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	02/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, and interviews with staff, it was determined the facility failed to implement interventions following prior elopement behavior and failed to revise the care plan to reflect newly identified elopement risk and escalating behavioral for one of one resident reviewed. (Resident R1) Findings include: Review of the facility's undated Leave of Absence (LOA) Policy indicated that a Leave of Absence is a temporary period when a resident leaves the facility with the expectation of returning. The policy requires staff to ensure the resident is clinically stable prior to departure, obtain a signed LOA form, document the date and time of departure, and provide any necessary instructions. Upon the resident's return, staff are required to document the time of return, complete a nursing assessment, and update the care plan if indicated. The policy also states that if a resident does not return as expected, staff must attempt to contact the responsible party and take additional steps, including notifying authorities if the resident's safety cannot be confirmed. Review of Resident R1's Minimum Data Set (MDS- a federally required assessment) dated January 10, 2026, revealed the resident was admitted on [DATE]. The resident scored 14 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. The assessment indicated the resident required partial to moderate assistance with sit-to-stand, chair-to-bed transfers, toilet transfers, and ambulation of 10 and 50 feet with turns, and was totally dependent for car transfers. Resident R1's diagnoses included coronary artery disease (narrowing of the arteries that supply blood to the heart), hypertension (high blood pressure), diabetes mellitus (a disorder affecting blood sugar regulation), cerebrovascular accident (CVA), also known as a stroke caused by interrupted blood flow to the brain, malnutrition (inadequate intake of nutrients needed for health), generalized weakness (reduced muscle strength affecting mobility), and a history of falls. The resident's medication regimen included antiplatelet medications (to prevent blood clots), hypoglycemic agents including insulin (to control blood glucose), and anticoagulant therapy (blood thinners used to prevent clot formation). Review of Resident R1's nursing notes revealed that on January 12, 2026 at 3:27 PM, Resident R1 was involved in a verbal altercation with another resident. During the incident, the other resident ran toward Resident R1 and punched the resident. No visible injuries were noted for either resident. The Director of Nursing (DON), physician, police, and the responsible party were notified of the incident. Continue review of nursing notes revealed that on January 13, 2026 at 9:52 AM, Resident R1 was transferred to room to another room. Within five minutes, the resident was involved in a verbal altercation with his new roommate. As a result, the resident was subsequently transferred to a different nursing unit. Nursing note dated January 20, 2026, at 9:23 AM, state that the facility contacted the emergency room (ER) and was informed that Resident had left the ER without being seen at 7:00 AM. The resident returned to the facility at 9:00 AM. A new elopement assessment was completed, and the resident was identified as a flight risk. The physician, Social (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services, and Administration were notified, and a full body assessment was completed with no skin issues noted. Review of Resident R1's elopement risk evaluation dated January 20, 2026, revealed that the resident is at risk for elopement, with a score of 2.0. The evaluation was based on several factors, including a history of attempting to leave the facility without informing staff, wandering behavior, and behavior that could compromise the safety or well-being of self or others. Additionally, the resident had been recently admitted within the past 30 days and had not fully adjusted to the facility. According to facility protocol, a score greater than 1 indicates that the resident is considered at risk for elopement. Review of nursing note dated January 30, 2026 at 2:25 PM, revealed the resident was found smoking in his room. Social Services was notified, and the resident verbally threatened another resident , stating he would beat him up. Continued review of nursing notes revealed a note dated February 4/2026 at 11:36 PM, the resident remained on a Leave of Absence (LOA). A phone call was placed to follow up, but there was no answer. A message was left for the responsible party. Review of Resident R1's care plan revealed multiple identified risk areas beginning December 17, 2025, including risk for impaired skin integrity, self-care deficits with expected ADL decline, risk for adverse medication reactions related to medication use, and discharge planning needs. Discharge planning was initiated upon admission, with goals to provide community resource information and ensure appropriate support systems are in place prior to discharge. The care plan further identifies diabetes management goals to prevent complications, continued monitoring for medication-related adverse effects, and fall risk with interventions to anticipate and meet resident needs. Additional problem areas include potential oral/dental health issues and nutritional concerns related to abnormal labs, heart disease, diabetes, and a history of high added-sugar dietary patterns. Behavioral concerns were added to the care plan on January 12, 2026, following an incident in which the resident punched another resident. The care plan reflects potential for physical and verbal aggression, as well as smoking-related behaviors. On February 4, 2026, a self-determination focus was added addressing the resident's choice not to follow facility smoking rules, with a goal for the resident to discuss and understand the potential negative consequences of noncompliance. Continue review of Resident R1's care plan revealed that there was no care plan developed for wandering behaviors or elopement risk. Interview with Social Worker, Employee E3 on February 26, 2026 at 08:58 a.m. confirmed she was familiar with the resident and spoke with the resident on January 20, 2026 regarding the facility's Leave of Absence (LOA) policy. She informed the resident that he could not go out that day because the physician was not available to provide consent. Employee E3 described the resident as someone who frequently expressed a desire to leave the facility. At the time of that discussion, she stated she was unaware that the resident had been identified as an elopement risk. She further indicated she was not aware that the care plan had been updated to reflect elopement risk status. 