STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 a Medicare/Medicaid Recertification Survey, and Civil Rights Compliance Survey, State Licensure Survey, completed on March 06, 2025, it was determined that Bryn Mawr Village, was not in compliance with the 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 0578 SS=D		F 0578		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents R26 and R149 are discharged from the facility. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit of the clinical records of current residents will be conducted to ensure that a code status is included, a physician order for code status is included, and the resident's family member is given an advance directive or clarification of the hospital code status to implement the residents wishes after admission to the facility. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578	staff and Social Services regarding the components of this regulation and how to properly document this regulation. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ or designee of five clinical records to ensure that they include a code status, a physician order for code status and that the family was involved in the wishes. Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0578 SS=D	Continued from page 3 Based on clinical record reviews and interviews with staff, it was determined that the facility failed to ensure that advanced directives were in place for two of 13 clinical records reviewed (Resident R149 and Resident R26). Findings include: Review of facility Policy on "Advance Directives " with a most recent revision date of 2016 revealed that under section "Policy Statement": Advance directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation #1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. #7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. #10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0578 SS=D	Continued from page 4 directive. Review of Resident R149's clinical record revealed that Resident R149 was admitted to the facility on February 23, 2025 with diagnoses of COPD (Chronic Obstructive Pulmonary Disease). Further review of Resident RT149's clinical record revealed that there was no Advance Directives indicated on Resident R149's face sheet. Further review of Resident R149's clinical record revealed no documented evidence that advanced directives or his choices related to his Advanced Directive was discussed with Resident R149. Review of Resident R149's physician order revealed that there was no physician's order for Advanced Directives. Interview with Unit Manager Employee E3 conducted on March 4, 2025 at 12:40 p.m. confirmed that there was no Advanced Directives in	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0578 SS=D	Continued from page 5 place for Resident R149 Review of Resident R26's clinical record revealed that Resident R26 was admitted to the facility on February 24, 2025 with diagnoses of Acute Respiratory Failure with Hypoxia (low levels of oxygen in the body tissue), and Multiple Sclerosis (slow progressive disease of the central nervous system). Further review of Resident R26's clinical record revealed that there was no Advance Directives indicated on Resident R26's face sheet. Further review of Resident R26's clinical record revealed no documented evidence that advanced directives or his choices related to his Advanced Directive was discussed with Resident R26. Interview with Unit Manager Employee E3 conducted on March 4, 2025 at 12:40 p.m. confirmed that there was no Advanced Directives in place for Resident R26	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0578 SS=D	Continued from page 6 Review of Resident R26's physician order revealed that there was no physician's order for Advanced Directives. 28 Pa Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0578		
F 0604 SS=D		F 0604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0604 SS=D	Continued from page 7 483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.	F 0604	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents R247, R248, R249 were interviewed by DON and NHA to obtain preferences for the placement of the beds and adjusted as needed. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: Residents with beds near the wall were interviewed by DON and NHA regarding their preferences and beds were adjusted and care plan updated to reflect their request. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing staff regarding the components of this regulation. (4) How the corrective action(s) will	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0604 SS=D	Continued from page 8 This REQUIREMENT is not met as evidenced by:	F 0604	be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five residents to ensure that bed placement preferences are in place and the care plan is being followed. Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0604 SS=D	Continued from page 9 Based on review of facility policies, clinical record review, observations, and staff interviews, it was determined the facility failed to identify the placement of beds against the wall as a restraint three one of 13 residents reviewed. (Residents R247, R248, R249). Findings Include: Review of facility policy titled, "Use of Restraints", revised 2017, revealed physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restrics freedom of movement or restricts normal access to one's body. Further review of policy "Use of Restraints" revealed the definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that	F 0604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0604 SS=D	Continued from page 10 resident's physical condition, and this restrics his/her typical ability to change postion or place, that device is considered a restraint. Clinical record review revealed Resident R247 was admitted to the facility February 23, 2025 with a diagnoses of Alzheimer's disease (A type of brain disorder that causes problems with memory, thinking and behavior), cognitive communication deficit, and lack of coordination. Observation on March 03, 2025 at 07:05 a.m. revealed Resident R247's asleep in bed and the bed (left side) against the wall. Review of Resident R247's care plan, dated February 24, 2025, revealed Resident 247 was at high risk for falls related to deconditioning, gait, and balance problems. No care plan or assessment was included in Resident R247's clinical record for safety or preference with a bed against the wall. Clinical record review revealed Resident R248 was	F 0604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0604 SS=D	Continued from page 11 admitted to the facility February 23, 2025 with a diagnosese of respiratory failure with hypoxia (low level of oxygen in the body tissue), muscle weakness, and repeated falls. Review of Resident R248's MDS, dated March 02, 2025, revealed the resident had a BIMS score of 13 indicating intact cognition. Observation on March 03, 2025 at 7:10 a.m. revealed Resident R248 asleep in bed and the bed (left side) against the wall. Review of Resident R248's care plan, dated February 24, 2025, revealed Resident 248 was at high risk for falls related to deconditioning, gait, and balance problems. No care plan or assessment was included in Resident R248's clinical record for safety or preference with a bed against the wall. Clinical record review revealed Resident R249 was admitted to the facility February 23, 2025 with a diagnoses of hypertensive urgency (dangerously high	F 0604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0604 SS=D	Continued from page 12 blood pressure), muscle weakness, and abnormalities of gait and mobility. Review of Resident R249's MDS assessment, dated March 02, 2025, revealed the resident had a BIMS score of 15 indicating intact cognition. Observation on March 03, 2025 at 7:12 a.m. revealed Resident R249 asleep in bed and the bed (right side) against the wall. Interview on March 03, 2025 at 7:52 a.m. with Licensed Practical Nurse, Employee E4, confirmed Residents R247, R248, and R249's beds were against the wall. Observation on March 04, 2025 at 11:38 a.m. revealed Resident R249 sitting on bed and bed (right side) against wall. Interview on March 04, 2025 at 11:40 a.m. with Resident R249 revealed upon admission to the facility the bed was already against the wall.	F 0604		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0604 SS=D	Continued from page 13 Resident R249 stated it is not Resident R249's preference for the bed to be against the wall. Observation on March 05, 2025 at 09:40 a.m. - 09:45 p.m. revealed Residents R247, R248, and R249's beds against the wall. Interview on March 05, 2025 at 09:50 a.m. with Director of Nursing, Employee E2, confirmed Resident R247, R248, and R249's beds were against the wall. 28 Pa. Code 211.8(e)(f) Use of Restraints. 28 Pa. Code:211.12(d)(1)(5) Nursing services.	F 0604		
F 0655 SS=D		F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0655 SS=D	Continued from page 14 483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 0655	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The care plan for Resident R149 was updated to include goals and interventions for the residents specific goals and needs. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit of current residents will be conducted to ensure that a baseline care plan was developed and implemented and that a written summary of the baseline care plan was provided to the resident and/or resident representative. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing staff and Interdisciplinary Team	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0655 SS=D	Continued from page 15 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:	F 0655	regarding the components of this regulation. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five clinical records to ensure that a baseline care plan was developed and that the resident/ resident representative received a copy of the baseline care plan. Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0655 SS=D	Continued from page 16 Based on clinical record review, staff interview, and review of facility policy, it was determined that the faciltiy failed to ensure that a baseline care plan was developed for one of 13 residents reviewed. (Resident R149) Findings include: Review of facility policy on care plan, Comprehensive-Person Centered revealed that. Under Section Policy Statement, a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the residents physical, psychological and functional needs is developed and implemented for each resident. Under section Policy Interpretation and Implementation. Revealed that. #1 The interdisciplinary team, in conjunction with the resident and his or her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. #7. The comprehensive person-centered care plan: #a.	