PRINTED: 07/01/2025 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MILL TIPLE CONSTRUCTION			OMB NO. 0938-03	
AND PLAN O	FCORRECTION	CTION I IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		34G119	B. WING			CIDEIDAGE	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD MAIDEN, NC 28650	<u> </u>	6/25/2025	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	10				
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;	CFR(s): 483.475(b)(1) §403.748(b)(1), §418 (1), §460.84(b)(1), §48 §483.475(b)(1), §485 [(b) Policies and procedure policies and procedure policies and procedure plan set forth in paragrand the communication this section. The policies reviewed and update for LTC facilities]. At a procedures must address must addres	a.113(b)(6)(iii), §441.184(b) 82.15(b)(1), §483.73(b)(1), .542(b)(1), §485.625(b)(1) edures. [Facilities] must int emergency preparedness es, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cles and procedures must atted every 2 years [annually a minimum, the policies and ress the following: absistence needs for staff they evacuate or shelter in not limited to the following: all and pharmaceutical of energy to maintain the rotect patient health and and sanitary storage of anguishing, and alarm disposal. at §418.113(b)(6)(iii):]	E 01	(E105) The home manager new emergency food items these are kept in date and repolicy every 6 months. The food items will be inventorie months by the QP for the net to ensure all items are in date of the food items.	to ensure otated per emergency d every three ext 6 months		
	ii) The provision of sub ECTOR'S OR PROVIDER/SUI	PPLIER REPRESENTATIVE'S SIGNATURE		TITLE		6) DATE	

Jasmin Dula, Administrator

7/8/2025

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.

