STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident interviews, it was determined that the facility failed to maintain the facility in a clean, comfortable and homelike condition for three of 22 residents reviewed (Resident R1, R55, R56). Findings include: Observations during the initial tour of the facility on January 20, 2026, revealed the following concerns: Observations on January 20, 2026, at 11:45 a.m., in room [ROOM NUMBER] revealed Resident R1 in the bed near the door who had her winter coat on and was under the blankets on her bed. It was very cold in the room. When asked about the temperature in the room, the resident said she was cold and while she liked the room cool, it was way too cold. It was dark in the room and when the PTAC heating unit was looked at there was light from outside shining through a gap in the wall between the heating unit and the wall and the 20 degree wind from outside was blowing through the crack into the room. Observation of the newly admitted resident in the bed near the heating unit revealed that she had only a t-shirt on and a thin blanket pulled up around her neck and she stated that she was freezing. Interview with Employee E7, Maintenance Director, on January 20, 2026, at 12:05 p.m. confirmed that there should not be a gap in the wall, that it was too cold in the room. Observation of his infrared temperature gun revealed temperatures of 49 degrees, 60 degrees and 53 degrees, well below the facilities acceptable range of 71-81 degrees. Interview with the Administrator on January 20, 2026, at 12:10 p.m. confirmed that the temperature in the room was too cold and he stated that the maintenance department was in the process of sealing the wall to get the temperature under control. Observation of his infrared temperature gun revealed temperatures of 57 degrees, 60 degrees and 55 degrees, below the acceptable temperature range. Observations on January 20, 2026, at 12:10 p.m., in room [ROOM NUMBER] revealed that the light above the bed near the door had a broken pull string which was only a few inches long and could not be reached by the resident in the bed and she said that it has been this way for a few days and she was tired of having to wait for staff to turn it on and off. Interview with Resident R1on January 23, 2026, at 10:15 a.m. revealed that she was upset that her ceiling was leaking and the wall beside her bed near the hallway was wet. Observation of this wall revealed it was damp to the touch and that the ceiling tile was also wet, and the ceiling tile out in the hall near this spot was also dark and wet. The resident said that there had also been a leak in the first floor dining room where they wait to go out to smoke. Observation on January 23, 2026, at 11:30 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. in first floor dining room revealed a dark and wet ceiling tile in the first-floor dining room between the hall doorway and the door going outside to the smoking area. These findings were acknowledged by the Administrator during a discussion on January 23, 2026, at 1:15 p.m. 28 Pa. Code 207.2(a) Administrator's responsibility Observation of resident room [ROOM NUMBER] on January 20, 2026, at 10:48 a.m. revealed that the resident room had curtains with stains on it appeared like liquid spill. Resident R56 and Resident R55 who lived in the resident room stated the curtain was dirty for a long time and staff did not clean or change it. Observation of the resident room also revealed that there was a towel placed on top of the air condition unit. Resident R55 and R56 stated there was cold air coming though the panel and the unit were not sealed properly. Observation of resident room [ROOM NUMBER] on January 21, 2026, at 10:46 a.m. revealed that the bathroom door did not close properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 on interviews and the review of clinical records, it was determined that the facility failed to ensure that a complete and through investigation was completed to rule out neglect for 1 out of 22 residents reviewed (Resident R8).Findings include: Review of the facility's policy, Abuse, Neglect, and Exploitation Prevention Policy, with an effective date of April 1, 2025 indicated that in reference to responding and investigating abuse, immediate protective measures are taken, which included ensuring immediate protective measure are taken which may include separating residents involved in the incident; staff documenting the incident factually and notifying leadership; the administrator of designee initiates an investigation and ensures external reporting. The policy also indicated that care plans are also updated to include interventions to prevent recurrences. Review of the January 2026 physician orders for Resident R8 included the following diagnosis: congestive heart failures (CHF-a long-term condition that affects your heart's ability to pump blood well); epilepsy (a brain disorders that causes recurring seizures); schizophrenia (a serious mental health disorder characterized by symptoms that include false beliefs seeing things that are not present, hearing voices, and sounds that are not real, and disorganized thinking, affecting how individuals perceive reality and interact with the world); intellectual abilities (a neurodevelopmental condition characterized by significant limitations in intellectual functioning and adaptive behavior, affecting everyday life skills and learning abilities); cognitive communication deficit (a condition that affects an individual's ability to communicate effectively due to impairments in cognitive processes such as attention, memory, reasoning, and problem-solving); anxiety (intense, excessive and persistent worry and fear about everyday situations), and psychosis (the term for a collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not).Review of a nursing note written by Employee E8 (license nurse) dated July 21, 2025 at 7:20 a.m. documented that a resident took a nurse aide's pocket book and ingested the medication, Zofran (4 milligram tablet), a prescription medication that the nurse aide reportedly had in her pocketbook, in addition to other items: At approximately 0630 at the nursing station, an aide observed that a patient had taken her pocket book. Upon being notified, this nurse conducted a search for the patient and her wheelchair, during which the pocketbook and other personal belongings were found in patient possession, IT was discovered that the patient had ingested medication from the pocketbook, specifically Zofran 4mg. The owner reported that her credit card, $6 in cash and drivers license were not recovered. The authorities were notified, and a report was filed. The supervisor was made aware of the incident DON was contacted. Provider to be called for medication ingestion.During an interview with Employee E8 on January 22, 2026 at 5:05 p.m. licensed nurse nursing note regarding the above referenced incident was reviewed and confirmed by the licensed nurse. Licensed nurse informed her that she was in the medication room when nurse aide (Employee E8) informed her that her pocketbook was missing from the nursing station. Licensed nurse reported that the nurse aide told her that she (nurse aide) knew that the resident took it because she (the resident) was just taking things. Licensed nurse reported that both she and the nurse aide found the resident in the dining room or her bed room and when the pocketbook was retrieved from the resident, the nurse aide reported that her keys,money and her Zofran were all missing. Licensed nurse reported that the nurse aide indicated that she was prescribed Zofran for nausea. Licensed nurse reported that the empty blister packs from the Zofran prescription were found in the trash can in the resident's room. Licensed nurse reported that the resident denied taking the nurse aide's pocket book, money, keys and medication when she was asked. Licensed nurse reported that while in the residents room, the resident opened her mouth and stated to both she and the nurse aide, Mommy look, but did not have anything in her mouth when they looked. Licensed nurse reported that she contacted the police because the nurse aide's money and keys had not been found. During an interview with the Nursing Home Administrator on January 22, 2026 at 9:51 a.m. the NHA confirmed that there was not documentation to show evidence that an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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	investigation was completed to rule out neglect of an allegation that the resident ingested Zofran due to a nurse aide leaving her pocketbook unattended at the nursing station.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy and interview with residents, it was determined that the facility failed to develop a person-centered resident care plan for one of twenty-two residents reviewed (Resident R77) Findings Include: Review of facility policy on care plans comprehensive persons-centered dated December 2016 Under section policy statement a comprehensive present-centered care plan that includes measurable goals and timetables must meet the residents physical psychological and functional needs is developed and implemented for each resident. Under section policy interpretation and implementation number one the interdisciplinary team in conjunction with a resident and his or her family or legal representative develops and implements a comprehensive person centered care plan for each resident #9 areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan #12 the comprehensive person centered care plan is developed within seven days of the completion of the required comprehensive assessment MDS (minimum data set, a federally required resident assessment completed at a specific interval) #13 assessments of residents are ongoing and care plans revised as information about the resident and the residents condition change #14 the interior disciplinary team must review and update the care plan at least quarterly in conjunction with a required