

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395852	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 06/26/2025
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NAME OF PROVIDER OR SUPPLIER: CLIVEDEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 6400 GREENE STREET PHILADELPHIA, PA 19119
STATE LICENSE NUMBER: 330402	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0921 SS=D	Based on an Abbreviated Survey in response to three complaints completed June 26, 2025, it was determined that Cliveden Nursing and Rehabilitation Center was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0921		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0921 SS=D	Continued from page 1 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 0921	<p>Immediate Corrective Action: Resident were assisted out of the 3rd floor multipurpose room and into the 1st floor lounge area where room temperatures were more comfortable.</p> <p>Housewide corrective actions: All multipurpose rooms were audited to ensure comfortable temperatures were reached. Portable AC units were audited to ensure proper function.</p> <p>Education: Nursing staff were re-educated to ensure residents are frequently offered fluids through summer months.</p> <p>Performance Monitoring: Maintenance Director or designee will complete weekly audits x 8 weeks of all multipurpose rooms and portable AC units to ensure temperatures are at a comfortable and appropriate level and to ensure AC units are functioning properly. Results will be reviewed during the monthly QAPI meeting. QA meeting will determine the need for continued</p>	<p>Completion Date: 08/01/2025 Status: APPROVED Date: 07/10/2025</p>

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F 0921 SS=D	Continued from page 2	F 0921	auditing.	

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F 0921 SS=D	<p>Continued from page 3</p> <p>Based on observations, and staff and resident interviews, it was determined that the facility failed to maintain a comfortable environment for one of three nursing units observed (3rd floor lounge).</p> <p>Findings Include:</p> <p>A tour of the facility was conducted on June 26, 2025, at approximately 10:30 a.m. with Maintenance Director, Employee E3, to monitor the temperatures of the building and resident care areas.</p> <p>Temperatures taken by Maintenance Director, Employee E3, on June 26, 2025, at 11:15 a.m. in the 3rd floor multipurpose room revealed temperatures reached up to 84 degrees. Temperature of the room felt hot, humid, and uncomfortable.</p> <p>Observations on June 26, 2025, at 11:15 a.m. in the 3rd floor multipurpose room revealed about 20 residents were gathered in the room and were being supervised by nurse aide, Employee E4. Interview with nurse aide, Employee E4, revealed these residents required supervision due to fall risks.</p> <p>Nurse aide, Employee E4, was observed to be sitting in a chair amongst the resident's drinking a cold, iced coffee. Further observations revealed 16 residents (Resident R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15,</p>	F 0921		

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F 0921 SS=D	Continued from page 4 R16, R17) were sitting without any kind of beverage. Nurse aide, Employee E4, confirmed the residents did not have water and would get a pitcher of water and ice to begin passing beverages. Further observations on June 26, 2026, at 11:15 a.m. revealed Resident R1 looked uncomfortable with a clammy/sweaty appearance. During an interview with Resident R1 the resident confirmed being uncomfortable due to the warm temperature of the room. Interviews with Resident R2 and R3 reported feeling hot and uncomfortable due to the temperatures of the room. 28 Pa Code: 201.14 (a) Responsibility of licensee.	F 0921		



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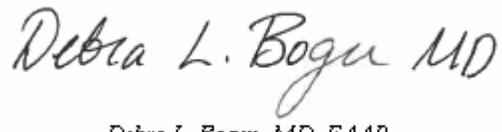
CLIVEDEN NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 330402

SURVEY EXIT DATE: 06/26/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY