

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/25/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WENDOVER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

W 000	INITIAL COMMENTS A revisit was conducted on 8/25/2025 for all previous deficiencies cited on 6/25/2025. A total of three of six deficiencies were not corrected. The facility failed to provide supporting documentation according to the plan of correction submitted. Deficiencies will be re-cited.	W 000		
{W 472}	MEAL SERVICES CFR(s): 483.480(b)(2)(i) Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: A revisit was conducted on 8/25/2025 for all previous deficiencies cited on 6/25/2025. A total of three of six deficiencies were not corrected. The facility failed to provide supporting documentation according to the plan of correction submitted. Deficiencies will be re-cited. 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: Morning observations on 6/24/25 at 7:20AM revealed staff to assist client #2 to the dining 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 menu items were prepared for the breakfast meal: two baked hash browns, mandarin oranges, three strips of bacon, juice and water. Continued observations revealed client #2 did not receive bacon during the breakfast meal. Subsequent observations at 7:35AM revealed staff to assist client #4 with preparing his plate	{W 472}	(W472) Staff will be in-serviced by the QP on Following the menu and making appropriate substitutions. Staff will be trained by the QP on following diet consistencies and ensuring these are followed per physicians orders. Mealtime assessments will be completed by clinical team members three times a month for the next three months.	9/15/2025

RECEIVED
SEP 11 2025
DHSR-MH Licensure Sect

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jasmin Dula, Administrator</i>	TITLE Administrator	(X6) DATE 9/9/25
--	----------------------------	-------------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/25/2025
NAME OF PROVIDER OR SUPPLIER WENDOVER HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
{W 472}	Continued From page 1 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 6/25/25 revealed a person-centered plan (PCP) (8/29/24), annual nutritional assessment (5/11/25), and physician's order (6/23/25). 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 did not reveal any meat restrictions during mealtimes. Review of the record for client #4 on 6/25/25 revealed a PCP dated 12/5/24, annual nutritional assessment dated 9/22/24 and physician's order dated 4/30/25. Further review of the record for client #4 revealed the following diet order: diabetic diet, pureed consistency, no grapefruit, no caffeine, thin liquids and 64 oz. fluid restriction. Drinking lactulose is permitted out of a measured cup. Continued review of the record for client #4 did not reveal any meat restrictions. Interview with the interim qualified intellectual disabilities professional (QIDP) on 6/25/25 verified both clients #2 and #4 must have food provided at a pureed consistency. Further interview with the QIDP revealed that although the bacon would be harder to process at a puree consistency, the clients should have been offered a meat alternative.	{W 472}			
{W 475}	MEAL SERVICES CFR(s): 483.480(b)(2)(iv)	{W 475}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/25/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WENDOVER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

{W 475}	<p>Continued From page 2</p> <p>Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: A revisit was conducted on 8/25/2025 for all previous deficiencies cited on 6/25/2025. A total of three of six deficiencies were not corrected. The facility failed to provide supporting documentation according to the plan of correction submitted. Deficiencies will be re-cited.</p> <p>Based on observation, record review and interview, the facility failed to assure that 3 of 4 sampled clients (#1, #2, #4) were provided with appropriate utensils to allow each client to eat as independently as possible according to their highest functioning level. The finding is:</p> <p>Afternoon observations on 6/24/25 at 5:28PM revealed clients to sit at the dining room table to prepare for the dinner meal. The dinner meal consisted of the following: chicken parmesan, pasta, sauteed vegetables, a dinner roll, and water. Further observations revealed client #2 to participate in the dinner meal without a rocker t knife. Observations also revealed client #1 to not be provided a shirt protector and dycem mat and #4 without a dycem mat during the dinner meal. Continued observations revealed client #4's plate to continue to slide as he consumed his meal. At no point during the observation did staff provide the adaptive equipment needed during the dinner meal as prescribed.</p> <p>Morning observations in the facility on 6/25/25 at 7:28 AM revealed clients #1, #2, and #4 to participate in the breakfast meal. The breakfast meal consisted of the following: bacon, two hash brown patties, mandarin oranges, milk, and juice. Further observations revealed clients #1, #2, and</p>	{W 475}	(W475) Staff will be in-serviced by the QP on all clients' adaptive equipment and ensuring these are utilized properly per physicians orders. Interaction Assessments will be completed three times a month for the next three months for increased monitoring.	9/15/2025
---------	--	---------	---	-----------

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/25/2025
NAME OF PROVIDER OR SUPPLIER WENDOVER HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
{W 475}	Continued From page 3 #4 to participate in the breakfast meal without their prescribed adaptive equipment. At no time during the observation was client #1 provided a shirt protector and dycem 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 therapy evaluation (OT evaluation) dated 3/17/25 which indicated the client has the following adaptive equipment during mealtimes: high sided divided dish, shirt protector, nonskid mat, and spoon. Review of the record for client #2 revealed a PCP dated 8/29/24 and a physician's order dated 6/23/25 which indicated the client has the following adaptive equipment during mealtimes: high sided divided dish, dycem mat, rocker t knife, and small spoon. Review of the record for client #4 revealed a PCP dated 12/5/24 and physician's order dated 4/30/25 which indicated the client has the following adaptive equipment: 10cc metered cup, shirt protector, high sided divided dish, and dycem mat. Interview with the interim qualified intellectual disabilities professional (QIDP) on 6/25/25 verified that clients #1, #2, and #4 have adaptive equipment that must be used during mealtimes. Further interview with the interim QIDP revealed staff have been trained to provide adaptive equipment for clients during mealtimes as prescribed.	{W 475}			
{W 488}	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4)	{W 488}			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/25/2025
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WENDOVER HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

{W 488}	<p>Continued From page 4</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>This STANDARD is not met as evidenced by: A revisit was conducted on 8/25/2025 for all previous deficiencies cited on 6/25/2025. A total of three of six deficiencies were not corrected. The facility failed to provide supporting documentation according to the plan of correction submitted. Deficiencies will be re-cited.</p> <p>Based on observations and interview, staff failed to provide appropriate dining utensils to 2 of 4 sampled clients (#1, #4) to enable them to eat at their developmental level. The finding is:</p> <p>Afternoon observations on 6/24/25 at 5:28PM revealed clients to sit at the dining room table to prepare for the dinner meal. Further observation revealed staff to place client #1's food on top of his shirt protector. Continued observation revealed client #1 to consume the dinner meal as staff would occasionally re-adjust the client's plate on top of the shirt protector.</p> <p>Morning observations on 6/25/25 at 7:20AM revealed staff to assist client #4 to the table to prepare for the breakfast meal. Further observation revealed staff to place client #4's food on top of his shirt protector. Continued observation revealed 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.</p> <p>Interview with staff E on 6/25/25 revealed staff place the clients' plates on top of the shirt</p>	{W 488}	<p>(W488) Staff will be in-serviced by the QP on all clients' adaptive equipment and ensuring these are utilized properly per physicians orders. Interaction assessments will be completed three times per month for the next three months to increase monitoring.</p>	9/15/2025
---------	---	---------	--	-----------

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/25/2025
NAME OF PROVIDER OR SUPPLIER WENDOVER HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{W 488}	Continued From page 5 protector to minimize spillage during mealtimes. Interview with the interim qualified intellectual disabilities professional (QIDP) on 6/25/25 revealed staff should not have placed the clients' plates on their shirt protectors during mealtimes. Further interview with the QIDP revealed staff have been trained to provide dignity and respect to clients and use the clients' adaptive equipment during mealtimes.	{W 488}		