STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0000	INITIAL COMMENTS The survey team entered the facility on 4/8/26 to conduct a complaint survey and exited on 4/9/26. The survey team returned to the facility on 4/13/26 to obtain additional information and to validate the credible allegation of immediate jeopardy removal and exited on 4/13/26. Therefore, the exit date was changed to 4/13/26. The following intake was investigated 2976489. Intake 2976489 resulted in immediate jeopardy. 1 of 1 complaint allegation resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.15 at tag F627 at a scope and severity J. Immediate Jeopardy began on 4/3/26 and was removed on 4/10/26.	F0000		
F0627 SS = J	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered;	F0627		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 1 (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 2 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 3 discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH,	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 4 assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Friend #1, Friend #2, Family Member, Home Health Nurse, Adult Protective Services Social Worker, hospital Social Worker, Nurse Practitioner, and Primary Care Physician interviews, the facility failed to ensure a safe and orderly discharge for a resident that had severe cognitive impairment, incontinent of bowel and bladder, required assistance with all activities of daily living, and was not capable of managing her medications prescribed for diabetes, hypertension, hypothyroidism, pain and depression. Resident #1 was discharged to her apartment where she lived alone with friends (Friend #1 and Friend #2) who indicated they were unable to provide the 24-hour	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 5 level of care the resident required. Resident #1's Family Member was not included in the discharge planning process and was not notified of the discharge by the facility. The discharge on 4/3/26 (Good Friday) occurred without confirmation of 24-hour support, necessary services or appropriate resources including durable medical equipment (DME) to ensure the resident's health, safety, and well-being could be maintained. The facility contacted home health on 4/2/26 and the home health service provider notified the facility it would be 24 to 48 hours from the date if the referral before a home health worker would be able to conduct an at home visit for Resident #1. The facility Social Worker contacted Adult Protective Services on 4/3/26 to report their concern the friends may not have been able to provide the 24-hour level of care the resident required and may have been at risk of harm. On 4/3/26 the friends were able to get Resident #1 into her apartment, provide a meal, change her, put her to bed but no medications were given. There were no arrangements made for the provision of care until one of the friends returned the next day. On 4/4/26 Friend #1 visited and found the resident very soiled due to incontinence and located a neighbor to clean up Resident #1. Friend #1 fixed Resident #1 a meal, did not administer any medications, and left in the evening. On Easter Sunday, 4/5/26, a home health nurse conducted an at home visit and found the resident to be in bed, soiled with incontinence from urine and bowel, unable to get out of bed, even with assistance, unable to answer the door, unable to vacate the premises in the event of emergency, and had not received her prescribed medications, including insulin since she had been discharged from the facility on 4/3/26. The home health nurse checked Resident #1's blood sugar and contacted the resident's Primary Care Physician about her blood sugar level history and administered insulin. The only DME present was the wheelchair that was delivered to the facility on 4/3/26. On 4/7/26, an APS worker made an in home visit to Resident #1 and found the resident to be in bed, soiled with incontinence from urine and bowel, unable to get out of bed, even with assistance, unable to answer the door, unable to vacate the premises in the event of emergency, and had not been consistently receiving her prescribed medications since the resident was discharged from the facility on 4/3/26. Resident #1 was unable to press the button on her medical alert necklace or call 911 for assistance on the phone. Based on the APS worker's assessment an order for provision emergency service order was obtained from the district court judge for Resident #1 to be transferred to the hospital on 4/7/26 and was	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 6 admitted with a urinary tract infection. The deficient practice occurred for 1 of 3 residents reviewed for discharge (Resident #1). Immediate jeopardy began on 4/3/26 when Resident #1 was discharged from the facility to home without the necessary 24-hour support and services the resident required to ensure her well-being and safety. Immediate jeopardy was removed on 4/10/26 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity (D) (no actual harm with a potential for minimal harm that is not immediate jeopardy) for the facility to complete employee staff training and monitoring to ensure interventions put into place are effective. The findings included: Review of the hospital discharge summary dated 3/16/26 revealed Resident #1's admission date to the hospital was 2/28/26. Further review revealed Resident #1 was documented as having lived alone and had not been taking medication for several weeks. Resident #1's primary care physician requested a wellness check from the police, and the resident was found down on the floor by a friend (Friend #1). Resident #1 was taken to the emergency room at the local hospital and later transferred to University of North Carolina (UNC) hospital for trauma evaluation. Resident #1 found to have a stroke, altered mental status with a recent diagnosis of dementia, stroke symptoms related to altered mental status, diabetes, and medication non-compliance. The assessment and plan documented by the hospital was for Resident #1 to be discharged to a skilled nursing facility for medication management and therapy services. A telephone interview was conducted on 4/8/26 at 1:26 PM with Resident #1's Primary Care Physician (PCP) from the community who stated there had been concerns about the resident's ability to continue to live alone due to decline in health and cognition based on missed appointments and change in health status during office visits. He stated he had called the police to do a wellness check (could recall date) which initiated the original hospital admission on 2/28/26. He indicated that a wellness check had been done for the resident at her home, where she was found down on the floor by a family friend (Friend #1), and had not been taking her medication for several weeks. He indicated several attempts had been made to reach the resident's Family Member and/or other support to assist with the resident's care prior to her	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 7 admission to the hospital and the facility. Resident #1 was admitted to the facility on 3/16/26 with diagnoses including anxiety, depression, stroke, communication deficit, diabetes, hypothyroidism, hyperlipidemia, anemia, osteoarthritis, hypertension, and dementia. Review of Resident #1's facility admission paperwork revealed Friend #1 signed the admission paperwork on 3/16/26. Review of the face sheet revealed Friend #1 was listed as 1st emergency contact, Friend #2 was the 2nd emergency contact and the family member as emergency contact #3. There was no responsible party listed on the face sheet. A telephone interview was conducted on 4/8/26 at 11:10 AM with Friend #1 who was listed as the 1st emergency contact person and stated Resident #1 lived alone and he and other friends were stopping by Resident #1's apartment to assist with basic things like shopping, cooking, or taking her to appointments. Resident #1 was able to take care of her personal needs, administer her own medication and handle her own financial affairs before she went to the hospital. Friend #1 stated he and Friend #2 visited Resident #1 at different times of the day to help as much as they were able. He indicated several friends were stopping by the apartment to check on the resident and taking her to appointments, doing the best they could to assist. He stated during a visit in February he found the resident on the floor and he called 911. He explained Resident #1 had a stroke and was not taking her medications. Friend #1 indicated he and Friend #2 came to the facility to assist with getting Resident #1 admitted. Friend #1 stated he signed all the paperwork for the admission as a friend and not the legally responsible person. Friend #1 stated Resident #1's Family Member was not actively involved prior to Resident #1's hospital admission and was not available to assist once the resident was admitted to the facility. A telephone interview was conducted on 4/9/26 at 8:25 AM with Friend #2 who was present with Friend #1 when Resident #1 was admitted to the facility. Friend #2 was listed in the medical record as emergency contact #2. Friend #2 stated she had previously assisted Resident #1 with intermittent home care supports prior to Resident#1's hospitalization and continued to visit during Resident #1's nursing home stay. Friend #2 stated she did not participate in a discharge planning	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 8 meeting. She stated the Admission Director and Social Worker (SW) mentioned financial responsibility and discharge plans when Resident #1 was admitted but nothing was finalized at the time. She stated the Admission Director and SW asked if she would be the guardian and assist with the Medicaid application. She informed the facility Admission Director and the SW that she was unable to provide 24-hour care for Resident #1 in the home and could not assume responsibility for making legal or healthcare decisions on behalf of Resident #1. Resident #1's care plan dated 3/17/26 included a focus area for activities of daily living (ADL) self-care performance deficit related to stroke. The goal indicated that the resident will improve current level of function in ADL. Interventions included Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. The resident requires maximum assistance by staff with bathing/showering as necessary. Bed mobility: The resident requires supervision to partial assistance by staff to turn and reposition in bed as necessary. Dressing: Assist the resident to choose simple comfortable clothing that enhances the resident's ability to dress self. Eating: The resident requires assistance from staff to eat. Personal hygiene/Oral care: The resident requires supervision to partial assistance staff for personal hygiene and oral care. Side rails: Quarter rails up as per physician order for safety during care provision, to assist with bed mobility. Toilet use: The resident is dependent on staff for toileting. Transfer: The resident requires partial to maximum assistance by staff to move between surfaces as necessary. A care plan dated 3/20/26 indicated the resident has diabetes. The resident will have no complications related to diabetes. Diabetes medication as ordered by doctor. Observe for side effects and effectiveness of diabetic medications. Observe for any signs/symptoms of hyperglycemia (high blood sugar), including increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (deep rapid breathing), acetone breath (smells fruity), stupor, and coma. Observe for any signs and symptoms of hypoglycemia (low blood sugar) including sweating, tremor, increased heart rate, pallor (paleness of the skin), nervousness, confusion, slurred speech, lack of coordination, and staggering gait. Observe for compliance with diet and document any problems. Offer substitutes for foods not eaten.	