STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395843	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Edge Rehabilitation & Healthcare Center	9501 State Road Philadelphia, PA 19114

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to ensure residents' advance directives and physician orders for Life-Sustaining Treatment (POLST) were followed according to the residents' expressed wishes for 2 of 24 residents reviewed (Resident R5 and R13). Findings include: Review of the facility policy titled Advance Directives Policy and procedure reviewed January 2026, revealed It is the policy of the facility to establish, implement and maintain written policies and procedures for advance directive. The resident has the right and the facility will assist the resident to formulate an advance directive at their option. The facility will inform and provide resident with a written description of the facility's policy to implement advance directives. Resident has the right to accept, request, refuse and/or discontinue medical or surgical treatment and to participate in or refuse to participate in experimental research. Further review revealed Resident wishes will be communicated to the staff via the care plan (identify facility protocol for communication of advance directives either in written or oral format) and to the resident physician. Review of the Pennsylvania POLST (Physician Orders for Life-Sustaining Treatment) is a medical order designed to ensure that a patient's treatment preferences, including life-sustaining interventions and comfort measures, are clearly documented and followed across healthcare settings. At the time the POLST is completed, any existing advance directives must be reviewed. The form must be signed by a physician and the patient or authorized surrogate, though verbal physician orders are acceptable if followed by a physician signature per facility policy. If the patient's condition changes, the patient or surrogate must be contacted to update the POLST. Oral fluids and nutrition should be offered when medically feasible, and comfort measures must be provided in an appropriate setting. Patients or authorized surrogates may revoke or modify any part of the POLST at any time, including withholding or withdrawing life-sustaining treatment. The POLST should be reviewed periodically, and if it becomes invalid or is replaced, the previous form must be voided by marking through sections AE and writing VOID across the form. If any section is incomplete, providers should follow other appropriate methods to determine treatment preferences. Review of Resident R5's clinical record revealed resident admitted to the facility on [DATE], with the diagnosis of Cerebral infarction (clot blocks a blood vessel that feeds the brain), and Dementia (loss of memory). Review of Resident R5's MDS (Minimum Data Set) dated June 26, 2025, revealed that resident's BIMS (Brief interview for mental status) score was 0, indicating severely cognitively impaired. Review of Resident R5's POLST (Physician Orders for Life-Sustaining treatment), dated May 15, 2025, revealed that resident's responsible party elected the following: Part A- Cardiopulmonary Resuscitation (CPR), person has no pulse and is not breathing: DNR (Do Not Resuscitate)/ Do not attempt resuscitation (allow natural death). Part B- Medical Interventions: Person has pulse and/or is breathing Comfort measures only, use medication by any route, positioning, wound care and other measures to relieve pain and suffering, Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location. Part C- Antibiotics: No antibiotics. Use other measures to relieve symptoms. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Part D- Artificially administered hydration/ nutrition, always offer food and liquids by mouth if feasible: No hydration and artificial nutrition by tube. The POLST form was signed by the physician and Resident R5's responsible party on May 15, 2025, acknowledging that the orders reflect the resident's known desires and best interests. Review of Resident R5's comprehensive care plan revealed focus initiated on June 22, 2025, I have requested that CPR measures are to be performed (Full code status). Review of Resident R5's face sheet revealed Code status: Full Code. Review of Resident R5's physician order, revised on June 21, 2025, for Full code. Interview with Employee E10, Unit Manager on March 24, 2026 at 9:48 a.m. confirmed Resident POLST indicated that the resident is a DNR (do not resuscitate) code, however care plan, orders and face sheet did not reflect this. Interview with Employee E2, Director of Nursing on March 24, 2026 at 10:00 a.m. confirmed Resident's Son (responsible party) does not wish to change anything about the resident's code status from what the POLST indicates (DNR/ comfort measures only). Confirmed Resident R5's care plan, orders and face sheet were not updated to indicate the resident's advance directive. Review of Resident R13's clinical record revealed resident was admitted to