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0655 SS=D	Continued from page 17 includes measurable objectives and time frames. #b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, or psychosocial well-being, #c. includes the resident's stated goals upon admission and desired outcomes. #d. builds on the resident's strengths and #e. reflects current recognized standards of practice for problem areas and conditions. Review of Resident R149's clinical record revealed that Resident R149 was admitted to the facility on February 23, 2025, with diagnoses of COPD (Chronic Obstructive Pulmonary Disease), Centrilobular Emphysema, Generalized Anxiety Disorder, Alcohol Dependence, Depression, Acute Pancreatitis, Anemia (low red blood count). Review of Resident R149's physician order revealed orders for but not limited to Lidocaine External Patch 4 %, apply to left shoulder daily topically one time a day for pain-dated 2/24/25; Eliquis Oral Tablet 5 milligrams (mg) give 1 tablet by mouth two	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0655 SS=D	Continued from page 18 times a day for DVT (Deep Vein Thrombosis- a condition in which a clot develops in the deep vein) prevention-dated 2/23/25, Gabapentin Oral Tablet 600 mg give 1 tablet by mouth three times a day for Neuropathy-dated 2/23/25. Further review of Resident R149's care plans revealed only one care plan in place which addressed " ADL (activities of daily living) self-care performance deficit". Further, the ADL care plan was initiated on March 3, 2025. Further, there was no other comprehensive care plans in place for Resident R149. Interview with Unit Manager Employee E3 conducted on March 3, 2025 on at 09:55 AM confirmed that there was no baseline care plan and no comprehensive resident centered care plan developed for Resident R149 until March 3, 2025, eight days after Resident R149 was admitted to the facility.	F 0655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0656 SS=D		F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0656 SS=D	Continued from page 20 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The care plan for Resident R33 was updated to include goals and interventions for the residents specific goals and needs. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit of current residents will be conducted to ensure that a comprehensive care plan was developed and implemented and that a written summary of the comprehensive care plan was provided to the resident and/or resident representative. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0656 SS=D	Continued from page 21 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656	staff and Interdisciplinary Team regarding the components of this regulation. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five clinical records to ensure that a comprehensive care plan was developed and that the resident/ resident representative received a copy of the baseline care plan. Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0656 SS=D	Continued from page 22 Based on review of facility policy, review of clinical record, observations, and staff interviews, it was determined that the facility failed to develop comprehensive care plan for one of thirteen residents reviewed related to weight changes(Resident R33). Findings Include: Review of facility policy on care plan, Comprehensive-Person Centered revealed that. Under Section Policy Statement, a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the residents physical, psychological and functional needs is developed and implemented for each resident. Under section Policy Interpretation and Implementation. Revealed that. #1 The interdisciplinary team, in conjunction with the resident and his or her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. #7. The comprehensive person-centered care plan: #a.	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0656 SS=D	Continued from page 23 includes measurable objectives and time frames. #b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, or psychosocial well-being, #c. includes the resident's stated goals upon admission and desired outcomes. #d. builds on the resident's strengths and #e. reflects current recognized standards of practice for problem areas and conditions. Review of Resident R33's clinical record revealed that Resident R1 was admitted to the facility on December 12, 2024 with diagnoses that included but not limited to Pleural effusion (build up of fluid in lungs), dysphagia (difficulty swallowing) and cognitive communication deficit. Review of Resident R33's weight record revealed the following weight values: December 6, 2024 -180 lbs (Admission weight) January 2, 2025 -147 lbs (-18.3%, -33 lbs) January 15, 2025 -148lbs (-17.8%, -32 lbs)	F 0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0656 SS=D	Continued from page 24 January 27, 2025 -150 lbs (-16.7%, -30 lbs) February 22, 2025 -150.4 lbs (-16.4%, -29.6 lbs) Further review of Resident R33's clinical record revealed no documented evidence that a comprehensive care plan was developed to address the resident's weight. 28 Pa. Code 211.12(d)(5) Nursing services	F 0656		
