providing services and volunteers, consistent	E 03	7			

Facility ID: 922856

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 06/28/2024 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY
		34G119	B. WING		_	06/2	26/2024
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
WENDOV	ER HOME			31 OLD PARK ROAD MAIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 037	procedures. All new p and assigned specific the CORF's emergence their first workday. Thi include instruction in t alarm systems and sig equipment. (v) If the emergency procedures are signifi must conduct training procedures. *[For CAHs at §485.6] The CAH must do all (i) Initial training in em- policies and procedure reporting and extingui and where necessary personnel, and guests cooperation with firefig authorities, to all new individuals providing s and volunteers, consis- roles. (ii) Provide emergence least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. (v) If the emergency procedures are signifi must conduct training procedures.	atation of the training. knowledge of emergency ersonnel must be oriented responsibilities regarding cy plan within 2 weeks of e training program must the location and use of gnals and firefighting preparedness policies and cantly updated, the CORF on the updated policies and 25(d):] (1) Training program. of the following: nergency preparedness es, including prompt shing of fires, protection, , evacuation of patients, s, fire prevention, and ghting and disaster and existing staff, services under arrangement, stent with their expected y preparedness training at	E 037				

Facility ID: 922856

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA				IO. 0938-039
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		34G119	B. WING		0	6/26/2024
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VENDOVE	ER HOME			631 OLD PARK ROAD MAIDEN, NC 28650		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
E 037	Continued From page	9 6	E 03	37		
	CMHC must provide i	initial training in emergency				
	preparedness policies	s and procedures to all new				
	<b>U</b>	ividuals providing services				
	with their expected ro	and volunteers, consistent				
	-	training. The CMHC must				
		wledge of emergency				
	•	ter, the CMHC must provide				
		ness training at least every 2				
	years.	at mat as suideneed by				
		not met as evidenced by: iew and interview, the facility				
		t care staff were trained on				
	the facility's emergen at least biennially. Th	cy preparedness plan (EPP) e finding is:				
		the facility's EPP revealed or biennial training on the				
	(PM) and qualified int professional (QIDP) of and biennial training f	with the program manager ellectual disabilities confirmed that initial training for current staff were not				
F 020	completed. EP Testing Requirem		<b>_</b>			
E 039	CFR(s): 483.475(d)(2		E 03	59		
	§460.84(d)(2), §482.1 §483.475(d)(2), §484 §485.542(d)(2), §485	113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §485.727(d)(2), .12(d)(2), §494.62(d)(2).				
	at §485.542, OPO, "C	§485.920, RHCs/FQHCs at				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/28/2024 MAPPROVED ). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		34G119	B. WING _			_	06/2	26/2024
NAME OF PF	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WENDOVE	ER HOME				31 OLD PARK ROAD IAIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page	97	E 0	39				
	.,	ity] must conduct exercises / plan annually. The [facility] owing:						
	accessible, conduct a exercise every 2 year (B) If the [facility] natural or man-made activation of the emer exempt from engaging community-based or if functional exercise for actual event. (ii) Conduct an addition years, opposite the year functional exercise un this section is conduct not limited to the follor (A) A second full-scale community-based or if functional exercise; of (B) A mock disaster d (C) A tabletop exercise a facilitator and include a narrated, clinically-r scenario, and a set of directed messages, o designed to challenge (iii) Analyze the [facilit	ery 2 years; or ity-based exercise is not a facility-based functional s; or experiences an actual emergency that requires rgency plan, the [facility] is g in its next required individual, facility-based llowing the onset of the onal exercise at least every 2 ear the full-scale or nder paragraph (d)(2)(i) of ted, that may include, but is wing: e exercise that is individual, facility-based r rill; or se or workshop that is led by des a group discussion using relevant emergency f problem statements, r prepared questions e an emergency plan.						
	exercises, and emerg [facility's] emergency *[For Hospices at 418							

