



Certified End Page

SILVER STREAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 192702

SURVEY EXIT DATE: 02/05/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
STATE LICENSE NUMBER: 192702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 192702 Component 01 Center Building</p> <p>Based on a Revisit to a Medicare/Medicaid Recertification Survey completed on December 16, 2024, it was determined that Silver Stream Nursing And Rehabilitation Center - Center Building was not in substantial compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a two-story, Type III (200), unprotected ordinary building, with a basement, that is fully sprinklered.</p>	K 0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	<p>NFPA 101 Building Construction Type and Height</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type</p> <p>1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p> <p>2 II (111) One story non-sprinklered Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0161	The facility requested and submitted a TLW on 1/9/2025 and completed and submitted an FSES on 2/11/2025.	<p>Completion Date: 02/11/2025</p> <p>Status: APPROVED</p> <p>Date: 02/24/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	Continued from page 2	K 0161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	Continued from page 3 Based on document review and interview, it was determined the facility failed to maintain the fire resistance rating for building construction, affecting the entire component. Findings include: 1. Document review on December 16, 2024, at 8:15 a.m., revealed the Center Building is a two-story structure, with a basement, classified as Type III (200), unprotected ordinary construction, which is fully sprinklered. The story height exceeds the maximum allowance for this construction type by one story. Exit Interview with the Administrator and Maintenance Director on December 16, 2024, at 11:45 a.m., confirmed the building exceeds the maximum allowable story height. ***** *****	K 0161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
STATE LICENSE NUMBER: 192702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	Continued from page 4 Document review and interview during an onsite revisit conducted on February 5, 2025, between 11:30 a.m. and 1:30 p.m., revealed the following: Item 1 - Not Completed. The story height exceeds the maximum allowance for this construction type by one story. The facility is working to obtain an FSES. Exit Interview with the Administrator and Maintenance Director on February 5, 2025, at 1:30 p.m., confirmed the construction type and story height of the building	K 0161		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 5 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	The facility will comply with emergency generator weekly visual checks, weekly battery voltage checks, monthly battery conductance testing, 30-minute monthly exercise, monthly operation of transfer switch and annual fuel tests. The facility completed a fuel analysis on 1/22/2025 and failed the analysis. The facility requested for fuel to be polished to successfully pass analysis and this work was completed on 2/13/2025. A TLW was requested on 1/24/2025 to fix the injector warning to address the deficiency from the 3/21/2024 inspection. The facility ran a monthly exercise on 2/13/2025. The facility corrected the wet stacks on 5/13/2024. All residents and areas have the potential to be affected. The Maintenance Director will be educated on the importance of conducting weekly and monthly inspections and scheduling the yearly test.	Completion Date: 03/05/2025 Status: APPROVED Date: 02/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 6 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	<p>LNHA will monitor all weekly, monthly and yearly tests.</p> <p>LNHA will monitor future generator inspection deficiencies for appropriate and timely corrections.</p> <p>LNHA / designee will audit weekly inspections, weekly x4 then bi-weekly x2 then monthly x2</p> <p>LNHA / designee will audit monthly inspections x3</p> <p>LNHA / designee will audit yearly tests, yearly.</p> <p>LNHA / designee will audit generator inspection deficiencies quarterly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 7 Based on document review and interview, it was determined the facility failed to maintain the emergency generator, affecting the entire facility. Findings include: Document review on December 16, 2024, at 8:15 a.m., revealed the following deficiencies: a. No weekly visual inspections performed after 7/18/2024; b. No weekly battery voltage inspections performed after 7/18/2024; c. No monthly battery conductance testing performed after 7/2024; d. No monthly exercise of the generator for 30 minutes performed after 7/2024; e. No monthly operation of transfer switches performed after 7/2024; f. No annual fuel quality test; g. Generator inspection dated March 21, 2024 noted the generator was wet stacked and there were fuel injector warnings.	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0918 SS=F	Continued from page 8 Exit Interview with the Administrator and Maintenance Director on December 16, 2024, at 11:45 a.m., confirmed the lack of documentation. ***** ***** Document review and interview during an onsite revisit conducted on February 5, 2025, between 11:30 a.m. and 1:30 p.m., revealed the following: Item e - Not completed. No monthly operation of transfer switches performed after 7/2024 Item f - Not completed. No annual fuel quality test Item g - Not completed. Generator inspection dated March 21, 2024 noted the generator was wet stacked and there were fuel injector warnings. Exit Interview with the Administrator and Maintenance Director on February 5, 2025, at 1:30	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
STATE LICENSE NUMBER: 192702					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
K 0918 SS=F	Continued from page 9 p.m., confirmed the confirmed the lack of documentation. Facility is waiting for delivery of parts to be able to complete these tasks.	K 0918			



Certified End Page

SILVER STREAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 192702

SURVEY EXIT DATE: 02/05/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
--------------------	--	---------------	--	--------------------