the facility on [DATE], with diagnosis of Chronic Obstructive Pulmonary Disease (disease process that causes decreased ability of the lungs to perform) and Heart failure. Review of Resident R13's MDS (Minimum Data Set) dated February 4, 2026, revealed that resident's BIMS (Brief interview for mental status) score was 9, indicating moderately cognitively impaired. Review of Resident R13's POLST (Physician Orders for Life-Sustaining treatment), dated March 10, 2025, revealed that resident elected the following: Part A- Cardiopulmonary Resuscitation (CPR), person has no pulse and is not breathing : DNR (Do Not Resuscitate)/ Do not attempt resuscitation (allow natural death). Part B- Medical Interventions: Person has pulse and/or is breathing: Limited additional interventions- includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care if possible. Part C- Antibiotics: Determine use or limitation of antibiotics when infection occurs, with comfort as goal. Part D- Artificially administered hydration/ nutrition, always offer food and liquids by mouth if feasible: No hydration and artificial nutrition by tube. The POLST form was signed by the physician and Resident R13 on March 10, 2025, acknowledging that the orders reflect the resident's known desires and best interests. Review of Resident R13's comprehensive care plan revealed no documented evidence of code status. Review of Resident R13's face sheet revealed DNI- do not intubate. No documented evidence of requested CPR interventions. Review of Resident R5's physician order, revised on March 10, 2025, for DNI- do not intubate. No documented evidence of order for requested CPR interventions. Interview with Employee E10, Unit Manager on March 25, 2026, at 12:35 p.m. confirmed Resident POLST indicates that resident is a DNR (do not resuscitate) code, however care plan, physician orders and face sheet do not reflect this. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa Code 211.2 (d)(7) Medical Director 28 Pa. Code 211.12 (d)(5) Nursing Services

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, and staff interview, it was determined that the facility failed to ensure that the grievance forms were available and that residents had the right to file an anonymous grievance for two of two nursing units (first and second floor).Findings include: On March 24, 2026, at 11:38 a.m., observations were conducted with the Administrator, Employee E1 confirmed that grievance forms were only available at the front desk, and residents would need to request a form in order to receive one. No method had been established for residents to file anonymous grievances. Observation of the second floor revealed that no forms were readily available to residents; forms could only be obtained upon request and were located in the filing cabinet behind the nursing stations. 28 Pa. Code 201.18 (b)(1)(3) Management 28 Pa. Code 201.29 (a) Resident Rights

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff interviews, it was determined that the facility failed to ensure that the physician documented either a 14-day stop date or a clinical justification for the continued use of PRN (as needed) psychotropic (alters mood, perception, and behavior) medication for two of four residents reviewed (Residents R7 and R5).Findings include: Review of facility policy Psychotropic Medication, dated 2026, revealed Resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:a. In excessive dose (including duplicate drug therapy); orb. For excessive duration; orc. Without adequate monitoring; ord. Without adequate indications for its use; ore. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; [NAME]. Any combination of the reasons. Further review of facility policy revealed PRN (as needed) orders for psychotropic drugs are limited to 14 days, except as provided if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. He or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Review of Resident R7's clinical record revealed Resident R7 was admitted to the facility on [DATE] with a diagnosis of dementia (decline in cognitive function that interferes with daily life), traumatic subdural hemorrhage (bleeding between the brain and it's outer protective covering, often resulting from head injuries), and severe protein-calorie malnutrition (insufficient intake of both protein and calories). Review of Resident R7's clinical record revealed a physician's order, dated February 04, 2026, for Ativan 1 milligram to be given by mouth every 24 hours as needed for anxiety. Further review of the physician's order revealed there was no documented stop date or clinical justification for continued use of the psychotropic medication beyond 14 days. Interview on March 25, 2026 at 10:45 a.m. with Director of Nursing, Employee E2, confirmed that Resident R4 lacked the required stop date within 14 days and a rationale for continued use beyond 14 days. 28 Pa. Code 211.2(d)(3) Medical director 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy and interview with residents and staff, it was determined that the facility failed to develop a person-centered resident care plan for two of twenty-four residents reviewed (Resident R5 and Resident R25).Findings Include: Review of facility policy titled Care plan dated September 2024. Under policy states It is the policy of the facility to participate in an individual, interdisciplinary plan of care for all residents. Under procedure states the plan of care shall be individualized to and based upon the assessment and diagnosis of a resident, To provide a comprehensive health care environment, all staff members should consider interdisciplinary collaboration to establish goals and appropriate interventions, and ongoing evaluations and revisions to resident care. Review of Resident R5's clinical record revealed resident admitted to the facility on [DATE], with the diagnosis of Cerebral infarction (clot blocks a blood vessel that feeds the brain), Dementia (loss of memory). Review of Resident R5's MDS (Minimum Data Set) dated June 26, 2025, revealed that resident's BIMS (Brief interview for mental status) score was 0, indicating severely cognitively impaired. Further review of Resident R5's clinical record revealed that there was no care plan developed to address Resident R5's activities. Interview with Resident R5's responsible party on March 24, 2026, at 11:45 p.m. revealed concerns related to sleeping too much during the day, not engaging in activities. Review of Resident R5's clinical tasks, titled activities indicated no data found for last 30 days. Interview with Employee E12, Activities Director on March 26, 2026, at approximately 12:00 p.m. revealed resident gets visited by activities staff 3 times a week for about 15 minutes. Resident isn't always interested in activities and spends a lot of time in his room. Interview with Employee E2, Director of Nursing on March 26, 2026, at approximately 11:00 p.m. confirmed no care plan in place and no documentation under activities task. Review of Resident R25's clinical record revealed resident admitted to the facility on [DATE], with diagnosis of Cerebral infarction (clot blocking blood flow to brain), dementia (loss of memory). Review of Resident R25's MDS (Minimum Data Set) dated February 2, 2026, revealed that resident's BIMS (Brief interview for mental status) score was 9, indicating moderately cognitively impaired. Further review of Resident R25's clinical record revealed that there was no care plan developed to address Resident 5's dementia care. Interview with Employee E2, Director of Nursing on March 26, 2026, at approximately 11:00 p.m. confirmed no care plan in place for dementia care. 28 Pa. Code 211.11(a) Resident care plan 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record, facility documentation, observations, and interviews with staff and residents, it was determined that the facility failed to provide Activities of Daily Living (ADL) assistance for one of the two residents reviewed (Resident R9). Findings include: Clinical record review revealed that Resident R9 was admitted to the facility on [DATE], with diagnoses including hemiparesis (weakness on one side of the body) following a cerebral infarction affecting the right dominant side (stroke) and muscle wasting and atrophy. A review of the physician orders dated October 26, 2025, indicated: Showers (Monday/Thursday on 3-11). Document if the patient/resident refuses shower in Health Status Note. A review of Resident R9's quarterly Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, reflecting cognitive intact. The functional abilities section of the MDS indicated that Resident R9 requires partial/moderate assistance with showering tasks. A review of the comprehensive care plan dated September 17, 2024, indicated: Resident R9 has an ADLs self-care performance deficit related to limited mobility and left-side weakness related to CVA (stroke). Observation and interview conducted on March 23, 2026, at 7:36 p.m. revealed that Resident R9 had greasy hair and facial hair. When asked when they last received a shower and shave, Resident R9 responded a couple of weeks ago. Resident R9 prefers bed baths and stated a desire to be shaved daily and have their hair washed. This information was communicated within a few minutes to Licensed Nurse Employee E5, who responded, Yes, we'll give him/her a shower. On March 25, 2026, at 9:59 a.m., an observation was conducted with the Director of Nursing, Employee E2, who confirmed that Resident R9 still had greasy hair and required a facial shave. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code: 211.12(d)(1)(5) Nursing services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on direct observation, clinical record review, and interviews with staff, it was determined that the facility failed to ensure enteral feedings were administered and monitored according to professional standards of practice, specifically related to labeling, for one of two resident's reviewed fed via enteral feeding (Resident R6).Findings include: Review of the facility's policy titled Enteral Feeding , last revised on 9/2025 under procedures, documentation bullet #16 stated Document administration of feeding on Medication Administration Record (MAR) including: Date, Formula, Rate, Continuous bolus. A review of the clinical record for Resident R6 indicated that the resident was admitted to the facility on [DATE], with diagnoses including, muscle wasting and atrophy, protein calorie malnutrition, cerebrovascular disease (long term weakness with speech and movement after a stroke), and immunodeficiency (immune system is weak). A review of the physician's order for Resident R6, dated March 20, 2026, indicated an enteral feeding order as follows: Jevity 1.5 at a rate of 65 mL/hour x16 hours. TV (total volume)= 1040 ml. Up at 2 pm and down at 6am or until TV is infused. And every shift monitoring- sign to confirm that feeding is infusing as ordered. On March 25, 2026, at 8:39 p.m., an observation was conducted with Licensed Nurse, Employee E5. revealed that Resident R6 was in bed receiving enteral feeding. The feeding bag was not labeled with no information. Employee E6 reported your right it's not labeled, and it should have a labeled on both internal feed bag and flushes. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.12(d)(3)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and interview with staff, it was determined that the facility failed to ensure pain medication was administered in accordance with the physician's order for one of four residents reviewed for pain management (Resident R33).Findings Include: Review of Resident R33's clinical record revealed Resident R33 was admitted to the facility on [DATE] with a diagnosis of local infection of the skin and subcutaneous tissue, polyneuropathy (condition that damages multiple peripheral nerves in the body), and anxiety disorder. Review of Resident R33's clinical record revealed physician's order, dated February 16, 2026, for Oxycodone 5 milligrams give 5 mg by mouth every 4 hours as needed for pain 6-10. Review of Resident R33's March 2026 Medication Administration Record (MAR) revealed that the as needed pain medication Oxycodone 5 milligrams was administered out of the parameter ordered by the physician as follows: March 1, 2026- Pain level 5March 2, 2026 at 8:38 a.m.- Pain level 5March 2, 2026 at 9:01 p.m.- Pain level 4March 7, 2026- Pain level 4March 8, 2026- Pain level 5March 10, 2026 at 8:47 p.m.- Pain level 5 March 10, 2026 at 7:58 p.m.- Pain level 4March 12, 2026- Pain level 0March 16, 2026- Pain level 5March 18, 2026- Pain level 5March 20, 2026- Pain level 4March 22, 2026- Pain level 3March 23, 2026- Pain level 4 Interview on March 25, 2026, at 12:45 p.m. with Director of Nursing, Employee E2, confirmed Resident R33's pain medication was not administered in accordance with the physician's order.28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for one of one residents sampled for post-traumatic stress disorder (PTSD). (Resident R14).Findings include: Review of Resident R14's clinical record revealed the resident was admitted to the facility on [DATE] with a diagnosis of parkinsonism (group of movement symptoms found in several conditions, including Parkinson's disease), post-traumatic stress disorder (PTSD- a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal loss), and anxiety disorder. Resident R14's care plan, dated February 15, 2026, revealed Resident R14 has a mood problem related to disease processes past medical history of obsessive-compulsive disorder and PTSD. Further review of the care plan did not address possible triggers that may cause re-traumatization. Interview with the Director of Nursing, Employee E2, on March 25, 2026, at 12:45 p.m. confirmed that Resident R14's care plan did not include possible triggers that may cause re-traumatization. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, resident and staff interviews, and a review of facility documentation, it was determined that the facility failed to provide food and drink that was palatable and served at palatable temperatures for six of 24 residents reviewed (Residents R3, R8, R12, R44, R80, and R112).Findings include: A review of facility policy titled food temperatures, undated, revealed foods will be served at the proper temperature to ensure food safety, Acceptable serving temperatures are: Meat, entrees-greater than 135 degrees but preferably 160 degrees to 175 degrees; potatoes greater than 135 degrees; vegetables greater than 135 degrees. Interview with Resident R112 on March 23, 2025, at 7:45 p.m. revealed food is always cold when it is served, it sits on the carts too long and it just doesn't stay hot. Observations during a test tray conducted on March 24, 2025, at 12:45 p.m. revealed that the last tray was passed at 12:45 p.m. Temperatures were taken by the Food Service Director (FSD), Employee E11, which revealed that the hamburger served was only 130 degrees Fahrenheit (F), broccoli was only 119 degrees F., and the potatoes were only 