STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335607	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehabilitation Nursing Center	2806 George Street Eden, NY 14057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review conducted during the Standard survey completed on 01/09/2025, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation did not involve abuse and do not result in serious bodily injury, to the administrator of the facility for one (1) (Resident #12) of one (1) resident reviewed. Specifically, Resident #12 was found to have an injury of unknown origin that was not reported to the administrator. The finding is:The policy titled Abuse - Investigation, Protection and Reporting, dated 10/24/2022 documented an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source) would be reported immediately, but not later than: A. two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or B. twenty-four (24) hours if the violation did not involve abuse and had not resulted in serious bodily injury. Any injury that was explained and appeared to be a result of abuse must be reported. An injury should be classified as an injury of unknown source when ALL the following criteria were met: the source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury was suspicious due to: the extent of the injury, or the location of the injury, or the number of injuries observed at one particular point in time, or the incident of injuries over time.The undated policy titled Weekly Skin Evaluation documented weekly skin evaluations were completed on each resident in the electronic medical record (point click care). Best practice was to do skin check on a shower day. The licensed nursed would examine the skin of each resident weekly on specified day, paying close attention to common areas of pressure. Each abnormality, e.g., skin tear, rash, excoriation, abrasion, bruise, and surgical wound would be checked on list. Color such as red and purple were late signs. If an abnormality was found then a weekly wound form was initiated based on facility would round protocol and the physician, Director of Nursing, and family were notified.Resident #12 had diagnoses including dementia without behavioral disturbances, depression, and chronic obstructive pulmonary disease (COPD). The Minimum Data Set (a resident assessment tool) dated 11/07/2025 documented Resident #12 was moderately cognitively impaired, was usually understood, and understands.The Kardex (a guide used by staff providing care) dated 01/04/2025 documented Resident #12 received their shower on Tuesday evening.The comprehensive care plan, dated 01/28/2025 documented Resident #12 was dependent on two (2) staff members for upper body dressing and transferring, requiring a mechanical lift, and a substantial/maximal assist of one (1) person for personal hygiene. Resident #12 had impaired skin integrity with interventions to evaluate skin integrity, provide skin care per facility guidelines, and for Resident #12 to wear long sleeve protectors when out of bed as tolerated.During an observation and interview on 01/05/2026 at 10:00 AM, Resident #12 was seated in their wheelchair sleeping, their sleeves were slightly pulled up and a large purple area was observed on their left forearm. When Resident #12 woke up, they stated they did not know where the purple area came from.During an observation on 01/06/2026 at 8:40 AM, Resident #12 was sitting up in their bed (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eating breakfast, the large purple area remained on their left forearm.Review of Resident #12s accident and incident reports from 08/01/2025 to 01/06/2026 revealed no reported incidents or findings regarding their left forearm.Review of nursing progress notes dated 12/31/2025 to 01/06/2026 revealed no documented evidence that Resident #12s injury of unknown origin was reported to administration.The Daily Unit Management Sheet dated 01/06/2026 2:00 PM to 10:00 PM shift, documented Resident #12 received a shower from Certified Nurse Aide #1 and Licensed Practical Nurse #1 was their assigned nurse.Review of Weekly Skin Check form dated 01/06/2026 at 7:35 PM, documented Resident #6s skin was intact with no new findings.Review of the nursing progress note dated 01/07/2026 at 9:45 AM, revealed the Regional Quality Improvement Nurse documented there was an area of discoloration to Resident #12s left forearm, purple in color, measuring 6.5 centimeters by 6.4 centimeters, they denied having any pain.Review of facility undated Internal Investigation Report documented on the morning of January 7th, 2026; a New York State Department of Health (DOH) surveyor notified a facility employee that they observed a purple discoloration on Resident #12s wrist. The surveyor further stated the discoloration