STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395330	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Independence Rehab and Nursing	600 W Cheltenham Avenue Philadelphia, PA 19126

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record review, and interviews with resident and staff, it was determined that the facility failed to assist and initiate a discharge plan for a resident who requested to be discharge from the facility for one of three residents reviewed. (Resident R1) Findings include:Review of the facility policy title Discharges dated October 1, 2025, revealed that the residents may not be discharged unless specific criteria are met and at the facility must provide written notice, physician documentation, and coordinate discharge planning with social services, nursing, MDS (resident assessment of care needs), and therapy. The policy requires a discharge notice include the reason for discharge, effective date, appeal rights, and discharge location, and that a post discharge plan of care be developed. Review of Resident R1's admission MDS dated [DATE], revealed that this resident was admitted into the facility on October 8, 2025. Resident R1 was assessed with a BIMS (Brief interview for Mental Status score of 14, indicating that the resident was cognitively intact. The assessment documented that she was independent with indoor mobility and required supervision or partial assistance with walking and transfers. Resident R1's diagnosis included cellulitis (skin infection) of the lower limb. Review of Resident R1's admission agreement packet dated October 8, 2025, revealed that Resident R1 signed the admission documents, which included information regarding anticipated care services. The packet indicated that the resident was admitted for short-term rehabilitation, defined by the facility as goal-oriented, comprehensive inpatient care provided to individuals with an acute illness, injury, or exacerbation of a disease process. The admission packet further states that all resident transfers and discharges will be conducted in accordance with applicable state and federal laws. It specifies that a resident may be transferred or discharged if their condition has improved sufficiently so that facility-level services are no longer required, or if the resident voluntarily chooses to be transferred or discharged . In all cases, the facility is required to collaborate with the resident or legal representative to develop and implement a safe, timely, and appropriate discharge plan.The admission documents also included the Resident Rights section, affirming the resident's right to be informed of and participate in their treatment, care planning process, expected goals and outcomes, and the duration and effectiveness of the plan of care.Resident R1 signed and acknowledged receipt of all documents included in the admission agreement. Interview with Resident R1 completed November 18, 2025, at 9:50 a.m. revealed that (she/he) stated (she/he) was at the facility only for rehabilitation and is eager to go home. Resident R1 expressed this desire for several weeks to the former social worker, but no action has been taken. The resident stated that (she/he) has discussed plans with her family and intends to stay with (her/his) daughter upon discharge. Interview with the social worker on November 18, 2025, at 11:35 a.m. revealed that she was aware the resident wished to leave the facility, but she was not confident about the resident's planned living arrangement. The social worker confirmed that Resident R1 is (her/his) own representative and is cognitively capable of making her own decisions. Review of the resident's care plan revealed that there was no documentation or mention of a discharge plan.Review of the resident's nursing notes revealed that on November 12, the social worker documented an attempt to contact the resident's daughter. No other documentation was found indicating that the resident or facility had initiated discharge planning.Review of the resident's physical therapy notes revealed that the resident is expected to return to living at home with family, with home assistance and support provided as needed. The notes identified potential barriers to discharge, including multiple medication management requirements, the need for physical assistance to function safely at home, and likely caregiver support in the next setting. Therapy notes dated November 13, 2025, indicated that the resident was compliant and actively participated in skilled interventions.Interview with the nursing home administrator on November 19, 2024, at approximately 2:30 PM revealed that he was aware the resident had requested a discharge. He stated that the request had been discussed at a recent meeting and confirmed that there was no documentation indicating that a discharge plan had been initiated or that any steps had been taken to facilitate the resident's discharge.25 Pa Code 201.14(a) Responsibility of licensee