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 9 Further review of Resident #1's care plans dated 3/20/26 revealed a person-centered care plan was not developed with goals and interventions for discharge planning that included identification of responsible caregivers, coordination of services to be provided for Resident #1's activities of daily living, limited psychosocial support, and financial need. An interview was conducted on 4/8/26 at 9:30 AM with the Admission Director who stated Friend #1 and Friend #2 were listed as primary contact person #1 and primary contact person #2 and the resident's family member was listed as contact #3 for Resident #1. She indicated Friend #1 and Friend #2 were present when Resident #1 was admitted. Friend #1 assisted and signed the paperwork for Resident #1 during the admission process. She stated she had reached out to the resident's Family Member to assist with the paperwork on 3/16/26; however, he was not responsive to taking over the responsibility of Resident #1's decision making or financial responsibilities. The Admission Director stated she had spoken with the friends about obtaining guardianship and applying for Medicaid on admission. She indicated both declined, indicating they were unable to handle or manage Resident #1's 24-hour care. The Admission Director stated she was not at the care plan/discharge planning meeting 3/20/26. She was informed by the SW that during the care plan meeting on 3/20/26 community placement had been discussed with Friend #1 and the interdisciplinary team for Resident #1 to return home. The admission Minimum Data Set (MDS) Assessment dated 3/20/26, revealed Resident #1 had severe cognitive impairment and needed assistance with transfers, bed mobility, and activities of daily living. The MDS indicated Resident #1 received insulin injections and had impaired range of motion to bilateral lower extremities. The Participation in Assessment and Goal Setting section of the MDS was not completed. Frequently incontinent of bowel and bladder. Review of the Social Service Progress note for Resident #1, dated 3/20/26, revealed an admission care plan meeting was held on 3/20/26 with Friend #1, Social Work, and the Rehabilitation (Rehab) Director. The discharge plan at the time was probable long-term care. SW advised the friend that the resident would need a guardian if the resident's Family Member was not able to participate in care decisions from [another state]. The Business Office	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 10 Manager had made contact with the resident's Family Member in [another state]. The resident's Family Member stated that he planned to travel to this area in the next month. The Admission Director requested that the resident Family Member present the Power of Attorney (POA) documents as soon as possible. The Medical Orders for Scope of Treatment (MOST) form had been uploaded. There was no power of attorney established. The Discharge Planning Review form for Resident #1, dated 3/20/26, which was completed by the SW documented the following Section A: Anticipated length of stay-short term care, as stated by friends, expects to be discharged to the community, the resident lived alone, family support and primary caregivers indicated friends check in daily. Overall discharge potential revealed discharge to home with friends' assistance. Home health and durable medical equipment will be ordered as needed. A telephone interview was conducted on 4/8/26 at 8:17 PM with the SW who stated Resident #1 was admitted to the facility with the assistance of friends. She indicated she did not reach out to resident's Family Member who was listed as a contact person for his input on Resident #1's care or discharge plans at the time of admission. The SW explained the Admission Director had spoken with the Family Member on admission about Resident #1's placement and financial concerns. She stated Friend #1 and Friend #2 were asked (date not provided) about seeking guardianship and assisting with the Medicaid application by the Business Office Manager and SW and the friends declined stating they did not want the responsibility of making decisions for Resident #1. The SW indicated the Admission Director handled the initial paperwork and financial review. The SW explained Friend #1 signed and assisted with the paperwork on behalf of Resident #1. The SW further stated the discharge plan was "discussed," on 3/20/26 and 3/31/26, but acknowledged the care plan was not updated to reflect finalized arrangements. The facility Physician assessment dated 3/26/26 indicated the chief complaint was fasting blood sugar follow-up evaluation. Resident #1 was being seen for diabetes, she was able to make her needs known and had no complaints. It was noted Resident #1 had a history of hypertension, diabetes, osteoarthritis, hypothyroidism, and peripheral neuropathy, and was presenting for follow-up after recent hospitalization 2/28/26 to 3/16/26 for right basal ganglion intraparenchymal hemorrhage (stroke). Physical exam revealed Resident #1 had no	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 11 acute respiratory distress, cardiovascular rate and rhythm without murmurs, no edema of lower extremities, gastrointestinal sounds were soft with bowel sounds present. Nontender and non-distended abdomen. She was alert and oriented times two (no details in the assessment). Plan and assessment revealed diabetes with hyperglycemia: uncontrolled; fasting blood sugar from low to 100 mid 100s so no longer having hypoglycemia, continue insulin glargine, metformin and monitor fasting blood sugar. Order hemoglobin A1c (a blood sugar test of the blood which measures average blood sugars of the past 2-3 months) 3 months after last value, diabetes with diabetic neuropathy controlled, continue gabapentin. Hypertension associated with diabetes controlled with valsartan. The facility Physician was unavailable for interview. Review of the Notice of Medicare Non-Coverage (NOMNC) a document which informs the resident, or responsible party, that the insurance provider and/or health plan determined that Medicare (including Medicare replacement plans) probably won't pay for Skilled Nursing Facility services after the provided date. The resident, or responsible party, may have to pay for any services received after the listed date. The letter included information about the resident's or responsibly party's right to appeal the decision, how to ask for immediate appeal and what happens next. Due to Resident #1's cognitive impairment, Friend #2 was contacted on 3/31/26 by the SW who obtained verbal consent for the NOMNC form. The form documented that skilled nursing facility services last covered date was 4/2/26 and the beneficiary liability (amount the resident or responsible party would be billed for) was expected to begin on 4/3/26 the day after last covered date of 4/2/26. The Social Worker was the only person that signed the form for verbal consent. The insurance company and/or benefits manager were unavailable for interview. A Social Service progress note written by the SW dated 3/31/26 revealed the SW issued NOMNC to Friend #2 who had been assisting Resident #1 for many years because the resident does not have family nearby. Resident #1's Family Member has a history of having very little contact with Resident #1. Resident #1 was cognitively impaired and did not understand intent of NOMNC. The NOMNC documented the last covered date was going to be 4/2/26. Representative (Friend #2) did not wish to appeal and had requested discharge.	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 12 A telephone interview was conducted on 4/8/26 at 8:17 PM with the facility's SW. The SW stated she stated she contacted Friend #2 on 3/31/26 and gave verbal notice of the discharge plan and date. She stated Friend #2 was informed Resident #1 was being discharged due to coverage of benefits being stopped by insurance. The SW explained that Friend #1 and Friend #2 stated there was no one in the home that could provide 24-hour care. Friend #1 and Friend #2 visited several times during Resident #1's stay and informal conversations were held during these visits. Friend #1 and Friend #2 had given the impression to the SW that friends could get 24-hour assistance for Resident #1 in the home through family and friends, therefore, the discharge was moved forward. The SW stated when the education on the appeal process was offered to Friend #1 on 4/3/26 and with Friend #2 verbally on the phone on 3/31/26 she indicated understanding and declined. The SW further stated they still decided to take the resident home. An interview was conducted on 4/8/26 at 9:30 AM with the Admission Director who stated the SW was responsible for reviewing the discharge plan with the resident and/or resident responsible person which would include the financial, medical and community plan of care at the meeting. The Admission Director stated when the SW received the non-coverage letter from the insurance company Resident #1's friends (Friend #1 and Friend #2) were contacted and informed of the end of coverage day by the SW. She stated the SW informed Friend #2 on 3/31/26 the end of coverage date was 4/3/26. She further stated she had asked Friend #1 and Friend #2 at the time of admission about obtaining guardianship and applying for Medicaid and both declined. Resident #1 did not have any additional financial coverage to stay beyond the Medicare covered days. She indicated the SW stated she had spoken with the friends about the appeals process when they were informed of the