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:	04/10/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SILVER STREAM REHABILITATION AND NURSING 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 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to three complaints completed on April 10, 2026, it was determined that Silver Stream Nursing and Rehabilitation Center was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.	F 0000		
F 0600 SS=D		F 0600		

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 0600 SS=D	Continued from page 1 483.12(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	Plan of Correction: The facility immediately assessed Resident R1 with no injuries noted. Resident R2 was immediately separated, placed on 1:1 supervision, sent to the hospital for evaluation, and remained on 1:1 supervision until cleared by psychiatry. The provider and responsible party were notified and the incident was reported to the Department of Health. The facility conducted an investigation and interviewed all available witnesses during the investigation. All residents have the potential to be affected by this deficient practice. An abuse and neglect checklist tool will be implemented to ensure all allegations are thoroughly investigated, including obtaining statements from all available witnesses. Education will be provided to staff on abuse/neglect reporting and	Completion Date: **05/15/2026** Status: **APPROVED** Date: **05/08/2026**

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 0600 SS=D	Continued from page 2	F 0600	investigation requirements, including immediate protection of residents and obtaining required witness statements. Administrator or designee will review all abuse investigations for completeness and required documentation. Audits will be conducted weekly x4 weeks, then monthly x3 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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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
SILVER STREAM REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 192702	P O BOX 397, 905 PENLLYN PIKE SPRING HOUSE, PA 19477

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F 0600 SS=D	Continued from page 3 Based on staff interviews and the review of clinical records, it was determined the facility failed to conduct a complete and through investigation for an allegation of abuse for 1 out of 3 residents reviewed (Resident R1). Findings include: Review of the facility abuse policy, "Abuse Investigating and Reporting," with a revision date of 2016 stated that if an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual, and ensure any further potential abuse, neglect, exploitation or mistreatment is prevented. Review of the April 2026 physician orders for Resident R1 included the diagnoses of dysphasia (difficulty swallowing); aphasia (a language disorder that affects an individual's ability to communicate effectively); dementia (a group of symptoms affecting memory, thinking and social abilities, and cerebral infarction (a stroke). Review of the resident's Minimum Data Set Assessment (MDS-periodic assessment of a resident's needs) dated January 2, 2026, indicated that the resident was cognately impaired. Review of the April 2026 physician orders for Resident R2	F 0600		

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F 0600 SS=D	Continued from page 4 included the diagnoses of diabetes (a chronic condition that occurs when the body cannot properly use blood sugar, leading to high blood sugar levels); seizures (a sudden surge of abnormal electrical activity in the brain that can affect aware ness, muscle control, behavior and sense; chronic kidney disease (a condition characterized by progressive damage and loss of function in the kidneys); schizoaffective disorder (a serious mental health condition characterized primarily by symptoms of schizophrenia, such as hearing things that are not present, seeing things that are not present, false beliefs, along with symptoms of a mood disorder, such as mania and depression) and front temporal neurocognitive disorders (a progressive brain condition that primarily affects the frontal and temporal lobes, leading to changes in behavior, personality, language, and movement). Review of the resident's quarterly MDS dated February 19, 2026, indicated that the resident was awake, alert and oriented. Review of the documentation submitted to the State Survey Agency dated March 17, 2026, on March 17, 2026, revealed that Resident R3 reported that Resident R1 was inappropriately touched in the dining room by Resident R2. Review of the facility's investigation included an incident report completed by Employee E3 (licensed nurse) dated March 17, 2026 at 6:00 p.m. Employee E3 stated that it was	F 0600		

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F 0600 SS=D	Continued from page 5 reported to her by a staff member (Activity worker, Employee E4) that Resident R1 was inappropriately touched by Resident R2 in the 1st floor dining room, and that both were immediately separated. Resident R1 was taken back to her 2nd floor bedroom and the resident's daughter was notified, who also called the police. A full body assessment was completed on the resident with no bruises or injuries found. During an interview with Employee E3 (licensed nurse) on April 9, 2026 at 1:05 p.m. lrevealed that she walked into the facility on March 17, 2026 for her shift at 3:00 p.m. on the 2nd floor and was notified by the activity worker that something happened downstairs on the 1st floor. Licensed nurse, Employee E3 reported that at the time she arrived, they were brining Resident R1 up to the 2nd floor.Employee E3 explained that she was not present for the incident, but was notified by the nursing supervisor (Employee E6) for the 3:00 p.m. through the 11:00 p.m. shift that she needed to complete an incident report on what she was told when she started her shift. License nurse, Employee E3 reported that she completed a body assessment on Resident R1 and found no bruises or injuries on the resident.The nursing supervisor contacted the resident's daughter to notify her of the alleged event. Review of a statement by activity staff member (Employee E4) dated March 1, 2026 stated that activity staff member witnessed Resident R2 caressing Resident's R1's inner	F 0600		

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F 0600 SS=D	Continued from page 6 thigh before he came over and removed him from the dining room. Review of a 2nd undated statement from activity staff member indicated that Resident R3 reported to him that he witnessed Resident R2 assaulting Resident R1, and that he stated to him that Resident R1 was being groped. During an interview with activity worker on April 9, 2026 at 1:25 p.m. the activity worker reported that Resident R1 and Resident R2 were sitting at the 2nd to last table near the back of the wall in the 1st floor dining room. Activity worker stated that there was a 2nd activity worker (Employee E7) also present in the first floor dining room who was giving out snacks. Activity worker reported that there were 2 activity aides present in the room and 50 residents. Activity worker reported that he heard Resident R3 call his name while in the activity room and told activity worker to remove Resident R2 from the dining room because he saw Resident R2 touch Resident R1 inappropriately. Activity worker reported that Resident R2 was feeling on Resident R1's thighs/breast and putting his hands in her pants. Activity worker reported that he took Resident R2 to the nursing station and waited for someone from nursing to come around so that he could report it to them. Activity worker reported that he reported to a nurse, whose name he could not remember, of what Resident R3 told him what he saw Resident R2 doing to Resident R1. Activity worker reported that Resident R2 observed back in the activity room after he was taken out and observed	F 0600		

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F 0600 SS=D	Continued from page 7 by the activity worker in the same area, near Resident R1 with his hand resting on her inner thigh "close to her vagina." Activity worker reported that he took Resident R2 back to the nursing station a 2nd time and sat with him until someone came back to the nursing station. Activity worker reported that he felt that Resident R2 "was very lucid and you can take his word on things," in regards to Resident R2's account of what he reported to the Activity worker. Review of an incident reported dated March 17, 2026 at 6: 00 p.m. written by licensed nurse (Employee E5) documented that Resident R2 was observed by another resident earlier, and that he was placed at the nursing station for supervision. Licensed nurse reported that during nursing rounds, Resident R2 went back into the same dining room on the 1st floor and was seen kissing the same female resident, Resident R1. Licensed nurse reported that Resident R2 was then placed on 1:1 supervision. During an interview with licensed nurse (Employee E5) on April 9, 2026 at 1:51 p.m. licensed nurse reported that she worker 7:00 a.m. through 7:00 p.m. on March 15, 2026 on the 1st floor. Licensed nurse reported that she was told by the activity aide that Resident R2 was witnessed touching and kissing Resident R1. Licensed nurse reported that she notified the Nursing Home Administrator (NHA) and Unit Manager (Employee E7) of the 1st incident and Resident R2 was removed from the dining room and was sitting at	F 0600		

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F 0600 SS=D	Continued from page 8 the nursing station. The resident went back in the dining room during nursing rounds and licensed nurse was notified of a 2nd incident that occurred which involved him kissing the same Resident R1 when he returned to the dining room. Licensed nurse reported that she notified the Nursing Home Administrator (NHA) and the Unit manager again, and the resident was assigned a 1:1 staff member for supervision. Review of a nursing note dated March 17, 2026 at 9:36 p.m. written by 3-11 p.m. nursing supervisor (Employee E6) reported that she was notified from a male staff member that Resident R2 was seen in appropriately touching Resident R1. The note documented that Resident R2 was placed on 1:1 supervision with a nurse aide, and that the physician was notified and ordered that Resident R2 be sent out to the emergency room for treatment and evaluation. During an interview with nursing supervisor (Employee E6) on April 10, 2026 at 11:20 a.m. nursing supervisor reported that she was completing an admission on her 3:00 p.m. through 11:00 p.m. shift when she was notified that Resident R2 was observed touching another resident (Resident R1) in the breast area. Nursing supervisor reported that by the time she left her office, both residents were already separated and Resident R2 was placed on a 1:1 with a nurse aide. Nurse supervisor she assed Resident R1 with a nurse aide, the physician was notified and there	F 0600		