Facility ID: 922856

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/28/2024 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE	
		34G119	B. WING _				06/:	26/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
WENDOW				63	31 OLD PARK ROAD			
WENDOVE				М	AIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
E 039	<ul> <li>(2) Testing for hospic patient's home. The hexercises to test the eannually. The hospication of the exercises to test the eannually. The hospication of the energence of the energency plan, the exercise under parager is conducted, that may to the following:</li> <li>(A) A second full-scal community-based or a exercise; or</li> <li>(B) A mock disaster or</li> <li>(C) A tabletop exercise a facilitator and include a narrated, clinically-rescenario, and a set of directed messages, or designed to challenge</li> <li>(3) Testing for hospice care directly. The hospice may appear to be the exercises to test the exercises to test</li></ul>	the sthat provide care in the nospice must conduct emergency plan at least e must do the following: I-scale exercise that is ery 2 years; or ty based exercise is not in individual facility based erery 2 years; or eriences a natural or y that requires activation of the hospital is exempt from equired full scale ercise or individual hal exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section y include, but is not limited le exercise that is a facility based functional drill; or se or workshop that is led by les a group discussion using elevant emergency f problem statements, r prepared questions e an emergency plan. es that provide inpatient spice must conduct emergency plan twice per ust do the following: nnual full-scale exercise that	E	039				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/28/2024 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMPI	SURVEY
		34G119	B. WING		_	06/2	26/2024
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
WENDOVE	ER HOME			31 OLD PARK ROAD			
			M	IAIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From page (A) When a communit accessible, conduct a facility-based function (B) If the hospice expo- man-made emergence the emergency plan, t engaging in its next re based or facility-based following the onset of (ii) Conduct an addition may include, but is no (A) A second full-scal community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise facilitator that includes narrated, clinically-relat and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the hosp maintain documentatit exercises, and emerger hospice's emergency *[For PRFTs at §441. §482.15(d), CAHs at § (2) Testing. The [PRT conduct exercises to t twice per year. The [I do the following:	ty-based exercise is not in annual individual hal exercise; or eriences a natural or y that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. ice's response to and on of all drills, tabletop tency events and revise the plan, as needed.	E 039				
	is community-based; (A) When a communit accessible, conduct a facility-based function	ty-based exercise is not in annual individual,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/28/2024
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	D. 0938-0391 SURVEY PLETED
		34G119	B. WING			_	06/:	26/2024
NAME OF PRO	OVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
WENDOVER				63	31 OLD PARK ROAD			
WENDOVER				Μ	IAIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
() a r f f c a f f c a f f c a f f c a f f c a f f c a f f c a f f c a f f c a f f f c a f f f f	actual natural or man- requires activation of the [facility] is exempt from required full-scale com facility-based function onset of the emergence (ii) Conduct an [a and that may include, following: (A) A second full-scal community-based or in functional exercise; or (B) A mock do (C) A tabletop exe led by a facilitator and discussion, using a na emergency scenario, a statements, directed r questions designed to plan. (iii) Analyze the [f maintain documentation exercises, and emerge [facility's] emergency [ *[For PACE at §460.8- (2) Testing. The PACE exercises to test the e annually. The PACE of following: (i) Participate in an ar is community-based; of (A) When a community accessible, conduct a facility-based function (B) If the PACE expert	bital, CAH] experiences an -made emergency that the emergency plan, the m engaging in its next nmunity based or individual, tal exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based r disaster drill; or ercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. 4(d):] E organization must conduct emergency plan at least organization must do the nnual full-scale exercise that or ty-based exercise is not n annual individual,	E	039				

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G119 B. WING 06/26/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD WENDOVER HOME **MAIDEN, NC 28650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 11 E 039 E 039 the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. \*[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that

