STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395354	A. BLDG: 00 B. WING:	12/12/2024

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F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, Civil Rights Compliance Survey, State Licensure Survey on December 12, 2024, it was determined that Silver Stream Nursing and Rehabilitation Center was not in compliance with the 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 0000		
F 0568 SS=D		F 0568		

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 0568 SS=D	Continued from page 1 483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by:	F 0568	The facility provided resident R28 a reimbursement for the $300 charge that resident R28 stated was not paid out to her, and facility was unable to locate a withdrawal receipt for. A receipt was signed by resident R28 and a copy provided to her. LNHA has completed an audit of all residents who have a facility account established, reviewing statements and withdrawal receipts from January 2024 through November 2024 and will complete a December 2024 audit. The facility will monitor residents' money requests by having the Business Office Manager withdraw the requested money and provide a receipt to be signed by the resident, confirming the resident has received the money. LNHA will educate the Business Office Manager on the process for categorizing resident money withdrawals. The Business Office Manager will maintain organized records of all resident withdrawal receipts. LNHA / designee will audit resident	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0568 SS=D	Continued from page 2	F 0568	funds withdrawal receipts monthly x3 months. LNHA / designee will audit resident statements quarterly x4 quarters Findings will be reported to the QAPI meeting.	

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F 0568 SS=D	Continued from page 3 Based on review of facility financial and accounting documentation and interview with administrative staff, it was determined that the facility failed to demonstrate the maintenance of a complete, separate, and accurate accounting of each residents personal funds entrusted to the facility on the residence behalf for one of 24 residents reviewed (resident R28). Findings include: Review of facility policy Titled "Personal Funds" revealed If the facility has been designated to handle the personal funds of the resident, the business office will maintain a full complete and separate accounting according to generally accepted accounting principles of each resident's personal fund entrusted to the facility. A copy of the quarterly statement will be submitted to the resident, or the residents designated representative on a quarterly basis and or at the request of the designated representative or resident. Review of information submitted to the Department revealed that On October 21, 2024, nursing home administrator employee E1 became aware that resident R28 alleged that there were inaccuracies	F 0568		

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F 0568 SS=D	Continued from page 4 with her most recent quarterly statement including charges she did not recognize. Continued review of this event revealed that resident R28 had questions about her statement and the director of nursing, employee E2, presented a withdrawal receipt to resident R28 of funds received with Residents R28's signature. The NHA, employee E1, interviewed the previous business office manager who stated that resident R28 withdrew sums of 100 dollars 200 dollars and 300 dollars. The NHA employee E1 determined that resident R28 had inconsistencies with the relaying information of use of the funds and the facility was unable to substantiate the residence funds have been misappropriated. Interview with resident R28 on December 09, 2024, at 09:55 a.m. revealed that she had concerns regarding her financial statement. Resident R28 stated she never withdrew any money other than the allotted $45 dollar allowance monthly. This resident was given her monthly statements and did not recognize the withdraws of money. Interview with Business office manager E4 on December 11, 2024, at 3:45 pm, revealed that is it the facility's protocol of when a resident requests money,	F 0568		

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F 0568 SS=D	Continued from page 5 the business director will withdraw the requested amount of money and provide a receipt to be signed by the resident confirming that they have received the money. This employee stated that there is a scheduled banking day once a month for residents to requests funds, if any resident should request funds other than on the banking day, they are to contact employee E4 and requests a transaction, the resident will then sign a statement that they are withdrawing from their account and the resident is then given the funds and a receipt. Continued interview with business officer manager employee E4 on December 12, 2024, at 10:00 a.m. revealed that she recently started the position of business office manager and has no knowledge of the above event. Employee E4 was unable to locate any copies of receipts of money paid out to resident R28. Interview with Nursing home administrator employee 1 on December 12, 2024 at 3:10 p.m. revealed there were only two dates of question regarding withdraw funds on resident R28 statement. The facility was unable to locate one of the receipts therefore reimbursing the resident for the money total of $300.	F 0568		

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F 0568 SS=D	Continued from page 6 28 pa code 201.18(e)(1) management	F 0568		
F 0600 SS=D		F 0600		

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F 0600 SS=D	Continued from page 7 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	The facility immediately educated employee E18 on abuse and suspended E18 pending investigation. LNHA opened event report 1055382. The facility immediately began the investigation by obtaining statements from resident R28, E18 and witnesses. The facility provided Psych services to resident R28. The facility has conducted an abuse training in-service with all staff. The facility will review abuse reporting with residents at Resident Council. The facility will conduct a random sample of 5 residents checking for resident's safety and comfort with staff. The facility will monitor employee training on abuse prevention upon hire and at least yearly thereafter or as needed. The facility will verify that information on how to report abuse is located on resident/visitor areas. The facility will monitor that grievance forms are available on the units for residents to file	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0600 SS=D	Continued from page 8	F 0600	complaints/make reports. The facility will review and remind residents of the types of abuse and how to report abuse at least every quarter at resident council meetings. Nurse Educator / designee will audit all current staff and new staff's education files for abuse prevention training upon hire and at least yearly, monthly x3 months Director of Social Services / designee will surveil that advocacy posters and grievances are highly visible in resident/visitor areas weekly x4 weeks then monthly x3 months Recreation Director / designee will monitor resident council meeting topics and audit resident council meeting minutes to include abuse prevention information to residents monthly x3 months Findings will be reported to the QAPI committee.	

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F 0600 SS=D	Continued from page 9 Based on observations, interviews with resident and staff, review of clinical records, and facility policy, it was determined that the facility failed to ensure one of 24 residents records reviewed were free from abuse/neglect (Residents 25). Findings include Review of the facility's employee abuse education received from the Nursing Homme Administrator defines abuse as the willful infliction of injury, unreasonable confinement intimidation or punishment with resulting physical harm, pain or mental anguish. The documentation defines types of abuse and explains Mental/Emotion abuse, verbal or nonverbal acts which causes humiliation, shame, degradation, intimidation, fear and agitation. Review of the same documentation states verbal abuse is a type of mental abuse that can be oral, written, gestured language or sounds. It can be directed at or within hearing distance of the resident. Examples included: Harassment, mocking, yelling, intimation, talking disrespectfully and scolding.	F 0600		

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F 0600 SS=D	Continued from page 10 Review of clinical records revealed Resident R25's last admission to the facility was on October 17, 2023, diagnosed with acute and chronic respiratory failure with hypoxia (lacking oxygen), chronic obstructive pulmonary disease (restricted airflow), shortness of breath, and ordered continuous oxygen therapy 3 liters a minute via nasal canula requiring the tubing to be changed weekly or as needed. Resident R25 was also diagnosed with mental health illnesses that included anxiety disorder, major depressive disorder, severe with psychotic symptoms, and dissociative fugue (a loss of memory and identity) On December 9, 2024, at approximately 11:00 a.m. surveyor observed Resident R25's care nurse Licensed Practical Nurse (LPN) Employee E18 remove the resident's spare oxygen cannula from his room. The LPN began to yell at Resident R25 from the nurses' station to the resident that was standing near his doorway, seen with oxygen in use and tubing near the length of his room. Nurse yells,	F 0600		

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F 0600 SS=D	Continued from page 11 "Stop it! Just stop! You know I take great care of you, stop being manipulative!" Resident R25 appeared upset that he no longer had his spare oxygen tubing. Still standing in the doorway, the resident's voice quivered as he says to the nurse, "It's mine, I need it to walk, it's mine and you took it" The LPN's sternly yells at the resident, "No! Just stop! You have a tube in your nose!" The resident looked anxious as he paces his doorway and again said, "I need it for when I walk." The nurse appears to lose her patience, raises her voice, and continues to yell at the resident. "No! No means no! Just stop! You will get one when you walk! Stop! You're not walking anywhere right now. Stop. Just stop!" The LPN informs the surveyors that Resident R25 has anxiety and behaviors and needs to be frequently redirected. The resident is now requesting cold water, LPN E18 tells the resident to, "Wait. Everyone's about to get water, being anxious isn't going to make them	F 0600		