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F 0600 SS=D	Continued from page 9 was an order to send Resident R2 out to the hospital for a change in mental status and in appropriate behavior. Nurse supervisor reported that she contacted Resident R1's daughter who then called the police. Review of the investigation the March17, 2026 incident indicated that the facility unsubstantiated the allegation of resident to resident abuse for inappropriate touching. The activity worker reported to the NHA that he witnessed Resident R2 return to the activity room after the 1st alleged incident witnessed by Resident R3 "caressing Resident R1's inner thigh before I came over and removed him from the dining room. She was wearing blue pants and he was touching the outside." Continued review of the unsubstantiated investigation did not include any statements from any residents who were present in the activity room during the alleged incidents. Continued review of the investigation also did not include any statements from the 2nd activity worker, Employee E7 regarding anything he witnessed and/or did not witness. The investigation also did not include a dated, signed interview with Resident R3 who reported inappropriate touching to the facility staff on March 17, 2026. During an interview with the Director of Nursing (DON) on April 9, 2026 at 2:40 p.m. the incident was reviewed and it was discussed that there were no statements from any residents who were present in the activity room, and that there were no statement from Resident R3, and no	F 0600		

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F 0600 SS=D	Continued from page 10 statement from the 2nd activity worker who was present in the activity room, Employee E7. During an interview on April 10, 2026 at 10:09 a.m. with the Director of Nursing, NHA and the Regional NHA, it was discussed that there were no residents witness statement who were present in the dining room, no witness statements from Resident R2 regarding the various accounts that he reportedly saw, no witness statement from the 2nd activity worker (Employee E7) of what he may/may not have witnessed. 28 Pa. Code 201.18(b)(1)(2)(e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident rights 28 Pa Code 211.12 (c) Nursing services	F 0600		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 11 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Plan of Correction: The facility reviewed the incident involving Resident R2 and Resident R1 related to supervision and inappropriate behavior. Resident R2 was immediately removed from the area. Following the incident, Resident R2 was placed on 1:1 supervision and sent to the hospital for evaluation and remained on 1:1 supervision post return from the hospital until cleared by psychiatry. Resident R1 was assessed with no adverse outcome noted. The provider was notified and the incident was reported to the Department of Health. All residents have the potential to be affected by this deficient practice. Education will be provided to staff on supervision requirements, including immediate intervention and ensuring residents who require supervision are appropriately monitored.	Completion Date: **05/15/2026** Status: **APPROVED** Date: **05/08/2026**

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F 0689 SS=D	Continued from page 12	F 0689	The Administrator or designee will conduct weekly audits to ensure residents requiring supervision are appropriately monitored. Audits will be conducted weekly x4 weeks, then monthly x2 months. Findings will be presented to the QAPI committee.	

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F 0689 SS=D	Continued from page 13 Based on interviews and the review of clinical records, it was determined that the facility failed to ensure that 1 resident (Resident R2) with an allegation of inappropriately touching a cognitively impaired resident (Resident R1) was properly supervised for 1 out of 3 residents reviewed. Findings include: Findings include: Review of the facility abuse policy, "Abuse Investigating and Reporting," with a revision date of 2016 stated that if an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual, and ensure any further potential abuse, neglect, exploitation or mistreatment is prevented. Review of the April 2026 physician orders for Resident R1 included the diagnoses of dysphasia (difficulty swallowing); aphasia (a language disorder that affects an individual's ability to communicate effectively); dementia (a group of symptoms affecting memory, thinking and social abilities, and cerebral infarction (a stroke). Review of the resident's Minimum Data Set Assessment (MDS-periodic assessment of a resident's needs) dated January 2, 2026, indicated that the resident was cognately impaired.	F 0689		