non-coverage notice and the friends declined. A telephone interview was conducted on 4/9/26 at 8:25 AM with Friend #2 who stated she received a call from the facility Social Worker on 3/31/26 informing her that Resident #1 would be discharged on 4/3/26 due to insurance coverage ending in the next few days. The Friend stated she was unaware of Resident #1's finances other than her Medicare benefits, therefore was unable to make a financial decision about payment for an extension of stay. Friend #2 stated she felt pressured to take Resident #1 home and reported she was not provided with clear information regarding the appeal process when	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 13 it was discussed or that she had the option to refuse to take the resident home. She indicated she contacted Friend #1 and informed him of the discussion held with the SW and both did not know their options and told the facility SW they would attempt to find additional family and friends who could assist with care following discharge, however, they indicated they were unable to provide 24-hour care or remain overnight in the home themselves. A telephone interview was conducted on 4/8/26 at 11:10 AM with Friend #1 who stated he and Friend #2 told the Admission Director and the Social Worker that they did not want to be responsible for making healthcare or financial decisions for Resident #1 when they were asked to be the guardian and fill out the Medicaid application. Friend #1 stated he and Friend #2 had visited Resident #1 in the facility a few times and continued to tell the SW worker that Resident #1 could not take care of herself, or live by herself, and they would only be able to stop by to assist with basic things Resident #1 needed like they did before she went to the hospital. Friend #1 stated he informed the facility Admission Director, SW and Rehab Director that he was unable to provide the 24-hour care Resident #1 needed because he was physically unable and could not stay overnight in the home with resident. He further stated he did inform the facility staff that he and other friends would stop to assist Resident #1 as much as possible but would not be providing the 24-hour care Resident #1 needed. He stated he could not recall the date he received the call, but Friend #2 received a call from the facility SW on 3/31/26 who informed them that the resident no longer had insurance coverage and needed to be picked up and returned home by 4/3/26. The Nurse Practitioner (NP) discharge summary note for Resident #1, dated 4/1/26, read in part: Resident #1 was seen for discharge and complaint of vision changes. Past medical history was significant for but not limited to hypertension, hyperlipidemia, diabetes, osteoarthritis, neuropathy and hypothyroidism. Resident #1's prior hospitalization was for a right basal ganglia intraparenchymal hemorrhage (stroke). Resident #1 did well during her stay, she was working with physical therapy and participated in activities. Resident #1 had some fluctuation in blood sugar, requiring some changes in her regimen. Resident #1 A1c (measures average blood glucose levels over the last two to three months) during stay was 11.4 (goal for a person with diabetes is below 7%). The resident's most recent blood sugar after adjustment in medications was noted to be 124. Resident #1 was being discharged on aspirin,	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 14 valsartan, gabapentin, zetia, levothyroxine, atorvastatin, fluoxetine, metformin, insulin glargine, and Humalog insulin. A therapy note documented some self-reported vision changes this morning during therapy. Resident #1 was sitting at her bedside, in her wheelchair, reported that she feels well, and denied any pain or vision changes. The NP documented the resident reported she had an ongoing issue with some blurry vision when participating in strenuous activities. The note documented that the resident had no additional acute complaints. The resident's discharge condition: Resident #1 average risk for readmission over the next 3-6 months related to multiple comorbidities and associated risks. Discharge medications: the resident's medications were appropriate; duration of all medications supplied to resident/staff based on facility protocol. Resident #1 needed to follow-up with her primary care physician within 1 to 2 weeks for further refills and medication management. The resident was being discharged to home with home health physical therapy and any appropriate durable medical equipment and keep follow-up appointments. Nursing and rehab therapy to discuss medication instructions and therapy restrictions with Resident #1 and family. A telephone interview was conducted on 4/8/26 at 2:15 PM with the NP who stated she assessed Resident #1 on 4/1/26 in preparation for discharge. She indicated the SW had informed her (unable to recall exact day she was informed) that Resident #1's end of coverage date was 4/3/26 due to exhaustion of benefits and the friends (Friend #1 and Friend #2) had requested the discharge. The NP stated Resident #1 had multiple health concerns following her recent hospitalization for a stroke and poor medication management. The NP stated Resident #1 did have some periods of confusion but was able to answer some basic questions about her general health and Resident #1 did not express any specifics about her discharge home. The NP indicated Resident #1 did have some blood sugar level concerns that resulted in a medication adjustment. She stated based on the therapy assessment Resident #1 had made some progress. She further stated Resident #1 would need 24-hour care and medication monitoring in the home. The NP indicated a discussion was held with the SW and the Nursing Manager a few days prior to discharge to discuss Resident #1's need for 24-hour care, home health, physical therapy, and nursing services in the home. The NP was not involved in the discussion. She stated the SW informed her that a discussion was held with the friends that were listed on the contact sheet about Resident #1's 24-hour medical	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 15 needs. Based on the discussion with SW the friends had been informed of the appeals process and declined, therefore, the discharge plan proceeded. The NP added the Social Worker contacted Adult Protective Services (APS) as a back-up to ensure Resident #1 received the home care services she needed. The Occupational Therapy discharge summary dated 4/2/26 revealed Resident #1's goals included Resident #1 would her improve ability to complete toilet/commode transfers with supervision or touching assistance with ability to right self-to achieve/maintain balance, improve ability to safely and efficiently perform lower body dressing with supervision or touch assistance with the use of adaptive equipment in order to facilitate ability to live in environment with the least amount of supervision and assistance. Resident #1 would improve her ability to safely and efficiently bathe self, including washing, rinsing and drying self with supervision or touch assistance. Resident #1 would increase ability to stand supported for 5 minutes in order to increase participation with activities of daily tasks. Resident #1 would complete all activities of daily living self-care tasks with set-up assistance with ability to right self- achieve/maintain balance. Resident #1 would improve ability to safely and efficiently maintain perineal hygiene, adjust clothes before/after voiding or have a bowel movement with setup or cleanup assistance in order to facilitate independence with toileting task. Functional assessment revealed Resident #1 required substantial/maximum assistance with shower/baths, lower body dressing, putting on and removal of footwear, toileting/hygiene, transfers, and bed mobility. The assessment summary indicated Resident #1 made progress with skilled therapy but insurance ended. Discharge recommendations were for an elevated toilet seat, 3 in 1 commode, assistance with activities of daily living, grab bars, home health services, in-home aide, and a hand reacher. The Physical Therapy discharge summary dated 4/2/26 revealed Resident #1's goals included Resident #1 would improve her ability to safely transfer from lying to sitting on the end of bed with setup assistance in order to participate in activities of daily living and prepare for transfer activities. Resident #1 would improve bilateral lower extremities muscle strength in order to increase ability to safely transfer position from sitting in a chair, wheelchair or on the side of the bed with standby assistance. Resident #1 would improve ability to safely and efficiently transfer to and from a	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 16 bed or wheelchair with standby assistance with ability to right self to achieve/maintain balance. Resident #1 would safely ambulate 50ft with contact guard assistance, using 2 wheeled-walker, demonstrating safe balance in order to increase independence with functional mobility within the facility. Resident #1 would increase her ability to stand supported for minutes in order to increase participation with activities of daily living tasks and functional mobility. Resident #1 discharged home due to exhausted benefits. Resident #1 discharged home with support from others. Functional skills assessment revealed Resident #1 required supervision or touch assistance with sit/lying down position, partial/moderate assistance with chair to bed transfers, toilet transfers, car transfers, and walking 10 to 50 feet with supervision or touch assistance. Assessment and summary of skilled services and recommendation revealed Resident #1 made functional gains in response to therapy services that included therapeutic exercise of bilateral lower extremities, bed mobility, transfer training to increase out of bed activities, and balance training for fall prevention. The summary indicated Resident #1 would need home health services, assistive devices for safe functional mobility and 24-hour care. The Speech Therapy discharge summary dated 4/2/26 revealed Resident #1's progress and response to treatment was completed due to insurance denial and Resident #1 returning to prior living arrangements. Resident #1 participated in cognitive activities and practice of cognitive-communication strategies in order to improve effective communication and enhance cognitive function with minimal progress noted due to extent of cognitive deficits. An interview was conducted on 4/8/26 at 11:36 AM with the Rehab Director who stated the resident was seen for therapy services from 3/16/26 through 3/31/26. The SW informed therapy that Resident #1 received the NOMNC non-coverage letter on 3/31/26, the last covered day was 4/2/26, and the resident would be discharged on 4/3/26. He stated he was not part of the discussion of the discharge plan on admission; his first communication about the discharge plan was at the 3/31/26 meeting. He stated the therapy department completed an assessment My Plan for Success form on 3/26/26 and the form was used by therapy staff to determine the individual discharge needs in the home setting. The form included assessment of transition location, mobility, transfers, food and liquid consistency, supervision and assistance needed for meal	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 17 preparation, grooming and bathing assistance, communication goals, and resident goals. He further stated a discharge planning meeting was held on 3/31/26 with the facility interdisciplinary team (Social Worker, Dietary Manager, Nursing Unit Manager, Activity Director) and Friend #1, who was present at the meeting. Resident #1 was cognitively impaired and unable to effectively communicate her needs or participate in the discharge planning discussion. The Rehabilitation Director reported Friend #1 stated he was unable to provide 24-hour care for Resident #1 but indicated he, along with other friends and family, would attempt to assist in arranging 24-hour coverage and care for the resident following discharge. The Rehabilitation Director stated Resident #1 had made some progress in therapy; however, the resident had not achieved sufficient independence to complete personal care tasks without 24-hour assistance. The Rehabilitation Director stated Resident #1 could have benefitted from additional services to achieve the therapy goals. The Rehabilitation Director did not indicate a discussion was held with Resident #1, or Friend #1, about reevaluating or appealing therapy service for a continuation of therapy services during the discharge planning meeting. The Rehabilitation Director further stated he completed the therapy section of the discharge plan summary on 4/2/26 which included the recommendation of continuation of occupational and physical therapy, adaptive devices such as the bedside commode, grab bars in the bathroom, raised toilet seat, wheelchair, and walker. He confirmed a wheelchair had been ordered and delivered to the facility to assist with the discharge. He was unable to confirm if the other recommended devices were ordered or delivered to the home after discharge. The Rehabilitation Director did not indicate a discussion was held about Resident #1's safety concerns related to her ability to use a cell phone or access an exit door in the event of an emergency. He stated the discharge assessment was based on the friend's (Friend #1 and Friend #2) communication that they would stop by the resident's apartment and assist with personal care, meals, and provision of 24-hour assistance so that Resident #1 would not be left alone. The friends were asked about what equipment Resident #1 already had in the apartment and what services were needed to maintain Resident #1 in the apartment. The friends indicated the resident had a walker and was able to walk to the bathroom before her hospitalization 2/28/26. He stated the initial discharge assessment form was a therapy form used to determine individual discharge needs in the home/apartment was completed on 3/26/25 (My Success Plan) which included the transition location,	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 18 mobility, transfers, food and liquid consistencies, supervision/assistance needed with meal prep, grooming/bathing assistance, communication/goals and resident goals. He indicated based on the discharge summary plan, physical therapy, and occupational therapy assessment Resident #1 was ambulatory with a walker and could walk to the bathroom. He further stated due to the non-coverage notice the resident was discharged from therapy services. He indicated the resident had made some progress; however, it was not enough that she would be able to provide personal care for herself without 24-hour assistance. The interdisciplinary team discussion was based on the discontinuation of therapy coverage and plan for discharge home. He indicated the resident was ambulatory with a walker for 200 feet and the decision to discharge was based on the exhaustion of benefits. A Discharge Plan and Summary form was completed and signed off by the interdisciplinary team on 4/1/26 through 4/3/26. The summary did not indicate a face-to-face meeting was held with Resident #1 or with any other parties acting on behalf of the resident, such as her friends. The summary revealed documentation was completed by the members of the interdisciplinary team. The documented reason for discharge was that the friend requested the resident to be discharged on 4/3/26, after NONMC last covered day was 4/2/26. The resident lived alone. Discharge goal barriers: cognitive impairment, medical management, physical challenges and medication management. Caregiver responsibilities: Resident did not have a caregiver at time of admission. Resident #1 will have caregivers after discharge including friends' assistance as needed. Discharge home with home health nurse/aide and home health therapy. Medication reconciliation indicated discharge medication information/instructions was provided and education given to Friend #1 on 4/3/26. Instructions included blood sugar checks that should be done 4 times a day with her sliding scale insulin coverage at breakfast, lunch, dinner and bedtime. Call primary care physician if blood sugar consistently lower than 70 or greater than 450. The Social Worker sent a copy on 4/2/26 of the labs that were drawn and the attached the medication list and discharge summary to the primary care physician. The following special treatments or procedures planned for discharge included physical, speech, occupational therapy, and nursing medical management. Rehabilitation services: rehabilitation potential was poor, assistive devices used were rolling walker, bedside commode, and wheelchair. Rehabilitation services in the home included home health occupational and physical	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 19 therapy. Resident #1 had no sensory impairments, unable to make her needs known with intermittent confusion, and fluctuations in consciousness. Final summary of resident status: Resident #1's orientation fluctuates. Alert to name and had intermittent confusion. Out of bed daily to wheelchair but she puts herself back to bed. Lacks safety awareness therefore she is at very high risk for falls. Does follow simple commands and can at times express what she wants. No vision or dental issues occurred during stay. No mood or behavior issues noted. Pleasant demeanor. She was incontinent of bowel and bladder and required maximum assistance with activities of daily living. Ate 75% of all meals. Skin intact at the time of discharge from facility. Blood sugars fluctuate some. The blood sugars were good but ran on the low side so blood sugar checks will be important and will need to continue post discharge. She did have diabetic medications adjusted while at the facility due to low blood sugars. Resident #1 required physical assistance with walking and required the use of assistive devices. Resident #1 required physical assistance and supportive devices for transfers, bathing, dressing, and toileting. Resident #1 required assistance with meal preparation, grocery shopping, housekeeping, personal, and home maintenance. Resident #1 was unable to take own medication, perform personal treatment/procedures and schedule medical appointment. Resident #1 needed home supplies and equipment that included a walker, wheelchair, raised toilet seat, activities of daily living aids, glucometer and supplies. Nursing note dated 4/3/2 revealed Resident #1 was sent home with glucometer and 1 week of supply strips, alcohol swabs, and cotton balls. Medication list provided at discharge was as follows: Aspirin 81 milligrams (mg) one tablet in the morning (nontraumatic hemorrhage). Atorvastatin 40mg at bedtime (hyperlipidemia). Ezetimibe (Zetia) 10 mg at bedtime (lowers cholesterol levels). Fluoxetine 20mg in the morning (major depressive disorder). Gabapentin 300 mg two times a day for pain (polyneuropathy). Humalog KwikPen per sliding scale if (0-150=0 units, less than 70 do SBAR(situation background	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 20 assessment) and notify provider; 151-200=1 unit; 201-250=2 units; 251-300 units=3 units; 301-350=4 units;, 351-400=6 units; 401—450=8 units; greater than 450 do SBAR and notify provider, inject three times a day (Diabetes). There were no times specified for the sliding scale insulin on the discharge medication list. Lantus 100 unit/ML (insulin glargine) inject twice a day (diabetes with hyperglycemia). Levothyroxine sodium 112 mcg (micrograms) in the morning (hypothyroidism). Metformin 1000 mg twice a day (diabetes). Valsartan 80 mg at bedtime (used to treat high blood pressure and heart failure). Review of a nursing progress note written by Nurse #1, dated 4/3/26, timed 1:55 PM, revealed Resident #1 was discharging home today. Copy of all medications along with education materials, glucometer, test strips and lancets were sent home with the resident. All medications were discussed with Friend #1, at the time of discharge. All necessary scripts (prescriptions) were sent home with the resident. SW had set up home health. The resident and Friend #1 voiced understanding of education provided. The resident left the facility via personal vehicle at 1:35 PM. The resident voiced no concerns at the time of discharge. The resident's skin was documented as having been dry and intact. The resident's vital signs were within normal limits. An interview was conducted on 4/8/26 at 12:47 PM with Nurse #1. She stated that Friend #1 and the resident were informed of the discharge instruction for medication, supplies for insulin, follow-up appointment, home health services information, the facility contact information, and this information was given to Friend #1. The resident had intermittent confusion but was excited about going home. Nurse #1 explained she went over the medications and both Friend #1 and Resident #1 indicated they understood the instructions and whom they needed to contact for follow-up appointments. Nurse #1 stated Friend #1 did not present or appear upset or uncomfortable taking the resident home. Friend #1 assisted Resident #1 into his car. She explained Resident #1 was discharged without any wounds and was able to use a walker and wheelchair to get to the car. Nurse #1 stated the resident did not mention what type of support she had in the home. Nurse #1 stated when she received the discharge paperwork on 4/3/26 therapy did