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F 0600 SS=D	Continued from page 12 move faster." During this time Resident R25 was interviewed and stated the night nurse gave him an extra tubing. "Look at this!" Wanting the surveyor to look closely at his nasal canula/tubing, "What happens if it breaks at night" the resident asked, implying he would not have any oxygen to breathe. The resident further said that Employee E18, was not nice, "She opened the drawer and took it (oxygen tubing) That was mine." Review of Resident R25's is care planned for unwanted behaviors included compulsiveness and anxiety. Intervention included anticipating and meeting the resident's needs and that the caregivers are to provide opportunities for positive interactions and attention dated May 2, 2023. Resident R25 was care planned for impaired thought processing related to his respiratory issues. Interventions include asking yes/no questions to determine the residents needs, dated August 10, 2022. Continue review of the resident's care plan revealed the	F 0600		

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F 0600 SS=D	Continued from page 13 resident was on continuous oxygen and that the resident requests using a long oxygen tubing to walk in his room and hallway. Review of psychological Services notes from the Licensed Clinical Social Worker (LCSW) dated October 8, 2024, noted symptoms of helplessness irritable and anxiety. Behavior challenges included attention seeking (Complaintive/Demanding), and uncontrolled anxiety . The LCSW stated significant developments since last session, session gains, additional recommendations, comments in the notes. "The resident appeared irritable, and anxious" and called the therapist in his room, he was not happy with his meal choice and insisted the counselor get him a sandwich. Resident R25 became "Increasingly anxious and demanding." The same note indicated that "Nursing said, 'he would hide his sandwich for later' and stated in her notes that that is not allowed for several reasons. "The goal is to decrease anxiety and manage mental health symptoms, more appropriately within the facility and decrease impulsivity.	F 0600		

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F 0600 SS=D	Continued from page 14 Psychological services note from LCSW dated October 24, 2024, notes, "Therapist empathized with client and offered ways to manage mental health symptoms when they come on. .... Client's mood seemed to improve by the end of the session ... Resident's and counselor's goal is to decrease depressive/anxious symptoms and increase mental and emotional functioning. On December 9, 2024, at approximately 12:00 p.m. Nursing Home Administrator (NHA) was informed of the incident surveyors witnessed indicating the nurse appeared to have escalated Resident R25's anxiety . The NHA determined the nurse did not have the authority to take the tubing out of his drawer without asking and Resident R25 was allowed to have an extra set of tubing in his drawer as long as it was unopened. After, the nurse, Employee E18 was reeducated for Abuse Training. 28 Pa. Code 201.18(b)(e)(1) Management.	F 0600		

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F 0600 SS=D	Continued from page 15 28 Pa. Code 201.29(a)(j) Resident Rights.	F 0600		
F 0660 SS=D	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the	F 0660	The facility has assessed and documented residents R11, R34 and R46 for placement and/or discharge goals. The facility will complete an audit of residents with a quarterly/annual review in the last 30 days to appropriately identify placement and/or discharge goals. The facility will monitor all residents' documentation and care plans identifying appropriate placement and/or discharge goal in the resident's health record and review at least quarterly at each care conference with the resident and/or resident representative. Social Worker / designee will complete a documentation and care plan audit for 8 residents, weekly x3 months Findings will be reported to the QAPI committee.	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0660 SS=D	Continued from page 16 development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the	F 0660		

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F 0660 SS=D	Continued from page 17 resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by:	F 0660		

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F 0660 SS=D	Continued from page 18 Based on interviews with residents and staff, clinical record and and policy and procedure reviews, it was determined that the facility failed to evaluate each resident for their discharge needs upon admission and throughout the resident's stay to ensure a successful individualized discharge plan was implemented for three of seven residents reviewed. (Residents R11, R34 and R46) Findings include: A review of the facility's policy and procedure titled "Discharge Summary and Plan" dated December, 2016 revealed that all residents would have a discharge plan developed to assist the resident to adjust to his/her living environment. The policy also indicated that every resident was to receive evaluation by the interdisciplinary care team to develop a plan for discharge to the community or to another facility with the resident and their	F 0660		

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F 0660 SS=D	Continued from page 19 family member. The policy indicated that each resident and representative would be asked about their interest in returning to the community or other plans for transferring to another skilled nursing facility, home health agency, long term care hospital or inpatient rehabilitation facility. The policy indicated that the facility staff was responsible for referring the resident to local agencies and support services to accommodate the resident's post discharge preferences. Clinical record review for Resident R11 revealed a quarterly comprehensive assessment MDS(an assessment of care needs dated October 18, 2024 that indicated that this resident was cognitively intact and able to express his needs to staff. Clinical record review for Resident R34 revealed a quarterly comprehensive assessment MDS (an assessment of care	F 0660		

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F 0660 SS=D	Continued from page 20 needs) dated November 6, 2024 that indicated that this resident was cognitively intact and capable of letting staff know his needs. Clinical record review for Resident R46 revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 23, 2024 that indicated that this resident was alert, oriented and cognitively intact expressing her needs to staff. Interviews with Residents R11, R34 and R46 throughout the days of the survey December 9, 10, 11 and 12, 2024 revealed that these residents were interested in a discharge plan to the community. Clinical record review for residents R11, R34 and R46 revealed lack of development of goals and implementation of an	F 0660		

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F 0660 SS=D	Continued from page 21 interdisciplinary discharge care plan for these residents. Clinical record review for Resident R46 revealed a social service progress note dated May 2, 2023 to indicate that this resident desired discharge plans to the community with her cousin. There was no further documentation related any discharge plans as Resident R46 preferred. Clinical record review revealed that on June 5, 2024 Resident R46 was physically aggressive with Resident R81. Residents R46 and R81 were observed physically pulling hair, scratching and punching each other. The follow-up to this abusive incident was to seek a transfer to another facility in the community, for Resident R46. The other facility was an adult group home, specializing in the care of behavioral wellness for Resident R46. There was no documented	F 0660		

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F 0660 SS=D	Continued from page 22 update for this discharge plan for Resident R46. Clinical record review revealed that Resident R46 had diagnoses of major depressive disorder, anxiety disorder, post traumatic stress disorder and schizo-affective disorder. Clinical record review for Resident R34 revealed that this resident was admitted to the facility on December 16, 2021. There was no discharge care plan established for the resident upon admission and updated throughout the resident's stay, despite the resident's preference to return to the community and closer to his family who live in Delaware and Northeastern Philadelphia. Clinical record review for Resident R11 revealed that this resident was requesting a transfer to another nursing home closer to his brother. The resident had made a statement on May 29, 2024 that he wanted to	F 0660		

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F 0660 SS=D	Continued from page 23 leave the facility against medical advice. There was no documentation to indicate that the social worker had assisted this resident with discharge planning after it was documented on August 9, 2024 that the resident wanted to discharge to another nursing home that had no available beds. Interview with Resident R11 at 11:30 a.m., on December 9, 2024 revealed that this resident was fearful that Resident R41 would punch him. Resident R11 said that Resident R41 passes by his room and gives him a look as to not come near him. Interview with Resident R41 at 2:30 p.m., on December 11, 2024 confirmed that if Resident R11 hand gestures negatively toward him or spits on him that he may punch him. Resident R41 also said that he and resident R11 had a confrontation with spitting and slapping in March, 2024 where the nursing staff changed rooms for resident R11 to room 227.	F 0660		

