

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 02/19/2026
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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews, the facility failed to label and date food and discard expired food from two nourishment refrigerators reviewed for food storage (400 hallway and 500 hallway nourishment refrigerators). These practices had the potential to affect food served to residents. Findings included: a. On 2/16/26, at 1:35 PM, an observation with the Dietary Manager of nourishment refrigerator #1 (400 hallway) revealed that the refrigerator contained a gallon-size clear plastic bag with a sandwich, a 4-ounce juice carton, and a snack bag with no name or date on them; a peanut butter and jelly sandwich in a plastic bag with no name or date; a takeout box containing pinto beans and seasoned rice with the date [DATE]th - 15th written on it; food wrapped in aluminum foil with no name or date; an opened 16-ounce soda bottle with no name or date; and a takeout 20-ounce coffee cup with no name or date. b. On 2/16/26, at 1:42 PM, an observation with the Dietary Manager of nourishment refrigerator #2 (500 hallway) revealed a small plastic container with homemade food that had no label indicating the resident's name or date; a gallon-size plastic container with homemade food with no resident name and the date 2/5 - 2/9 written on it; and a grocery bag containing a box of fried chicken with no name or date. During an interview on 2/16/26, at 1:37 PM, the Dietary Manager stated that the nursing staff were responsible for labeling and dating food brought in by visitors for residents. He explained that food could be stored in the refrigerator for seven days before being discarded. He further stated that either he or the dietary staff checked the nourishment refrigerators daily when restocking snacks and drinks and discarded any expired food. During an interview on 2/18/26, at 1:30 PM, the Director of Nursing (DON) stated that all nursing staff (nurses and nurse aides) were responsible for labeling and dating any food brought in by family for residents before placing it in the nourishment refrigerator. She explained that food should be discarded within seven days and that no personal staff food should be placed in the nourishment refrigerator. She added that the dietary staff were responsible for ensuring all food was discarded after seven days. During an interview on 2/18/26, at 2:00 PM, the Administrator stated that residents' food should be labeled and dated before being placed in the nourishment refrigerators. She emphasized that staff should follow policy related to residents' food brought in by their families and that dietary staff should ensure all expired food was discarded.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, manufacturer instructions review, and staff interviews, the facility failed to date opened multi-dose pen injectors of insulin and failed to remove expired multi-dose pen injectors of insulin from 1 of 5 medication administration carts (500-hall). Findings Included: On 2/16/26 at 1:25 PM, an observation of the 500-hall medication cart with Nurse #1 revealed 2 open and undated multi-dose vials of Lantus insulin pens injectors. Review of the manufacturer's instructions indicated to discard Lantus insulin multi-dose vial 28 days after opening. In the second drawer of the 500-hall medication cart, there were: one opened Lispro insulin multi-dose pen injector, marked as expired on 2/10/26, one opened Aspart Flex insulin pen injector, marked as expired on 1/15/26, and one opened Glargine insulin multi-dose pen injector, marked as expired on 2/9/26. On 2/16/26 at 1:30 PM, during an interview, Nurse #1 indicated the nurses who worked on the medication carts were responsible for discarding open and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medication vials. The nurse acknowledged she had not checked the date of opening or expiration date on insulin pen injectors in her medication administration cart at the beginning of her shift. Nurse #1 confirmed she had not administered open and undated or expired medications during her shift. On 2/16/26 at 1:55 PM, during an interview, the Director of Nursing indicated that the nurses were responsible for checking the date of opening and the expiration dates of the medications in the medication administration carts at the beginning of the shift. She expected that no expired items be left in the medication carts.</p>		