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	01/21/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy, resident and staff interviews, it was determined that the facility failed to maintain the facility in a safe, clean and homelike condition on two of four nursing units (1st floor [NAME] Unit and 4rth floor nursing unit). Findings: A review of the facility policy titled Policy Number: RR1.01 revised 09/2025 stated under bulletin 3. gg. Section p.8 F584 Safe/Clean/Comfortable/Homelike Environment- 1. Right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely. 2. Housekeeping and maintenance services that maintain a sanitary, orderly, and comfortable interior 3. Clean bed and bath linens that are in good condition 4. Private closet space in each resident room [ROOM NUMBER]. Adequate and comfortable lighting levels in all areas, comfortable and safe temperatures levels (71F-81F), and maintenance of comfortable sound levels. On January 21, 2026, at 9:30 a.m., an observation on the first-floor [NAME] unit revealed that room [ROOM NUMBER] had a temperature of 52 degrees F, and the restroom light was not functioning. The sink water was turned off at the valve, and the Maintenance Director, Employee E7, had to turn it back on by opening the valves beneath the sink. Resident R7 was lying in bed wrapped in multiple blankets and reported that he/she was cold and that it had been cold for the past three months. Resident R7 refused a room change. room [ROOM NUMBER] had a temperature of 69 degrees F. The restroom showed rusted metal edges on the wall, with rust flaking off. [NAME] rust discoloration was observed around the toilet and toilet valves. The floor tile behind the toilet also had brown rust discoloration. On January 21, 2026, at approximately 9:40 a.m., an interview with Resident R8, who resided in room [ROOM NUMBER], revealed that he/she reported feeling cold in the room. Further observations during the same time screening revealed that room [ROOM NUMBER] had a temperature of 57 degrees F. Resident R9 reported feeling cold in the room. The [NAME] hallway unit had a total of two sanitizer dispensers, both of which were empty. It was further discovered that the left side of the first-floor [NAME] nursing unit heating system was not functioning. The following room temperatures were recorded: room [ROOM NUMBER] – 61 degrees F room [ROOM NUMBER] – 62 degrees F room [ROOM NUMBER] – 66.5 degrees F room [ROOM NUMBER] – 57 degrees F room [ROOM NUMBER] – 52 degrees F (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All rooms from 111-116 had a restroom light that was not functioning. These observation were confirmed by the maintenance director, Employee E7. On January 21, 2026, at 9:58 a.m., an observation in room [ROOM NUMBER] revealed a strong smell of cigarette smoke near Bed A. Resident R10 was interviewed and denied smoking; however, the Unit Manager, Employee E40, confirmed the strong smoking odor in the room and reported that the resident is a smoker who has a contract with the facility not to smoke but is noncompliant. They conducted a search and found a lighter. On January 21, 2026, at 10:18 a.m., an interview with Resident R10 revealed, It's freezing, but they did something and it got better. On January 21, 2026, at 11:27 a.m., an interview with the Administrator, Employee E1, and the Director of Nursing, Employee E2, revealed that there were heating issues on the left side of the first-floor [NAME] nursing unit. An invoice from a vendor indicated that on January 20, 2026, the vendor worked on the HVAC units and reported the following: We replaced the inducer motor on a rooftop unit, diagnosed another rooftop unit, and cleaned the limit switch. The unit also needs a rollout switch. In addition, the thermostat on one of the units needs to be replaced. Admin confirmed that thermostat was replaced and rollout switch was obtained by vendor. Everything was fixed as of January 20. 2026. The Administrator further reported that the facility would offer room changes and provide blankets to residents in room [ROOM NUMBER]-116. Frequent monitoring of room temperatures would be conducted if residents refused to change rooms. The Medical Director would be contacted to determine whether the room temperatures could affect residents' medical status. Residents' body temperatures would be checked every four hours for signs of hypothermia. A vendor was scheduled to return that day. The inducer motor was fixed the previous day. The facility had blankets on hand and placed an additional order for blankets the previous day in anticipation of worsening weather the following weekend. On January 21, 2026, at 1:26 p.m., the Maintenance Director, Employee E7, reported that the vendor shut down and reset the rooftop unit, after which the heat began functioning. All six rooms were back in compliance, with temperatures ranging from 72 degrees F to 79 degrees F. The Administrator reported that heat checks would be conducted every two hours for the next week to monitor room temperatures on the first-floor [NAME] unit. During a tour with the Nursing Home Administrator on January 5, 2026, at 1:20 p.m. room [ROOM NUMBER] where Resident R2 residents did not have any working cold water when the faucet in the bathroom was turned on. During an observation in room [ROOM NUMBER] during the above referenced time period, no working cold water was found when the faucet in the bathroom for room [ROOM NUMBER] was turned on. Resident R4 reported that she told them, about it, but could not recall who she told when she was asked. During an interview with the Director of Maintenance (Employee E7) on January 5, 2026, at 2:00 p.m. the Director of Maintenance reported that he was aware that room [ROOM NUMBER] did not have any working cold water when he went to fix the toilet in that room on December 10, 2025. The Director of Maintenance reported that he had known since this time and had not had time to fix it. In regard to room [ROOM NUMBER] not having any working cold water, the Director of Maintenance stated that he was notified of that after the above referenced observation in room [ROOM NUMBER]. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18(e)(2.1) Management

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of information submitted by the facility, review of facility documents, and staff interview, it was determined the facility failed to ensure a resident was free of abuse for one of two residents reviewed (Resident R1). This failure resulted in actual harm to Resident R1. Resident R1 was involved in a physical altercation with a staff member, during which the staff member punched Resident R1 in the face. A reasonable person would determine that a staff member striking a resident with moderate cognitive impairment caused actual harm. Due to the resident's cognitive limitations and dependence on staff for care and protection, the impact of the incident is magnified and places the resident at risk for ongoing psychological trauma. This deficiency was cited as past non-compliance. Findings include: Review of the facility policy, Freedom from Abuse Neglect and Exploitation, with a revision date of September 2025, indicated the facility must provide a safe resident environment and protect residents from abuse, and not use verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion. Review of Resident R1's clinical record revealed January 2026 physician orders included the following diagnosis: Epilepsy (brain condition that causes recurring seizures); Hypertension (high blood pressure); Chronic Obstructive Pulmonary Disease (COPD- a term for lung and airway diseases that restrict your breathing); Dementia (group of symptoms affecting memory, thinking and social abilities and interfere with a person's daily life), and unspecified Psychosis (term used for a collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not). Review of Resident R1's Comprehensive Minimum Data Set Assessment (MDS-periodic assessment of a resident's needs) dated November 19, 2025, indicated the resident had moderate cognitive impairment. Review of information dated November 23, 2025, at approximately 7:00 p.m. submitted by the facility on November 23, 2025, it was reported that [Resident R1] was being physically aggressive towards staff and attacked and hit an employee. According to the report another employee attempted to de-escalate the situation by speaking to [Resident R1]. [Resident R1] attacked that employee and the employee allegedly took a swing at [Resident R1]. The facility substantiated the incident as resident abuse. Review of the facility investigation revealed dietary worker (Employee E3) reported being approached and punched in the face by the resident while they were in the elevator. Continued review of the facility investigation documentation revealed Employee E4, dietary supervisor (alleged perpetrator) was interviewed and stated he was notified the resident hit an employee in his department while the employee and the resident were both in the elevator. Employee E4 reported that he went to find out what happened and attempt to calm the resident down. Dietary supervisor reported the resident started to get aggressive with him and he asked (him/her) to stop multiple times. Dietary supervisor reported that he attempted to exit the situation, then the resident took a swing at him. The dietary supervisor reported that he swung back and hit the resident. Review of written statement by the dietary aide dated November 23, 2025, indicated the dietary aide was hit by the resident. Review of a second written statement by the dietary aide indicated the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	dietary aide was walking to get the truck and that a resident asked him to walk with them to see something. The dietary aide reported that when the lady came out, the resident grabbed a plate and then put it back. Dietary aide reported the resident asked him if he (the dietary aide) could hear (him/her) and he (dietary aide) stated that he could. The dietary aide reported the resident then started to approach him, so he (dietary aide) backed up and the resident swung at him and hit him in the face. During an interview with the dietary aide on January 7, 2026, at 3:23 p.m. the dietary aide reported, he was on the first floor, west wing getting the food truck. He stated a nurse was about to put a tray on the cart when (the resident) asked to check the tray. The dietary aide stated the resident asked him (dietary aide) if he could hear (him/her), he replied yes, then the resident started to approach him and hit him in the face. Dietary aide reported that he told the dietary supervisor what happened and called his mother. Dietary aide reported he wrote a statement about what occurred with the above-referenced resident. The dietary aide reported he saw the resident knocking on the double doors that lead to the kitchen but did not witness the dietary supervisor get hit by the resident and only heard about the incident. Review of statement obtained from the dietary supervisor dated November 23, 2025, revealed the dietary aide came to the dietary supervisor and told him what happened with Resident R1. The dietary supervisor reported he went to find out where resident was and went to the hallway where he found Resident R1. Dietary supervisor reported he saw the resident and told the resident that he needed to stop, and he said this a couple of times. Continued review of the dietary supervisor's statement indicated Resident R1 tried to swing at him and he (dietary supervisor) swung back and hit him. Review of a witness statement by a resident witness (Resident R3) dated November 23, 2025, revealed Resident R3 was sitting in front of the nursing office and saw Resident R1 walk towards the kitchen. Resident R3 witness statement revealed the dietary staff opened the doors and Resident R1 was trying to go by them. Resident witness reported that Resident R1 put (his/her) hands up to fight the staff and the dietary supervisor tried to talk with Resident R1 to find out what was wrong. Resident R3 witnessed Resident R1 hit the dietary supervisor and the dietary supervisor hit Resident R1 back. Resident witness (Resident R3) has been discharged from the facility since the incident on November 23, 2025, and was not interviewed regarding (his/her) statement that (he/she) provided to the facility. Review of witness statement by activity aide (Employee E5) dated November 23, 2025, revealed that around 7:00 p.m. on the date of the incident the dietary aide notified her that he was hit by Resident R1. The activity aide reported she notified the nursing supervisor (Employee E6). The activity aide reported, she was with the dietary aide and the dietary supervisor near the kitchen door where the resident was also. Activity aide reported Resident R1 was shaking and wobbling while throwing (his/her) hands up at the dietary supervisor and that the dietary supervisor reacted and hit the resident on the right side of the face. During interview with the activity aide on January 8, 2026, at 11:39 a.m. the activity aide reported that during the time of the incident on November 23, 2025, she was working as the front desk receptionist. The activity aide reported during the interview the dietary aide notified her that Resident R1 hit him on the elevator. Activity aide indicated that she notified the nursing supervisor who came down to speak with the dietary aide. The activity aide stated both she and the nursing supervisor went around to the kitchen area (the area near the double doors that lead to the kitchen area) and they notified the dietary supervisor about the incident. Activity aide revealed that Resident R1 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	walked around to the area where they were all standing and had his fist balled up. Activity aide reported the dietary supervisor was standing near the resident who had (his/her) fist balled up, and the dietary supervisor hit the resident on the side of (his/her) face. The activity aide reported that she did not witness the resident hit the dietary supervisor. Activity aide reported that she moved the resident out of the way and the nursing supervisor called someone and she (activity aide) went back to the front desk. Review of written statement from nursing supervisor (Employee E6) dated November 23, 2025, revealed that the nursing supervisor was called to the dietary department because it was reported to her that Resident R1 hit the dietary aide. Nursing supervisor reported that when she arrived at the kitchen she was met by Resident R1 who stated to the nursing supervisor, where is he? Nursing supervisor reported that she did not respond, and that she went into the kitchen and asked the dietary aide if the resident hit him. The nursing supervisor indicated in the statement that the dietary aide told her that the resident punched him. Nursing supervisor indicated that dietary supervisor then came from the kitchen, and the resident had his hands up as if (he/she) was going to fight. Nursing supervisor indicated the dietary supervisor asked the resident what happened, and what could he do for (him/her) since he was notified by the dietary aide that the resident hit him. Nursing supervisor reported that as the dietary supervisor approached the resident, the resident punched the dietary supervisor. Nursing supervisor indicated that the dietary supervisor then began hitting the resident, and stated to the resident, you messing with the wrong one, and then punched the resident in the face. Based on review of facility documents and interview with staff, a reasonable person would determine that a staff member striking a resident with moderate cognitive impairment caused actual harm. Due to the resident's cognitive limitations and dependence on staff for care and protection, the impact of the incident is magnified and places the resident at risk for ongoing psychological trauma. This action compromised the resident's right to be free from abuse and undermined the resident's sense of safety. This deficiency was cited as past non-compliance. Review of facility Action plan/Follow up documentation revealed the following information. Resident R1 was immediately removed from the area and assessed by the charge nurse. There were no signs of bruising or redness. Resident R1 was transferred to the hospital on 302 for psychiatric evaluation. The staff member involved immediately suspended immediately pending investigation. Staff member was terminated 11/24/2025. On 11/23/2025 the nursing supervisor and NHA interviewed residents and facility staff to [NAME] that there were no other incidents. On 11/23/2025 the nursing supervisor started education for Facility Staff regarding Abuse and de-escalation. The NHA, DON and/or designee continue De-escalation training for facility staff. An ad-hoc QAPI was held on 11/24/2025. The facility has engaged vendor provider to provide de-escalation training. Training will be conducted on February 2, 2026. NHA, DON and /or designee will conduct audits of allegation of staff-to-resident abuse allegations. Results of the audits will be reviewed at the QAPI meeting held monthly. The facility alleged a date of compliance with this plan of correction as November 24, 2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Facility education records and subsequent audits were verified as complete. Staff were interviewed to confirm education on the facility's de-escalation policy for all staff. Staff interviews were also conducted to verify compliance with the plan of correction. No continuing concerns were identified through record review, interviews, or observation. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interviews and the review of clinical records, it was determined that the facility failed to ensure that one resident (Resident R2) was properly assessed by nursing staff and failed to ensure that 2 residents received medications according to physician orders (Resident R5 and R6). Findings include:Review of the January 2026 physician orders for Resident R2 included the following diagnosis: epilepsy (a brain condition that causes recurring seizures); depression (a mood disorder that causes a persistent feeling of sadness and loss of interest); post-traumatic stress disorder (PTSD- a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it); adjustment disorder (excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior); anxiety (frequent intense, excessive and persistent worry and fear about everyday situations, hypertension (high blood pressure), and diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high).During an interview with Resident R2 on January 4, 2025, at 1:15 p.m. the resident reported concerns that a drawer fell my right shoulder.my arm and reported that no one at the facility who spoke to her about it believed her. Resident R2 reported during the above referenced interview that her arm hurt. Review of the clinical record did not show any documentation that the alleged event occurred and/or that a nursing assessment was completed on the resident regarding the incident that she reported to ensure that the resident was properly assessed for any possible additional care, the physician was notified of her reported incident and could provide any necessary instructions and/or orders to the nursing staff, and that such assessment was complete and accurately documented in the clinical record. (e.g. no documentation in the clinical record that the resident's arm/shoulder area was assessed over a period of time, or that any vital signs.During an interview with Employee E10 (licensed nurse) on January 6, 2026 at 12:44 p.m. reported that the resident notified him that a dresser fell on her shoulder while she was sitting on her bed. Discussed with the licensed nurse that there was no documentation of the reported incident, no documentation of any assessment done on the resident to include assessment of the area where the dresser reportedly fell on, vital signs, . in the clinical record. The licensed nurse reported that he was told by the manger on duty, Human Resources Manager (Employee E9) to not document anything regarding event in the clinical record. Review of the January 2025 physician orders for Resident R5 included the following diagnosis: kidney failure (a condition in which one or both of your kidneys no longer work on their own); osteoporosis; psychosis (the term for a collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not), and post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it). Continued review of the resident's January 2025 physician orders included an order for the resident to be administered 1-2 milligram tablet of the medication Haloperidol in the morning for the treatment of psychosis and schizophrenia.During the medication administration observation, on January 6, 2026 at 10:11 a.m. Employee E11 (licensed nurse) could not locate the medication haloperidol on the medication cart, or in the medication room when she looked. During the above date and time, the license nurse reported that resident's above referenced medication could not be administered because the resident had no more left, and it had to be reordered from the pharmacy.Review of the January 2026 physician orders for Resident R6 included the following diagnosis: lumbago with sciatica (characterized by pain radiating from the lower back and into the legs and feet); hypertension (high blood pressure), and epilepsy (a brain disorder that causes repeated seizures).Continued review of the resident's January 2026 physician orders included a physician's order for the administration of 1-15 milligram tablet of the pain (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	medication, oxycodone to be administered by mount every 10 hours. oxycodone HCl Oral Tablet 15mg (Oxycodone HCl) Give 1 tablet by mouth every 10 hours related to LUMBAGO WITH SCIATICA, LEFT SIDE.During a medication administration observation on January 6, 2026 at 10:38 a.m. Employee E12 (licensed nurse)went in to administer the medication for Resident R6 when R6 asked the licensed nurse do you have my pain medication? Licensed nurse reported that the oxycodone was not available for the resident to take because it had not been delivered by the pharmacy because a prescription from the physician is needed. During an interview with the resident during the above reference date and time, the resident reported I am in a lot of pain and I need my pain medication. 28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations and interviews, it was determined that the facility failed to ensure complete and accurate clinical record regarding the consumption of a meal for 1 out of 3 residents observed (Resident R5).Findings include:Review of the January 2025 physician orders for Resident R5 included the following diagnosis: kidney failure (a condition in which one or both of your kidneys no longer work on their own); osteoporosis; psychosis (the term for a collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not), and post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it).Review of a physician's order for Resident R5 with an order date of August 25, 2022 and monthly thereafter included an order for the resident to have a fortified cereal one time a day during her breakfast meal for the additional calories and protein intake. Fortified Cereal one time a day for additional kcal and protein intake. With breakfast. During the medication administration observation, on January 6, 2026 at 10:11 a.m. Employee E11 was observed documenting in the clinical record with her initial indicating that the resident had at least received the fortified cereal/and or consumed it. When asked if she observed the resident with the cereal on her breakfast tray and/or if she consumed it, Employee E11 confirmed that she did not see her with it, and stated, they (referring to dietary) usually send it up.