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F 0660 SS=D	Continued from page 24 Clinical record review for resident R41 revealed a comprehensive assessment MDS (an assessment of care needs) dated November 14, 2024 that indicated that resident was alert and cognitively intact. Interview with the director of nursing, Employee E2 and social work staff, Employee E17, at 3:00 p.m., on December 12, 2024 confirmed the lack of interdisciplinary care planning for discharge to the community or transfers to another facility for continuum of healthcare and safe environment, as preferred by Residents R11, R34 and R46. 28 PA. Code 211.12(d)(1)(2)(3)(5) Nursing services 28 PA. Code 211.10(a)(b)(c)(d) Resident care polies	F 0660		

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F 0660 SS=D	Continued from page 25 28 PA. Code 211.5(f)(ii)(iii)(ix)(xi) Medical records	F 0660		
F 0676 SS=D		F 0676		

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F 0676 SS=D	Continued from page 26 483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 0676	The facility immediately made available to resident R34 a reclining manual wheelchair. The facility has re-educated nursing staff on safe mechanical lift and transfers. The facility will compile a list of residents that need assistance with mobility (transfer and ambulation) and complete an audit to identify that the respective residents have the appropriate, safe and comfortable adaptive equipment for mobility. The facility will monitor residents that need assistance with mobility (transfer and ambulation) to review that resident's adaptive mobility equipment remains appropriate at least quarterly at each care conference or as needed. The facility will monitor nursing staff training and competency on safe mechanical lift and transfers upon hire and at least yearly thereafter, or as needed. Director of Rehabilitative Therapy / designee will audit residents' adaptive mobility	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0676 SS=D	Continued from page 27 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 0676	equipment for each scheduled resident's quarterly / annual review, semi-weekly x3 months Nurse Educator / designee will audit all current nursing staff and new nursing staff's education files for safe mechanical lift and transfers training and competency, monthly x3 months Findings will be reported to the QAPI committee.	

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F 0676 SS=D	Continued from page 28 Based on clinical record reviews, interviews with residents and staff, observations of care and services and policy and procedure reviews, it was determined that for one of three residents reviewed the facility failed to provide safe and comfortable adaptive equipment to ensure activities of daily living were maintained for mobility. (Resident R34) Findings include: A review of the policy titled Activities of Daily Living, Supporting dated March of 2018 revealed that the facility was responsible for providing care, services and treatment to maintain or improve a residents' ability to carry out activities of daily living (hygiene, mobility, elimination, dining or communication). This policy indicated that the care and services was to be provided for residents who were unable to carry out ADL's independently. Clinical record review for Resident R34 revealed a quarterly comprehensive assessment dated	F 0676		

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F 0676 SS=D	Continued from page 29 November 6, 2024 that indicated this resident was cognitively intact. The assessment also indicated that this resident was dependent on staff to transfer from the bed to the chair. Interview with Resident R34 at 10:15 a.m., on December 9, 2024 revealed that this resident was supposed to be getting assistance from the nursing and physical therapy staff daily with mobility (transfer and ambulation) out of bed. Resident R34 reported that he had not been getting the assistance he needed for his mobility needs. Observations of resident R34's room revealed a manual wheel chair. The resident confirmed that staff have to use a mechanical lift to transfer him from the bed to his manual wheel chair. Clinical record review revealed a physical therapy assessment dated August 13, 2024 that indicated that resident R34 required maximum assistance from staff to roll side to side in bed. This assessment also indicated that Resident R34 required maximum	F 0676		

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F 0676 SS=D	Continued from page 30 assistance of staff for transfers supine to sit to participate in activities of daily living. Interviews with the nursing staff, licensed practical nurse, Employee E12 and nursing assistant, Employee E13 at 2:00 p.m., on December 10, 2024 revealed that the nursing staff were most familiar with Resident R34 and his mobility care needs. The nurses explained that it was difficult and unsafe to transfer Resident R34 with the available wheel chair in his room; because the back of the wheel chair was not adjustable. The nursing staff demonstrated that they have to tilt the chair backward to try to align Resident R34 in a center position in the wheel chair. The staff explained that they need a chair with a reclining and adjustable back so that after the transfer into the wheelchair they could position the resident properly and comfortably. The nursing staff reported that they have been reluctant to transfer Resident R34 from the bed to the wheelchair; for their safety and the safety of the resident, fearing that the wheel chair could tip over from the poor and awkward position	F 0676		

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F 0676 SS=D	Continued from page 31 of Resident R34. Interview with the physical therapist, Employee E16 at 11:00 a.m., on December 11, 2024 revealed that a wheel chair with a reclining back was an option for the mobility of Resident R34. The physical therapist said that the rehabilitation department did not order the safe and adjustable adaptive equipment (reclining/adjustable wheel chair) for Resident R34; since they were unaware of the problems the nursing staff were encountering with transferring Resident R34 properly. The physical therapist reported that there were no observations of the actual attempts, by the nursing staff to transfer Resident R34 form the bed to the wheelchair; since August, 2024. Interview with the director of nursing at 9:30 a.m., on December 12, 2024 confirmed the lack of providing adaptive equipment for the nursing staff to performing their transfers of Resident R34 safely out of bed and into a comfortable wheelchair as care planned to meet his mobility needs.	F 0676		

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	395354	A. BLDG: __00_____ B. WING: _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **192702**	**P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477**

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F 0676 SS=D	Continued from page 32 28 PA. Code 211.12(d)(1)(2)(3)(5) Nursing services 28 PA. Code 211.10(a)(b)(c)(d) Resident care polies 28 PA. Code 201.219(c) Use of outside resources 28 PA. Code 201.18(b)(e)(1) Management	F 0676		
F 0684 SS=D		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=D	Continued from page 33 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident R56 received their suboxone on 11/29/2024. Resident R61 received their suboxone on 5/28/2024. The facility completed a suboxone supply count immediately to verify appropriate supply before needing to request a refill. The facility has re-educated all licensed nurses on the facility's policy on Medication/Opioid Management and Reordering such as: when counting controlled drugs, the licensed nurses must be alert for medications needing refills or new script within 10 days of the last dose. The facility has re-educated all nursing staff on Bowel and Bladder policy and protocol including monitoring, assessing, documenting resident's bowel movements. The facility will complete a medication audit on all residents who are presently on suboxone to monitor consistency and	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=D	Continued from page 34	F 0684	appropriateness of pain management regimen and receiving their medication in a timely manner. The facility will complete a bowel and bladder audit on 10 residents to ensure a proper bowel and bladder protocol is in place. The facility will monitor and check for knowledge on licensed nurses' ability to verbalize understanding of facility's policy on Medication/Opioid Management and Reordering. The DNS will oversee and serve as the point of escalation in contacting the physician and/or pharmacy for refill and/or new script and specifically monitor Suboxone supply. The facility will monitor for effective bowel and bladder program and verify that nursing staff are appropriately documenting and following physician orders and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=D	Continued from page 35	F 0684	DNS / designee will audit 4 residents prescribed Opioids to monitor consistent, timely and appropriate medication administration and pain management regimen. Audits will be conducted daily x2 weeks, then weekly x4 weeks and then monthly x3 months UM / designee will audit 4 residents BM log to monitor for consistent and appropriate bowel hygiene and regimen. Audits will be completed weekly x4 weeks then monthly x2 months Findings will be reported to the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0684 SS=D	Continued from page 36 Based on interviews with residents and staff, review of clinical records and facility documentation and policies it was determined that the facility failed to provide the necessary treatment for opioid addiction for two residents (Resident R56 and R61) in a timely manner which resulted in and/or a potential to cause the residents experiencing unwanted discomfort and withdrawal symptoms and failed to adequately assess a resident (Resident R61) in accordance with professional standards of practice and failed to inform the medical director when services were not rendered for two residents reviewed (Resident R56 and R61) and failed to properly assess and provide bowel care for one resident (Resident R81) of the 24 resident records reviewed. Findings include: Review of facility policy for Medication Shortage/Unavailable Medication revised April 2018 states when medications are not received for the resident the licensed nurse will urgently initiate	F 0684		