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F 0689 SS=D	Continued from page 14 Review of the April 2026 physician orders for Resident R2 included the diagnoses of diabetes (a chronic condition that occurs when the body cannot properly use blood sugar, leading to high blood sugar levels); seizures (a sudden surge of abnormal electrical activity in the brain that can affect aware ness, muscle control, behavior and sense; chronic kidney disease (a condition characterized by progressive damage and loss of function in the kidneys); schizoaffective disorder (a serious mental health condition characterized primarily by symptoms of schizophrenia, such as hearing things that are not present, seeing things that are not present, false beliefs, along with symptoms of a mood disorder, such as mania and depression) and front temporal neurocognitive disorders (a progressive brain condition that primarily affects the frontal and temporal lobes, leading to changes in behavior, personality, language, and movement). Review of the resident's quarterly MDS dated February 19, 2026, indicated that the resident was awake, alert and oriented. Review of the documentation submitted to the State Survey Agency dated March 17, 2026, on March 17, 2026, revealed that Resident R3 reported that Resident R1 was inappropriately touched in the dining room by Resident R2. Review of the facility's investigation included an incident report completed by Employee E3 (licensed nurse) dated	F 0689		

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	395354	A. BLDG: __00_____ B. WING: _____	04/10/2026

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F 0689 SS=D	Continued from page 15 March 17, 2026 at 6:00 p.m. Employee E3 stated that it was reported to her by a staff member (Activity worker, Employee E4) that Resident R1 was inappropriately touched by Resident R2 in the 1st floor dining room, and that both were immediately separated. Resident R1 was taken back to her 2nd floor bedroom and the resident's daughter was notified, who also called the police. A full body assessment was completed on the resident with no bruises or injuries found. During an interview with Employee E3 (licensed nurse) on April 9, 2026 at 1:05 p.m. lrevealed that she walked into the facility on March 17, 2026 for her shift at 3:00 p.m. on the 2nd floor and was notified by the activity worker that something happened downstairs on the 1st floor. Licensed nurse, Employee E3 reported that at the time she arrived, they were brining Resident R1 up to the 2nd floor.Employee E3 explained that she was not present for the incident, but was notified by the nursing supervisor (Employee E6) for the 3:00 p.m. through the 11:00 p.m. shift that she needed to complete an incident report on what she was told when she started her shift. License nurse, Employee E3 reported that she completed a body assessment on Resident R1 and found no bruises or injuries on the resident.The nursing supervisor contacted the resident's daughter to notify her of the alleged event. Review of a statement by activity staff member (Employee E4) dated March 1, 2026 stated that activity staff member	F 0689		

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F 0689 SS=D	Continued from page 16 witnessed Resident R2 caressing Resident's R1's inner thigh before he came over and removed him from the dining room. Review of a 2nd undated statement from activity staff member indicated that Resident R3 reported to him that he witnessed Resident R2 assaulting Resident R1, and that he stated to him that Resident R1 was being groped. During an interview with activity worker on April 9, 2026 at 1:25 p.m. the activity worker reported that Resident R1 and Resident R2 were sitting at the 2nd to last table near the back of the wall in the 1st floor dining room. Activity worker stated that there was a 2nd activity worker (Employee E7) also present in the first floor dining room who was giving out snacks. Activity worker reported that there were 2 activity aides present in the room and 50 residents. Activity worker reported that he heard Resident R3 call his name while in the activity room and told activity worker to remove Resident R2 from the dining room because he saw Resident R2 touch Resident R1 inappropriately. Activity worker reported that Resident R2 was feeling on Resident R1's thighs/breast and putting his hands in her pants. Activity worker reported that he took Resident R2 to the nursing station and waited for someone from nursing to come around so that he could report it to them. Activity worker reported that he reported to a nurse, whose name he could not remember, of what Resident R3 told him what he saw Resident R2 doing to Resident R1. Activity worker reported that Resident R2 observed back	F 0689		

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F 0689 SS=D	Continued from page 17 in the activity room after he was taken out and observed by the activity worker in the same area, near Resident R1 with his hand resting on her inner thigh "close to her vagina." Activity worker reported that he took Resident R2 back to the nursing station a 2nd time and sat with him until someone came back to the nursing station. Activity worker reported that he felt that Resident R2 "was very lucid and you can take his word on things," in regards to Resident R2's account of what he reported to the Activity worker. Review of an incident reported dated March 17, 2026 at 6:00 p.m. written by licensed nurse (Employee E5) documented that Resident R2 was observed by another resident earlier, and that he was placed at the nursing station for supervision. Licensed nurse reported that during nursing rounds, Resident R2 went back into the same dining room on the 1st floor and was seen kissing the same female resident, Resident R1. Licensed nurse reported that Resident R2 was then placed on 1:1 supervision. During an interview with licensed nurse (Employee E5) on April 9, 2026 at 1:51 p.m. licensed nurse reported that she worker 7:00 a.m. through 7:00 p.m. on March 15, 2026 on the 1st floor. Licensed nurse reported that she was told by the activity aide that Resident R2 was witnessed touching and kissing Resident R1. Licensed nurse reported that she notified the Nursing Home Administrator (NHA) and Unit Manager (Employee E7) of the 1st incident and Resident	F 0689		

