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	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Extended Care Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, review of facility documentation and clinical records, and staff and resident interviews, it was determined the facility failed to ensure Resident R3, was adequately secured during transportation in the facility's contracted transportation service van. This failure resulted in actual harm to Resident R3 who sustained a fracture of right tibial plateau, for which the treatment involved surgical procedure for one of two residents reviewed (Resident R3) Findings Include: Review of Resident R3's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 9, 2026, revealed Resident R3's diagnoses included Hemiplegia (total paralysis of one side of the body) and Hemiparesis (weakness or partial loss of muscle movement on one side of the body, both resulting from brain or spinal cord damage), Cerebrovascular Accident (CVA-stroke), Psychotic Disorder (mental health condition that causes a person to lose touch with reality, making it difficult to distinguish between what is real and what is not), Seizure Disorder (chronic brain condition characterized by recurring, unexpected electrical storms in the brain, disrupting normal brain function, causing temporary symptoms like staring spells, uncontrollable shaking, confusion, or loss of awareness), End Stage Renal Disease (permanent stage of kidney failure), and Depression (mental health condition characterized by persistent sadness and a loss of interest in activities). Continued review of Resident R3's MDS assessment revealed the resident's BIMS (Brief Interview of Mental status) score of 15, which indicated the resident was cognitively intact. Further review of the MDS assessment indicated Resident R3 used a wheelchair for mobility. Review of Resident R3's care plan developed July 16, 2024, revealed the resident had impaired Activities of Daily Function related to impaired mobility, Right Hemiparesis/Hemiplegia secondary to CVA and History of Right Hip Fracture. Continued review of Resident R3's care plan revealed a care plan developed on October 28, 2024, related to the resident being at risk for falls related to impaired mobility. Review of information submitted to the Pennsylvania Department of Health by the facility on February 21, 2026, revealed Resident R3 sustained a fall on February 21, 2026, in the transportation van. [Resident R3] with BIMS score of 15 boarded .van a contracted transportation service of the facility, to be taken to (his/her) scheduled dialysis appointment, on February 21, 2026, at approximately 9 a.m. At approximately 9:30 a.m., Nursing staff, Employee E3 received a call from the contracted transportation service's van driver, (Employee E5). (Employee E5) informed the facility staff (Resident R3) sustained a fall to the floor of the van. (Van driver, Employee E5) made an abrupt stop of the van as vehicles in front of the van stopped unexpectedly, causing Resident R3 to fall out of (his/her) wheelchair and onto the floor of the van. (Van driver, Employee E5) stated that he was going to return the resident to the facility, and at that time the nurse of the facility advised the driver to (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

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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	take the resident to the ER (emergency room) for evaluation. MD (physician) and Responsible Party of [Resident R3] were made aware of [Resident R3's] then healthcare status along with the name and location of the hospital the resident was being taken to. Continued review of the information submitted to the Department revealed, Facility nursing staff has called the initial Hospital were [Resident R3] was taken, to obtain a follow up report. Facility Nursing staff was told by ER (Emergency room) Nurse of the hospital that [Resident R3] was being transferred to, a Major Hospital for surgery of the Right Tibia (shin bone). Administrator of the facility called the Contracted Transportation Service Company for their incident reports of the event. According to the Contracted Transportation Service Company driver's (Employee E5) statement, [Resident R3] was not secured in [Resident R3's] wheelchair in the van. Police was called and the incident report was given to Police Officer. The facility was looking for a new non-emergent transportation service. Review of Resident R3's clinical record revealed a nursing note dated February 21, 2026, confirming the same information as documented above. Review of Resident R3's hospital Emergency Department record, dated February 21, 2026, revealed Resident R3 arrived to the Emergency Department after a motor vehicle accident. The patient was sitting in (his/her) wheelchair on a transport on (his/her) way to Dialysis. Another vehicle cut them off and the driver slammed on the brakes. The patient fell out of the chair and struck (his/her) right side against the seats in front of them. Now having pain on the right side of (his/her) body which includes right shoulder, elbow, knee, and ankle. Also reports a headache with neck pain. No Loss of Consciousness. (He/she) is on Eliquis (anticoagulant). Review of Resident R3's hospital X-ray dated February 21, 2026, in the hospital Emergency Department record revealed; there was a fracture of the tibia. On March 9, 2026, at 12:54 p.m., an interview was conducted with Assistant Director of Nursing (ADON), Employee E3 regarding the incident involving Resident R3. Employee E3 (ADON) revealed received notification of the incident from the van driver, Employee E5, on February 21, 2026. During the interview, Employee E3 revealed the van driver (Employee E5) acknowledged Resident R3 was not secured with a wheelchair- seatbelt, Resident R3 fell inside the vehicle contracted by the transportation service company. Further interview on March 9, 2026, at 1:09 p.m. with Employee E3 (ADON), revealed on February 21, 2026, the van driver called to notify staff that he/she was bringing Resident R3 back to the facility because the resident had fallen out of his/her wheelchair after the van came to an abrupt stop. Employee E3, reported to have instructed the van driver to take Resident R3 directly to the hospital but the van driver insisted on bringing Resident R3 back to the facility. Continued interview with Assistant Director of Nursing (ADON), Employee E3, revealed she was waiting at the front entrance when the van pulled up front with Resident R3 inside the van. Employee E3 (ADON), revealed Resident R3 was physically assessed and was observed to have redness on his/her face with fresh blood above the eyebrow. Resident R3 told Employee E3, that he/she fell forward out of the wheelchair and was in a lot of pain. Van driver reportedly informed Employee E3, that he/she only secured the resident's wheelchair in the van but failed to apply Resident R3's seatbelt. Assistant Director of Nursing (ADON), Employee E3, revealed Resident R3 remained in the vehicle, and he/she again directed the van driver to transport Resident R3 to the hospital for further (continued on next page)

