| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (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: Eden Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 226 N Oakland Avenue Eden, NC 27288 | |

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) |
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| F 0627<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE] (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 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<br>(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 0627<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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 [DATE] 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 [DATE]. 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 admission to the hospital and the facility. Resident #1 was admitted to the facility on [DATE] 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 meeting. She stated the admission Director and Social Worker (SW) mentioned financial responsibility and<br>(continued on next page) |

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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. 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 [DATE], 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<br>(continued on next page) |

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| F 0627<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | not able to participate in care decisions from [another state]. The Business Office 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 [DATE] 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 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 (continued on next page) |

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| F 0627<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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.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 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 (continued on next page) |

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| F 0627<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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, 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 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 [DATE] 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 (continued on next page) |

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| F 0627<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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 [DATE] 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 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 [DATE] 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 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 servic |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (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 Eden Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 226 N Oakland Avenue Eden, NC 27288 | |

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 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] through discharge on [DATE] 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, 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 process for guardianship for cognitively impaired individuals who had<br>(continued on next page) |

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|---|---|
| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | no legal decision maker or for completion of a financial application for Medicaid and/or other payor sources. |