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F 0689 SS=D	Continued from page 18 R2 was removed from the dining room and was sitting at the nursing station.The resident went back in the dining room during nursing rounds and licensed nurse was notified of a 2nd incident that occurred which involved him kissing the same Resident R1 when he returned to the dining room. Licensed nurse reported that she notified the Nursing Home Administrator (NHA) and the Unit manager again, and the resident was assigned a 1:1 staff member for supervision. Review of a nursing note dated March 17, 2026 at 9:36 p.m. written by 3-11 p.m. nursing supervisor (Employee E6) reported that she was notified from a male staff member that Resident R2 was seen in appropriately touching Resident R1. The note documented that Resident R2 was placed on 1:1 supervision with a nurse aide, and that the physician was notified and ordered that Resident R2 be sent out to the emergency room for treatment and evaluation. During an interview with nursing supervisor (Employee E6) on April 10, 2026 at 11:20 a.m. nursing supervisor reported that she was completing an admission on her 3:00 p.m. through 11:00 p.m. shift when she was notified that Resident R2 was observed touching another resident (Resident R1) in the breast area. Nursing supervisor reported that by the time she left her office, both residents were already separated and Resident R2 was placed on a 1:1 with a nurse aide. Nurse supervisor she assed Resident	F 0689		

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F 0689 SS=D	Continued from page 19 R1 with a nurse aide, the physician was notified and there was an order to send Resident R2 out to the hospital for a change in mental status and in appropriate behavior. Nurse supervisor reported that she contacted Resident R1's daughter who then called the police. Review of the investigation the March17, 2026 incident indicated that the facility unsubstantiated the allegation of resident to resident abuse for inappropriate touching. The activity worker reported to the NHA that he witnessed Resident R2 return to the activity room after the 1st alleged incident witnessed by Resident R3 "caressing Resident R1's inner thigh before I came over and removed him from the dining room. She was wearing blue pants and he was touching the outside." Continued review of the unsubstantiated investigation did not include any statements from any residents who were present in the activity room during the alleged incidents. Continued review of the investigation also did not include any statements from the 2nd activity worker, Employee E7 regarding anything he witnessed and/or did not witness. The investigation also did not include a dated, signed interview with Resident R3 who reported inappropriate touching to the facility staff on March 17, 2026. During an interview with the Director of Nursing (DON) on April 9, 2026 at 2:40 p.m. the incident was reviewed and it was discussed that there were no statements from any residents who were present in the activity room, and that	F 0689		

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F 0689 SS=D	Continued from page 20 there were no statement from Resident R3, and no statement from the 2nd activity worker who was present in the activity room, Employee E7. During an interview on April 10, 2026 at 10:09 a.m. with the Director of Nursing, NHA and the Regional NHA, it was discussed that there were no residents witness statement who were present in the dining room, no witness statements from Resident R2 regarding the various accounts that he reportedly saw, no witness statement from the 2nd activity worker (Employee E7) of what he may/may not have witnessed. During an interview on April 10, 2026 at 10:09 a.m. with the DON, NHA and the Regional NHA, it was discussed that when an allegation of in appropriate touching was reported the 1st time by Resident R3, Resident R2 was removed from the dining room, but went back in and was observed by Activity worker (Employee E4) observed by the activity worker touching a cognitively impaired resident a 2nd time due to in appropriate supervision by the facility. 28 Pa. Code 201.18(a) Management 28 Pa. Code 201.18(b)(1)Management 28 Pa. Code 201.18 (b)(3)Management 28 Pa. Code 201.18(d) Management	F 0689		

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F 0689 SS=D	Continued from page 21 28 Pa. Code 211.10(b) Resident care policies	F 0689		

Certified End Page

SILVER STREAM REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 192702

SURVEY EXIT DATE: 04/10/2026

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