had been observed previously on Monday January 5th, 2026. A weekly skin assessment completed on January 6th, 2026, documented no skin impairment. The nurse who completed the assessment was interviewed and stated they performed a thorough head to toe assessment on 01/06/2026 and the area was likely obscured by the resident's wrist band.During an interview on 01/07/2026 at 9:18 AM, Certified Nurse Aide #2 stated they were Resident #12 assigned nurse's aide, but Resident #12 had been dressed already when they came in for their shift that morning, they had not provided any hands-on care including dressing yet that morning.During an observation and interview on 01/07/2026 at 9:19 AM, Licensed Practical Nurse #1 observed Resident #12 and stated the resident had a purple area on their left forearm. Licensed Practical Nurse #1 stated they were not aware of Resident #12 having any new injuries, and if they were they would have reported it to administration so the area could be monitored, and an investigation could be started.During an observation and interview on 01/07/2026 at 9:25 AM, the Assistant Director of Nursing stated they were not aware of any new skin issues with Resident #12. They reviewed Resident #12s electronic medical record and stated there was only a new order for a fungal rash from 01/06/2026. The Assistant Director of Nursing observed Resident #12s left arm and stated they would have expected whoever found the area to have reported it, and any staff caring for Resident #12 could have.During an interview on 01/08/2026 at 1:07 PM, Licensed Practical Nurse #1 stated Resident #12 had received a shower from Certified Nurse Aide #1 on the evening of 01/06/2026, when they were called in to do a skin check they did not see the purple area on Resident #12s left forearm, but they should have.During a telephone interview on 01/08/2026 at 12:13 PM, Certified Nurse Aide #3, who was Resident #12s assigned aide on the over night shift (10:00 PM to 6:00 AM) on 01/05/2026, stated they do not turn the lights on when they complete care in that room because one of the roommates complains about the light being turned on at night, so they did not see any purple area on Resident #12.During a telephone interview on 01/08/2025 at 12:53 PM, Certified Nurse Aide #1 stated they assisted with giving Resident #12 a shower on 01/06/2026 on the evening shift (2:00 PM to 10:00 PM) and did not see any purple areas on their left forearm. They stated they did observe the area on 01/07/2026 when they worked next, and it was quite large. Certified Nurse Aide #1 stated if they saw a new skin issue with a resident, they would report it right away to figure out how it occurred. They would report any discoloration of the skin, whether it was a suspected bruise or suspected purpura.During an interview on 01/09/2026 at 10:01 AM, in the presence of the Regional Quality Improvement Nurse, the Director of Nursing stated they expected any staff caring for a resident to report any new skin issues, including a bruise, to their superior, so that it could be reported to administration. They would have expected staff to have been more observant when caring for Resident #12 and have noticed the purple area on their left forearm and reported it. During an interview on 01/09/2026 at 11:25 AM, the Administrator stated they monitor all reportable incidents in the facility, and discuss the findings in their Quality Assurance meetings, there had not (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been any issues identified with reporting in the facility.During a telephone interview on 01/09/2026 at 1:40 PM, the Medical Director stated the facility was supposed to report any injury of unknown origin, including a bruise, to administration, it was the facility policy. They would have expected the nursing staff providing hands on care to Resident #12 to have noticed the purple area and reported it so that a decision could be made about the next steps.10 NYCRR 415.4(b)(4)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that services being provided met professional standards of quality for one (1) (Resident #6) of one (1) resident reviewed. Specifically, an order for an antiviral medication was not continued upon readmission to the facility for an influenza (viral infection) positive resident. Additionally, there was a physician order placed to test/swab residents for influenza on [DATE], the testing supplies were not available until [DATE].The findings are: The policy titled Admission/readmission procedure, dated [DATE], documented the purpose of the policy was to establish a clear procedure for the admission and re-admission of residents to ensure compliance with federal and state regulations, including Centers for Medicare and Medicaid (CMS) Requirements of Participation as outlined in Appendix PP, and to promote quality and continuity for each resident. Upon residents' admission the charge nurse would familiarize themselves with the records accompanying the resident, review hospital medical record, discharge medications, and discharge summary. The Nursing Supervisor would review orders with the provider and enter/review medication orders. The policy titled Reconciliation of Medications on Admission/Re-Admission, dated [DATE], documented a complete medication reconciliation for all residents upon admission and readmission was completed to ensure accurate, safe, and continuous medication management. All medications, including prescription, over the counter, and supplements, shall be reviewed for accuracy, appropriateness, and potential interactions, and discrepancies shall be resolved and documented to support resident safety and continuity of care. If there was a discrepancy or conflict in medications, dose, route, or frequency, determine the appropriate action to resolve the discrepancy, such as contacting the physician from the referring facility or admitting physician. Resident #6 had diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (loss of use of left extremities following stroke), anxiety, and dementia without behavioral disturbances. The Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #6 was moderately cognitively impaired, understands, and was usually understood by others. The comprehensive care plan dated [DATE] (current) documented that Resident #6 on [DATE] had an altered respiratory status related to a recent hospitalization for Influenza A and was to have oxygen on via nasal cannula at two (2) liters per minute as needed. Review of Order Recap Report dated with a printout date of [DATE] revealed an order for Resident #6 initiated on [DATE] to be swabbed for the flu. The order was discontinued on [DATE] because Resident #26 was transferred to the hospital. Review of nursing progress notes dated [DATE] to [DATE] revealed the following: On [DATE] at 4:43 PM Registered Nurse #1 documented Nurse Practitioner #1 saw Resident #6 and ordered them to be swabbed for influenza (flu). On [DATE] at 14:50 PM, Assistant Director of Nursing documented Resident #6 continued with cold symptoms, had not eaten anything that day, and remained in bed. Family was made aware of resident's sickness. Resident was afebrile (no fever) but very lethargic (lack of energy, drowsiness, reduced mental alertness). On [DATE] at 2:04 PM, Assistant Director of Nursing documented Resident #6 continued with cold symptoms and not feeling well, had not eaten that day. On [DATE] at 2:57 PM, the Assistant Director of Nursing documented the flu swabs were received from lab, they spoke with Nurse Practitioner #1 and informed them the flu swabs were received. Assistant Director of Nursing documented Nurse Practitioner #1 stated to not swab at that time and treat upper respiratory symptoms conservatively. Review of provider progress note dated [DATE], Nurse Practitioner #1 documented Resident #6 recently had an upper respiratory infection, suspected to be influenza due to exposure in facility. Was not tested due to no respiratory cultures available. Patient was managing symptoms with supportive care, has had decline today. Nursing reported not eating or drinking well, difficulty taking medications, appeared to have decreased mentation, pupils pinpoint, on supplemental oxygen. Recommended initiating antibiotics and obtaining chest x-ray to rule out pneumonia. Family (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requests Resident #6 be sent to the emergency room for further evaluation. Review of the Hospital History and Physical dated [DATE] revealed Resident #6's medications to include but not limited to the following: [COMPLETED]: oseltamivir (Tamiflu) capsule 75 milligram once on [DATE] at 8:41 PM. **FOLLOWED BY** [START ON [DATE]] oseltamivir (Tamiflu-antiviral medication used to treat and prevent the flu) capsule 30 milligrams, oral twice a day (BID). Review of the hospital Discharge summary dated [DATE] documented Resident #6 was admitted to the hospital with shortness of breath and productive cough, was found to be positive for Influenza A. The discharge summary did document Resident #6 completed oseltamivir (Tamiflu) therapy in the hospital course. Further down the discharge summary documented: Issues requiring follow-up included to follow up with primary care and continue Tamiflu. The After Visit Summary, with a print date of [DATE] at 1:46 PM documented Resident #6's medications had changed. The medication list revealed: START taking Tamiflu, guaifenesin (expectorant medication used to relieve chest congestion and loosens mucous in the airways), and Benzonate (cough suppressant). In the medications listed on