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PRINTED: 06/28/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 06/28/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	-	(X3) DATE	
1		34G119	B. WING			_	06/2	26/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WENDOVI	ER HOME				31 OLD PARK ROAD MAIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	requires activation of LTC facility is exempt required a full-scale c individual, facility-basi following the onset of (ii) Conduct an additi may include, but is not (A) A second full-sca community-based or a functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator includes a narrated, clinically-reli and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the [LTC and maintain docume exercises, and emerger [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/I to test the emergency The ICF/IID must do t (i) Participate in an ar is community-based; in (A) When a communit accessible, conduct a facility-based function (B) If the ICF/IID experi- man-made emergency the emergency plan, t engaging in its next re- community-based or i	the emergency plan, the from engaging its next community-based or ed functional exercise the emergency event. onal annual exercise that of limited to the following: le exercise that is an individual, facility based r drill; or se or workshop that is led by a group discussion, using a evant emergency scenario, statements, directed ed questions designed to ncy plan. facility] facility's response to entation of all drills, tabletop jency events, and revise the emergency plan, as needed. 8.475(d)]: ID must conduct exercises y plan at least twice per year. the following: nual full-scale exercise that or ty-based exercise is not an annual individual, nal exercise; or. eriences an actual natural or cy that requires activation of the ICF/IID is exempt from	E	039				

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 34G119 B. WING 06/26/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD WENDOVER HOME **MAIDEN, NC 28650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 039 Continued From page 13 E 039 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill: or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. \*[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted. that may include, but is not

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/28/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/28/2024 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		34G119	B. WING			06/	26/2024
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
WENDOV	ER HOME				631 OLD PARK ROAD MAIDEN, NC 28650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	limited to the following (A) A second full- community-based or a functional exercise; of (B) A mock disas (C) A tabletop ex led by a facilitator and discussion, using a na emergency scenario, statements, directed n questions designed to plan. (iii) Analyze the HHA' documentation of all of emergency events, an emergency events, an emergency plan, as n *[For OPOs at §486.3 (d)(2) Testing. The Of to test the emergency following: (i) Conduct a paper-b workshop at least and led by a facilitator and discussion, using a na emergency scenario, statements, directed n questions designed to plan. If the OPO expen- man-made emergency the emergency plan, f engaging in its next re following the onset of (ii) Analyze the OPO's documentation of all t	g: -scale exercise that is an individual, facility-based r ster drill; or tercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency s response to and maintain drills, tabletop exercises, and nd revise the HHA's needed. 360] PO must conduct exercises y plan. The OPO must do the mased, tabletop exercise or nually. A tabletop exercise or nually. A tabletop exercise is d includes a group arrated, clinically relevant and a set of problem messages, or prepared o challenge an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from equired testing exercise i the emergency event. s response to and maintain tabletop exercises, and nd revise the [RNHCI's and	E	039			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/28/2024 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`,		E CONSTRUCTION		(X3) DATE	
		34G119	B. WING			_	06/	26/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WENDOV	ER HOME				631 OLD PARK ROAD MAIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039 W 249	must do the following (i) Conduct a paper-b least annually. A table discussion led by a fa clinically-relevant eme of problem statements prepared questions de emergency plan. (ii) Analyze the RNHC maintain documentati and emergency event emergency plan, as m This STANDARD is r Based on record revi failed to conduct bien emergency prepared finding is: Review on 6/25/24 of no evidence of a full-s facility-based training or tabletop exercise. Interview on 6/26/24 w (PM) and qualified int professional (QIDP) of conducted a full-scale training, or an addition exercise. PROGRAM IMPLEMI CFR(s): 483.440(d)(1 As soon as the interdiformulated a client's interview formulated a client's interview	<ul> <li>8]: NHCI must conduct emergency plan. The RNHCI assed, tabletop exercise at etop exercise is a group cilitator, using a narrated, ergency scenario, and a set s, directed messages, or esigned to challenge an</li> <li>Cl's response to and on of all tabletop exercises, ts, and revise the RNHCI's eeded.</li> <li>not met as evidenced by: ew and interview, the facility nial testing of the facility's ness plan (EPP). The</li> <li>the facility's EPP revealed scale community or , or an additional mock drill</li> <li>with the program manager ellectual disabilities confirmed the facility has not e community or facility-based nal mock drill or tabletop</li> <li>ENTATION</li> </ul>		245				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/28/2024 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE	
		34G119	B. WING			_	06/	26/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
WENDOVI					631 OLD PARK ROAD			
WENDOVI					MAIDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 249	and frequency to suppobjectives identified in plan.		W	24	)			
	Based on observation interviews, the facility clients (#1 and #3) re- treatment program as Person-Centered Plan of a prescribed gait be training goals. The fin	ns, record reviews, and failed to ensure that 2 of 6 ceived a continuous active identified in the n (PCP) relative to the use elt and implementing dings are:						
	Observations in the g 5:30 AM revealed clie couch in the living roc shoe and a slipper an Continued observatio #1 to stand and push from the living room to holding onto the cart prepare the breakfast observation at 6:04 A his cart to the dining r the dining room table time during the obser provide client #1 with	roup home on 6/26/24 at ent #1 to be seated on a om wearing one specialized d to not wear a gait belt. n at 5:55 AM revealed client a cart with body off gait o the kitchen and to stand while watching the staff meal. Continued M revealed client #1 to push room and prepare to sit at with staff assistance. At no vation was staff observed to his prescribed gait belt. 6/26/24 revealed a physical ted 5/10/24 which ue contact guard						