quarterly MDS assessment. Review of resident R77 clinical record revealed that resident R77 was admitted to the facility on [DATE], with diagnoses of diagnosis of but not limited to Type 2 Diabetes Miletus, Dry Eyes Syndrome of Bilateral Lacrimal Glands. Review of Resident R77's MDS dated [DATE], section B1000 (Vision) revealed that Resident R77 was visually impaired; Section C - Cognitive Patterns, C0500. BIMS Summary Score (brief interview for mental status) was coded 15 suggesting that Resident R77 was cognitively intact. Further review of Resident R77's clinical record revealed that there was no care plan developed to address resident R77's visual impairment. Interview with resident R77 conducted on January 20, 2026, at 1:37PM revealed that he cannot see. 28 Pa. Code 211.11(a) Resident care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Based on interviews, and reviews of clinical records, facility documentation and employee records, the facility failed to ensure that staff assigned to supervise residents during dining and provided cardio-pulmonary resuscitation (CPR) to a resident who was choking were certified in cardio-pulmonary resuscitation (CPR). One of 22 residents reviewed. Findings Include:Review of facility policy Cardiopulmonary Resuscitation (CPR) dated 2025, revealed that Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. Obtain and/or maintain American Red ' Cross or American Heart Association certification in Basic Life Support (BLS)/ Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts.Review of facility policy Meal Supervision Policy dated January 2025, revealed that This policy applies to all nursing staff, healthcare assistants, dietary aids and any designated personnel involved in supervision of patient meals. All patients who require meal supervision will be supported According to. Individualized care plans promote safety, nutritional adequacy, and dignity during meals. Nursing staff are responsible for ensuring appropriate supervision is provided based on clinical risk assessments. Mealtime Supervision Protocol.Ensure a calm, respectful, and safe dining environment.Confirm the correct tray/Diet is delivered as per the diet order.Monitor for signs of aspiration or choking.Offer verbal cues or physical assistance if needed.Limit distractions or stressorsEncourage independence while maintaining safety.Do not leave high-risk patients unsupervised while eating or drinking. Review of facility document Dining Room Supervision standard revealed that Supervision Guidelines: High-risk residents (e.g., on thickened liquids or pureed diets) must have direct observation throughout their meal. CNAs and floor staff must remain alert and within close proximity. Never walk away from a resident mid-meal if they require supervision. Ensure proper seating posture (upright, 90-degree angle). Minimize distractions; no talking with residents while chewing/swallowing. Assist only one resident at a time during feeding to ensure safety and focus. Signs of Distress During Meals: Coughing or throat clearing Pocketing food in the cheeks Wet or gurgled voice Shortness of breath Sudden change in color or alertnessif any of these are observed, STOP feeding immediately and notify the nurse.Review of facility investigation dated May 20, 2025 revealed that Nurse Aide, Employee E12 provided Resident R114 with his lunch tray in the main dining room. Employee E13, Nurse Aide, also in the dining room, observed Resident R114 sitting with his tray and started coughing and his hands up by his chest. Resident R114 was sitting upright in chair. Employee E12 immediately administered back blows and started the Heimlich maneuver(clears airway obstructions by applying sharp, upward pressure above the navel to force out lodged objects) while calling for Assistance. Two nurses immediately came over and administered CPR which included Heimlich maneuver. Further review of the facility investigation revealed that Employee E12 and Employee E13 were the only two staff available at the nurse's station. Review of personal file for Employee E12 and Employee E13 revealed that both employees did not possess a valid CPR certification at the time of the incident. Review of personal file for Employee E12 revealed that the employee completed an online CPR certification, (not AHA or American Red Cross) the day of the incident.Interview with the Director of Nursing on January 22, 2026, at 2:00 p.m. revealed that the employee realized that the CPR certification was expired after providing CPR to Resident R114 and took the online certification after the incident. Interview with the Unit Manager, Employee E11 on January 22, 2026, at 1:00 p.m. stated there should at least a nurse in the dining room where residents who were at risk for aspiration or on aspiration precaution eat to supervise.Interview with the Administrator and Director of Nursing on January 23, 2026, at 12 p.m., confirmed that both employees who were assisting in the dining room did not possess a valid CPR certification at the time of the incident and the nurses were present in the dining room. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.18(e)(1) Management28 Pa. Code (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	211.10(d) Resident care policies28 Pa. Code 211.12(d)(1) Nursing services28 Pa. Code 211.12(d)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical record review and interviews with staff, it was determined that the facility failed to follow the physician orders related to Medication Administration for one of 23 residents reviewed (Resident R53) Review facility policy on administering medications dated December 2012 reveal that under section policy statement medication shall be administered in a safe and timely manner and as prescribed. under section policy interpretation and implementation #2 the director of nursing services will supervise and direct all nursing personnel who administer medications and or have related functions #3 medications must be administered in accordance with the orders including any required time frame #4 medications must be administered within one hour of their prescribed time unless otherwise specified for example before and after meal orders #7 the individual administering the medication must check the label three times to verify the right resident the right medication the right dose the right time and right method.Review of Resident R53's clinical record revealed that Resident R53 was admitted to the facility on [DATE], with diagnosis of but not limited to Hypokalemia (low potassium level in the blood), Hypertension, Congestive Heart Failure (co0ndition where the heart pumps inefficiently)Review of Resident R53's physician's orders revealed an order for the following medications: Potassium Chloride (KCl) ER tablet Extended Release 20 MEQ Give 2 tabs by mouth two times a day, Toprol XL oral tablet extended release 24-hour 50 mg, give 1 tab by mouth one time a day for HTN (hypertension) to be given with meals, Metformin hydrochloride oral tablet 500 milligrams give one tablet by mouth in the morning for diabetes take with breakfast, Lasix oral tablet 40mg give one tablet by mouth one time a day every Monday, Tuesday, Wednesday, Thursday, Saturday for CHF (congestive heart failure), Eliquis tablet 5MG give one tablet by mouse two times a day for DVT (deep vein thrombosis), Diltiazem Hydrochloride oral tablet 30MG give one tablet by mouth one time a day for A-fib (At fibrillation), Gabapentin 100mg give one capsule by mouth two times a day for a neuropathy, Alopurinol Oral tablet 100kg give one tablet by mouth one tab a day for gout.Review Resident R53's quarterly MDS (minimum data set, a federally required resident assessment completed at a specific interval) dated November 14, 2025, revealed that section C Cognitive Patterns, C0500. BIMS Summary Score revealed that resident R53 was coded 15 suggesting that Resident R53 was cognitively intact.Review of Resident R53's Medication Administration Audit Report revealed the following: Potassium Chloride (KCl) ER tablet Extended Release 20 MEQ Give 2 tabs by mouth two times a day which was scheduled to be administered on December 6, 2025, at 9:00AM was administered on December 6, 2026, at 4:05PMToprol XL oral tablet extended release 24-hour 50 mg, give 1 tab by mouth one time a day for HTN (hypertension) to be given with meals which was scheduled to be administered on December 6, 2025, at 9:00 AM was administered on December 6, 2025, at 4:05PM.Metformin hydrochloride oral tablet 500 milligrams give one tablet by mouth in the morning for diabetes take with breakfast, which was scheduled to be administered on December 6th, 2025, at 9:00 AM was administered on December 6, 2025, at 4:05 PMLasix oral tablet 40mg give one tablet by mouth one time a day every Monday, Tuesday, Wednesday, Thursday, Saturday for CHF (congestive heart failure) which was scheduled to be administered on December 6, 2025, at 9:00 AM was administered on December 6, 2025, at 04:08 PM.Eliquis tablet 5MG give one tablet by mouth two times a day for DVT (deep vein thrombosis) which was scheduled to be administered on December 6, 2025, at 9:00 AM was administered on December 6, 2025, at 4:08PMDiltiazem Hydrochloride oral tablet 30MG give one tablet by mouth one time a day for A-fib (At fibrillation) which was scheduled to be administered on December 6, 2025, at 9:00 AM was administered on December 6, 2025, at 4:08PMGabapentin 100mg give one capsule by mouth two times a day for a neuropathy which was scheduled to be administered on December 6, 2025, at 9:00 AM was administered on December 6, 2025, at 4:08PM.Alopurinol Oral tablet 100kg give one tablet by mouth one tab a day for gout which was scheduled to be administered on December 6, 2025, at 9:00 AM was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered on December 6th, 2025, at 4:08 PMInterview with Resident R53 conducted on January 20, 2026, at 1:15PM revealed that the nurses give him his medications very late.Interview with licensed nurse Employee E2 confirmed that medications that were scheduled to be administered on December 6, 2025, at 9:00AM were documented as administered after 4:00 PM on December 6, 2025. 