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F 0684 SS=D	Continued from page 37 action in cooperation with the attending physician and the pharmacy provider. If unable to obtain a response from the attending physician in a timely manner notify the nursing supervisor and contact the Medical Director for orders/directions. During a group session on December 10, 2024, at approximately 10:30 a.m., Resident R56 and R61 both agreed there are times the facility fails to have their medication Suboxone. Resident R61 said it happens a lot. Resident R56 stated recently went three days during Thanksgiving when the medication didn't come in. Suboxone is a prescription drug (Buprenorphine HCl-Naloxone HCl Dihydrate) used to treat opioid dependence. Withdrawal symptoms from Suboxone can occur when the medication is missed. Physical symptoms may include nausea vomiting headaches muscle aches, digestive distress, anxiety, irritability, fever, chills and sweating when the dose is missed approximately 12 hours after last dose. .	F 0684		

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F 0684 SS=D	Continued from page 38 Review of Resident R56's physician orders revealed the resident was admitted to the facility on December 23, 2023, diagnosed with opioid abuse, and ordered Suboxone Sublingual Film 4-1 mg. instructed to give 1 film sublingually two times a day for withdrawal at 9:00 a.m. and 5 p.m. Further interview with Resident R56 on December 10, 2024, at 11:00 a.m. stated, "Its nothing to them if they don't have my medication. A few weeks ago, around Thanksgiving they didn't have my medication for days. After a couple missed doses, I started getting sick. I had stomach pains and was achy and sweating. The feeling is worse than coming off the actual drug (opiates). When I missed the Suboxone nursing didn't check on me to see if I was sick. Review of the nursing medication administration notes and the narcotic ledger for Resident R56's Suboxone revealed on November 27, 2024, the resident's 5:00 p.m. dose was not administered, on November 28, 2024, both doses were not administered, and on November 29th both doses	F 0684		

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F 0684 SS=D	Continued from page 39 were not administered until it was delivered by the pharmacy that night at 11:10 p.m. Facility documentation dated Wednesday, November 27, 2024, revealed DON request to physician for Suboxone prescription for Resident R56 indicating "Used last one this morning." Friday, November 29, 2024, at 10:28 a.m. DON notifying physician that "Pharmacy has not yet received the prescription for (Resident R56) and he is out of his Suboxone." Review of Resident R61's physician orders revealed an active order of Suboxone Film 8-2 MG (Buprenorphine HCl-Naloxone HCl) since July 28, 2022, instructed to give two times a day at 9: a.m. and 9:00 p.m. . Further interview with Resident R61 on December 10, 2024, at 10:30 a.m. stated, "After a day without the medication you really don't' feel well. All you can do is keep asking for your medication and go to the nurses' desk to see if it arrived. They would tell me, 'It will be here later on' but when it doesn't come, you don't know what to do, you're	F 0684		

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F 0684 SS=D	Continued from page 40 stuck. Resident R61 indicated during the times her medication is missed nursing has not asked about feeling ill or having withdrawal symptoms. Review of Resident R61's nursing medication administration notes revealed the medication was not administered for both doses on May 27, 2024, due to "Waiting for script to be filled" and "Ordered." May 28, 2024, at 8:35 a. m. noted nursing was "awaiting pharm." Review of the nurses' narcotic ledger for Resident R61's suboxone revealed no documented evidence the 9:00 a.m. and the 9:00 p.m. dose was administered on May 27 and May 28, 2024. Facility documentation dated May 28, 2024, at 12:07 p.m. revealed DON request to physician for refill prescription of Suboxone for Resident R61. Indicating to the physician Resident R61 "Been without for 3 days." Further review of Resident R61's clinical record did not revealed nursing notes and/or assessments during the time the medication was not administered. Interview with the Director of Nursing on December	F 0684		

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F 0684 SS=D	Continued from page 41 13, 2024, at 10:00 a.m. stated the residents were not receiving the Suboxone medication because either the physician doesn't send the prescription to the pharmacy in a timely manner or we are waiting on the pharmacy to deliver the medication. Clinical record review for resident R81 revealed that this resident had a hospital stay on July 31, 2024 and was treated for stomach distention. The hospital record indicated that Resident R81 was given antibiotic therapy and normal saline solution while nothing was given to the resident by mouth. Clinical record review revealed that the physician gave Resident R81 a diagnosis of constipation on August 6, 2024. Resident R81 was ordered Colace 100 mg orally two times a day for prevention of constipation on August 6, 2024. Resident R81 was ordered senna 8.6 mg by mouth at bedtime to prevent constipation on August 6, 2024. Resident R81 had physician's orders for the nursing staff to administer four ounces of prune juice instead of milk if resident had no bowel movement for two days to	F 0684		

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F 0684 SS=D	Continued from page 42 prevent constipation on August 6, 2024. Resident R81 had physician's orders for the nursing staff to administer milk of magnesia suspension 30 ml by mouth if no bowel movement every 72 hours. to prevent constipation. Clinical record review revealed that Resident R81 had no bowel movement documented for December 6, 7, 8 and 9 2024. There was no docmentation to indicate that the nursing staff followed the physician's orders for prune juice administration or milk of magnesia administration as ordered by the physician for December 6, 7, 8, 9, 2024. The lack of following the bowel protocol for Resident R81 was confirmed by the registered nurse, Employee E5, at 10:00 a.m., on December 12, 2024. Clinical record review of the bowel record for December, 2024 for Resident R81 revealed that the established care plan to include the bowel protocol was not implemented as planned for this resident on December 6, 7, 8, 9, 2024, despite the nursing staff documenting that the resident had no	F 0684		

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F 0684 SS=D	Continued from page 43 bowel movements on these days. Clinical record review revealed that on December 10, 2024 Resident R81 was sent to the hospital for a stomach ache and vomiting. The nursing progress note on December 10, 2024 for Resident R81 indicated that the resident was sent to the hospital for further evaluation and to rule out small bowel obstruction. 28 PA. Code 211.12(c)(1)(2)(3)(5) Nursing services 28 PA. Code 211.5(f)(i)(iii)(vi)(vii)(ix) Medical records	F 0684		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 44 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	Resident R56 received their suboxone on 11/29/2024. Resident R61 received their suboxone on 5/28/2024. The facility completed a suboxone supply count immediately to verify appropriate supply before needing to request a refill. The facility has re-educated all licensed nurses on the facility's policy on Medication/Opioid Management and Reordering such as: when counting controlled drugs, the licensed nurses must be alert for medications needing refills or new script within 10 days of the last dose. The facility has re-educated on assessing and documenting residents for withdrawal symptoms and reaching the medical provider for an alternative to manage withdrawal symptoms and/or pain. The facility has informed the pharmacy account manager of the importance in receiving ordered medications in a timely manner and agreed upon filling the	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0755 SS=D	Continued from page 45 This REQUIREMENT is not met as evidenced by:	F 0755	Omnicell/Pixus as a backup system. The facility will complete a medication audit on all residents who are presently on suboxone to monitor consistency and appropriateness of pain management regimen and receiving their medication in a timely manner. The facility will monitor and check for knowledge on licensed nurses' ability to verbalize understanding of facility's policy on Medication/Opioid Management and Reordering. The facility will monitor and check for knowledge on licensed nurses' ability to verbalize understanding of signs and symptoms of opioid withdrawal and how to appropriately assess and communicate with the medical provider for recommendations. The DNS will oversee and serve as the point of escalation in contacting the physician and/or pharmacy for refill and/or new script and	

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F 0755 SS=D	Continued from page 46	F 0755	specifically monitor Suboxone supply. The facility will monitor for timely receipt of medications from the pharmacy and immediately inform the pharmacy account manager of any concerns, as needed. DNS / designee will audit 4 residents prescribed Opioids to monitor consistent, timely and appropriate medication administration and pain management regimen. Audits will be conducted daily x2 weeks, then weekly x2 weeks and then monthly x2 months Findings will be reported to the QAPI committee.	

