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	04/13/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based clinical record reviews, interviews with residents and staff and reviews of policies and procedures, it was determined for three of eleven residents reviewed that the administrative staff failed to conduct and complete a thorough investigation into an incident of physical altercation between two residents (Resident R1 and Resident R2) and a physical altercation between Resident R1 and nursing staff member (Employee E7).Findings include:A review of the facility's policy titled accidents and incidents investigation and reporting dated July 2017 revealed that all accidents and incidents involving residents, employees, visitors and vendors occurring on the premises were to be investigated and reported to the administrator. The policy indicated that the nursing supervisor, charge nurse or department director was to promptly initiate and document the investigation of the accident or incident. The policy indicated that the following data was to be included in the documented investigation report: date and time of the incident, nature of the injury, circumstances surrounding the incident, where the incident took place, names of the witnesses and their accounts of the incident, the condition of the persons involved in the incident, any corrective action taken, follow-up information, other pertinent data as necessary and the signature and title of the person completing the report. The policy indicated that the director of nursing was to ensure that the administrator received a copy of the incident investigation. Interview with the Nursing Home Administrator at 2:30 p.m., on April 13, 2026, confirmed that the Nursing Home Administrator had no documentation of the completed incident investigation that occurred on February 15, 2026. Further interview with the administrator revealed that the former director of nursing took the documented incident investigation. Clinical record review for Resident R1 revealed a nursing progress note dated February 15, 2026, that indicated Resident R1 hit Licensed Nurse, Employee E7, and began punching the roommate Resident R2. Clinical record review for Resident R1 revealed a nursing note dated February 15, 2026, that indicated the Registered nurse, Employee E6, was called to the second-floor nursing unit because Resident R1 was being physically aggressive toward staff and the roommate. The Registered nurse documented that the Licensed nurse proceeded to adjust the air temperature in the residents' room and Resident R1 backed her up against the wall and slapped her face. The Employee E7 reported yelling for help several times. Registered nurse, Employee E6 documented that Resident R1 started punching Resident R2 in the face, in the hallway outside their bedroom. The Registered nurse, Employee E6 said that another nurse helped separate the residents. The progress note indicated that 911 (Emergency Medical Services) was called and Resident R1 was taken into custody. Clinical record review for Resident R1 dated February 15, 2026, indicated that Licensed nurse, Employee E8, documented that Resident R1 was arrested and removed from the facility at 5:49 a.m. There was no documentation available for review that indicated statements were obtained from Employees E6 or E8. There was no documentation available for review that indicated Resident R1, Resident R2 or Resident R3 were asked to give a statement of their accounts of the incident that occurred on February 15, 2026. Interview with the social worker, Employee E9 at 1:45 p.m., on April13, 2026 confirmed that Resident R1, R2 and R3 were roommates on February 15, 2026. Observations of Resident R1 and R3 on April 13, 2026, revealed that they occupy the same bedroom on the second-floor nursing unit. Interview with Resident R3 at 1:30 p.m., on April 13, 2026 revealed that (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R1 controls the air temperature in their room. Resident R1 adjusts the room temperature so hot, at times that it negatively affects his breathing. Resident R3 reported having a diagnosis of asthma. Resident R3 also reported that after the Resident R1 had been aggressive with their former roommate Resident R2, he would think it was unsafe asking Resident R1 to change the air temperature in the room so that it would be comfortable for both of them. Resident R3 had requested to have a room change at 1:30 p.m., on April 13, 2026. Clinical record review revealed a quarterly comprehensive assessment (MDS-an assessment of care needs) dated March 17, 2026, for Resident R3 that indicated this resident had the ability to understand others and was able to make self-understood by verbal expression. Clinical record review revealed a comprehensive quarterly assessment (MDS-an assessment of care needs) dated February 17, 2026, for Resident R2 that indicated this resident had the ability to express ideas, wants and need to staff. The assessment said that Resident R2 was understood and had clear comprehension. Clinical record review for Resident R2 listed diagnoses of Alzheimer's disease and dementia on March 27, 2023. Clinical record review revealed a psychiatric nurse practitioner's progress note dated February 26, 2026, that indicated Resident R1 reported that he got into a fight with his roommate and tried to punch the roommate Resident R2. Resident R1 also reported that the police department came into the facility and arrested him and brought him to the police station. The progress note indicated that the nursing staff confirmed that Resident R1 got into a fight with his roommate and tried to punch Resident R2. Clinical record review revealed a psychiatric nurse practitioner's progress note dated February 26, 2026, that also indicated that Resident R1 was assessed as being linear coherent. The nurse practitioner also said that Resident R1 was oriented to person, place and time. The nurse practitioner assessed Resident R1 as having adequate cognition. The nurse practitioner indicated that Resident R1 had a diagnosis of frontotemporal dementia (a progressive neurodegenerative disease that effects behavior, personality and language abilities). 28 PA. Code 211.12(d)(1)(2)(3)(5) Nursing services28 PA. Code 211.10(d) Resident care policies28 PA. Code 201.14(a) Responsibility of licensee28 PA. Code 201.18(b) (1) Management