28 Pa. Code 211.10(a) Medication administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on the review of clinical records, it interviews with staff, it was determined that the facility failed to prevent accident hazards for 1 out of 22 residents reviewed (Resident R8). Findings include:Review of the January 2026 physician orders for Resident R8 included the following diagnosis: congestive heart failures (CHF-a long-term condition that affects your heart's ability to pump blood well); epilepsy (a brain disorders that causes recurring seizures); schizophrenia (a serious mental health disorder characterized by symptoms that include false beliefs seeing things that are not present, hearing voices, and sounds that are not real, and disorganized thinking, affecting how individuals perceive reality and interact with the world); intellectual abilities (a neurodevelopmental condition characterized by significant limitations in intellectual functioning and adaptive behavior, affecting everyday life skills and learning abilities); cognitive communication deficit (a condition that affects an individual's ability to communicate effectively due to impairments in cognitive processes such as attention, memory, reasoning, and problem-solving); anxiety (intense, excessive and persistent worry and fear about everyday situations), and psychosis (the term for a collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not).Review of a nursing note written by Employee E8 (license nurse) dated July 21, 2025 at 7:20 a.m. documented that the resident took a nurse aide's pocketbook and ingested the medication, Zofran (4 milligram tablet), a prescription medication that the nurse aide reportedly had in her pocketbook, in addition to other items: At approximately 0630 at the nursing station, an aide observed that a patient had taken her pocketbook. Upon being notified, this nurse conducted a search for the patient and her wheelchair, during which the pocketbook and other personal belongings were found in patient possession, IT was discovered that the patient had ingested medication from the pocketbook, specifically Zofran 4mg. The owner reported that her credit card, $6 in cash and driver's license were not recovered. The authorities were notified, and a report was filed. The supervisor was made aware of the incident DON was contacted. Provider to be called for medication ingestion.During an interview with Employee E8 on January 22, 2026 at 5:05 p.m. licensed nurse nursing note regarding the above referenced incident was reviewed and confirmed by the licensed nurse. Licensed nurse informed her that she was in the medication room when nurse aide (Employee E8) informed her that her pocketbook was missing from the nursing station. Licensed nurse reported that the nurse aide told her that she (nurse aide) knew that the resident took it because she (the resident) was just taking things. Licensed nurse reported that both she and the nurse aide found the resident in the dining room or her bedroom and when the pocketbook was retrieved from the resident, the nurse aide reported that her keys, money and her Zofran were all missing. Licensed nurse reported that the nurse aide indicated that she was prescribed Zofran for nausea. Licensed nurse reported that the empty blister packs from the Zofran prescription were found in the trash can in the resident's room. Licensed nurse reported that the resident denied taking the nurse aide's pocketbook, money, keys and medication when she was asked. Licensed nurse reported that while in the residents room, the resident opened her mouth and stated to both she and the nurse aide, Mommy look, but did not have anything in her mouth when they looked. Licensed nurse reported that she contacted the police because the nurse aide's money and keys had not been found. During an interview with the Nursing Home Administrator on January 22, 2026 at 9:51 a.m. the NHA confirmed that it is expected that nursing staff personal belongings are kept in the employee break room in the basement and not at the nursing station.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interviews and the review of facility documentation, it was determined that the facility failed to ensure that a resident's significant weight loss was addressed in a timely manner for 1 out of 22 residents reviewed (Resident R6).Findings include:Review of the facility policy, Weight Assessment and Intervention, with a revision date of March 2022 indicated that any weight change of 5% or more since the last weight assessment is taken is retaken the next day for confirmation. Review of the resident's January 2026 physician orders included the following diagnosis: hypertension (high blood pressure); cerebral infarction (a stroke); chronic kidney disease (when the kidneys have become damaged over a specific period of time and have a hard time doing all their important