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STATE LICENSE NUMBER: **192702**	

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F 0755 SS=D	Continued from page 47 Based on the review of facility documentation, clinical records, staff and resident interviews, it was determined that the facility failed to provide necessary pharmaceutical services for two of 24 residents reviewed. (Resident R56 andR61). Findings include: Review of facility policy for Medication Shortage/Unavailable Medication revised April 2018 states when medications are not received for the resident the licensed nurse will urgently initiate action in cooperation with the attending physician and the pharmacy provider. If unable to obtain a response from the attending physician in a timely manner notify the nursing supervisor and contact the Medical Director for orders/directions. During a group session on December 10, 2024, at approximately 10:30 a.m., Resident R56 and R61 both agreed there are times the facility fails to have their medication Suboxone.	F 0755		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0755 SS=D	Continued from page 48 Suboxone is a prescription drug used to treat opioid dependence. Withdrawal symptoms from Suboxone occur when the medication is missed in approximately 12-24 hours after the first missed dose. Physical symptoms may include nauseas vomiting headaches muscle aches, digestive distress, anxiety, irritability, fever, chills and sweating. Review of Resident R56's physician orders revealed the resident was admitted to the facility on December 23, 2023, diagnosed with opioid abuse, and ordered Suboxone Sublingual Film 4-1 mg. (Buprenorphine HCl-Naloxone HCl Dihydrate) instructed to give 1 film sublingually two times a day for withdrawal at 9:00 a.m. and 5 p.m. Review of the nursing medication administration notes and the narcotic ledger for Resident R56's Suboxone revealed on November 27, 2024, the resident's 5:00 p.m. dose was not administered, on November 28, 2024, both doses were not administered, and on November 29th both doses were not administered until it was delivered by the	F 0755		

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F 0755 SS=D	Continued from page 49 pharmacy that night at 11:10 p.m. Review of Resident R61's physician orders revealed an active order of Suboxone Film 8-2 MG (Buprenorphine HCl-Naloxone HCl) since July 28, 2022, instructed to give two times a day at 9: a.m. and 9:00 p.m. Review of Resident R61's nursing medication administration notes revealed the medication was not administered for the 9: a.m. and 9:00 p.m. doses on May 27, 2024, due to "Waiting for script to be filled" and "Ordered." May 28, 2024, at 8:35a.m. noted nursing was "awaiting pharm." An interview with the Director of Nursing on December 13, 2024, at 10:00 a.m. stated the residents were not receiving the Suboxone medication because the physician either doesn't send the prescription to the pharmacy in a timely manner or we are waiting on the pharmacy to deliver the medication.	F 0755		

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F 0755 SS=D	Continued from page 50 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.9(a)(1)(f)(2)(4)(g)(h)(k) Pharmacy services.	F 0755		
F 0758 SS=D		F 0758		

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F 0758 SS=D	Continued from page 51 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	The facility has assessed resident R88 for the use of Depakote. The nurse has clarified the other for the Depakote with the physician to provide adequate indications for its use for resident R88. The facility will complete an audit for all residents on Depakote to verify that documentation and order substantiates the appropriate use of Depakote. The facility conducted a review of the current Psychotropic Use policy and made no changes. The facility will monitor the appropriate use of Depakote and verify that orders and documentation validate the use of Depakote. The facility will monitor the effectiveness of the Depakote and side effects will be monitored and recorded. DNS / designee will audit 20% of all PRN psychotropic medication weekly x4 weeks, then monthly x2 months. Findings will be reported to the QAPI committee.	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0758 SS=D	Continued from page 52 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758		

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F 0758 SS=D	Continued from page 53 Based on clinical record review, interviews with staff and policy and procedure reviews, it was determined that the facility failed to use, monitor and assess one of six residents for continued psychotropic drug use. (Resident R88) Findings include: A review of the policy titled psychotropic drug use dated January 1, 2021 revealed that it was the responsibility of the physician, facility staff, psychiatrist and pharmacist to choose the most effective medication for the resident that had the fewest possible side effects, adverse drug reactions and in the smallest effective dose. The policy indicated that each resident using psychotropic drugs would be monitored for adverse side effects, appropriate drug selection and appropriate drug dose. Clinical record review revealed a physician's ordered for divalproex sodium (depakote) oral capsule delayed release 125 mg give three capsules	F 0758		

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F 0758 SS=D	Continued from page 54 by mouth two times a day for agitation, since October 30, 2024. Pharmaceutical diagnoses for use of depakote was for epilepsy, mood disorder or migraines. Divalproex sodium was a stable compound of Valproic acid. Clinical record review lacked documentation to indicate that the nurse clarified the order for the depakote with the physican to provide and document adequate indications for its use for Resident R88. Clinical record review revealed a psychiatrist assessment dated November 21, 2024 that indicated resident R88 had diagnoses of dementia with behavioral disturbance. The psychiatrist documented that the resident was exhibiting agitation with aggressive behaviors. The psychiatrist noted that Resident R88 was prescribed depakote and Risperdal as needed. The psychiatrist planned to discontinue the Risperdal (antipsychotic) and start Zyprexa (antipsychotic) for Resident R88. The physician also prescribed Ativan (anti anxiety	F 0758		

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F 0758 SS=D	Continued from page 55 medication) four times a day as needed for anxiety. Clinical record review revealed that the nurse had not verified the order to clarify the duration, dosage and intended used for Depakote for Resident R88. The nurse failed to clairfy with the physician if the administration of depakote was to be given as needed or in a standard administration twice a day, based on the psychiatrist progress note dated November 21, 2024. Clinical record review for October 30, 2024 through December 9, 2024 revealed that there were no Valproic acid blood levels available for review for Resident R88. There was no documentation to indicate that the nursing staff obtained an order from the physician to adequately monitor the continued use of the use of this medication for Resident R88. Interview with the director of nursing, Employee E2, at 1:00 p.m., on December 11, 2024 confirmed that the nursing staff failed to clarify the adequate indications for use for the medication depakote,	F 0758		

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F 0758 SS=D	Continued from page 56 obtain an order for adequate monitoring of the drug depakote and ensure the drug (depakote) was not used for an excessive duration for Resident R88. 28 PA. Code 211.12(b)(d)(1)(2)(3)(5) Nursing services 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies 28 PA. Code 211.5(f)(i)(ii)(iii)(vi)(vii)(viii)(ix) Medical records	F 0758		

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F 0758 SS=D	Continued from page 57	F 0758		
F 0760 SS=D		F 0760		

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F 0760 SS=D	Continued from page 58 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 0760	The facility immediately assessed resident R69 after administering the incorrect dosage of Coumadin. The facility immediately contacted the medical provider, and a PT/INR was ordered. The facility continued to monitor resident R69 for bleeding or bruising. The facility followed all subsequent MD orders. The facility immediately assessed resident R64 after administering the wrong medication on 7/14/2024. The medical provider was notified. Resident R64 did not require any further intervention, as per MD. The facility immediately interviewed LPN that administered incorrect medication and issued a written education to the LPN. The facility immediately assessed resident R64 after administering the Metformin medication 90 minutes prior to the scheduled time on 8/12/2024. The medical provider was notified. Resident R64 "spit out the medication and" did not require any further intervention as per MD,. The	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0760 SS=D	Continued from page 59	F 0760	facility immediately interviewed the LPN and took appropriate disciplinary action. The facility immediately initiated education to licensed nurses on medication administration and documentation in resident's electronic health record. All residents have the potential to be affected by the deficient practice. The facility will educate all licensed nurses on medication administration and documentation in resident's electronic medical record. The facility will utilize medication administration record documentation audit tool. Director of Nursing / designee will complete random audits of 5 resident MAR weekly x4 weeks, then monthly x2 months Findings will be reported to the QAPI committee.	

