

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Independence Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, review of facility policy and information of alcohol-based hand sanitizer, it was determined the facility failed to adequately supervise and monitor Resident R1. This failure resulted in Resident R1 obtaining and ingesting alcohol-based hand sanitizer on three separate dates resulting in an Immediate jeopardy situation for one out of three residents reviewed (Resident R1).</p> <p>Findings include:</p> <p>Review of the facility's policy, Accident & Injury Prevention and Response Policy dated January 1, 2026, indicated that the purpose of the policy was to ensure that all residents of the facility are protected from avoidable accidents and injuries through proactive assessment, environmental safety, staff training, and timely response.</p> <p>Review of the Safety Data Sheet for the ProCure Alcohol Gel Hand Sanitizer 70% indicated the chemical name as Ethyl Alcohol with 70-75% concentration. The first aide measure to follow if ingested stated to contact a physician or a poison control center immediately, do not induce vomiting, and to never give anything by mouth to an unconscious person.</p> <p>Review of Resident R1's MDS (Minimum Data Set - periodic assessment of resident's abilities) assessment dated [DATE], revealed Resident R1 was assessed with a BIMS score of 10, indicating the resident had moderate impaired cognition.</p> <p>During an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on March 10, 2026 at 10:45 a.m. it was discussed Resident R1 drank and/or was observed with hand sanitizer in a cup on 3 separate occasions, has a history of alcohol abuse, and continued to have access to hand sanitizer at the facility.</p> <p>Review of Resident R1's March 2026 physician orders revealed the diagnoses of alcohol abuse (medical condition characterized by impaired ability to control alcohol consumption despite negative consequences); Bipolar Disorder (condition of periods of depression and periods of extreme happiness), Chronic Obstructive Pulmonary Disease (disease process that causes decreased ability of the lungs to perform), Heart Failure (chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and Dementia (group of symptoms affecting memory, thinking and social abilities).</p> <p>Review of Resident R1's hospital records dated May 24, 2025, revealed the resident was brought to the local hospital by (her/his) son on May 24, 2025. The resident had been staying with (her/his) son (continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>due to (her/him) being discharged from another long term care facility the prior week for alcohol abuse, issues with (her/his) insurance and behavioral issues.</p> <p>Review of Resident R1's nursing note dated January 23, 2026, at 2:15 p.m. by Licensed nurse, Employee E3 revealed While rounding, this nurse observed the resident drinking hand sanitizer. Nurse informed and educated resident that the substance was hand sanitizer, not water. The hand sanitizer was immediately removed from residents possession. A full assessment was completed, and vitals 128/76 (normal blood pressure 120/80); 87 (normal pulse 60-100); 97% (normal oxygen saturation 95%-100 %), 97.4 (normal temperature 97.5 degrees Fahrenheit) are stable. This nurse will continue to monitor residents, reassess as indicated, and follow up throughout the shift. Resident paired care.</p> <p>Continued review of Resident R1's clinical record failed to reveal documented evidence the physician was notified of Resident R1 drinking hand -sanitizer on January 23, 2026, and failed to reveal documentation of interventions to monitor and supervise the resident in relation to the consumption of hand- sanitizer.</p> <p>Review of a nursing note by Unit manager, Employee E4 dated February 28, 2026, at 9:04 a.m. revealed Resident found drinking a cup of hand sanitizer. Cup thrown away. Residents educated on why she should not drink hand sanitizer and the dangers of ingestion of the product. MD (physician) and RP (resident's responsible party) made aware.</p> <p>Review of Resident R1's person-centered plan of care included a care plan dated February 28, 2026 indicating Resident drinks hand -sanitizer, with interventions including: administering medications as ordered, analyzing key times, places, circumstances, triggers and what deescalates behavior and document, assess resident's coping skills and support system, continue to provide reeducation and discuss risks/benefits of refusals, and encourage resident to discuss feelings and allow resident to vent.</p> <p>Review of a nursing note on March 1, 2026, at 12:42 p.m. confirmed that Resident R1 was observed by Licensed nurse, Employee E3 in her room with a bottle of hand- sanitizer and a cup with hand sanitizer inside of it. Upon helping resident put on shoes this nurse observed a bottle of hand sanitizer and a cup with hand sanitizer in it, in resident room. Bottle and cup were removed.</p> <p>Review Psychologist's notes on March 2, 2026, at 12:00 p.m. stated: Resident was observed drinking hand sanitizer from a cup There was no other documentation that this was further addressed with the resident or interventions to prevent reoccurrence.