124 degrees F., all outside the acceptable temperature range for palatability. An interview with the Food Service Director (FSD), Employee E11, on March 24, 2025, at 12:55 p.m. confirmed that these food items were outside the acceptable temperature range and therefore not palatable. Further confirmed kitchen was short on heat plates and covers during observed service on March 24, 2025, so resident meals were delivered wrapped in plastic wrap. On March 25, 2026, at 8:58 a.m., an interview was conducted with Resident R80 and a family member who visits daily. They reported that the facility's meals include too many carbohydrates; for example, a slice of pizza is served with mashed potatoes. During interview with Resident R3 conducted on March 23, 2026, at approximately 7:00 p.m., the resident stated that the food does not taste good. During interview with Resident R12 conducted on March 23, 2026, at approximately 1910 with Resident R12, revealed food does not taste good and needs improvement. Interview conducted on March 23, 2026, at approximately 7:20 p.m. with Resident R44 revealed food does not taste good and does not match the menu. Interview conducted on March 23, 2026, at approximately 7:30 p.m. with resident R8 revealed food does not taste good, the food is cold and does not match the menu. 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.14(a) Responsibility of licensee

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility assessment and staff interview, it was determined that the facility failed to ensure the direct care staff and input from residents, resident representatives, and/or family members was included when conducting the facility assessment.Findings include: Review of the facility's facility assessment, dated January 29, 2026, revealed there was no indication that the facility involved direct care staff, input from residents, resident representatives, and/or family members. Interview with the Administrator, Employee E1, on March 25, 2026, at 12:00 p.m., confirmed there was no direct care staff, resident representatives, and/ or family members included in the facility assessment. 28 Pa. Code 201.18(b)(3) Management28 Pa. Code 211.12(c)(d)(1) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documents, and staff interview, it was determined that the facility failed to ensure residents had the capacity to understand the terms of a binding arbitration agreement (a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not) for three of five residents reviewed (Resident R135, R126, R7). Findings include: Review of Resident R135 revealed the resident was admitted to the facility on [DATE] with a diagnosis of disorder of kidney and ureter (kidneys or the tubes that carry urine from the kidneys to the bladder are not working properly, which can affect how the body filters waste and removes urine), cerebrovascular disease (condition that affects the blood vessels in the brain, reducing blood flow and potentially causing brain damage, such as a stroke), and anxiety disorder. Review of Resident R135's Brief Interview for Mental Status (BIMS), dated March 18, 2026, revealed a BIMS summary score of 7, indicating severe cognitive impairment. Review of Resident R135's admission paperwork revealed Resident R135 signed an Arbitration Agreement on March 17, 2026. Review of Resident R126 revealed the resident was admitted to the facility on [DATE] with a diagnosis cerebral infarction (when part of the brain is damaged because blood flow to that area is blocked, often resulting in a stroke), Alzheimer's disease (condition that slowly damages the brain, causing memory loss, confusion, and difficulty thinking and making decisions), and encephalopathy (condition in which the brain does not function properly, leading to confusion, memory problems, or changes in behavior). Review of Resident R126's Brief Interview for Mental Status (BIMS), dated March 13, 2026, revealed a BIMS summary score of 0, indicating severe cognitive impairment. Review of Resident R126's admission paperwork revealed Resident R126 signed an Arbitration Agreement on March 13, 2026. Review of Resident R7 revealed the resident was admitted to the facility on [DATE] with a dementia (decline in memory and thinking skills severe enough to affect a person's daily life and ability to function), traumatic subdural hemorrhage (bleeding between the brain and its outer covering caused by a head injury, which can put pressure on the brain and affect how it works), and severe protein-calorie malnutrition (serious condition where the body does not get enough protein and calories, leading to extreme weight loss, weakness, and poor overall health). Review of Resident R7's Brief Interview for Mental Status (BIMS), dated February 03, 2026, revealed a BIMS summary score of 7, indicating severe cognitive impairment. Review of Resident R7's admission paperwork revealed Resident R7 signed an Arbitration Agreement on February 02, 2026. Interview with the admission Director, Employee E13, on March 25, 2026, at 10:45 a.m. confirmed Resident R135, R126, and R7 had severe cognitive impairment based on their BIMS score, indicating the residents did not have the capacity to understand the terms of a binding arbitration agreement. 28 Pa Code: 201.18(b)(1)(3) Management. 28 Pa Code: 201.24(a) admission policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395843	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Edge Rehabilitation & Healthcare Center	9501 State Road Philadelphia, PA 19114