28 Pa. Code 201.18(b) Management 28 Pa. Code 211.12(c)(d)(5) Nursing Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, review of clinical records, and interviews with staff it was determined that the facility failed to provide adequate supervision for 1 of 1 sampled resident identified as being at risk for elopement and failed to implement interventions following prior elopement behavior. (Resident R1) Findings include: Review of the facility's admission Agreement indicated that residents may temporarily leave the facility on a Leave of Absence or pass in accordance with facility policies and procedures. The agreement states that the resident or legal representative assumes responsibility for the resident while the resident is away from the facility and releases the facility, its owners, directors, officers, and employees from liability for injury, illness, or decline in condition that may occur during the absence. The agreement also indicates that residents leaving on pass must follow facility requirements, which may include obtaining a physician's order for medications and medical information, meeting escort requirements if applicable, and providing advance notice of the planned leave in accordance with facility policy. Review of the facility's 'Elopement Prevention Policy' undated indicated residents are to be assessed for elopement risk upon admission, routinely, and with any significant change in condition. The policy states that residents identified as an elopement risk will have individualized care plan interventions implemented to promote safety and monitoring. Staff are required to document exit-seeking behaviors, promptly report attempts to leave the premises, and remain with the resident while notifying the charge nurse and obtaining assistance if a resident attempts to leave the facility. Review of the facility's Leave of Absence (LOA) Policy undated, indicated that a Leave of Absence is a temporary period when a resident leaves the facility with the expectation of returning. The policy requires staff to ensure the resident is clinically stable prior to departure, obtain a signed LOA form, document the date and time of departure, and provide any necessary instructions. Upon the resident's return, staff are required to document the time of return, complete a nursing assessment, and update the care plan if indicated. The policy also states that if a resident does not return as expected, staff must attempt to contact the responsible party and take additional steps, including notifying authorities if the resident's safety cannot be confirmed. Review of Resident R1's Minimum Data Set (MDS- a federally required assessment) dated January 10, 2026, revealed the resident was admitted on [DATE]. The resident scored 14 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. The assessment indicated the resident required partial to moderate assistance with sit-to-stand, chair-to-bed transfers, toilet transfers, and ambulation of 10 and 50 feet with turns, and was totally dependent for car transfers. Resident R1's diagnoses included coronary artery disease (narrowing of the arteries that supply blood to the heart), hypertension (high blood pressure), diabetes mellitus (a disorder affecting blood sugar regulation), cerebrovascular accident (CVA), also known as a stroke caused by interrupted blood flow to the brain, malnutrition (inadequate intake of nutrients needed for health), generalized weakness (reduced muscle strength affecting mobility), and a history of falls. The resident's medication regimen included antiplatelet medications (to prevent blood clots), hypoglycemic agents including insulin (to control blood glucose), and anticoagulant therapy (blood thinners used to prevent clot formation). Review of resident R1's elopement risk evaluation dated December 17, 2025 (upon admission) revealed a score of 0, indicating no identified risk for elopement at the time of admission. There were no findings suggesting the resident was at risk for leaving the facility unsafely. Review of Resident R1's elopement risk evaluation dated January 20, 2026, revealed that the resident is at risk for elopement, with a score of 2.0. The evaluation was based on several factors, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including a history of attempting to leave the facility without informing staff, wandering behavior, and behavior that could compromise the safety or well-being of self or others. Additionally, the resident had been recently admitted within the past 30 days and had not fully adjusted to the facility. According to facility protocol, a score greater than 1 indicates that the resident is considered at risk for elopement. Review of Resident R1's nursing notes dated February 3, 2026, revealed that Resident R1 was picked up for a leave of absent (LOA) and returned to the facility the same evening without incident. Further review of Resident R1's clinical record revealed social service notes dated February 4, 2026, which revealed that the resident left the faciity on leave of absence at approximately 11:00 AM. Resident did not return as expected social service director attempted to contact resident via phone with no response. Social service director contacted the shelter were resident previously resided but was not located. Review of the Leave of Absence log maintained at the front desk, where residents and family sign out when leaving the facility, revealed the following:On February 3, 2026, Resident R1 left the facility at 10:20 AM and returned at 3:20 PM, accompanied by (his/her) brother.On February 4, 2026, Resident R1 again left the facility at 11:05 AM, also accompanied by (his/her) brother. Resident did not return Interview with Medical Director Employee E4 on February 26, 2025, at 10:50 a.m. stated that he does not write blanket orders for Leave of Absence (LOA). He indicated that it would be highly irregular to issue an LOA order on the same day a resident was admitted to the facility. He explained that an order should be written each time a resident leaves the facility. The Medical Director further confirmed that if a resident is identified as an elopement risk, the resident should not leave the facility without staff supervision. He stated that he would not give an order permitting a resident identified as an elopement risk to leave the facility independently. Interview with the Director of Nursing (DON)on February 26, 2026, at 11:30 a.m. Employee E2 stated that when residents leave the facility, it is considered a day pass. The DON, Employee E2 reported that documentation for LOA/day passes is limited to the resident signing out. She stated that for one-day passes, there is no requirement for formal documentation, education, or medication reconciliation. While nurses may verbally speak with the resident or escort prior to departure, she indicated that this communication does not require documentation. Interview with Social Worker, Employee E3 on February 26, 2026, at 8:55 a.m., confirmed she was familiar with Resident R1 and had spoken with him on January 20, 2026, regarding the facility's Leave of Absence policy. She stated that on that date, the resident was not allowed to leave because the physician was unavailable to provide consent. Employee E3 stated not being aware that the resident had been identified as an elopement risk. Employee E3 further reported that she was unfamiliar with the facility's policies regarding elopement and Leave of Absence procedures. 28 Pa Code 201.14 (a)(c) Responsibility of Licensee 28 Pa. Code (b)(1) Management 28 Pa. Code 211.12 (c)(d)(5) Nursing Services