not mention any concern with	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 21 the progress of therapy. Nurse #1 stated she was unaware of the actual discharge plan prior to receiving the paperwork from SW on the morning of discharge on 4/3/26. The discharge Minimum Data Set (MDS) assessment dated 4/3/26 indicated Resident #1 had severe cognition impairment. The discharge was coded return not anticipated. The discharge location was to home. The facility Social Service Progress Note dated 4/3/26 revealed resident representative (friends) requested discharge when the non-coverage notice (NOMNC), last covered date: 4/2/26 was issued by the Business Office Manager who had discussed filing for Medicaid with representative, prior to discharge and was told resident would not qualify by the resident representative (friends). Did not file a NOMNC appeal. Requested discharge 4/3/26. The Social Worker ordered a wheelchair through durable medical equipment provider that was delivered to her in her room. Follow up appointment was scheduled with primary care physician. Home Health Therapy, Nursing (medical management) care and nurse aide were arranged with home health. Discharge summary, copy of all labs, and order summary were faxed to primary care physician (PCP), copies were also provided to the resident. SW attempted to call Adult Protective Services (APS) 4/3/26, when the call at Department of Social Service (DSS) was transferred, and the call was dropped (disconnected). SW called APS regarding considered unsafe discharge again twice on 4/6/26. Both attempts resulted in dropped call again. SW attempted 3rd time and was able to connect with at APS on 4/6/26. Full report was provided to APS Intake. SW also spoke with PCP physician. A telephone interview was conducted on 4/8/26 at 8:17 PM with the facility SW who stated education on the appeal process was offered and she talked to both Friend #1 and Friend #2 who indicated understanding and declined. They still decided to take the resident home. The Social Worker stated she had reservations about the friend's ability to provide 24-hour care for Resident #1 based on Friend #1 and Friend #2's statements that they would not be able to stay in the home with Resident #1 24-hours a day and they would get assistance from other family or friends to assist with Resident #1's care. The SW indicated she did not feel the friends could provide the consistent care Resident #1 needed. Therefore, she decided to call Adult Protective Services as a backup measure to ensure that the friends were providing the 24-hour care	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 22 they said they would do. When asked since she had reservations about the friend's ability to provide the recommended 24-hour care, why was the discharge not stopped and re-evaluated by the facility team. She stated she did what she thought was right by contacting APS and the Primary Care Physician and informed them of the discharge to make sure the resident was receiving the services in the home that were needed. She further stated she had sent out the referral for home health on 4/2/26 and was told they would not be able to visit the home for 24 to 48 hours from the date of the referral. It was the assumption that family and friends would be in the home until the home health visit based on the discussion held with the friends who had assisted in the home prior to admission. The SW noted telephone communication with the durable medical company was on 4/2/26. She further stated she had not confirmed the recommended ordered home equipment (bedside commode, elevated toilet seat, grab bars, and walker) had been delivered. There was no response as to why she had not confirmed the delivery or recommended devices. The wheelchair was delivered to the facility for transport. She indicated the discharge discussion was primarily held with the friends and she did not call the Family Member since he had not responded to previous discharge discussions. The SW indicated all interdisciplinary team members were responsible for completing their section of the discharge plan prior to discharge. An interview was conducted on 4/8/26 at 9:30 AM with the Admission Director who stated the SW stated she had spoken with the friends about the appeals process when they were informed of the non-coverage notice and the friends declined. She was unaware of the extent of the discharge discussion but was informed by the SW that the friends indicated they would provide the 24-hour care and coverage Resident #1 needed through family and friends. Per discussion with the SW, the Admission Director stated she was aware the Social Worker called APS to ensure that the friends were able to provide the care Resident #1 needed. A telephone interview was conducted on 4/9/26 at 1:40 PM with Durable Medical Equipment (DME) staff from the company who delivered the assistive devices to the community. She stated they received a call 4/3/26 from the facility for a wheelchair for Resident #1 to be delivered to the facility on 4/3/26. The staff member stated there were no other orders for home equipment to be delivered to the facility or Resident #1's home.	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 23 A telephone interview was conducted on 4/8/26 at 11:10 AM with Friend #1 who stated he and Friend #2 received a call from the facility SW (unable to recall exact date) who informed them that the resident no longer had insurance coverage and needed to be picked up and returned home 4/3/26. He stated he and Friend #2 came to the facility to pick up Resident #1 because of the call received from the SW. The two of them put her in the car with staff assistance with the wheelchair that was provided by the facility. He stated he and Friend #2 felt pressure to take the resident back to the apartment and was not told about the appeal process until he was walking out the door. He further stated he did not understand and had no idea what the appeal process meant or how to execute the process. He explained the SW was persistent on getting Resident #1 out of the facility. He stated they tried to get friends to stop by and check on Resident #1 when she was brought home on Friday 4/3/26. He stated he and Friend #2 got Resident #1 settled in the apartment with a meal and changed her and left her in bed. She was unable to do much for herself because she was not able to walk or stand for long periods. Friend #1 explained they both had to leave, so the resident was left alone in the apartment overnight. He stated Resident #1 was unable to walk or do anything for herself, so once they got her in bed, she would remain there until someone visited the next day 4/4/26. He stated he was given a list of medications and prescriptions and a few diabetes supplies by the facility nurse. He stated he had not gotten the prescriptions filled and he was not comfortable giving Resident #1 the medication or providing any care because that was not what he did when he visited. He stated Friend #2 left to go out of town with family. Friend #1 stated he visited on Saturday 4/4/26 (could not recall the exact time) and the resident was very soiled and needed to be cleaned up, so he tried to call around to members of the church to come help. He indicated a neighbor from the building came to change Resident #1. He fixed her meal and left in the evening, and he did not give her any medication. Friend #1 stated he returned on Easter Sunday (4/5/26) and the home health nurse came in the afternoon to assess Resident #1. He stated he told the home health nurse that he felt pressure to take resident home because she was unable to pay. He stated the resident should not have been sent home and there was no one available to provide the 24-hour care she needed. Friend #1 indicated he asked if the home health agency would do something to get her back to a facility or the hospital. The home health nurse indicated she would call Resident #1’s primary care physician. The home	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 24 health nurse tried to get Resident #1 up and get her up to walk and Resident #1 was helpless and she had no idea what was going on around her. He stated Resident #1 was unable to get to the door or call anyone in an emergency. Friend #1 indicated Resident #1 was confused and had a life alert and would have difficulty using it. He was unaware if the resident could use or had access to a cell phone. He noted unless someone stopped by to check on her, she would be alone for a long period of time. He further stated on Tuesday 4/7/26 Adult Protective Service (APS) came and saw the resident had not been changed or received medication and made the decision to send Resident #1 to the hospital. He indicated he informed Adult Protective Service that he and the friends could not provide the direct care or medication management Resident #1 needed to stay in the home. He informed APS that the son lived out of state and the facility did not call him to let him know they were discharging Resident #1 and the friends called to let the son know what was going on 4/7/26, that Resident #1 was sent back to the hospital. A telephone interview was conducted on 4/9/26 at 8:25 AM with Friend #2 who stated she was unaware of Resident #1's finances other than her Medicare benefits, therefore was unable to make a financial decision about payment for an extension of stay. The friend stated she felt pressured to take Resident #1 home and reported she was not provided with clear information regarding the appeal process when it was discussed or that she had the option to refuse to take the resident home. She indicated she contacted Friend #1 and informed him of the discussion held with the SW on 3/31/26. Friend #2 stated based on the discussion with the SW Resident #1 needed to be discharged due to no insurance coverage. Friend #2 explained they did not fully know or understand the options available regarding the discharge plan and indicated they would attempt to arrange 24-hour care and assistance for Resident #1. Friend #2 stated they were unable to provide 24-hour care or remain overnight in the home themselves. Friend #2 stated when she and Friend #1 arrived at the facility on 4/3/26, a wheelchair was provided to assist Resident #1 into the car. She indicated Resident #1 had difficulty walking and standing and it was difficult getting Resident #1 into her second-floor apartment because she was very weak, confused, and unable to do for herself. She indicated she and Friend #1 cleaned up, fed, and placed Resident #1 in the bed for the evening. She indicated she had not given Resident #1 any medications before she left for the evening. Friend #2 stated she had called the	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 