STATEMENT	OF DEFICIENCIES	(VA) PROVIDED OF THE PERSON				OMB NO. 0938-039		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G119	B. WING			ne in ener		
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		06/25/2025		
WENDON	ER HOME		1	31 OLD PARK ROAD				
- VILINGO	LK HOME			AIDEN, NC 28650				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES						
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JI D BE	(X5) COMPLETION DATE		
E 015	Continued From pa	ge 1	E 045					
		and patients, whether they	E 015					
	evacuate or shelter	in place, include, but are not						
	limited to the followi	ing:						
		edical, and pharmaceutical						
	supplies.	one pharmaceutical						
	(B) Alternate source	es of energy to maintain the						
	following:							
	(1) Temperatures to	protect patient health and						
		afe and sanitary storage of						
	provisions.							
	(2) Emergency lighti							
	(3) Fire detection, ex	ktinguishing, and alarm						
	systems. (C) Sewage and was	ato diamenal						
	This STANDARD is	not met as evidenced by:						
	Based on observation	on, documentation review,						
	and interviews, the fa	acility failed to implement the						
	emergency prepared	Iness policy relative to the						
	provision of subsiste	nce food supply needs for all						
	clients (#1, #2, #3, #4	4, #5, #6) and staff as						
	required in the facility	y's emergency operations						
-	plan (EOP). The find	ing is:						
	Observations during	the 6/24/25-6/25/25						
	recertification survey	revealed a locked hallway						
	closet where the eme	ergency food supply was						
		vations revealed several						
	food items to be expir	red ranging from						
	12/28/24-4/24/25.							
	Interview with staff D	on 6/24/25 revealed the						
	house manager does	the shopping for the	The same of the sa					
	emergency food supp	ly. Further interview with						
		nergency food is rotated						
•	every six months.							
1	nterview with the inte	rim qualified intellectual						
0	disabilities profession	al (QIDP) on 6/25/25						
r	evealed staff did not	make her aware there was						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY
		34G119	B. WING			CIDEIDAGE
	PROVIDER OR SUPPLIER VER HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD MAIDEN, NC 28650	1 0	6/25/2025
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
E 018	a need to shop for eminterview with the QID emergency food supp and rotated every six does not expire.	nergency food. Further P verified that the ly should be fully stocked months to ensure the food	E 018			
W 129	emergency food supply should be fully stocked and rotated every six months to ensure the food does not expire. PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure clients have a right to personal privacy for 1 of 4 sampled clients (#2) during personal care. The finding is: Morning observations on 6/25/25 at 6:50AM revealed staff to transition client #2 to the bathroom for personal care. Further observation at 6:58AM revealed staff to exit the bathroom and leave the door open while client #2 was toileting. Continued observation revealed client #2 to continue toileting which could be seen from the hallway as staff and peers walked past the door. Interview with the interim qualified intellectual disabilities professional (QIDP) on 6/25/25 revealed staff should have respected client #2's privacy by keeping the door closed while the client was toileting. Further interview with the		W 129	(W129) All staff will be in-service QP on maintaining client private dignity. Interaction assessment completed by the clinical team, times per month for the next the months for increased monitorin	cy and is will be three ree	07.11.2025
W 472	the privacy of all clients personal care. MEAL SERVICES CFR(s): 483.480(b)(2)(i) Food must be served in)	W 472			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING NAME OF PROVIDER OR SUPPLIER WENDOVER HOME IDENTIFICATION NUMBER: A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD MAIDEN, NC 28650	OTATELE AS A STATE OF THE STATE				OMB			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD MAIDEN, NC 28650	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT		
WENDOVER HOME STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD MAIDEN, NC 28650			34G119	B. WING			c io r io s o r	
WENDOVER HOME 631 OLD PARK ROAD MAIDEN, NC 28650	NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	6/25/2025	
MAIDEN, NC 28650	WENDOV	/ER HOME						
					MAIDEN, NC 28650			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE	
This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure food was served in appropriate quantity for 2 of 4 sampled clients (#2, #4). The findings are: Afternoon observations on 6i/24/25 at 7:20AM revealed staff to assist client #2 to the clining table to prepare for the breakfast meal. Further observations revealed staff to assist client #2 with preparing his plate using hand over hand assistance. The following men where prepared for the breakfast meal: two baked hash browns, mandarin oranges, three strips of becon, juice and water. Continued observations revealed client #2 did not receive bacon during the breakfast meal. Further observations revealed client #4 to not be offered bacon during the breakfast meal. Review of the record for client #2 on 6i/25/25 revealed a person-centered plan (PCP) (8i/29/24), annual nutritional assessment of J11/25), and physician's order (8i/23/25). Further review of the PCP, nutritional assessment and physician's order indicated client #2 has the follow diet: regular, heart healthy diet, puree consistency, double portions at all meals, no caffeine, no grapefruit, no fatty, spicy, or fried foods, sugar free drinks or water only. Continued review of the record for client #2 on 6i/25i/25 Review of the record for client #4 on 6i/25i/25 Review of the record for client #4 on 6i/25i/25 Review of the record for client #4 on 6i/25i/25		This STANDARD is Based on observation interview, the facility served in appropriate clients (#2, #4). The facility served in appropriate for the observations revealed preparing his plate us assistance. The follow prepared for the break for the break fast meal. Subsequent observation staff to assist client #4 during the break fast meal. Review of the record for the break fast meal. Review of the record for revealed a person-cern annual nutritional assess order indicated client #4 regular, heart healthy of double portions at all in grape fruit, no fatty, spifree drinks or water on record for client #2 did restrictions during means.	not met as evidenced by: on, record review and failed to ensure food was e quantity for 2 of 4 sampled findings are: Ins on 6/24/25 at 7:20AM st client #2 to the dining the breakfast meal. Further d staff to assist client #2 with sing hand over hand wing menu items were kfast meal: two baked hash anges, three strips of bacon, tinued observations not receive bacon during ions at 7:35AM revealed 4 with preparing his plate meal. Further observations not be offered bacon during for client #2 on 6/25/25 thered plan (PCP) (8/29/24), the sament (5/11/25), and the sament and physician's #2 has the follow diet: diet, puree consistency, meals, no caffeine, no cy, or fried foods, sugar thy. Continued review of the not reveal any meat altimes.	W 47:	QP on following the menu ar substitutions as appropriate. trained by the QP on following consistencies and ensuring the followed per physician orders assessment will be complete team members three times a	nd making Staff will be ng diet hese are s. Mealtime ed by clinical	07.11.2025	