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	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Extended Care Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	evaluation. On March 9, 2026, attempts to interview the van driver, Employee E5, were unsuccessful as Employee E5 was no longer employed by the facility. Review of the New Hire-Training Acknowledgement Form of the Contracted Transportation Service Company for Employee E5 revealed Employee E5 completed the New Hire- Training on May 20, 2025. Further review of Employee E5's personnel file revealed; Employee E5 also received training on October 8, 2025, Passenger Assistance Safety and Sensitivity (Pass) 8 Basic Online Training Program. (The training is widely used in the U.S. for drivers who transport people with disabilities, seniors, or medical passengers (like paratransit or non-emergency medical transport.) During interview on March 12, 2026 at 2:07 p.m. with the Nursing Home Administrator, Employee E1, and Director of Nursing, Employee E2, surveyor asked how the van driver should have responded to an injured resident in the van and if it was appropriate for the van driver to assist the resident off the floor and back into the wheelchair without direction from a medical provider. Continued interview with the Nursing Home Administrator, Employee E1, revealed he/she did not know how the van driver should have proceeded after Resident R3 fell out of the wheelchair. The facility failed to ensure that Resident R3 was adequately secured during transportation in the facility's Contracted Transportation Service Van. This failure resulted in actual harm to Resident R3 who sustained a fracture of right tibial requiring surgery. 28 PA Code 201.18(b)(3)(e)(1) Management 28 PA Code 211.10(d) Resident care policies

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)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations, and staff and resident interviews, it was determined that the facility failed to ensure a resident was provided the self-determination in regard to a room change for one of 33 residents reviewed (Resident 157).Findings Include: Review of facility policy Resident Rights and Facility Responsibilities Policy reviewed October 7, 2025, 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 that they can understand. Review of Resident Rights Room Assignments & Changes revised July 2011, revealed during the course of a residents stay, room changes may be necessary for the welfare of each resident. The facility will try to give the Resident and Resident Representative reasonable notice, prior to change, including an explanation for the change. Review of Resident R157's comprehensive Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated January 28, 2026, revealed the resident was admitted to the facility on [DATE], and had diagnoses of muscle weakness, cognitive communication deficit, and need for assistance with personal care. Continued review of Resident R157's comprehensive MDS dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS - brief screener that aids in detecting cognitive impairment) score of 12 (moderately impaired). Observations on March 11, 2026, at 1:55 p.m. revealed Resident R157 was in the hallway, visibly upset, holding a few of his/her personal belongings. Interview on March 11, 2026, at 1:55 p.m. with Resident R157, the resident expressed being upset and frustrated because he/she was abruptly informed and subsequently transferred to a new room. Resident R157 stated he/she did not want to move rooms but indicated he/she felt a choice was not provided. Resident R157 stated he/she was only informed within the last 30 minutes, and his/her personal belongings were already moved with the assistance of nursing staff. Licensed Nurse, Employee E10, was present at the time of the interview with Resident R157 on March 11, 2026, at 1:55 p.m. Licensed Nurse, Employee E10, stated he/she was given instruction by the Admissions Director that Resident R157 needed move into a new room so a room could become available for a new male admission. Interview on March 11, 2026, at 2:08 p.m. with the Director of Nursing, Employee E2, revealed he/she was unaware Resident R157 was transferred to a new room. Interview on March 11, 2026, at 2:15 p.m. with Social Services Director, Employee E11, confirmed Resident R157 should not have been moved, as staff were also unable to get in contact with the resident's representative. 28 Pa Code 201.29(a) Resident rights