25 son and informed him of the discharge from the facility a few days after Resident #1 was discharged and then when the resident was sent to the hospital. She explained she was out of town when the home health nurse and APS did their visit with Resident #1. A telephone interview was conducted on 4/8/26 at 1:48 PM with the Resident's Family Member who stated he was unaware that she had been discharged from the skilled facility until 4/8/26 when he called back home to talk to friends and family. He stated he had not received any calls from Resident #1's primary care physician, nursing home staff, or APS about her being discharged from the facility. He stated he was told that Resident #1 was readmitted to the hospital on 4/7/26 for further evaluation to see if she would be able to live independently. The Family Member indicated he had not had any direct discussion with anyone about her ability to live alone or if she would be returned to a skilled facility. The interview further revealed friends had visited and assisted when they were able, but no one mentioned that they would provide direct 24-hour care. The Family Member confirmed he lived out of state and was unable to provide 24-hour care or become her guardian. The Family Member indicated he did not have power of attorney papers for Resident #1. A Home Health clinical summary dated 4/5/26 (Easter Sunday) written by the home health nurse was reviewed. The referral was received on 4/2/26: read in part: Clinical Summary revealed a female discharged from skilled nursing facility on 4/3/26 with orders for home health to provide skilled nursing, physical therapy, and occupational therapy. Resident #1 has a past medical history including but not limited to non-traumatic intracranial hemorrhage, hypertension, hyperlipidemia, diabetes, polyneuropathy, hypothyroidism, major depression, anemia, mild protein-calorie, malnutrition, muscle weakness, abnormalities of feet, osteoarthritis, cognitive communication deficit, and dementia. Resident #1 lived alone in an apartment. Friends and family were to assist with care daily. Resident #1's Friend #1 was present during skilled nursing visit and stated they wanted to have Resident #1 placed back into a skilled nursing facility as they were unable to provide 24/7 care and the facility would not take Resident #1 back. Home Health Nurse to request an order for a medical SW from the primary care provider to do an assessment for transfer to the hospital. Resident #1 was alert and oriented to person and place, bilateral lung fields clear. Bilateral lower extremity with 1 plus edema (slight swelling).	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 26 Skin intact. Resident #1 was incontinent of urine and feces. Resident #1 was non-ambulatory. Family (friends) unable to administer insulin due to no needles in the home for insulin pen. Skilled nursing educated Resident #1's Friend #1 on checking blood glucose, getting prescription filled, incontinence care, importance of providing 24-hour 7 day a week supervision, normal blood glucose range, normal blood pressure range, emergency evacuation plan, emergency plan, when to call home health nurse and when to call 911. Resident #1's Friend #1 verbalized understanding but required further teaching. A skilled nurse required for prevention of hospitalization, assessment and teaching on diabetes, insulin administration, hypertension, and fall prevention. Home Health Nurse provided the needles for the insulin pen. A telephone interview was conducted on 4/9/26 at 3:42 PM with the Home Health Nurse who did the clinical assessment on 4/5/26 for Resident #1. She stated when she arrived at Resident #1's apartment, Friend #1 was there and informed her that Resident #1 should be sent back to the facility because the friends and the resident's family could not provide 24-hour care. The Home Health Nurses stated the friend explained to her that no-one was staying with the resident overnight or keeping up with the resident's medication. The Home Health Nurse stated Resident #1 was lying in bed and was heavily soiled with both urine and fecal matter. She explained Resident #1 was unable to get out of bed without extensive assistance of two people. Resident #1 was confused, very stiff, and helpless when attempts were made to get Resident #1 to stand, transfer or assist with pivot. She explained Resident #1 was unable to walk to the door or call for assistance in an emergency. She indicated if Friend #1 had not been in the home when she arrived, she would not have been able to get into the apartment to assess the resident. She further stated Resident #1 did not have appropriate assistive devices available for care such as a bedside commode, raised toilet seat in the bathroom, and personal hygiene supplies. She stated Friend #1 did have a list of Resident #1's medications with prescription and a few supplies (syringes with no needles for the diabetic pen), but the prescriptions had not been filled. The nurse continued and stated there were old medications leftover but no needles for the diabetic pen. She indicated she had provided the needle for the pen when she took the blood sugar level. She clarified, the friend stated he had not given any meds to the resident. The Home Health Nurse explained she reviewed the medication list provided to Friend #1 and what was available in the apartment	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 27 and noted there were some old medications leftover that were not on the list. She stated she checked Resident #1's blood sugar level and it was about 195 (normal range 70 to 99). The Home Health Nurse was not specific on what was normal for Resident #1 since because this was the first assessment. She indicated she contacted Resident #1's primary care physician in the community on 4/5/26 to discuss the blood sugar level history and gave insulin from the medication that matched what was on the current list that was sent home with the resident. She stated based on her observation she did not see the durable medical equipment; it was clear the resident needed 24-hour care and was unable to communicate her needs and Resident #1 was unsafe in the home alone. She asked the primary care physician for an order to have a medical SW visit, and the medical SW visit was scheduled for 4/6/26. The interview further revealed home health was scheduled to return on 4/7/26 and Resident #1 was admitted to the hospital on 4/7/26. A telephone interview was conducted on 4/9/26 at 2:40 PM with the Adult Protective Services (APS) Social Worker who stated the initial referral came from the facility on 4/3/26 (Good Friday) due to the facility SW's concern that the friends would not provide the necessary 24-hour care Resident #1 needed in the home. The APS Social Worker stated when they went to the home on 4/7/26 they were unable to get into the apartment on the second floor without the assistance of Friend #1 due to Resident #1's inability to walk or get to the door. The APS Social Worker had the number of Friend #1 from the referral. She stated when she arrived the resident was in bed soiled with feces and urine; Resident #1 was non-ambulatory and unable to get out of bed. Resident #1 was confused and disoriented and unable to state her needs or provide any form of care for herself. The APS worker explained a wheelchair was available in the apartment, but the resident required 2-person assistance with all activities of daily living; Resident #1 had a life alert and was unable to use the life alert or press the button or call 911 for assistance on a phone. APS worker stated the environment was unsafe because in an emergency the resident lacked the overall ability to get out of bed, answer the door, or provide any form of care for herself. She stated when speaking with Friend #1 onsite and Friend #2 via telephone they stated the facility was informed they were unable to provide any direct care for Resident #1, and they were unable to provide 24-hour assistance in the home because they both lived outside of the resident's home area. The friends had also asked the home health nurse that visited on	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 28 4/5/26 to send Resident #1 back to the facility but were told the resident would not be accepted back to the facility due to a lack of insurance coverage. The APS worker stated the friends did not call the facility and further explained Resident #1 did not have the proper durable medical equipment of a bedside commode, raised toilet seat, grab bars in the bathroom, was not being properly cared for, and medication monitoring was a concern. She stated based on her assessment an order for provision to have the resident transferred to the hospital for emergency service order was obtained from the district court judge for Resident #1 to be transferred to the hospital. She further stated the hospital evaluation revealed Resident #1 had a urinary tract infection. The hospital Social Work progress note dated 4/7/26 at 4:53 PM, revealed the hospital SW received a call from the local APS notifying the hospital SW that Resident #1 was being sent to the hospital and that they had an open case on Resident #1. The APS worker had been working on placement at another skilled nursing facility and Medicaid application for Resident #1 when she was ready for discharge. A telephone interview was conducted on 4/9/26 at 4:00 PM with the hospital SW who stated they had received a call from APS requesting admission and evaluation for Resident #1. Resident #1 was admitted to the hospital for evaluation and treatment of a urinary tract infection. She was informed by the APS Social Worker that APS had an active case and was seeking placement in an alternate facility. She indicated they were made aware by the APS Social Worker that Resident #1 was unsafely discharged to the home without recommended support and services. A telephone interview was conducted on 4/8/26 at 1:26 PM with Resident #1's Primary Care Physician from the community who stated he was unaware of the discharge plan from the facility until he received a referral and discharge summary from the facility SW on 4/3/26, which was the day of the discharge. He stated he called the facility on 4/6/26 and spoke with the SW who stated that the resident had been discharged due to non-coverage from the insurance He stated the SW informed him that friends or family had not wanted to be responsible or sign any documents for guardianship or the application for Medicaid. The Physician stated he was informed that friends were involved trying to provide support as much as they were able due to limited/lack of contact with the Family Member. He stated he did	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 29 receive a call from the home health agency on 4/6/26 to obtain authorization for services, physical therapy, occupational therapy, and nursing (home visits). He stated he was notified on 4/7/26 that the resident was returned to the emergency room by Adult Protective Service (APS). He stated the resident was unable to live alone and that was why he initiated a wellness check (the physician did not recall exact date of call) and called APS which resulted in the resident being hospitalized the first time. He explained based on the clinical notes received from home health, Friend #1 had indicated they could not meet Resident #1's needs in the home or assist with the care she needed. An interview was conducted with the Director of Nursing (DON) on 4/9/26 at 8:44 AM who stated the discharge planning process started at the time of admission and when a designated discharge date was established. The interdisciplinary team included nursing, rehab, dietary and social work who would meet and review the resident's goals and discharge plan and service needs. The SW would make all the necessary community support arrangements for residents and family. Each department head was responsible for completing the discharge plan section for their area on admission at the initial discharge planning meeting and the final discharge summary. The SW would notify the team of the discharge date and schedule a meeting with the team, resident, and responsible person to discuss the discharge plan and/or any concerns. She stated she was not present at the discharge planning meeting for Resident #1. The interdisciplinary team met and discussed the discharge plan for Resident #1's return home with family and friend support and 24-hour care coverage at the discharge meeting on 3/31/26. The DON stated based on her knowledge from the Admission Director and the SW, both of them indicated they had discussed with the friends the discharge plan for Resident #1 to return home. She indicated the SW had informed the friends, who were listed as the primary contact people, of the appeal process regarding the end of insurance paying for the resident's stay and they declined. The DON stated the SW indicated the friends elected to take Resident #1 home and gave the impression they were able to provide 24-hour support and care for the resident. She was unaware of any concern that the friends would not do what they said since that had been assisting Resident #1 prior to admission to the facility. The DON explained once the SW provided the nursing team with the paperwork necessary for discharge, nursing would obtain the medication list, prescription orders, and supplies needed for discharge. The nurse	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 30 discharging the resident would review all medications, follow-up appointment information, and contact information for pharmacy, home health information, and provide resident and responsible person with a copy of the discharge summary. She indicated if there were any reservations about whether a resident's healthcare needs could not be met in the home the discharge would be stopped and the team would reevaluate. The Director of Nursing did not indicate she had spoken with the friends about the discharge plan. DON stated the SW handled the discharge process and discussion with the friends. An interview was conducted on 4/9/26 at 2:00 PM with the Administrator who indicated she did not attend the discharge planning meetings in general. The Administrator stated discharge planning begins prior to the interdisciplinary team meeting with an assessment of the resident's needs, anticipated discharge date, and identification of required services, equipment, and supports. The Administrator further stated the IDT meeting was conducted to review the proposed discharge plan, discuss recommendations, and address any concerns or reservations identified by the team members, the resident, and/or the responsible party. If concerns were identified, the discharge plan was revised to address the identified needs. The Administrator stated the facility did not proceed with a discharge until necessary services, equipment, medications, and follow-up appointment were confirmed. The Administrator further stated discharges may be postponed, or withheld, when the discharge plan needs were not fully arranged to ensure a safe and appropriate discharge to home. The Administrator stated she was unaware of the SW's reservations regarding the discharge plan for Resident #1. She indicated she became aware of the concern related to the discharge of Resident #1 after learning the SW contacted Adult Protective Services as a precautionary measure to verify the ability of the identified friends who indicated they would provide the necessary 24-hour care for Resident #1, consistent with the discharge plan discussion. Hospital records were requested for Resident #1's 4/7/27 admission but had not been received by the time the Statement of Deficiencies (2567) was posted. The Administrator was notified of the Immediate Jeopardy on 4/9/26 at 5:38 PM. The facility provided the following credible allegation of immediate jeopardy removal:	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 31 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance The facility failed to ensure safe and orderly discharge for Resident #1. Resident #1 was discharged from the facility with a family friend who could not provide the recommended 24-hour activities of daily living or medication management. Resident #1 was sent home with individuals who were unable to provide the recommended 24-hour care Resident #1 required to be maintained in the home independently. Resident #1's family was not notified of the discharge. The resident went home on 4/3/26 without 24-hour services and support equipment. On 4/5/26 home health visit revealed Resident #1 without the recommended 24-hour care and was unsafe in the home due to cognitive communication deficit, limited physical capabilities to provide self-care, and non-ambulatory. The assistance and support were not consistently available as recommended and needed. The support system communicated the need for Resident #1 to return to a facility. Home Health obtained an order for assistance from a medical SW to assist with the return. APS visit on 4/7/26 confirmed unsafe discharge and referred resident back to hospital. Resident admitted with a urinary tract infection on 4/7/26. On 4/9/2026 the Nursing Home Administrator, Director of Nursing, Admissions Coordinator, Unit Manager and Minimum Data Set (MDS) Coordinator completed an audit, which included phone interviews for all residents discharged in the last 30 days to ensure responsible parties were notified, resident and/or responsible parties understood discharge instructions, home health services are present as indicated, equipment needs were met at time of discharge and do they feel their discharge was completed safely, this includes verbal verification/return verbalization to ensure understanding of discharge instructions. On 4/9/2026 the Minimum Data Set (MDS) Coordinator and the Minimum Data Set (MDS) Nurse completed an audit of all resident's care plans to ensure discharge plans are accurate and up to date by reviewing individual Discharge Planning Review Summaries in the resident's electronic medical records and/or verbal confirmation from the resident or resident's responsible parties. Any concerns were immediately corrected	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 32 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete The Interdisciplinary Team, which includes the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services Director, Business Office Manager, Rehab Program Manager, Activities Director, Minimum Data Set (MDS) Coordinator and the Admissions Coordinator were educated on 4/9/2026 by the Regional Clinical Director to ensure a safe and appropriate discharge plan using the facility policy and procedure for Discharge Plan (Post Discharge). This education included: Social Services Director responsibility will include: will within 48 hours of admission or first business day if on weekend will confirm patient/responsible party plans and support system, Social Services Director will identify post discharge needs with the interdisciplinary team daily in the morning meeting, keep interdisciplinary team informed of discharge planning as indicated with changes during morning meetings, assist with, apply for, and/or secure needed services post discharge to include Equipment, Personal Care, and home health services, finalize and confirm services prior to discharge, and communicate all discharge plans with the resident, Responsible Party of resident, support system and/or interested parties. The Social Services Director will discuss with the Interdisciplinary team immediately, if at any time there is a concern or question for safety during the discharge process. The Interdisciplinary Team will form a resolution to ensure a safe and appropriate discharge to home. Education also included that if the Interdisciplinary Team identifies potential barriers to discharge the Interdisciplinary Team will discuss with the Social Services Director and form a resolution to ensure a safe and appropriate discharge to home. The Business Office Manager will be responsible for ensuring: The Resident and/or Responsible Party receives written and verbal notification of denial of appeal or if the Resident is discharged from insurance, the appeal process is explained in plain language, including timelines and rights, assist the Resident and/or Resident Responsible Party with the	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 33 Medicaid application process, and the resident and/or Residents Responsible Party will verbalize and demonstrate understanding by accurately restating key instructions. If the Resident and/or Residents Responsible Pary does not comprehend, the Social Services Director will: Provide repeated education, involve alternative decision-makers if available, document barriers to understanding. The facility will assist with filing appeals as requested and appropriate. If insurance denies continued stay and no safe discharge plan exists: The resident will not be discharged until a safe discharge plan exists, which includes: Explore alternative placement options, continue pursuing payer solutions (Medicaid, private pay, etc.), escalate to Administrator and Medical Director as needed, and continue with insurance appeals as indicated For Residents without Capacity or Legal Representative, Social Services Director will: Initiate referral for guardianship or surrogate decision-maker, Collaboration with Adult Protective Services (APS) as needed, the Interdisciplinary Team will act in the