K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 192702 Component 03 Villa Building</p> <p>Based on a Revisit to a Medicare/Medicaid Recertification Survey completed on December 16, 2024, it was determined that Silver Stream Nursing And Rehabilitation Center - Villa Building was not in substantial compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a two-story, Type V (000), unprotected wood frame building, with a basement and unused attic, that is fully sprinklered.</p>	K 0000		
--------	---	--------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	<p>NFPA 101 Building Construction Type and Height</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type</p> <p>1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p> <p>2 II (111) One story non-sprinklered Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0161	The facility requested and submitted a TLW on 1/9/2025 and completed and submitted an FSES on 2/11/2025.	<p>Completion Date: 02/11/2025</p> <p>Status: APPROVED</p> <p>Date: 02/24/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	Continued from page 2	K 0161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	Continued from page 3 Based on document review and interview, it was determined the facility failed to maintain the fire resistance rating for building construction, affecting the entire component. Findings include: 1. Document review on December 16, 2024, at 8:15 a.m., revealed the Villa Building component is a two-story structure, with a basement, classified as Type V (000), unprotected wood frame construction. The story height exceeds the maximum allowance for this construction type by one story. Exit Interview with the Administrator and Maintenance Director on December 16, 2024, at 11:45 a.m., confirmed the building exceeds the maximum allowable story height. ***** ***** Document review and interview during an onsite revisit conducted on February 5, 2025, between	K 0161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
STATE LICENSE NUMBER: 192702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	Continued from page 4 11:30 a.m. and 1:30 p.m., revealed the following: Item 1 - Not Completed. The story height exceeds the maximum allowance for this construction type by one story. The facility is working to obtain an FSES. Exit Interview with the Administrator and Maintenance Director on February 5, 2025, at 1:30 p.m., confirmed the construction type and story height of the building	K 0161		
K 0225 SS=C	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by:	K 0225	The facility submitted a FSES on 2/11/2025.	Completion Date: 02/11/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0225 SS=C	Continued from page 5 Based on document review and interview, it was determined the facility failed to maintain the fire resistance rating of stairway enclosures, affecting three of four levels within this component. Findings Include: 1. Document review on December 16, 2024, at 8:15 a.m., revealed the communicating stairway enclosure lacked one hour fire rated construction, due to the presence of wired glass in wooden frames, non-rated doors, frames, and hardware utilized within the stairway. Exit Interview with the Administrator and Maintenance Director on December 16, 2024, at 11:45 a.m., confirmed the condition of the communicating stairway. ***** ***** Document review and interview during an onsite	K 0225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0225 SS=C	Continued from page 6 revisit conducted on February 5, 2025, between 11:30 a.m. and 1:30 p.m., revealed the following: Item 1 - Not Completed. The communicating stairway enclosure lacked one hour fire rated construction, due to the presence of wired glass in wooden frames, non-rated doors, frames, and hardware utilized within the stairway. Exit Interview with the Administrator and Maintenance Director on February 5, 2025, at 1:30 p.m., confirmed the condition of the communicating stairway. Facility is working to obtain an FSES	K 0225		
K 0241 SS=C	NFPA 101 Number of Exits - Story and Compartment Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment.	K 0241	The facility submitted a FSES on 2/11/2025.	Completion Date: 02/11/2025 Status: APPROVED Date: 02/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
--	---	---	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0241 SS=C	Continued from page 7 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by:	K 0241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025	
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 192702		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0241 SS=C	Continued from page 8 Based on document review and interview, it was determined the facility lacked two approved exits remote from each other, for each floor or fire section of the building, affecting the entire component. Findings include: Document review on December 16, 2024, at 8:15 a.m., revealed the facility lacked acceptable fire exits, with exiting reliant on the communicating stair way within the center of the building. Exit Interview with the Administrator and Maintenance Director on December 16, 2024, at 11:45 a.m., confirmed the lack of exiting. ***** ***** Document review and interview during an onsite revisit conducted on February 5, 2025, between 11:30 a.m. and 1:30 p.m., revealed the following: Item 1 - Not Completed. The facility lacked	K 0241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
STATE LICENSE NUMBER: 192702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0241 SS=C	Continued from page 9 acceptable fire exits, with exiting reliant on the communicating stairway within the center of the building. Exit Interview with the Administrator and Maintenance Director on February 5, 2025, at 1:30 p.m., confirmed the facility lacked acceptable fire exits. Facility is working to obtain an FSES	K 0241		



Certified End Page

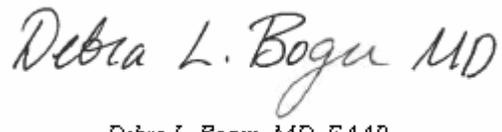
SILVER STREAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 192702

SURVEY EXIT DATE: 02/05/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395354	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>04</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: SILVER STREAM NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477		
STATE LICENSE NUMBER: 192702				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 192702 Component 04 Back Hall</p> <p>Based on a Revisit to a Medicare/Medicaid Recertification Survey completed on December 16, 2024, it was determined that Silver Stream Nursing And Rehabilitation Center - Back Hall, was in substantial compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a two-story, Type II (222), fire resistive building, with a basement, that is fully sprinklered.</p>	K 0000		

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.



Certified End Page

SILVER STREAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 192702

SURVEY EXIT DATE: 02/05/2025

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


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY