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	09/02/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, it was determined that the facility failed to ensure that residents were free from misappropriation of personal property when narcotic medications were stolen/diverted for two of two clinical records reviewed. (Resident R1 and Resident R2).Findings include:A review of the facility's policy titled Abuse (Revised June 1, 2025) defines abuse as: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services necessary to maintain physical, mental, and psychosocial well-being. Continued review of the policy defines misappropriation of resident property as: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Review all facility policy titled Drug Buster dated May 2,2023 revealed only authorized licensed nursing pharmacy personnel should have access to controlled substances maintained on the premises. Before destroying controlled substances, medication must be counted for accuracy and verified by two licensed nurses. Both nurses must sign the disposition of narcotics section of the narcotic record verifying the accurate count and method of disposition. The narcotic record must not be discarded it remains a part of the resident's permanent medical record.Review of facility policy titled Controlled Substance Log Dated April 24, 2023, and last revised August 2025, revealed the facility shall comply with all laws regulations and other requirements related to receiving, handling, storage, disposal, and documentation of Scheduled II and other controlled substances. Follow the index page to perform a complete count of all scheduled II to IV controlled drugs at the change of shifts or at any time in which narcotic keys are surrendered from one licensed nurse staff to another. The count must be performed by two licensed nursing staff per state regulation; the two licensed nursing staff must be those who are relinquishing and accepting the narcotic keys. Both licensed nursing staff participating in the count must confirm the inventory page reflects the quality of drugs present in the container, verify the amount remaining as noted in the amount left column of each inventory page, do not fold pages, one page is full and narcotic completed destroyed highlighted narcotic page and correlating line on the index sheet, both licensed nurses sign the shift count page in the Controlled Substance books to acknowledge the completion of the shift count. Review of facility documentation submitted to the Department of Health revealed that on July 31, 2025, at approximately 2:00 PM, a Licensed nurse, Employee E3 identified a discrepancy involving the medications of Resident R1 and Resident R2. Two medications were reported missing. At the time of discovery, Resident R2 had been discharged from the facility on July 30, 2025, while Resident R1 remained at the facility. According to the nurse's testimony, the overnight nurse administered only one narcotic during her shift. Suboxone (a medication used to treat opioid dependence) was last administered at 6:00 AM and documented both in the narcotic count book and the electronic medication administration record (eMAR). Resident R2's Oxycodone (opioid pain medication) was last administered prior to her discharge on [DATE]. During the shift change, the overnight Licensed nurse, Employee E 4 conducted a medication count with the oncoming 7:00 AM-3:00 PM Licensed nurse, Employee E 3. Both nurses confirmed that the narcotic count was complete and accurate at the time of the 7:30 AM handoff. A review of Resident R1's admission Minimum Data Set (MDS- a mandatory periodic resident assessment tool), dated August 4, 2025, revealed that the resident was admitted to the facility on [DATE] with the diagnoses of Viral Hepatitis (an infection that causes liver inflammation), Rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the bloodstream), and Pulmonary Fibrosis (a chronic lung disease in which damaged and scarred lung tissue makes breathing difficult). Continued review of the clinical record revealed that the resident experienced frequent pain and received anticoagulant therapy. The Brief Interview for Mental Status (BIMS) score was 15, signifying that the resident's cognitive function is intact.Review of Resident R1's physician orders revealed an order dated July 28, 2025, for Buprenorphine HCL-Naloxone (Suboxone) Sublingual film 8-1 was prescribed to give one film sublingually every 8 hours for opioid withdrawal.Review of Resident R1's medication administration record (eMAR) revealed on July 30, 2025 Suboxone was administered at 6:00 a.m. , 2:00 p.m. and 10:00 p.m. and on July 31, 2025, Suboxone was administered at 6:00 a.m. and 10:00 p.m. The medication was not documented as administered at 2:00 p.m. The medication was signed off by Licensed nurse Employee E3, and it was documented that the medication was not available.Review of Resident R2's quarterly Minimum Data Set (MDS- a mandatory periodic resident assessment tool) date May

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, interviews, and record reviews, the facility failed to conduct a thorough investigation into an allegation of drug misappropriation and to protect residents from misappropriation of controlled substances for two of two residents reviewed. (Residents R1 and R2)Findings include:Review of Facility Policy titled Abuse (Revised [DATE]) defines abuse as: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services necessary to maintain physical, mental, and psychosocial well-being.Continued review of the policy defines misappropriation of resident property as: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The facility policy further states that all reports of abuse, neglect, exploitation, and misappropriation must be promptly and thoroughly investigated. When a crime is suspected, staff must preserve evidence and handle materials carefully to avoid compromising any potential criminal investigation. Review of facility documentation submitted to the Department of Health revealed that on [DATE], at approximately 2:00 PM, a licensed nurse Employee E3 identified a discrepancy involving the medications of Resident R1 and Resident R2. Two medications were reported missing. At the time of discovery, Residents R2 had been discharged on [DATE], while the other remained admitted . According to the nurse's testimony, the overnight nurse administered only one narcotic during her shift. Suboxone (a medication used to treat opioid dependence) was last administered at 6:00 AM and documented both in the narcotic count book and the electronic medication administration record (eMAR). Resident R2's Oxycodone (opioid pain medication) was last administered prior to her discharge on [DATE]. During the shift change, the overnight licensed nurse, Employee E4 conducted a medication count with the oncoming 7:00 AM-3:00 PM Licensed nurse Employee E3. Both nurses confirmed that the narcotic count was complete and accurate at the time of the 7:30 AM handoff. Review of Facility's Investigation revealed three staff statements were obtained, a basic audit of all six medication carts was completed, revealing no additional discrepancies. Continued review of facility investigation included, medical provider notified, replacement medications were ordered, and the local police department was notified. However, the investigation lacked critical elements: No Inventory Reconciliation was documented/performed, there were no documented medication counts included, no waste documentation was provided, interviews were conducted with only three employees not all staff who had access to the medication cart, and the exact count and accounting of the missing drugs were not documented, the missing medications (9 Suboxone films and 10 Oxycodone tablets) were only mentioned during interviews and were not documented in the investigation report. Review of Licensed nurse, Employee E5 (Nursing Supervisor) written statement dated [DATE], stated that on [DATE], during the 11 PM-7 AM shift, a resident expired at 5:33 AM. The charge nurse, Employee E4, was instructed to secure the deceased resident's medications. The nurse claimed the only medication present was one full blister pack of Lisinopril, and no discrepancies were reported at that time.Review of Licensed nurse, Employee E3 's written statement dated July31, 2025, reported that she conducted a medication count with the morning nurse and did not recall counting Oxycodone or Suboxone. When this discrepancy was noticed, the Director of Nursing (DON) was immediately notified.Review of Licensed nurse, Employee E4's written statement dated [DATE], indicated proper narcotic counts were conducted at the start and end of shift. The only narcotic administered was one dose of Suboxone at 6:00 AM.Review of employee E 4 Personnel File revealed that the license was verified as current and the criminal background check was marked as pending. Nursing Home Administrator (Employee E1) provided the completed background check only after it was requested by the surveyor.Review of provided medication carts audit revealed the audit documentation included basic charting of dates, locations, insulin vial status, presence of loose pills, and need for follow-up, but did not include any actual narcotic counts.Interview with Director of Nursing, Employee E 2 on [DATE], at 10:20 a.m. revealed that the Investigaton determined that licensed nurse Employee E4 was responsible for the missing medications. This employee is not an employee of the facility but an agency nurse. She has worked at the facility twice. Employee E2 concluded that the nurse manipulated the pages of the narcotic book to indicate an inaccurate about of medication that were counted. This overnight nurse was not charged but noted on a do not return list of the facility. Continued interview with Employee E2 revealed that he conducted a full audit of all medication carts and determined no other