

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Bryn Mawr Extended Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 956 Railroad Avenue Bryn Mawr, PA 19010	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and interview with staff, it was determined that the facility did not ensure that appropriate infection control practices were maintained during wound care for one of 29 residents reviewed (Resident R12). Findings include:Review of the Pennsylvania Department of Health document Checklist for Infection Control, last updated January 2026, revealed that, Gloves should be changed and hand hygiene performed when moving from dirty to clean wound care activities (e.g. after removal of soiled dressings, before handling clean supplies, and Aseptic non-touch technique .aims to prevent the transmission of microorganisms to the wound. Review of Resident R12's clinical record revealed that the resident was most recently readmitted to the facility on [DATE], with the diagnoses of cerebral infarction (stroke caused by a blood clot or other obstruction in the brain), hemiplegia (paralysis of one side of the body) of the right dominant side, aphasia (inability to speak) following stroke. Review of wound treatment orders obtained March 9, 2026, revealed the following wound care orders: Cleanse right ischium (hip area) with NSS (normal saline solution), pack with calcium alginate (a special type of dressing that absorbs excess fluid to keep the wound dry) and cover with CDD (clean dry dressing) once a day.Cleanse sacrum (tailbone) with NSS, pack with calcium alginate and cover with CDD once a day. Observation of wound care for Resident R12 was conducted on March 12, 2026, at 10:10 a.m. During the care that was provided by Registered nurse, Employee E12, the nurse performed hand hygiene and donned gloves before preparing the clean field. The resident was rolled onto her left side. After placing an absorbent pad under the resident's hip and buttocks, the nurse removed the soiled bandages from the wound on the ischium and the wound on the sacrum, as well as uncovering an area on the left inner thigh.Employee E12 then removed her soiled gloves and donned clean gloves without performing hand hygiene. The nurse cleansed all three wounds with normal saline without changing gloves or performing hand hygiene between wounds. Before cleaning the thigh wound with a saline soaked gauze pad, Employee E12 noticed a drip coming from the sacral wound. She used the saline soaked gauze to wipe up the drip before using the same gauze to cleanse the thigh wound. Alginate was applied to all three wounds which were then covered with adhesive bordered gauze. The clean dressings were applied with the same gloves that were used to clean the wounds. After the resident's wounds were dressed, Registered nurse, Employee E12 gathered the soiled dressings and other trash, wrapping them into the absorbent pad, which she then placed on the resident's bedside table. The soiled draw sheet was removed from the bed and placed on the resident's chair. A clean draw sheet was placed, and the resident was repositioned.Continued observation revealed Employee 12 washing hands and donning clean gloves, Employee E12 picked up the bundle of soiled material and placed it into a biohazard bag which she took to the soiled utility room to dispose of in the biohazard bin. An interview with the Director of Nursing (DON), Employee E2, on March 12, 2026, at 11:20 a.m. confirmed that the nurse had missed many indications for hand hygiene, including moving between wounds and in between dirty and clean wound care activities. DON further confirmed that the nurse should not have had all three wounds open at the same time. She stated that the wound to the inner thigh was excoriation, which should have been treated with a moisture barrier cream, not alginate and a dressing. Employee (continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E2 confirmed that the nurse should not have place soiled materials on the resident's bedside table or her chair. 28 Pa Code 201.18(b)(1) Management 28 Pa. Code 201.14(a) Responsibility of licensee</p>		