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)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of facility records and interview with staff, it was determined that the facility failed to transmit the required initial comprehensive MDS assessment for one of 29 residents reviewed (Resident R153)Findings include:Review of MDS (Minimum Data Set- a periodic assessment of resident needs) transmission data for Resident R153 revealed an admission MDS was transmitted on October 28, 2025. A quarterly assessment was transmitted on February 28, 2026. An initial comprehensive assessment was not found to have been transmitted.An interview with Employee E1, the Nursing Home Administrator confirmed that no MDS assessment was transmitted between October 28, 2025, and February 28, 2026. 28 Pa. Code S 201.14(a) Responsibility of licensee

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	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Extended Care Center	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations, and interviews with staff and residents it was determined that the facility failed to review and revise resident care plans in accordance with resident needs for one of 33 residents reviewed (Resident R134). Findings Include: Review of Resident R134's quarterly Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 13, 2026, revealed the resident had severe cognitive impairment and a diagnosis of aphasia (communication deficit). Review of Resident R134's comprehensive care plan dated August 27, 2025, revealed the resident had potential for falling related to limited mobility and impaired balance. Intervention dated August 10, 2025, specified scoop mattress in place. Observations and interview on March 12, 2026, at 11:00 a.m. with Registered Nurse, Employee E12, revealed Resident R134 did not have a scoop mattress. Resident R137 had a regular pressure reduction mattress in place. Interview on March 12, 2026, at 11:22 a.m. with Director of Nursing, Employee E2, revealed Resident R134 was seen by the wound practitioner in October 2025 after the resident sustained a skin tear to the thigh. Per the wound care communication log dated October 29, 2025, the wound practitioner recommended discontinuing the scoop mattress as he/she felt it would inhibit the turning and repositioning of Resident R134. Continued interview on March 12, 2026, at 11:22 a.m. with Director of Nursing, Employee E2, confirmed the facility failed to revise Resident R134's care plan to remove the scoop mattress intervention. Review of Resident R3's quarterly Minimum Data Set, dated [DATE], revealed Resident R3's diagnoses included Hemiplegia (total paralysis of one side of the body) and hemiparesis (weakness or partial loss of muscle movement on one side of the body, both resulting from brain or spinal cord damage), Cerebrovascular Accident (CVA-stroke), Psychotic Disorder (mental health condition that causes a person to lose touch with reality, making it difficult to distinguish between what is real and what is not), Seizure Disorder (a chronic brain condition characterized by recurring, unexpected electrical storms in the brain. These sudden bursts of electricity disrupt normal brain function, causing temporary symptoms like staring spells, uncontrollable shaking, confusion, or loss of awareness), End Stage Renal Disease (permanent stage of kidney failure), and Depression (mental health condition characterized by persistent sadness and a loss of interest in activities). Continued review of Resident R3's MDS assessment revealed the resident's BIMS (Brief Interview of Mental status) score of 15, which indicated that the resident was cognitively intact. Further review of the MDS assessment indicated Resident R3 used a wheelchair for mobility. Review of Resident R3's care plan developed July 16, 2024, revealed the resident had impaired Activities of Daily Function related to impaired mobility, Right Hemiparesis/Hemiplegia secondary to CVA and History of Right Hip Fracture. Continued review of Resident R3's care plan revealed a care plan developed on October 28, 2024, related to the resident being at risk for fall related to impaired mobility. 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical documentation and interviews with staff, it was determined that the facility did not ensure physician orders were followed related to wound treatment for one of 29 residents reviewed (Resident R12). Findings include: Review of Resident R12's clinical record revealed that the resident was most recently readmitted to the facility on [DATE], with 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 March 2026 physician orders revealed wound treatment orders obtained March 9, 2026 toCleanse 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.and 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, 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. The nurse cleansed all three wounds with normal saline. Alginate was applied to all three wounds which were then covered with adhesive bordered gauze. An interview with the Director of Nursing (DON), Employee E2, on March 12, 2026, at 11:20 a.m. confirmed that the wound to the inner thigh was excoriation, which should have been treated with a moisture barrier cream, and that the resident did not have an order for alginate and dressing for the thigh wound. 28 Pa Code 201.18(b)(1) Management28 Pa. Code 201.14(a) Responsibility of licensee