the after-visit summary, oseltamivir (Tamiflu) was listed to start one (1) 75 milligram capsule by mouth in the morning and one (1) 75 milligram capsule before bedtime. Last time was given: 30 milligrams on [DATE] at 8:41 AM. Medications to be picked up at the pharmacy were listed at the bottom, Tamiflu included. Review of nursing progress notes dated [DATE] to [DATE] revealed Resident #6 had an occasional nonproductive cough and complaints of not feeling well. Review of provider progress note dated [DATE], Nurse Practitioner #1 documented Resident #6 was readmitted from the hospital on [DATE] after hospitalization due to Influenza A and dehydration. Resident #6 was able to be weaned off oxygen, received intravenous fluids, and was started on Tamiflu. Resident #6 seen that day and appeared stable, complains of continued cough, sore throat and body aches. Reviewed hospital course and discharge summary with recommendations. Completed course of Tamiflu. Supportive care with Tylenol for fevers and aches. During a telephone interview on [DATE] at 1:58 PM, Resident #6's family stated Resident #6 had gone to the hospital on [DATE], was diagnosed with Influenza, and was started on the standard course of antivirals while there. During an observation and interview on [DATE] at 8:23 AM, Resident #6 was sitting up in their bed eating breakfast and had a wet occasional cough. Resident #6 stated they were feeling crummy. During an interview on [DATE] at 2:56 PM, Registered Nurse #2 Infection Preventionist stated they reviewed Resident #6's After Visit Summary upon re-admission to the facility on [DATE], which did document they were supposed to continue a course of Tamiflu and thought they had been continued on it upon return from the hospital. Registered Nurse #2 reviewed Resident #6's Medication Administration Record and stated they did not see an order for the Tamiflu, active or discontinued, and there should have been one. They stated whoever the admitting nurse was should have called the facility provider to clarify the discrepancies or reached out to the hospital provider. Registered Nurse #2 Infection Preventionist stated they thought that the Assistant Director of Nursing completed the admission orders for Resident #6, but being the Infection Preventionist, they should have caught the missing order. Additionally, Registered Nurse #2 Infection Preventionist stated the order for Resident #6 to be swabbed for the flu was placed on [DATE], but the facility did not have proper supplies in the building, as they were expired. They stated Nurse Practitioner #1 was made aware they did not have swabs available, and on [DATE] when they came from the lab, Nurse Practitioner #1 was again made aware. Nurse Practitioner #1 said to not swab Resident #6 and just treat for an upper respiratory infection. On [DATE] antibiotics were recommended by Nurse Practitioner #1 due to Resident #6's continuing symptoms, but the family requested Resident #6 be sent out to the hospital. During an interview on [DATE] at 9:30 AM, Assistant Director of Nursing stated when a readmission came into the facility, the admitting nurse would review all their paperwork and review the orders with whatever provider was on call. Assistant Director of Nursing stated they did not enter Resident #6's order on [DATE] upon readmission, Registered Nurse #2 Infection Preventionist did. Additionally, Assistant Director of Nursing reviewed Resident #6's discharge summary and after visit summary with this writer and stated, I'm going to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assume the hospital had Resident #6 on Tamiflu 75 milligrams for one day then started them on 30 milligrams on [DATE] and wanted them to continue the course upon discharge. During a telephone interview on [DATE] at 12:58 PM, Pharmacy Consultant stated they review all documents available in a resident's electronic medical record upon admission/ readmission, review medications, look for discrepancies, and report any if found. Pharmacy Consultant stated they reviewed Resident #6's after visit summary, discharge summary and medication list on [DATE] upon readmission from the hospital and did not note any discrepancies. Pharmacy Consultant reviewed all medications listed on after visit summary with this writer and identified Tamiflu as being a medication listed for Resident #6 upon discharge from the hospital, reviewed the residents medications ordered upon admission to the facility and stated there was no record of Resident #6 being on Tamiflu in the facility, they do not know what their exact mindset was when they completed the review, but should have noticed the discrepancy and reported it. They stated they read Nurse Practitioner #1's note on [DATE] when they did their next review that day and determined based on