## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES			AH "A" FORM
STATEMENT	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:
FOR SNFs AN	D NFs	345241	B. WING	7/27/2023
NAME OF PROVIDER OR SUPPLIER EDEN REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCI	ES		
	Accuracy of Assessments   CFR(s): 483.20(g)   \$\\$483.20(g)   \$\\$643.20(g)   \$\\$\$483.20(g)   \$\\$\$483.20(g)   \$\\$\$483.20(g)   \$\\$\$483.20(g)   \$\\$\$483.20(g)   \$\\$\$483.20(g)   \$\\$\$483.20(g)   \$\\$\$\$483.20(g)   \$\\$\$\$483.20(g)   \$\\$\$\$\$483.20(g)   \$			

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

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