STATEMENT		T			OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		34G119	B. WING_		ASIDEIDADE
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD MAIDEN, NC 28650	06/25/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	assessment dated 9/3 dated 4/30/25. Further client #4 revealed the diabetic diet, pureed of no caffeine, thin liquid Drinking lactulose is pure cup. Continued review did not reveal any me Interview with the interview with the interview with the interview with the QID the bacon would be had consistency, the client a meat alternative. MEAL SERVICES CFR(s): 483.480(b)(2) Food must be served a This STANDARD is not Based on observation failed to ensure food wappropriate temperature as a first observations at 7:30AM revealed sever the countertop in the kilobservation revealed the date of the counter of the parameter observation revealed the date of the counter of the parameter observation revealed the date of the counter of the parameter observation revealed the date of the counter of the parameter observation revealed the date of the counter of the parameter observation revealed the date of the counter of the parameter observation revealed the date of the clients' plates without appropriate temperature observation revealed the clients' plates without the clients' plates without the parameter of the	22/24 and physician's order or review of the record for following diet order: consistency, no grapefruit, is and 64 oz. fluid restriction. It is an accordance of the record for client #4 at restrictions. Trim qualified intellectual and (QIDP) on 6/25/25 oz. and #4 must have food consistency. Further Prevealed that although arder to process at a puree of should have been offered of the facility was served at an order for 6 of 6 clients (#1, #2, or in the facility. The finding on the facility on 6/25/25 at earl uncovered plates on techen. Further of revealed staff to serve out reheating the food to an order of the reproximately 45 minutes	W 47	3 (W473) Staff will be in-serviced of temperature guidelines and ensuthese are followed for the continuhealth and safety of all individual support.	uring ued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G119	B. WING		00	3/25/2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 631 OLD PARK ROAD MAIDEN, NC 28650	1 00	3232323
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
	Interview with the interview disabilities profession revealed staff should until it was ready to be necessary. Continued revealed staff have be serve menu items at a prior to serving to the MEAL SERVICES CFR(s): 483.480(b)(2) Food must be served of This STANDARD is not assed on observation interview, the facility fas ampled clients (#1, #2 appropriate utensils to independently as possinghest functioning leverage of the dinner of consisted of the following pasta, sauteed vegetal water. Further observations also be provided a shirt protous to continue to slide as in the point during the observations to continue to slide as in the point during the observations to continue to slide as in the point during the observations the continue to slide as in the point during the observations the continue to slide as in the point during the observations the continue to slide as in the point during the observations the continue to slide as in the point during the observations the continue to slide as in the point during the observations the continue to slide as in the protough the continue to slide as in the point during the observations the continue to slide as in the point during the observations the continue to slide as in the point during the observations the continue to slide as in the point during the observations the continue to slide as in the continue to sli	al (QIDP) on 6/25/25 have kept the food warm e served and reheat as l interview with the QIDP een trained to prepare and an appropriate temperature clients. ((iv) with appropriate utensils. ot met as evidenced by: a, record review and ailed to assure that 3 of 4 2, #4) were provided with allow each client to eat as ible according to their el. The finding is: s on 6/24/25 at 5:28PM at the dining room table to meal. The dinner meal ng: chicken parmesan,	W 473		ent and y per	07.11.2025
	Morning observations in 7:28 AM revealed client	n the facility on 6/25/25 at is #1, #2, and #4 to				