residents' best interests using clinical judgment and regulatory guidance, and the discharge will not occur until a safe and appropriate plan is established and a responsible party has been established. Nursing Staff will utilize the Discharge Planning and Summary at time of discharge, as completed by the Interdisciplinary Team to ensure: Residents and/or Responsible Party receive written and/or Escribed prescriptions for all ordered medications. If Resident and/or Responsible Party cannot obtain prescriptions at pharmacy of choice, medications will be sent home with Resident and/or Responsible Party from the facility, and education on medication administration, including insulin if applicable. Demonstration and return demonstration when appropriate for residents requiring blood sugar monitoring or insulin administration the facility will confirm: Resident and/or Responsible Party capability or Home health nursing services are arranged prior to discharge, if the resident cannot safely manage medications the discharge will not proceed without appropriate support in place, nursing staff will ensure a 7-day supply of medical supplies (e.g., insulin, syringes, pen needles,	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 34 lancets, glucometer, test strips) are provided at discharge. Therapy and Nursing responsibilities will include assessing and determining Durable Medical Equipment (DME) needs. Social Services will: Order and coordinate delivery of all required Durable Medical Equipment (DME) and provide confirmation of delivery prior to discharge or estimated time of arrival. Therapy will assess mobility and determine needs of equipment and educate Resident and/or Responsible Party as indicated on mobility/transfer needs, feeding, Activities of Daily Living assistance and communication needs. Therapy will ensure Resident and/or Responsible Party can verbalize and demonstrate understanding by accurately restating key instructions. Emergency Services Accessibility; The Nursing Staff will confirm: The resident and/or Responsible Party verbalize and demonstrate understanding by accurately restating key instructions on what to do in the event of an emergency, including when and how to seek emergency assistance All discharges will be reviewed by the Interdisciplinary Team and agreed upon by all relevant disciplines prior to the actual discharge during daily morning standup meeting and with any changes. Discharges will be discussed during the initial care conference with residents and/or residents responsible parties and will be reviewed during daily morning standup meetings with the Interdisciplinary Team. The Nursing Home Administrator will be responsible for compliance. An Ad-Hoc Quality Assurance Performance Improvement Committee was held on 4/9/2026, which included the Regional Clinical Director, Medical Director (via phone), the Director of Nursing, Assistant Director of Nursing, Administrator, Social Service Director, Activities Director, Rehab Program Manager to formulate and approve a plan of correction for the deficient practice. The Administrator will be responsible for the completion of the corrective action plan. Immediate Jeopardy Removal Date of 4/10/2026 The Credible Allegation was validated on 4/13/26. Staff educations records were reviewed and confirmed that interdisciplinary team members	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0627 SS = J	Continued from page 35 including nursing, social services, therapy and administration, received education regarding safe discharge planning and requirement for ensuring resident needs were met prior to discharge. A review of discharge audited completed by the facility demonstrated ongoing monitoring of discharge planning processes. The audits included verification of residents' needs, coordination of services, confirmation of equipment, availability of medication access, and documentation of resident and/or responsible party agreement prior to discharge. Interviews conducted with facility staff included nursing, new hires, social services, therapy, confirmed understanding of the revised discharge planning process and the requirement to delay discharge when discharge needs have not been met. A review of the recently discharged residents' records indicated discharge planning documentation was included in the care plans, discussions were held at the initial care plan meeting, post discharge meeting in social service notes to indicate discussion of meeting, and plan of care recommendations. The Administrator and the Regional Nurse Consultant team did a completed audit of care plan on 4/11/26 for residents that were discharged in the past 30 days. During the admission process the admission director and social worker will review the discharge plan with the resident and resident representative 24 hours in advance of the scheduled discharge date. Revisions to the discharge plan summary included: discussion of discharge plan to be held within 48 hours of admission, the resident representative will verbalize understanding of the caregiver responsibilities, durable medical equipment and therapy services will be identified, and home resources and services needs will be clearly identified. Nursing staff were interviewed and educated and provided with a safe discharge checklist for a safe and orderly discharge. Therapy service was interviewed and received education and responsibility to ensure all recommended durable equipment has been ordered and delivered to the resident's home. The Director of Nursing was observed providing telephone interviews to the nursing staff that were not scheduled to work about discharge plan summary and transfer education via telephone and onsite to new hires and agency staff of the facility discharge plan process The facility's immediate jeopardy removal date of 4/10/26 was validated on 4/13/26.	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0745 SS = D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure a resident with severe cognitive impairment, no established legal decision maker for financial or healthcare decisions, and no payor source when Medicare skilled benefit days were exhausted was assisted with pursuit of a legal decision maker (guardianship) and the completion of a Medicaid application for 1 of 3 residents reviewed for discharge planning (Resident #1). The findings included: Resident #1 was admitted on 3/16/26 with diagnoses that included anxiety, depression, communication deficit and dementia. Review of the clinical record did not specify a responsible party, guardian, or power of attorney for Resident #1. The admission Minimum Data Assessment (MDS) dated 3/20/26 revealed Resident #1 was severely cognitively impaired. Resident #1's care plan initiated on 3/20/26 did not include interventions addressing lack of a legal decision maker or assistance with completion of a Medicaid application. The discharge Minimum Data Set (MDS) assessment dated 4/3/26 indicated Resident #1 had severe cognitive impairment. The discharge was coded as return not anticipated. The discharge location was to home/community. A review of Resident #1's medical record from admission on 3/16/26 through discharge on 4/3/26 revealed the following information. Resident #1's payor source on admission was a Medicare managed care plan that covered a limited number of days in skilled nursing care under Medicare Part A. Resident #1 exhausted the Medicare Part A coverage benefits on 4/3/26. There was no additional payor source identified for Resident #1. There was no evidence assistance was provided with the completion of a Medicaid application for Resident #1. Additionally,	F0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0745 SS = D	Continued from page 37 there was no evidence that the facility had made any efforts to refer the resident for a guardianship evaluation or any other interventions to assist the resident with establishing a legal decision maker or additional financial coverage. During an interview on 4/8/26 at 9:30 AM with the Admission Director she revealed Resident #1 did not have an established legal representative. She stated during the resident's stay at the facility she discussed guardianship and a Medicaid application with friends of the resident that assisted with Resident #1's admission. Friend #1 signed the admission paper and declined assuming responsibility for Resident #1's decision making. She further stated Resident #1 did not have any additional financial coverage to stay at the facility beyond the Medicare covered days. The Admission Director further stated that the responsibility for addressing the need for initiating guardianship and completion of the Medicaid application was referred to the Social Worker who was responsible for this task. The Admission Director confirmed that to her knowledge no Medicaid application or guardianship referral had been initiated or completed on behalf of Resident #1. During an interview on 4/8/26 at 8:17 PM with the Social Worker (SW) she stated the facility was aware Resident #1 did not have a legal representative available to assist with financial decisions, medical decisions or other legal matters. The Social Worker indicated she was made aware that Resident #1 did not have a legal representative by the Admission Director and the friends of Resident #1 who assisted the resident when she was admitted to the facility. She acknowledged that Resident #1 was unable to make informed decisions financially and medically due to cognitive impairment. The SW confirmed that Resident #1's need for guardianship and Medicaid application assistance had been discussed with the Admission Director (no date was provided of when the discussion was); however, no referral for guardianship was made and no assistance with the Medicaid application was provided for Resident #1. The SW indicated the resident was discharging within a few days of the discussion with the Admission Director and she ran out of time. An interview was conducted on 4/13/26 at 9:30 AM with the Administrator who stated there was a breakdown in communication and coordination between the two departments. The Administrator indicated the previous policy and procedure did not specify the role and responsibilities of the Admission Director and Social Worker to initiate the	F0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345241	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation and Healthcare Center	**226 N Oakland Avenue , Eden, North Carolina, 27288**

(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
F0745 SS = D	Continued from page 38 process for guardianship for cognitively impaired individuals who had no legal decision maker or for completion of a financial application for Medicaid and/or other payor sources.	F0745		