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement enhanced barrier precautions for three residents reviewed who had a indwelling Foley catheter, wound and internal feeding tube. (Residents R6, R91, and R108).Based on a review of the facility's Infection Control requirements Influenza Vaccine for Unvaccinated Healthcare workers to be wearing a mask, the facility failed to ensure that unvaccinated healthcare workers are wearing a mask. Specifically, vaccinated record for one Licensed Practical Nurse, who refused the Influenza Vaccine was not wearing a mask. Findings Include: According to the facility policy titled Influenza Vaccine (reviewed December,2025) number 11, the use of source control for unvaccinated health care workers will be based on state guidelines or outbreak status. On the Mask Acknowledgement form, it states that during influenza season a surgical mask will be worn during direct resident contact, in common areas of the facility, and Flu season October to May. A review of the facility policy titled, Enhanced Barrier Precaution Policy and Procedure last revised 11/2024, revealed enhance Barrier Precautions are to be implemented for all residents with any of the following during high-contact resident care activities: Infection or colonization with an MDRO when Contact precautions do not apply. Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ Ventilator) regardless of MDRO colonization status. A review of the facility's healthcare workers vaccine records revealed that a Licensed Practical Nurse, Employee 4 refused the Influenza Vaccine on November 3, 2025. Observations conducted on March 25, 2026 at 9:22 a.m. revealed that Licensed nurse, Employee E4 was not wearing a mask during medication pass. On March 25, 2026, during an interview with the Infection Preventionist, Employee 3 confirmed that all healthcare workers who refuse the Influenza vaccine must wear a mask during flu season. This was also confirmed by the Director of Nursing Employee 2 on March 25, 2026 approximately 1:00 p.m. A review of the clinical record for Resident R6 indicated that the resident was admitted to the facility on [DATE], with diagnoses including muscle wasting and atrophy, protein calorie malnutrition, cerebrovascular disease (long term weakness with speech and movement after a stroke), and immunodeficiency (immune system is weak). A review of the physician's order for Resident R6, dated March 20, 2026, indicated an enteral feeding order as follows: Jevity 1.5 at a rate of 65 mL/hour x16 hours. TV (total volume) = 1040 ml. Up at 2 pm and down at 6am or until TV is infused. And every shift monitoring- sign to confirm that feeding is infusing as ordered. On March 23, 2026, at 8:11 p.m., Nursing Aide, Employee E7 provided direct care to Resident R6 while only wearing gloves. When asked if Resident R6 was on enhanced barrier precautions, as indicated by the sign outside the door, Employee E7 responded, No, [Resident R6] is not on enhanced barrier precautions. A review of the clinical record for Resident R108 indicated that the resident was admitted to the facility on [DATE], with diagnoses including dysphagia (difficulty swallowing), chronic respiratory failure with hypoxia (lungs unable to supply enough oxygen), Alzheimer's disease (memory loss), and nutritional deficiencies. Resident R108's physician order dated November 21, 2025 indicated Enhanced Barrier Precautions related to wounds. On March 24, 2026, at 9:32 a.m., Nurse Aide, Employee E8 provided direct care to Resident R108 while only wearing gloves. When Resident R108 needed to be transferred using a two-person mechanical, Employee E8 confirmed in the hallway that they were not wearing the appropriate personal protective equipment (PPE), even though a sign outside Resident R108's door indicated that the resident was on enhanced precautions. A review of the clinical record for Resident R91 indicated that the resident was admitted to the facility on [DATE]. Review of Resident R91's care plan dated December 12, 2025, revealed [Resident R91[receives care with Enhanced Barrier Precautions R/T (related to) indwelling catheter. On March 23, 2026, at 8:31 p.m., Licensed Nurse, Employee E5 provided catheter care while only wearing gloves. Assisting Director of Nursing Employee E9 confirmed that Resident R91 was on enhanced barrier precautions, and Employee E5 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not wearing the required PPE. 28 Pa. Code 211.10 (d) Resident care policies 28 Pa. Code 211.12 (d)(5) Nursing services