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F 0760 SS=D	Continued from page 60 Based on review of clinical records, and staff and resident interviews, it was determined that the facility failed to ensure two residents were free from significant medication errors for 2 of 8 residents reviewed. (Residents R69 and R64) Findings: Review of the National Institute of Health article titled "Nursing rights of medication administration" dated September 2023 revealed that it is standard during nursing education to receive instruction to clinical medication administration and upholding patient safety known as the five rights of medication administration, the five rights are : the right patient, right drug, right route, right time, and right dose. Patient safety and quality of care are essential components of nursing practices and priorities that demand consideration to enable the delivery of high-quality patient centered care and overall, well-being. Review of the Centers for Medicare and Medicaid Services "Drugs and biologicals must be prepared and administered in accordance with the federal and state laws, the orders of the practitioner and practitioners'	F 0760		

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F 0760 SS=D	Continued from page 61 responsibility for the patients care as specific specified under 482 .12 and accepted standards of practice. All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in according to state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. Basic safe practices for medication administration the patient's identity, the correct medication, the correct dose, the correct route, any appropriate time. Review of resident R 69's clinical record revealed that resident R 69 had medical diagnosis' including heart failure(also know this congestive heart failure is a condition that develops when your heart doesn't pump enough blood for your body's needs) ,chronic atrial fibrillation(a condition in which the upper chambers of the heart be rapidly and irregularly), left bundle branch block(A condition that occurs when something blocks the electrical impulse that causes the heart to beat, this leads to an abnormal heart rhythm),and essential hypertension(also known as primary hypertension refers to high blood pressure that is preexisting and has no identifiable cause)	F 0760		

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F 0760 SS=D	Continued from page 62 Review of residence R 69's care plan revealed the resident has potential for bleeding related to anti coagulant therapy with interventions including administer medications as a weather, monitor signs and symptoms of bleeding, and monitor lab studies. Further review of resident R 69's clinical record revealed physician orders for the drug Coumadin. On order of coumadin dated October 12, 2024, with instructions give five milligrams orally once daily. Another order for the medication Coumadin dated on November 5, 2024 revealed an order for six milligrams to be given daily. Review of manufacturers Bristol Myers Squibb company medication coumadin package insert revealed product warning this medication can cause major or fatal bleeding. Is more likely to occur during the starting or with a higher dose. Patients should be instructed about prevention measures to minimize risk of bleeding and to report immediately to physician signs and symptoms of bleeding. Review of resident R 69's clinical record nursing notes dated November 6, 2024, revealed "Charge	F 0760		

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F 0760 SS=D	Continued from page 63 nurse reported that she gave resident 11mg a 5mg tab and a 6 mg tablet of coumadin at hs . when pharmacy delivered medication this morning that she was expecting to receive 5mg and 6mg tablets of coumadin for this resident. When she only received 6mg tablets the nurse went back to check the order from 11/5/24 and noticed resident had 2 different orders for coumadin on the mar one order to give 5mg and one order to give 6mg. Nurse gave both doses." Review of Resident R64's clinical record revealed diagnosis' including diabetes type two (long term condition occurs when the body fails to regulate glucose levels leading to high blood sugar levels) arthritis(condition that causes inflammation or swelling in the joint tissue around the joints or other connective tissue) and low back pain. Further review of resident R 64's clinical record revealed physician orders for the drugs gabapentin 600 milligrams and Metformin 500 milligrams given daily. Review of Manufacturer CSPC Ouyi pharmaceutical Co. drug metformin insert revealed metformin	F 0760		

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SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **192702**	**P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477**

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F 0760 SS=D	Continued from page 64 hydrochloride tablets are indicated as an adjunct to diet and exercise to improve glycemic control with type with people with type two diabetes The most common adverse effect is diarrhea nausea vomiting indigestion and headache. Interview with resident R 64 on December 9, 2024, at 10:15a.n. revealed that the nurse gave the resident the wrong medication, the resident required hospitalization. Review of resident R 64's clinical record nursing notes dated July 14, 2024, revealed "203B and 203A both advised me on an 203B given the wrong medication this AM, but he spit it out & refused to take it. Mouth check was done no abnormal findings. Resident refused vitals. Resident stated he was ok but was upset she gave him the wrong medication wanted a supervisor." Further review of resident R 64'sclinical record revealed a nurses note dated August 12, 2024 revealed "Medication was given to Resident and received metformin instead of Gabapentin. Resident metformin is due at 8am. Resident did not swallow pill he spit it out. Resident is stable. resident was	F 0760		

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F 0760 SS=D	Continued from page 65 transferred to Abington. 28 Pa. Code 211. 9(d) pharmacy services 28 Pa. Code 211. 12(d)(1)(5) nursing services	F 0760		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 66 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Employee E5 was reeducated on facility treatment policy to align with infection control practices Residents in the 1st floor dining room were indirectly affected by the cited deficient practice. Residents were assessed by clinical team and do not have any ill effects related to the cited deficient practice. All residents have potential to be affected by deficient practice. The facility infection control risk assessment will be reviewed to monitor for accuracy and will be revised, as needed on or before January 3, 2025. The new IPN will educate all nursing staff on proper wound care treatment and following the facility's infection control policy. Infection Preventionist / designee will conduct visual rounds on both units to monitor that staff are practicing appropriate infection control practices during wound care Audits will be done weekly x4 weeks then monthly x3 month. Findings will be reported to the QAPI committee.	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0880 SS=D	Continued from page 67 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 68	F 0880		

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F 0880 SS=D	Continued from page 69 Based on the review of facility policies, resident interviews, and interview with staff, it was determined that the facility failed to maintain proper infection control practices related to wound care for one of three residents reviewed for wound care. (Resident R47) Findings include: Review of facility policy titled "Wound Care" revised October 2010 revealed the purpose of this policy is to provide guidelines for the care of wounds to promote healing. One key element is cleanliness. Items to be used during procedure must be clean and arranged on a clean environment. Review of facility policy titled "Enhanced Barrier Precautions Policy", revealed enhanced barrier precautions EBP will be initiated for residents as an applicable in accordance with CMS and or state regulations in accordance with the CDC guidance to reduce the risks of transmission of multiple drug resistant organisms MDROS. Enhanced barrier	F 0880		

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F 0880 SS=D	Continued from page 70 precautions are applicable for residents with any of the following infection where colonization with an MDRO, wounds, in dwelling medical devices such as central line, urinary cavity, ventilator regardless of colonization status. Enhanced barrier precaution is primarily intended to apply to care that occurs within a residence room where high contact resident care activities are commonly bundled together enhanced barrier precautions should additionally be followed when performing transfers. Review of facility policy titled "Infection Control Program "revealed the infection prevention and control program is a facility wide effort involving all disciplines and individuals and integral part of the quality assurance and performance improvement program. The infection prevention and control program are coordinated and overseen by an infection prevention specialist. One of the major elements of the infection prevention program is prevention of the infection. Some important facets of infection prevention include identifying possible infections or potential complications of existent	F 0880		

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F 0880 SS=D	Continued from page 71 infections, instituting measures to avoid complications, educating staff and ensuring that they adhere to proper techniques and procedures, enhance screening for possible significant pathogens, immunizing residents and staff to prevent illness, implementing appropriate isolation precautions when necessary and follow established general and disease-specific guidelines such as those of the Centers for Disease Control CDC. Review of resident R47's clinical record revealed that resident R47 has diagnosis' including ; Venus insufficiency (condition in which means in the legs are damaged, causing blood to flow more slowly and return to the heart), Chronic Venus hypertension with ulcer of right lower extremity(condition that occurs when the valves in the leg veins are damaged, causing blood pressure to remain high and leading to ulcers on the ankles, chronic venous hypertension with ulcer of left lower extremity), local infection of the skin and subcutaneous tissue(a condition characterized by the invasion of harmful bacteria or fungi into the skin layers), Localize	F 0880		