jobs).Review of a monthly weight in the resident's clinical record dated May 3, 2025 documented the resident's weight at 138 pounds. Review of a monthly weight dated June 6, 2025 documented the resident's weight as 129 pounds, which is -9 pounds weight loss and a significant weight loss of -6.5%. Continued review of a clinical record did not show that a re-weight was taken for the significant weight loss from May 2026 through June 2026 to ensure that any interventions related to the resident's weight loss, if needed, can be identified and implemented in a timely manner. Review of a note written by a dietician on June 11, 2025 at 7:50 a.m. indicated that a weight loss for the resident was noted and that she was waiting on a reweight. Weight loss noted. Reweigh requested.Continued review of the resident's clinical record did not show evidence that a re-weight was completed in a timely manner to verify the actual weight loss, and to ensure that any services and interventions were in implemented, if needed, were in implemented in a timely manner.Review of a note written by the dietician (Employee E10) on June 25, 2025 at 12:33 p.m. indicated that the dietician was still awaiting the re-weight. The dietician also recommended an increase in house shakes until an accurate weight is determined. During an interview with the dietician (Employee E10) on January 23, 2026 at 10:40 a.m. it was reviewed and confirmed with the dietician during this time that the resident sustained at a -6.5 significant weight loss. The dietician's notes regarding the request and need for a reweight was also reviewed (June 11 and June 25 note). It was also discussed with the dietician that there was no documentation that a re-weight was completed on the resident to verify the weight loss and that the next weight recorded in the clinical record was recorded on July 1, 2025, which was 25 days after a significant weight loss was recorded by facility staff. The dietician also reported during the interview that the facility did not have a standard time frame for obtaining re-weights for residents who show a possible significant weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, resident and staff interviews, it was determined that the facility failed to offer routine dental services for one of 22 residents reviewed (Resident R74).Findings include: Review of the clinical record for Resident R74 revealed that the resident was admitted to the facility on [DATE], and the resident was a long-term care resident. The payment source for resident's stay was listed as Medicaid/Medicaid plans. Review of Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 74, dated December 10, 2025, revealed that the resident was cognitively intact. Review of Pennsylvania Medical Assistance Dental Coverage for Adults revealed that an adult can receive exams, x-rays, and cleanings once every 6 months.An interview with Resident R74 on January 20, 2026, at 2:01 p.m. stated he did not see dentist since she was admitted to the facility in March of 2025. He said he was having tooth pain, and he needed his tooth extracted. Review of clinical records revealed no documented evidence that Resident 74 had seen a dentist or was scheduled for an appointment to see the dentist since his admission to the facility in March of 2025 till January 2026.Interview with the Unit Manager, Employee E11 on January 23, 2026, at 11:20 a.m. confirmed that Resident R74 had not seen a dentist or had a consult with a dentist since his admission. Employee Said there was no documented evidence that the resident refused the appointment/consult. Employee stated there is an appointment scheduled after he reported tooth pain but no routine dental exams/visits were scheduled. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing Services 28 Pa. Code 211.15(a) Dental Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395354	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Stream Nursing and Rehabilitation Center	905 Penllyn Pike Spring House, PA 19477

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and an interview with staff it was determined that the facility did not ensure that garbage and refuse was disposed of properly. Findings include:An initial tour of the Food Service Department was conducted on January 20, 2026, at 10:15 a.m. with Employee E5, Food Service Director (FSD), which revealed the following:Observation in the receiving area revealed a green dumpster with equipment piled behind it including a hospital style bedframe on the ground partially covered in snow, a stainless-steel counter height ice machine and a wheelchair with six leg rests piled on top of the armrests.Interview with the FSD at 9:30 a.m. on January 20, 2026, confirmed the above findings, and that the ice machine was no longer working. Interview with the Administrator on January 21, 2026, at 11:30 a.m. confirmed that the equipment did not belong in the receiving area and that it had been moved. 28 PA Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(3) Management