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	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Extended Care Center	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)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and the review of clinical records, it was determined that the facility failed to maintain complete dialysis records related to dialysis communication for two of two Dialysis-Residents reviewed (Residents R3 and R16).Findings include: Review of Resident R3's clinical record revealed that the resident was admitted to the facility on [DATE], with the diagnoses of End-Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Review of Resident R3's physician order, dated August 14, 2024, revealed; Resident R3 received dialysis treatment at an outpatient dialysis facility on Tuesdays, Thursdays and Saturdays. The physician ordered a special instruction for the dialysis communication tool, to be completed. Review of Resident R3's Hemodialysis Communication Record named; Dialysis Communication Tool, revealed that on uncountable days, in the months of February 2026, January 2026, and December 2025, it was lacking the signature of the Dialysis Facility Nurse on the Part to be completed by the Dialysis Staff in the communication log. Review of Resident R16's clinical record revealed that resident R16 was diagnosed with of End-Stage Renal Disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). Review of Resident R16's physician order, dated May 02, 2024, revealed; Resident R16 received dialysis treatment at an outpatient dialysis facility on Mondays, Wednesdays and Fridays. The physician ordered a special instruction for the dialysis communication tool, to be completed. Review of Resident R16's Hemodialysis Communication Record named; Dialysis Communication Tool, revealed that on uncountable days, in the months of February 2026, January 2026, and December 2025, it was lacking the signature of the Dialysis Facility Nurse on the Part to be completed by the Dialysis Staff in the communication log. Interview with the Director of Nursing, on March 12, 2026, at 11:14 a.m., confirmed incomplete Dialysis communication log of Residents R3, and R16. 28 Pa Code 211.5(f) Clinical records 28 Pa Code 211.12(d)(3) Nursing services

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	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Extended Care Center	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)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on review of facility policy, review of clinical records, observations, and interviews with staff, residents, and resident representatives it was determined that the facility failed to have available a thermometer to heat of food brought from home by a family member for one of 33 residents reviewed (Resident R162).Findings Include: Review of facility policy Food Brought in From Outside the Facility reviewed November 2024, revealed staff outside the dietary department will store and handle food in accordance with food safety standards when residents or their friends/family bring food into the facility. Further review of facility policy revealed if food needs to be reheated, reheat food in microwave so that all parts of the food reach a temperature of at least 165 degrees Fahrenheit (F). After reheating the food, staff should take the temperature to confirmed food has reached an internal temperature of 165 degrees. Staff should allow food to cool to 130-155 degrees F when served to residents. Review of Resident R162's comprehensive care plan dated March 6, 2026, revealed the resident was at increased nutrition/hydration risk related to a diagnosis of severe protein-calorie malnutrition (insufficient intake of protein and calories, leading to muscle and fat loss and impaired bodily functions), and decreased food intake. Interventions dated March 4, 2026, included to respect/honor resident dietary choices and to provide assistance with meals as needed to encourage intake. Observations on March 11, 2026, at 11:45 a.m. revealed a resident family member was standing at the nurse's station and was visibly upset. Interview on March 11, 2026, at 11:45 a.m. with Licensed Nurse, Employee E10, revealed the family member was upset because he/she brought in food for Resident R162, but staff did not have a thermometer to reheat the food. Interview on March 11, 2026, at approximately 11:50 a.m. with Resident R162's family member revealed he/she brought in Resident R162's favorite homemade meal of spaghetti and meatballs to encourage meal intakes but the nurse, identified as Employee E13, refused to heat the food up. Interview on March 11, 2026, at approximately 11:50 a.m. with Resident R162 the resident expressed desire for spaghetti and meatballs, noting it was a favorite meal. Continued interview on March 11, 2026, at approximately 11:50 a.m. with Resident R162's family member revealed he/she had spoken with the Registered Dietitian earlier in the week who encouraged the family to bring in food items from home to encourage Resident R162's meal intakes and support nutrition status. Interview on March 11, 2026, at approximately 12:00 p.m. with Licensed Nurse, Employee E13, revealed Resident R162's food could not be reheated because a thermometer was unavailable and the kitchen was unable to heat up the food. Interview on March 11, 2026, at approximately 12:05 p.m. with Registered Dietitian, Employee E8, confirmed he/she encouraged Resident R162's family to bring in food from home. Further interview confirmed the nurse should have obtained/requested a thermometer to assist Resident R162 in consuming his/her meal from home. 28 Pa. Code 201.29 (a) Resident rights.