what was documented in the note and the order not being in Resident #6's current physician orders that they had completed the course. During an interview on [DATE] at 1:29 PM, Nurse Practitioner #1 stated they reviewed all the paperwork sent with Resident #6 upon readmission to the facility when they did their review on [DATE]. The discharge summary documented Tamiflu had been completed in the hospital. The typical course for Tamiflu was three (3) to five (5) days, the blister pack was preset, so they assumed it was just a three-day course that was completed. Additionally, Nurse Practitioner #1 stated they were made aware on [DATE] after they ordered the flu swab for Resident #6 that it was not available and then was updated on [DATE] that they were not available, told nursing staff to treat symptoms as they arouse. During a follow up interview on [DATE] at 11:13 AM, Assistant Director of Nursing stated they worked on [DATE] when the flu swabs arrived at the facility, contacted Nurse Practitioner #1 who instructed to not swab Resident #6, and just treat conservatively based on their symptoms. Assistant Director of Nursing stated there should have been documentation that Nurse Practitioner #1 was made aware on [DATE] that the swabs were not available other than the 24-hour report because the 24-hour report was not a part of Resident #6's medical record. It was important to document pertinent things in the resident's electronic medical record so that there could be follow through with the issues. During a telephone interview on [DATE] at 10:47 AM, Medical Director stated they would have expected the admitting nurse to review all documents sent with Resident #6 upon readmission to the facility and follow the recommendations for Tamiflu. If there was a discrepancy, to follow up with whatever provider was on call that day. It was the facilities policy. During a follow up interview on [DATE] at 1:44 PM, Nurse Practitioner #1 reviewed Resident #6's discharge summary with this writer, reviewed where it was documented under issues requiring follow up: to continue Tamiflu and stated they would have expected the admitting nurse to clarify with the hospital the discrepancies between the documents sent with Resident #6 regarding the Tamiflu order. If they could not reach that hospital provider, then clarify with the provider on call in the facility. During a telephone interview on [DATE] at 10:29 PM, Registered Nurse #1 stated they received a verbal order from Nurse Practitioner #1 on [DATE] to swab Resident #6 for influenza, they let Nurse Practitioner #1 know right then that they did not think they had swabs available. They stated they should have documented that in Resident #6's electronic medical record. Registered Nurse #1 stated they placed an order with the lab via fax that on [DATE], but the swabs had still not arrived by [DATE]. They stated they made the Director of Nursing aware. During an interview on [DATE] at 10:01 AM, the Director of Nursing and Regional Quality Improvement Nurse stated whatever nurse admitted Resident #6 was responsible for ensuring that the documents and medications were reviewed and discussed with the on-call provider. The Director of Nursing reviewed Resident #6's discharge summary and stated the summary read for Resident #6 to complete Tamiflu. They would have expected the admitting nurse to have read all paperwork pertinent to the resident and clarified the orders with a provider. They stated it was important to ensure continuity of care and that all residents were getting (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the treatment they needed. Additionally, Director of Nursing stated swabs were delivered from their lab whenever requested, and it was a collaborative effort by the facility to ensure they had proper supplies. Director of Nursing stated ideally there should not be expired items in the supply room. Director of Nursing stated they were made aware on [DATE] by Registered Nurse #1 that flu swabs were ordered for Resident #6, but the swabs in the facility were expired, and an order was placed for new ones. On [DATE] when Registered Nurse #1 updated them that the swabs had not arrived, they placed a call to the lab to see why. They were told the swabs were on back order. They had not documented that anywhere. During a follow up telephone interview on [DATE] at 11:43 AM, the Medical Director stated they had not had a chance to review Resident #6's documents from the hospital yet, and did not recall speaking to anyone about Resident #6's medications. Medical Director stated they would have expected all recommendations to have been followed for Resident #6 from the hospital, and if any discrepancies, to have them clarified with themself or another provider in the facility. 10 NYCRR 415.11(c)(3)(i)