STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395311	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Extended Care Center	956 Railroad Avenue Bryn Mawr, PA 19010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41471 Based on review of clinical records, review of facility policies and procedures and interviews with staff, it was determined that the facility failed to promptly notify resident's physician of a fall with injury resulting in hospitalization during a leave of absence from the facility for one of six residents reviewed (Resident R6). Findings include: Review of facility policy titled Resident Change in Condition Policy dated June 27, 2024, revealed The licensed nurse will recognize and intervene in the event of a change in resident condition. The Physician/Provider and the Family/Responsible Party will be notified as soon as the nurse has identified the change in condition and the resident is stable. A Significant Change of Condition is a decline or improvement in the resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical intervention[s]; and/or one that 2. Impacts more than one area of the resident's health status; and/or one that 3. Requires interdisciplinary review and/or revision to the care plan. The Physician/Provider and Resident /Family/Responsible Party will be notified when there has been: a. An accident or incident involving the resident; b. A discovery of an injury c. A reaction to medication or treatment; d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment, including a change in provider orders (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R6's nursing progress note dated August 11, 2024, revealed that resident went to leave of absence with family to church. Review of Resident R6's nursing progress note dated August 11, 2024, revealed that resident returned to the nursing unit at 4:30 p.m., and, accompanied by brother. Resident's family was notified by the resident about hospitalization ; and family picked up resident from the hospital by the car and transferred back to the facility. Resident noted with pain and discomfort. An abrasion was noted to right thumb, and pain noted to right side. As needed pain medication given. Review of facility reported incident dated August 14, 2024, revealed that while on leave of absence with church members on August 11, 2024, approximately 1:30 p.m., Resident R6 sustained a witnessed fall at church landing on his right side and was taken to the hospital by a church member. Review of Resident R6's entire clinical record revealed no documented evidence that the physician was notified promptly of Resident R6 fall while on leave of absence from the facility which resulted in injury and hospitalization . Interview with the Regional Nurse, Employee E3 on November 1, 2024 at 12:00 p.m. confirmed that there was no evidence in the clinical record that the physician was notified promptly of Resident R6 fall while on leave of absence from the facility. 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(5) Nursing services.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 29720 Based on observation, review of facility policy and interview with staff, it was determined that the facility did not ensure personal privacy and confidentiality related to signage for enhanced barrier precautions for 5 of 8 residents on transmission based precautions (Residents R56, R126, R117, R88 and R61). Finding include: Review of facility policy, title Resident Rights, revised September 3, 2020, revealed, It is the facility's policy to comply with all Resident Rights, and to communicate these rights to residents and their designated representatives in a language they can understand. Review of facility policy, Transmission Based Precautions and Isolation policy, last revised April 14, 2024 revealed: Enhanced Barrier Precautions (EBP). EBP are intended to prevent transmission of multi-drug resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to highrisk residents. EBP are indicated for high contact care activities for residents with chronic wounds and indwelling devices (such as central lines, urinary catheters and trachs) and for all those colonized or infected with a MDRO currently targeted by the CDC. Further review of the above policy revealed, Signage indicating the appropriate type(s) of precautions and indicating that visitors should stop at Nurse's Station before entering, will be placed on the resident's door. Staff will educate visitors regarding donning appropriate Personal Protection Equipment while adhering to the resident's right for privacy protection. Observation tour on October 31, 2024 at 11:00 a.m. revealed eight residents had transmission based precautions signage posted on their door. Five of eight transmission based precautions signs revealed personal and confidential medical information. Transmission Based Precaution signage for Resident R56 revealed a staff member identified peg tube (feeding tube) and wound. Transmission Based Precaution signage for Resident R126 revealed a staff member identified trach (tracheostomy), peg tube (feeding tube) and wound. Transmission Based Precaution signage for Resident 117 revealed a staff member identified peg tube (feeding tube). Transmission Based Precaution signage for Resident R88 revealed a staff member identified peg tube (feeding tube) and trach (tracheostomy). Transmission Based Precaution signage for Resident R61 revealed a staff member identified foley (catheter) 28 Pa Code 211.12(c)(d)(1) Nursing services

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 41471 Based on clinical record review and interviews with staff, it was determined that the facility failed to accurately complete a resident assessment related to discharge status for one of 27 residents reviewed (Resident R129). Findings include: Review of Resident R129's progress note revealed a nursing note dated July 31, 2024, which stated, resident discharged to home. Review of Resident R129's discharge Minimum Data Set (MDS- assessment of resident care needs) dated July 31, 2024, revealed that the residents discharge status was coded, Short term general hospital (acute hospital). Interview with the Registered Nurse Assessment Coordinator, conducted on November 1, 2024, at 11:30 a. m. confirmed that the MDS discharge status, dated July 31, 2024, for Resident R129 was coded inaccurately. 28 Pa. Code 201.14(a) Responsibility of licensee 2 Pa. Code 211.5(f) Medical records

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 36609 Based upon review of clinical records and interviews with family and review of facility documentation, it was determined that the facility did not ensure resident requiring continuous oxygen therapy received such services per the physician orders for one of 28 resident records reviewed (Resident R1). Findings include: Review of Resident R1's clinical record revealed that the resident was initially admitted to the facility in September 2022 for acute respiratory failure with hypoxia. Review of the grievance log revealed Resident R1's family indicated during a visit they observed the resident without the oxygen mask, stating it was the third time this month. Review of the Resident R1's October 2024 physician orders revealed an order for 2 liters of oxygen to be given continuously via nasal canula and to check the concentrator to endure functioning and appropriate setting. Statement received by the nursing assistant indicated on May 14, 2024, she removed the oxygen mask while giving care and forgot to replace the mask. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609 Based on a review of clinical records, review of facility documentation, review of facility policy, review of hospital records and interviews with staff, it was determined that the facility failed to assess resident's pain and timely obtain pain medication for adequate pain management for one of 28 residents reviewed. This failure resulted in actual harm to Resident R381 whose pain to the left foot was not properly relieved and managed and continued to experience uncontrolled pain. (Resident R381). Findings include: Review of the facility's policy for Emergency Medication Supplies (Emergency kit) revised December 2023 stated the pharmacy may provide the facility with Emergency Medication. Emergency medications shall be accessed by authorized facility staff when a medication is medically necessary to be administered before the next scheduled pharmacy delivery and for New Admissions. Review of the facility's pain management policy revised August 2024 stated the policy of this community to ensure any resident admitted to the facility is assessed for pain and/or potential for pain. A pain evaluation will occur on admission and with a significant change in condition. The evaluation will include active pain, including the type, intensity, characteristics, and frequencies, what pharmacological interventions used in the past to address the pain and the efficacy of such interventions, including use of opioids and any history of opioid use .Using the numeric pain rating scale (an 11-point scale where 0 indicates no pain and 10 indicates the worst pain imaginable) when evaluating the presence of pain. Further review of the facility's pain policy indicates, when the pharmacological interventions are needed the effect of the medication will be documented, and The physician will be notified of new onset of pain or a significant increase in pain as appropriate. Review of Resident R381's clinical records revealed the resident was admitted to the hospital on October 5, 2024, when emergency services found (him/her) outside screaming in pain, due to a chronic ulcer wound on (his/her) right ankle. Review of the hospital's physical therapy note, dated October 11, 2024, noted the resident complained of pain, with contractures in multiple joints and limited range of motion in (resident) hips and knees with chronic right ankle deformity. Therapy notes stated the resident remained in (his/her) wheelchair 24/7 without transferring for toileting or sleeping and was unable to lay flat on (his/her) back. Review of admission documentation revealed that Resident R381 was admitted to the facility on [DATE]. Resident R381 was admitted to the facility with the diagnoses of an unspecified open wound, left ankle sequela (any complication or condition as a result of a previous disease or injury), chronic leg pain, Peripheral Vascular Disease (poor circulation of the extremities) and Cellulitis (potentially serious bacterial infection that effects the deeper layers of the skin). Review of hospital medication orders revealed that the resident was ordered pain medication Oxycodone IR (immediate release) 5 milligrams by mouth every 6 hours. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of admission progress note dated October 12, 2024, at 2:17 a.m. Licensed Practical Nurse (LPN) Employee E9 revealed Received resident sitting on the side of the bed complaining of pain. APAP (Acetaminophen) 975 MG (milligrams) was offered to resident and (he/she) refused stating (resident) wants (his/her) oxycodone. This writer then informed resident that its not available this second take tylenol until we're able to obtain it, resident still refused APAP. Review of Resident R381's October 2024 Medication Administration Record (MAR) revealed that the resident was ordered on October 11, 2024, Acetaminophen 325 milligrams two tablets by mouth every 4 hours as needed for headache/pain. The resident was administered the medication on October 11, 2024, at 8:12 a.m. for a pain level of 9 on his/her right knee and left ankle. Continued review of the MAR revealed that this was the only occasion Acetaminophen 325 milligrams was administered to the resident. There was no documented evidence that the resident's pain level was assessed on October 11, 2024, during the evening and night shifts. The next time the resident was medicated for pain was October 12, 2024, that an order was obtained for Oxycodone 5 milligrams one tablet by mouth every 6 hours for severe pain over 7/10 (pain severely scale of 0-10). The resident was administered Oxycodone 5 milligrams on October 12, 2024, at 9:55 a.m. for a pain level of 9. Continued review of nursing notes dated October 12, 2024, at 1:15 p.m. revealed that the resident was requesting as needed Oxycodone. Licensed nurse, Employee E9 explained again that its every 6 hours and it has only been 3 hours. Resident was offered APAP (Acetaminophen) in which he refused. The resident began to demand to see the supervisor and DON saying its every 4 hours. Supervisor explained to resident it's every 6 hours and that it's too soon to administer. Continued review of Resident R381's clinical record revealed, approximately an hour after receiving the first dose of Oxycodone, a note written by physical therapist at 10:59 a.m. stated the resident, Perseverates on LLE (left lower extremity) pain and states (he/her) is in 10/10 pain; nursing is aware and reports patient received pain meds this AM . Pt continues to refuse any further mobility and states, 'The only therapy I want to do is jump out the window and hopefully slit my carotid on the way, when pressed regarding statement pt reports [Resident] is in a lot of pain at this time. Nursing supervisor and charge nurse made aware of patient's statements and behaviors. When the resident expressed to the therapist, (Resident) was in a severe pain there was no evidence the physician was notified. Instead of acknowledging the resident's pain, a late note written by the supervisor, dated October 12, 2024, documented that the therapist reported the resident with suicidal ideation and was immediately placed on a 1:1 supervision, and further stated After that, resident did not report suicidal ideation. Continued review of the clinical record revealed the resident was Placed on 1:1 for suicidal ideation related to pain management. The LPN, Employee E9 witness statement indicated, 'The supervisor and the Director of Nursing asked the resident to stay and 'Wait for pharmacy to deliver (his/her) meds.' During interview with the Director of Nursing (DON) on October 31, 2024, at 2 p.m. the DON was asked why the medication wasn't available. In addition, the delay obtaining an authorization code, and why the emergency medication was not utilized sooner. The DON was also interviewed as to no evidence that the resident's physician was notified regarding the resident's pain. The DON had no response for not calling the physician nor waiting for the authorization number but did reply it was the weekend and staff did not want to bother the physician. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The facility failed to ensure that Resident's left foot pain was managed resulting in actual harm to Resident R381 who continued to experience uncontrolled pain. 28 Pa. Code 211.2 (d)(9)(10) Medical director 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 41471 Based on clinical record review and staff interview, it was determined that the facility failed to ensure that laboratory studies were promptly obtained as ordered by the physician for one of 28 clinical records reviewed (Resident R107). Findings include: Review of Resident R107's physician progress note dated October 18, 2024, indicated that resident had complained of headache, dizziness, and lightheadedness. Resident's nurse practitioner was notified and ordered for lab work, CBC (complete blood count), CMP (complete metabolic panel), Urine culture and sensitivity, and electrocardiogram (EKG). Further review of Resident R107's clinical records revealed the staff collected the urine sample on October 19, 2024, at night shift however it was not set to the lab in a timely manner. Continued review of Resident R107's clinical records revealed the staff recollected the urine sample on October 21, 2024, and sent to the lab. Review of clinical record for Resident R107 revealed no evidence that the staff obtained the result or inquired about the result of urine test result sent on October 21, 2024. Interview with the Registered Nurse, Employee E5 on October 31, 2024, at 11:28 a.m. stated the urine container leaked on the way to the lab and it was discarded, lab tried to reach the facility but was unable to connect, no follow up was completed and no new urine sample was sent out. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 41471 Based on the review of facility policies, clinical record review and staff interviews, it was determined that the facility failed to ensure that resident's physician was notified about abnormal laboratory test results for one of 28 residents reviewed (Resident R107). Findings include: Review of Resident R107's physician progress note dated October 18, 2024, indicated that resident had complained of headache, dizziness, and lightheadedness. Resident's nurse practitioner was notified and ordered for lab work, CBC (complete blood count), CMP (complete metabolic panel), Urine culture and sensitivity, and electrocardiogram (EKG). Review of Resident R107's progress note dated October 19, 2024, indicated that the lab work was obtained, and the results were pending. Review of resident's clinical record including paper record and electronic record available at the facility revealed no evidence that the lab results which was ordered on October 18, 2024, were available to review. Interview with the Registered Nurse, Employee E5 on October 31, 2024, at 11:28 a.m. stated the lab work was completed for CBC and CMP, however it was not printed from lab electronic system and there was no evidence that the physician was notified. Further review of Resident R107's laboratory studies which was printed by Employee E5 revealed the results of CBC and CMP completed on October 19, 2024, indicated that some of the results were flagged for out of range. Resident's blood Sodium level was 133 with a normal range of 136-144. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 36609 Based on observations, review of facility documentation, and resident interviews, it was determined that the facility failed to ensure menus were followed for 10 of 28 clinical records reviewed (Resident R32, R35, R43, R57, R99, R122 and R440R40, R59 and R109). Finding include: During lunchtime on October 29, 2024, at 1:08 p.m. Resident R109 complained that she did not order the chicken she was served and was given cranberry juice that she stated she was unable to drink. Review of Resident R109's lunch ticket indicated the resident requested roast beef, brown gravy, creamed spinach, and egg noodles. Also included on the lunch ticket was a request that indicated no cranberry juice. Interview with Resident R59 on October 29, 2024, at 3:00 p.m. stated he always gets the wrong meal and never gets what he asks for. Review of the grievance log revealed Resident R40 complained the kitchen serves the wrong food. Interview with Resident R40 on October 30, 2024, confirmed this still continues. During resident council on October 30, 2024 at 1:00 p.m. with seven residents (Resident R32, R35, R43, R57, R99, R122 and R440) voiced concerns that the served food did not match with the food ticket. 28 Pa. Code 201.18(b)(3) Management

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 41471 Based on observations and staff interviews, it was determined that the facility failed to ensure that resident bathrooms were equipped with the appropriate call bell system for one out of 28 residents reviewed (Resident R21) Findings include: During an observation in Resident R21's on rooms on October 29, 2024, at 1:44 p.m. revealed that there was no wired call bell in residents' room, the wires were removed from the wall. Further observation revealed that there was a tap bell in the room across from resident's foot of the bed, which was out of reach for the resident who was laying in the bed. Resident R21 stated she uses the bell to call for staff and no one responds. Further observation revealed that resident pressed the tap bell at 1.49 p.m. Resident stated she needed to be changed as she had an incontinence episode. Staff did not respond until 1:58 p.m. and the surveyor observed staff at the nurse's station. Employee E4 who was assigned staff for Resident R21 stated she saw the bell sitting across from the resident when she was in her room before, but she thought the resident have a corded call bell. Observation in Resident R21's on rooms on October 30, 2024, at 11:14 a.m. revealed that the resident pressed the tap bell numerous times. Resident was lying on the bed and stated she wanted to get ready to go lunch. There was no response from staff until 11:27 a.m., it was revealed that the tap bell was not audible at the nurse's station, where there was music playing in the next room. Further observation on October 30, 2024, at 11:28 a.m. revealed that Registered Nurse, Employee E5 was passing medication in the hallway two rooms away from the resident. Employee E5 stated she did not hear the tap bell. During an interview with the Nursing Home Administrator and the Regional Nurse on November 1, 2024, at 12:00 p.m. stated the call system provided for Resident R21 was not adequate. 28 Pa. Code 205.67(j) Electric requirements for existing construction

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41471 Based on review of personnel files and interviews with staff, it was determined that the facility failed to ensure that nurse aides received at least 12 hours of continuing education per year as required for three of five nurse aide personnel files reviewed (Employees E6). Findings include: A copy of five nurse aide employee educational record was requested to the facility administrator on November 1, 2024, at 9:30 a.m. Review of personnel files for Employees E6, Certified Nursing Assistant, revealed that there was no evidence that the employees completed at least 12 hours of continuing education per year as required. Interview on November 1, 2024, at 1:00 p.m. the Nursing Home Administrator revealed that there were no 12-hour educational records for Employees E6 at the time of the survey. 28 Pa Code 201.19(7) Personnel policies and procedures 28 Pa Code 201.20(d) Staff development