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 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) Management28 Pa. Code 201.14(a) Responsibility of licensee

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	STREET ADDRESS, CITY, STATE, ZIP CODE
Bryn Mawr Extended Care Center	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that a call bell system was functioning for one of 33 residents reviewed. (Resident R2) Findings include: Review of Resident R2's quarterly assessment dated [DATE], indicated Resident R2 was cognitively intact. The assessment also indicated that this resident required moderate assistance with toilet transfers, sit to standing positioning, chair to bed/ bed to chair transfers and to walk ten feet. This assessment said that Resident R2 was frequently incontinent of bowel and bladder. Review of Resident R2's nursing notes dated November 19, 2025, indicated Resident R2 was found sitting on the floor near the bed. The nursing note indicated that Resident R2 was asked to use the call bell system to alert the nursing staff to assist with transfer needs for toileting. Review of nursing note dated December 19, 2025, indicated Resident R2 was witnessed standing up from the wheelchair to proceed to transfer without assistance. Resident R2 complained of pain post fall. The physician sent the resident to the hospital for further evaluation. The hospital report indicated that Resident R2 was diagnosed with a right hip fracture post fall on December 19, 2025. The nursing progress notes indicated that Resident R2 was asked to use the call bell to request the assistance of staff for standing and transfer needs. Clinical record review for Resident R2 revealed a nursing progress note for January 3, 2026, that indicated the resident had experienced a fall, while trying to self-transfer from bed to wheelchair. The nursing note indicated that the resident sustained an injury a skin tear of the shin during the fall. The nursing progress note indicated that Resident R2 was asked to use the call bell system to notify the nursing staff of the resident's care needs for transfer assistance. Review of Resident R2's nursing notes dated January 25, 2026, indicated Resident R2 fell while attempting to transferring self to the wheelchair. The nursing progress note said the Resident R2 needs staff assistance to safely transfer from wheelchair to bed and bed to wheelchair. The nursing progress note indicated that Resident R2 was reminded to ask for staff assistance. The resident was asked to use the in room call bell system to alert the nursing staff of Resident R2's care needs. Interview with Resident R2 at 9:30 a.m., on March 10, 2026, revealed that the resident was reporting that staff do not answer the call bell system in a timely manner to provide assistance with care needs. Resident R2 was reporting that he prefers to get out of bed early after he eats breakfast. The resident verified needed assistance with standing, transferring and toileting. Observations at 10:00 a.m., on March 10, 2026, revealed that Resident R2's call bell system was not fully functioning. The call bell was pushed and activated in the resident's room however the light above the door and panel light at the nurse's station was not sounding or lighting to alert the staff of Resident R2's request for assistance with care needs. Interview with the registered nurse, Employee E6, at 10:15 a.m., on March 10, 2026, confirmed that the call bell system for Resident R2 was not operating according to manufacturer's specifications. Interview with the Director of Nursing, at 10:00 a.m., on March 11, 2026, revealed that a temporary three-way call system was purchased for Resident R2. The three-way call system rings at the nurse's station, vibrates on the person assigned to the resident and Resident R2 was given a press button call activator for the bedroom. 28 PA. Code 211.10(d) Resident care policies28 PA Code 211.12(d)(1)(2)(3)(5) Nursing services