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F 0880 SS=D	Continued from page 72 edema , cellulitis of right lower limb, cellulitis of left lower limb(bacterial infection of the skin and tissue beneath your skin), unspecified intellectual disability (refers to limitations in mental abilities affecting intelligence, learning, and everyday life skills), schizophrenia(mental health condition characterized by hallucinations, delusions, disorganized thinking and behavior), asymptomatic human immunodeficiency virus infection(Also known as chronic HIV infection or clinical latency, is a stage of HIV infection where a person may not experience any symptoms), cognitive communication deficit(A communication difficulty caused by cognitive impairment). Further review of resident R47's clinical record revealed a physician note dated November 25, 2024, of documentation of resident R47 wounds. The note specified that resident R 47 was assessed with have two lower extremity wounds. Review of resident R 47's physician orders revealed an order for instruction to apply calcium alginate	F 0880		

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F 0880 SS=D	Continued from page 73 silver dressing to both lower extremities topically every day continued review of resident 47's physician orders revealed an order for the ointment Santyl to be applied daily to resident 47's right lower leg. Interview with resident R64 on December 9, 2024, at 10:00 a.m. revealed that this resident voiced concerns of staff performing wound care on a resident in the resident dining room. Resident R 64 provided video of the reported incident of employee performing wound care in the resident dining room with residents present. Resident 64 stated that he provided the video the the nursing home administrator. Resident stated it was disgusting, unsanitary and had concerns of infections. Interview with infection Preventionist employee E 5 on Wednesday December 11, 2024, at 3:00 pm confirmed that the allegation of improper wound care was attempted in the resident dining room. Employee E 5 stated that resident R47 possessed behaviors and often refused care. There was an	F 0880		

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F 0880 SS=D	Continued from page 74 opportunity at that time to perform wound care, so employee E5 believed "the benefits outweighed the risks". The wound care was not completed at that time due to resident 47 displaying undesirable behaviors. 28 Pa. Code 211.12(d)(1)Nursing Services 28 Pa. Code 201.18(d) Management	F 0880		
F 0881 SS=D		F 0881		

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F 0881 SS=D	Continued from page 75 483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 0881	The facility will complete an audit of antibiotics stewardship including all new and current antibiotic usage for the last 15 days to be completed by the Infection Preventionist. All residents on antibiotics have the potential to be affected. Residents receiving or that have received antibiotics in the last 15 days will be audited by the IPN for proper surveillance and tracking. Education provided to the infection preventionist on Antibiotic stewardship program to include tracker that consists of surveilling infection description, antibiotic dose and duration, and lab or pharmacy reports. The facility will utilize a tracker that consists of surveilling infection description, antibiotic dose and duration, and lab or pharmacy reports. Director of Nursing / designee will conduct audits of antibiotic stewardship surveillance program to monitor for proper tracking. Audits will be completed weekly x4 weeks then monthly x2 months.	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0881 SS=D	Continued from page 76	F 0881	Findings will be reported to the QAPI committee.	

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F 0881 SS=D	Continued from page 77 Based on a review of facility documentation, facility policies, Centers for Disease Control and Prevention (CDC) guidelines and staff interview, it was determined that the facility failed to maintain an effective antibiotic stewardship program that includes a system to effectively monitor antibiotic usage for four or four months of antibiotic stewardship program data reviewed. (August 2024, September 2024, October 2024, and November 2024) Findings include: A review of CDC (Centers for Disease Control and Prevention) guidelines, "The core Element of Antibiotic Stewardship for Nursing Homes", revealed that "Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. 1. Antibiotic stewardship refers to a set of commitments and actions designed to "optimize the treatment of infections while reducing the adverse events associated with the antibiotic use". 2. The Center for Disease Control and Prevention (CDC)recommends that all acute care hospitals implement an antibiotic stewardship program (ASP) and outline the seven core elements which are necessary for implementing	F 0881		

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F 0881 SS=D	Continued from page 78 successful ASPs. 3. CDC also recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g. acceptance) may help determine whether feedback is effective in changing prescribing behaviors. Integrate the dispensing and consultant pharmacists into the clinical care team as key partners in support supporting antibiotic stewardship in nursing homes. Pharmacists can provide assistance in ensuring antibiotics are ordered appropriately, reviewing culture data, and developing antibiotic monitoring and infection management guidance in collaboration with nursing and clinical leaders. Identify clinical situations which may be driving inappropriate causes of antibiotics such as	F 0881		

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F 0881 SS=D	Continued from page 79 asymptomatic bacteria or urinary tract infection prophylaxis and implement specific interventions to improve use. Perform reviews on resident medical records for new antibiotics starts to determine whether the clinical assessment, prescription documentation and antibiotics selection were in accordance with facility antibiotic use policies and practices. When conducted overtime, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians. Track the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions. Some antibiotic use measures provide a snapshot of information, while others, like nursing home-initiated antibiotics starts and days of therapy are calculated and tracked when an ongoing basis. Selecting which antibiotic use measures to track should be based on the type of practice intervention being implemented. Interventions designed to shorten the duration of antibiotic courses, or discontinue antibiotic based on post prescription review, may not necessarily change the rate of antibiotic starts, but would decrease the antibiotics days of therapy (DOT)."	F 0881		

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F 0881 SS=D	Continued from page 80 Review of facility policy titled "Antibiotic stewardship" revised 2016 revealed antibiotics will be prescribed and administered to residents under the guidance of the facility antibiotic stewardship program. If an antibiotic is indicated prescribers will complete antibiotic orders including the following elements drug name, dose, frequency of administration, duration of treatment, root of administration, and indication for use. When a cultural and sensitivity is ordered lab results and the carrying clinical situation will be communicated to the prescriber as soon as available to determine if the antibiotic therapy should be started continued, modified, or discontinued. Review of facility policy titled "Infection Control Program" reveals that antibiotics stewardship includes cultural reports sensitivity data and antibiotic usage reviews are included in surveillance activities. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. And antibiotic usage is evaluated, and practitioners are provided feedback on review. Surveillance tools are used for recognizing their currents of infections, recording their number and	F 0881		

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SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **192702**	**P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0881 SS=D	Continued from page 81 frequency, detecting outbreaks in epidemics, monitoring employee infections, and detecting unusual pathogens with infection control implications. Review of facility antibiotic tracking log from August 1st, 2024, to November 30th, 2024, revealed no documented evidence that the facility utilized any surveillance for antibiotic use for any of the antibiotics ordered. Records did not include consultant pharmacist reports, laboratory reports, infection description, antibiotic dose and duration according to the facility antibiotic stewardship program. Facility did not provide any other information related to the antibiotic stewardship program during this survey. Interview with infection preventionist Employee E5 December 11, 2024 at 3:00 p.m. confirmed that the facility antibiotic stewardship program did not include reports or data from the pharmacist and or laboratory. 28 Pa. Code 211. 12(a)(c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10 (a) Resident care policy	F 0881		

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	395354	A. BLDG: 00 B. WING:	12/12/2024