STATEMENT OF DEFICIENCIES (X1)				OMB NO. 0938-0			
AND PLAN C	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION G	(X3) DA	ATE SURVEY DMPLETED	
		34G119	B. WING				
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	06/25/2025	
WENDO	WENDOVER HOME			631 OLD PARK ROAD MAIDEN, NC 28650			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE:	(X5) COMPLETION DATE	
W 475	Continued From page	e 6	W 47	5			
	The second secon	akfast meal. The breakfast	***				
	meal consisted of the	following: bacon, two hash					
	brown patties, manda	arin oranges, milk, and juice.					
	Further observations	revealed clients #1, #2, and					
	#4 to participate in the	e breakfast meal without					
	their prescribed adap	tive equipment. At no time					
	during the observation	n was client #1 provided a					
		cem mat, #2 a rocker t knife,					
	and #4 a dycem mat.						
	Review of the record	for client #1 revealed a					
	person centered plan	(PCP) dated 8/29/24 and					
	an occupational thera	py evaluation (OT					
	evaluation) dated 3/17	7/25 which indicated the					
	client has the following	g adaptive equipment during					
	protector, nonskid ma	mealtimes: high sided divided dish, shirt protector, nonskid mat, and spoon.					
	Review of the record f	for client #2 revealed a PCP					
	dated 8/29/24 and a p	hysician's order dated					
	6/23/25 which indicate						
	high sided divided dist	ipment during mealtimes:					
	knife, and small spoon	nigh sided divided dish, dycem mat, rocker t knife, and small spoon.					
		or client #4 revealed a PCP					
	dated 12/5/24 and phy						
	4/30/25 which indicate						
		ipment: 10cc metered cup,					
	shirt protector, high sid dycem mat.	ded divided dish, and					
	Interview with the inter	terview with the interim qualified intellectual					
	disabilities professiona	I (QIDP) on 6/25/25					
		#2, and #4 have adaptive					
		e used during mealtimes. the interim QIDP revealed					
1	runner interview with t staff have been trained				The state of the s	-	
	equinment for clients d						

		MILDICAID SERVICES			OMBIN	IO. 0938-039°	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G119	B. WING			6/25/2025	
NAME OF P	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	0/23/2023	
				631 OLD PARK ROAD			
WENDOV	ER HOME						
-				MAIDEN, NC 28650			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	QI QI	PROVIDER'S PLAN OF CORRECT		(X5)	
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION	
W 475	Continued From page	e 7	W 475				
	prescribed.						
W 488	DINING AREAS AND	SERVICE	W/ 400	(M/400) Cheff will be in a in		27 44 222	
** ***	CFR(s): 483.480(d)(4		VV 400	(W488) Staff will be in-serviced QP on all clients' adaptive equ	d by the	07.11.2025	
		•		ensuring these are utilized pro	perty per	1	
	The facility must assu	ure that each client eats in a		physician orders. Interaction	periy per		
	manner consistent wi	ith his or her developmental		assessments will be completed	d three		
	level.			times per month for the next th	ree		
		not met as evidenced by:		months for increased monitoring	100		
		ns and interview, staff failed		mentile for interested morntoni	19.		
		e dining utensils to 2 of 4					
	sampled clients (#1, #4) to enable them to eat at						
	their developmental le	evel. The finding is:					
	Afternoon observation	ns on 6/24/25 at 5:28PM					
		at the dining room table to					
		meal. Further observation					
	revealed staff to place	e client #1's food on top of					
	his shirt protector. Co						
		consume the dinner meal as					
	staff would occasional	lly re-adjust the client's plate					
	on top of the shirt protector.						
	Morning observations	on 6/25/25 at 7:20AM					
		t client #4 to the table to					
	prepare for the breakfa						
	observation revealed staff to place client #4's						
	food on top of his shirt						
		client #4 to have difficulty					
	eating while his plate sat on top of the shirt protector. Additional observation revealed staff to adjust the plate on top of the shirt protector for client #4 during the breakfast meal.						
	Interview with staff E o	on 6/25/25 revealed staff					
	place the clients' plate						
		spillage during mealtimes.					
	Interview with the inter	im qualified intellectual					
					1		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		34G119	B. WING		04	8/25/2025
	PROVIDER OR SUPPLIER		631 (SET ADDRESS, CITY, STATE, ZIP CODE OLD PARK ROAD DEN, NC 28650		12020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 488	revealed staff should plates on their shirt Further interview with have been trained to	ge 8 phal (QIDP) on 6/25//25 d not have placed the clients' protectors during mealtimes. In the QIDP revealed staff or provide dignity and respect e clients' adaptive equipment	W 488	JEP MENUT)		