</p> <p>Review of Psychologist's notes from October 2025 to March 2026 including the following dates: 3/2/26; 2/21/26; 2/9/26; 1/25/26; 1/14/26; 12/28/25; 12/10/25; 11/30/25; 11/16/25; 11/2/25; 10/26/25 included resident's alcohol and cocaine abuse history, in addition to documentation of the resident reporting to the psychologist that (she/he) currently drinks, does not plan to stop and that (she/he) drank at (her/his) previous nursing home.</p> <p>Interview conducted with Unit manager, Employee E4 on March 9, 2026, at 1:55 p.m. the unit manager revealed she notified the physician once she observed the resident with the half-filled medication cup of hand sanitizer in (her/his) room, and the physician ordered labs (bloodwork) for the resident and to monitor the resident for diarrhea. Unit manager, Employee E4 revealed she took the 4-ounce medication cup from the resident, [Resident R1] walks throughout the building unrestricted, explaining this statement revealed the resident could get more on (her/his) own without anyone (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>knowing. Unit manager, Employee E4 further revealed resident replied, sorry, when confronted with the hand filled cup. Unit manager, Employee E4 revealed she did not ask the resident where the resident got the cup of hand sanitizer from because I don't think (she/him) would have told me anyway. Employee E4 stated that she updated Resident R1's plan of care and referred the resident to psych (psychologist) as intervention. Employee E4 reported that she was unaware of the previous occurrence when Resident R1 drank hand sanitizer on January 23, 2026.</p> <p>Continued interview with the Unit manager, Employee E4 revealed on, March 1, 2026, she was notified by Licensed nurse, Employee E3 that Resident R1 had bottle of hand sanitizer and a cup filled with hand sanitizer with ice, which was taken from the resident by the Licensed nurse, Employee E3.</p> <p>Interview conducted with Licensed nurse, Employee E3 on March 10, 2026, at 11:47 a.m. regarding her nursing notes from January 23, 2026. It was discussed with Licensed nurse, Employee E3 the clinical record failed to evidence in nursing notes that Employee E3 notified the physician regarding the incident or notified any other clinical staff.</p> <p>During an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on March 10, 2026 at 10:45 a.m. it was discussed Resident R1 drank and/or was observed with hand sanitizer in a cup on 3 separate occasions, has a history of alcohol abuse, and continued to have access to hand sanitizer at the facility.</p> <p>Based on the above findings an Immediate Jeopardy to the safety of Resident R1 was identified to the Nursing Home Administrator on March10, 2026 at 1:08 p.m. for failure to ensure Resident R1 was provided with an environment free of hazardous substances and adequate supervision. This failure placed Resident R1 in an Immediate Jeopardy situation, who had access to alcohol-based hand sanitizer and ingested the hand- sanitizer in three different instances. The Immediate Jeopardy template was provided to the Administrator, and an immediate action plan was requested.</p> <p>On March 10, 2026, at 4:09 p.m. the facility provided the following corrective action plan:</p> <ol style="list-style-type: none"> 1. Resident R1's personal environment audited to ensure no hazardous substances are in possession or in reach. 2. Resident R1 CP (care plan) updated to include hx (history) of alcohol and substance. 3. Entire staff in-service initiated on sign and symptoms of alcohol and substance consumption. As well as need to report to direct supervisor. Supervisor will notify MD (physician) and family in the event of consumption. All staff in building at this time were in -serviced. This is a 97 or our 155 (62%) current staff. In -service will continue until every staff member in-serviced. Every staff member will be contacted by tomorrow morning. 4. Staff notified/in-serviced of residents behaviors and educated to monitor when Resident R1 comes in view. In-service completed for all staff currently in building. 5. All sanitizers that potentially can be accessible to resident were removed from units, (all refills from wall dispensers removed at this time, actual dispensers are being removed as well), this includes wall dispensers as well as other self-standing bottles. 6. All staff in building received and will continue to be provided will be provided with pocket sanitizers (continued on next page) 		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>going forward. No Hand sanitizer will be available in the facility aside from these.</p> <p>7. Staff educated to keep sanitizers on person only at all times.</p> <p>8. Audit report of all residents with hx (history) of alcohol and substance abuse conducted. All residents identified. Care Plans are now being updated to include this history and appropriate interventions.</p> <p>9. Facility will continue to audit units on every shift (7-3, 3-11, 11-7) x 4 weeks.</p> <p>10. Followed by monthly x 3 months. Results of both will be reported to QAPI (Quality Assurance Improvement Plan)</p> <p>Following verification of the implementation of the immediate action plan and review of staff education documentation, the Immediate Jeopardy was lifted on March 11, 2026, at 4:54 p.m.</p> <p>The Immediate Jeopardy identified for Resident R1 occurred from March 23, 2026, to March 11, 2026</p> <p>28 Pa. Code 201.18(b)(3)(e)(1) Management</p> <p>28 PA. Code 211.10(d) Patient care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		