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F 0881 SS=D	Continued from page 82	F 0881		
F 0908 SS=F	483.90(d)(2) Essential Equipment, Safe Operating Condition §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 0908	The facility will order and put into service heated pellet and thermal pellet holder. All residents receiving meals from the Food Services department have the potential to be affected. The facility will observe the use of the heated pellet and thermal pellet holder for its intended purpose of essential pieces of food service equipment used for the transportation, holding and delivery of hot foods to residents. Food Services Director / designee will conduct observations for the use of the heated pellet and thermal pellet holder 3 times a week x4 weeks, then monthly x2months. Findings will be reported to the QAPI committee.	Completion Date: **02/05/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0908 SS=F	Continued from page 83 Based on observations of the Food and Nutrition Services Department, interviews with residents and staff, reviews of clinical records and policies and procedures, it was determined that essential pieces of food service equipment used for the transportation, holding and delivery of hot foods from the dietary services department to the nursing units, resident rooms and dinning areas were not in use, to ensure consistently safe and satisfactory food temperatures of foods for the residents. (Residents R11, R57, R56, R5, R55, R28, R64, R46, R37, R34, R41, R27, R14 and R19). Findings include: A review of the undated facility policy titled resident tray assessment indicated that all hot foods were to be served hot at a temperature greater than or equal to 130 degrees Fahrenheit and served satisfactory for the residents' preferences and dietary care planning. A review of the undated policy titled service of hot	F 0908		

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F 0908 SS=F	Continued from page 84 liquids to prevent spills revealed that hot beverages were to be served hot and at a temperature less than 140 degrees Fahrenheit to meet the food preferences of the residents. Observations between 11:30 a.m. and 1:00 p.m., on December 9, 2024 of the food delivery service system from the main kitchen of the Food and Nutrition Services Department to the first and second floor nursing units revealed that the facility was not utilizing a complete and standard thermal system to transport, hold and deliver hot foods to the residents. The lack of essential equipment for dietary staff use did not ensure that hot foods were being served safe, palatable and in accordance with residents' appetite satisfaction on a regular basis. Individual interviews with Residents R57, R11 and R34 between 10:00 a.m. and 10:30 a.m., on December 9, 2024 revealed the the temperature and taste of the foods are luke warm and taste was undesirable. The residents described the foods as tasting burnt although at times they don't look black	F 0908		

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F 0908 SS=F	Continued from page 85 or burnt. The residents reported that the hot beverage was never hot. They said they can not get the powdered creamer to dissolve in the coffee because it was too cold. The residents said that the kitchen staff can not serve a grilled cheese sandwich that was appetizing. The cheese would be served hard and unmelted. One of the residents reported that he mostly eat meals in his room and by the time I get a hot meal it would be cold. Interviews with alert and oriented residents assembled in a group at 9:30 a.m., on December 10, 2024 revealed that the hot foods during breakfast, lunch or dinner meals were always served to them cold. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 18, 2024 for Resident R11 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly	F 0908		

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F 0908 SS=F	Continued from page 86 comprehensive assessment MDS (an assessment of care needs) dated August 31, 2024 for Resident R57 that indicated that this resident was cognitively intact. Clinical record review revealed an annual comprehensive assessment MDS (an assessment of care needs) dated November 10, 2024 for Resident R56 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated November 2, 2024 for Resident R5 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated November 5, 2024 for Resident R55 that indicated that this resident was cognitively intact.	F 0908		

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F 0908 SS=F	Continued from page 87 Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated November 13, 2024 for Resident R28 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 18, 2024 for Resident R64 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 23, 2024 for Resident R46 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 25, 2024 for Resident R37 that indicated that this resident was cognitively intact.	F 0908		

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F 0908 SS=F	Continued from page 88 Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated November 6, 2024 for Resident R34 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated November 14, 2024 for Resident R41 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated November 13, 2024 for Resident R27 that indicated that this resident was cognitively intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 18, 2024 for Resident R14 that indicated that this resident was cognitively	F 0908		

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F 0908 SS=F	Continued from page 89 intact. Clinical record review revealed a quarterly comprehensive assessment MDS (an assessment of care needs) dated October 25, 2024 for Resident R19 that indicated that this resident was cognitively intact. Interviews with the director of dietary services, Employee E10 and the registered dietitian, Employee E8 at 1:30 p.m., on December 11, 2024 confirmed that the food and nutrition department's essential equipment was lacking; that was the dietary staff were not using a complete system of standard dietary equipment to transport foods that were being prepared hot in the main kitchen to the residents on the first and second floor nursing unit. Further interview with the dietary staff, Employees E8 and E10, that were responsible for the delivery of safe and appetizing hot foods for the residents revealed that the equipment that was not in use were the heated pellet and thermal pellet holder. The	F 0908		

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F 0908 SS=F	Continued from page 90 pellet was heated to 160 to 170 degrees Fahrenheit inside a lowerator. The pellets and lowerator were used to keep hot foods hot for twenty minutes beyond the time the food leaves the kitchen and was transported to the nursing units for the residents. 28 PA. Code 211.10(a)(b)(c)(d) Resident care policies 28 PA. Code 201.14(a) Responsibility of licensee 28 PA. Code 201.18(b)(1)(3)(d)(e)(1) Management	F 0908		
F 0925 SS=D		F 0925		

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F 0925 SS=D	Continued from page 91 483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	The facility completed work on the kitchen floor in the identified areas on 12/31/2024 to allow for easy cleaning and avoid food debris and pooling of water to accumulate. All residents have potential to be affected by deficient practice. The facility identified the focus areas to be in the kitchen where the flooring had no ceramic tiles. The facility will educate dietary staff to maintain the kitchen flooring clean of food debris and pooling of water. The facility will educate all dietary staff to report to the Maintenance Director when there are deficiencies in the grout and or tiles in kitchen. Pest control professionals will evaluate the identified areas to verify that they are up to par. Food Services Director / designee will monitor kitchen flooring at least 3x a week for 4 weeks, then 3weekly	Completion Date: **01/20/2025** Status: **APPROVED** Date: **01/03/2025**

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F 0925 SS=D	Continued from page 92	F 0925	x3 months. Findings will be reported to the QAPI committee.	

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F 0925 SS=D	Continued from page 93 Based on observations of the physical environment of the food and nutrition department, reviews of the pest control operators reports and interviews with staff, it was determined that the facility failed to maintain an effective pest control program so that the facility was free of common household pests and rodents. Findings include: Observations of the main kitchen of the Food and Nutrition Department in the presence of the director of dietary services, Employee E10, at 9:30 a.m., on December 9, 2024 revealed the following: The industrial sized dish machine and the flooring surrounding this food service equipment was covered with a white/grayish tinted film, resembling hard water deposits of calcium and lime. The boundary of the flooring next to the wall area underneath the dish machine and three compartment sink contained a heavy accumulation of dirt and brown saturated slim.	F 0925		

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F 0925 SS=D	Continued from page 94 The grouting was missing between the ceramic tiles in the dish room and the food preparation area near the steam table, of the main kitchen. The flooring was porous, not easily cleanable and contained grooves that allowed food debris and pooling of water to accumulate. The grouting was worn away from the continuous use of water in these areas of the kitchen. The water damaged flooring provided a place for food debris, dirt and moisture to settle. The food debris and moisture provided food for pests to live and breed. Many ceramic tiles were totally missing about the flooring in the dish room area. The director of maintenance, Employee E14, reported during an interview at 9:30 a.m., on December 11, 2024 that new plumbing was installed beneath the flooring three months ago.	F 0925		

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F 0925 SS=D	Continued from page 95 Review of the pest control operator's reports for September, October, November and December, 2024 revealed that the pest control operator was visiting the facility regularly for treatment of common household pests (roaches, fruit flies, drain flies and mice) in the kitchen and dry food storage of the basement. 28 PA. Code 201.18(b)(1)(3)(2.1) Management 28 PA. Code 205.13(b) Floors 28 PA. Code 201.14(a) Responsibility of licensee	F 0925		

Certified End Page

SILVER STREAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 192702

SURVEY EXIT DATE: 12/12/2024

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
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