Event ID: FIPQ11

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/28/2024 APPROVED . 0938-0391					
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY					
		34G119	B. WING		_	06/2	26/2024					
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE							
WENDOV	ER HOME			631 OLD PARK ROAD MAIDEN, NC 28650								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE					
W 249	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Continued record review revealed a (PCP) dated 4/30/24 which notes client #1's gait belt for ambulation daily. Interview with the qualified intellectual disabilities professional (QIDP) on 6/26/24 confirmed that client #1's PCP and physical therapy evaluations are current. Continued interview with the QIDP confirmed that staff should provide client #1 with his gait belt for use in ambulating in the group home. B. The facility failed to implement training goals for client #3. The findings are: Observations in the group home from 6/25/24 to 6/26/24 revealed client #3 to participate in activities which included watching television, using a handheld game, putting cups and silverware on the table for dinner, putting dishes in the dishwasher, and showering. Continued observations was staff observed to prompt client #3 to assist in preparing the dinner and breakfast meal, to sweep kitchen and dining room, and clean bathrooms. Review of records on 6/26/24 for client #3 revealed a PCP dated 4/16/24. Continued review of the PCP revealed goals for client #3 to include washing body, medication administration, sweeping the kitchen and dining room, cleaning the bathrooms, fixing breakfast and dinner, and grocery store.		W 249									

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CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	· · ·	OMB NO. 0938-039 (X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  34G119		IDENTIFICATION NUMBER:	A. BUILDING	COM	<b>IPLETED</b>		
		B. WING		0	06/26/2024		
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CC	DE		
WENDOV	ER HOME			OLD PARK ROAD IDEN, NC 28650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 249	Continued From page	e 18	W 249				
	with the QIDP confirmed that staff should be implementing training goals for client #3.						
W 440		S	W 440				
	at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review of record and interview, the facility failed to show evidence quarterly fire drills were conducted with each shift of personnel relative to second and third shift. The finding is: Review of the facility fire drill reports from 6/23 through 5/24 revealed missing fire drills for 7/23, 9/23 and 12/23. Continued review of the fire drills revealed a drill to be conducted on 8/23 during first shift and documented to be second shift with a 6-minute evacuation time. Further review of the fire drill reports revealed a second shift drill conducted on 2/5/24 and 5/3/24 and a third shift drill completed on 6/1/23 and 3/5/24. There was no additional documentation available conducting second and third shift drills during the review year.						
	6/26/24 confirmed fac been conducted quar Continued interview w there was no addition	gram manager (PM) on cility fire drills should have terly for each shift. with the QIDP confirmed nal documentation to reflect e conducted during the					

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