STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395852	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cliveden Nursing and Rehabilitation Center	6400 Greene Street Philadelphia, PA 19119

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews and the review of clinical records, it was determined that the facility failed to ensure that a person-centered plan of care was developed for a resident who the facility documented as hoarding items in her room for 1 out of 2 residents reviewed (Resident R1). Findings include: Review of the March 2026 physician orders included the following diagnosis: seizures; anxiety (intense, excessive and persistent worry and fear about everyday situations);chronic obstructive pulmonary disease (COPD-a term used to describe a group of lung diseases that cause airflow blockage and breathing-related problems), and multiple sclerosis (a neurological illness that affects the brain and spinal cord). During an observation in the resident's room on March 6, 2026 at 11:00 a.m. the resident was observed lying in her bed with an abundance of items surrounding her entire room overcrowding both her and her roommate's drawers side by side each other on the left side of the resident's side of the room. The piles on both drawers were reportedly those of Resident R1 despite the items being on both drawers pilled up, leaving her roommate (Resident R2) with no room on top of her drawer. Items of Resident R1 were also observed on the floor area surrounding Resident R1's bedroom area on the heating unit, bedside table, a chair and a bedside dresser on the right side of the resident's bed, all with a number of items piled on top of each other in the room that she shares with another female resident. The items consisted of, but were not limited to stuffed animals, papers and pocketbooks. Piles of items in the resident's room were so compacted, and items that items in-between the piles could not be made out without lifting the piles of items up. During an interview with Resident R1 on March 6, 2026, at 11:00 a.m. Resident R1 reported during this survey that her room was junky because she has had items that have gone missing since she has been at the facility in 2021. During a visit on March 6, 2026, at 1:00 p.m. to Resident R1's room on March 6, 2026 1:00 p.m. with the Director of Nursing (DON) that she shares with her roommate, the condition of Resident R1's side of the room was discussed and observed. During a discussion with the DON on March 6, 2026, at 1:35p.m DON discussed that the resident did have hoarding behaviors. Concerns regarding Resident R2 having to be resident in a room with a description such as the above were also discussed during the above discussion. Review of the resident's current person-centered plan of care plan documents that the resident has hoarding behaviors [name of resident] has a behavior problem of hoarding, and that the goal was for the resident to have no evidence of behavior problem hoarding by the next care plan review date but there were no interventions on the care plan outlined as to how this goal would be achieved in order for the resident to address this care area and assist the resident with the care and services that she may need (e.g behavioral health treatment; assistance with a storage area; prioritizing; assisting resident with going through the items in her room and determine which items should be thrown out, put in storage, etc, involvement of family, friends as support). During an interview with the Director of Nursing on March 6, 2026 at 12:36 p.m. the resident's plan of care for hoarding behaviors having no interventions was reviewed and discussed with the DON. 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.11(d) Resident care plan 28 Pa. Code 211.12(c(1))Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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: 395852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Cliveden Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6400 Greene Street Philadelphia, PA 19119	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations and staff interviews, it was determined that the facility failed to ensure that a resident received showers as scheduled for one of two residents reviewed (Resident R2).Findings include: Review of the facility policy, Activities of Daily Living (ADL's) with a review date of December 2024 indicated that it was the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring that all staff, across all shifts and departments, understands the principles of quality of life, and honor and support these principles for each resident; and that the care and services provided a are person-centered, an honor and support each resident's preferences, choices, values and beliefs. Review of Resident R2's March 2026 physician orders included the diagnoses of seizure disorder; anxiety (intense, excessive and persistent worry and fear about everyday situations); chronic obstructive pulmonary disease (COPD-a term used to describe a group of lung diseases that cause airflow blockage and breathing-related problems), and multiple sclerosis (a neurological illness that affects the brain and spinal cord). Review of the resident's significant change Minimum Data Set Assessment (MDS- periodic assessment of a resident's needs) dated January 21, 2026 documented the resident as awake, alert and oriented. During an interview with Resident R2 on March 6, 2026 at 11:00 a.m. the resident reported that she had not had a shower since May 5, 2025 due to being told that the facility no longer had a bariatric shower bed with a size that was able to accommodate her. The resident reported that she prefers to take a shower on her scheduled shower days, which are on Wednesdays and Saturdays between the hours of 3:00 p.m. through 11:00 p.m. Review of the resident's bathing record from February 5, 2026-March 6, 2026 included documentation that the resident had not had a shower at any time during the specified time period, and was only given bed baths on the days that her showers were scheduled. Review of Resident R2's person-centered plan of care included a plan of care for the resident's adl's (activites of daily living) [resident name] has an ADL self-care performance deficit, with the goal of the resident approving/maintaining her current level of function in adl's. The interventions related to this care area included that the resident prefers showers on Wednesday and Saturday. evening, and that she requires the assistance of 1 person with bathing and showering. During a discussion with the Director of Nursing (DON) on March 6, 2026, at 1:35p.m it was discussed with the DON that the resident's bathing record documented by the resident's assigned nurse aide on the assigned shower days, did not show evidence that the resident was provided with a shower on those designated days. 28 Pa.Code 201.29(j) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services