F 0677 SS=D		F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0677 SS=D	Continued from page 25 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident R243 and R244 facial hair were trimmed by licensed staff. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit of current residents was conducted by the DON/Designee to ensure that facial hair is groomed based on residents wishes. Any additional concerns identified during the audit will be corrected immediately. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: DON/Designee will re-educate facility clinical staff on the components of this regulation with an emphasis on ensuring that residents receive appropriate	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0677 SS=D	Continued from page 26	F 0677	grooming of hair/facial hair and footcare/nail care. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: DON/Designee to conduct random visual audits 10 residents 1x a week x4 weeks, 2x a month x3 months, then monthly x2 months to ensure that residents are being groomed appropriately and that facial hair is trimmed. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly x6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0677 SS=D	Continued from page 27 Based on clinical record review, resident and staff interviews, it was determined that the facility failed to provide services to maintain adequate grooming of residents that required staff assistance with activities of daily living for two of 13 residents reviewed (Resident R243, R244). Findings include: Clinical record review revealed Resident R243 was admitted to the facility February 15, 2025 with a diagnosis that included but not limited to chondrocalcinosis (form of arthritis that causes sudden episodes of pain and swelling in joints), lack of coordination, and cognitive communication deficit. Review of Resident R243's Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated February 27, 2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7 indicating severe cognitive impairment.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0677 SS=D	Continued from page 28 Observation on March 04, 2025 at 12:05 p.m. revealed Resident R243's beard was not adequately groomed. Interview on March 04, 12:07 p.m. with Resident R243 and Resident R243's family member revealed resident has not been adequately groomed by facility since admission. Resident R243's family member revealed resident's family member came to facility with razor to shave resident since no assistance was being provided by facility. On March 04, 2025 at 12:15 p.m. interview with Licensed Nurse, Employee E4, confirmed there was no documentation or evidence that staff provided Resident R243 with grooming assistance. Clinical record review revealed that Resident R244 had a diagnosis that included but not limited to cirrhosis of liver (disease of liver resulting in scarring and liver failure), muscle weakness, and cognitive communication deficit.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0677 SS=D	Continued from page 29 Review of Resident R244's Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated March 3, 2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. Observation on March 04, 2025 at 10:45 a.m. revealed Resident R244's beard overgrown and hair growing over resident's upper lip. Interview on March 04, 2025 at 10:47 a.m. revealed Resident R244 has not received adequate grooming since resident's admission to facility. Resident R244 further stated that his beard is hanging over upper lip causing him to not eat properly and comfortably. Interview with Director of Nursing, Employee E2, confirmed Resident R244's beard is overgrown and resident required assistance with grooming.	F 0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0677 SS=D	Continued from page 30 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0677		
F 0686 SS=D		F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0686 SS=D	Continued from page 31 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Treatment was provided to Residents R1 to address the pressure ulcer and prevent new ulcer from developing. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit will be conducted for all Residents at risk for pressure ulcers to ensure proper treatment is being provided. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing staff regarding the components of this regulation. (4) How the corrective action(s) will be monitored to ensure the practice	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0686 SS=D	Continued from page 32	F 0686	will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five residents to ensure that treatment to prevent pressure ulcers is being provided and physician orders are followed. Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0686 SS=D	Continued from page 33 Based review of clinical records, facility policies and interviews with staff, it was determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice and physician orders, to promote healing of pressure ulcers and prevent development of pressure ulcers for one of 13 residents reviewed for pressure ulcer. (Resident R1) Findings include: Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on February 3, 2025 with diagnoses that included but not limited to fracture of lower end of left femur (break in the thigh bone), closed fracture with routine healing, and muscle weakness. Review of Resident R1's Minimum Data Set (MDS - federally mandated resident assessment and care screening) dated February 10, 2025, revealed in section GG00130 Resident R1 was dependent for	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0686 SS=D	Continued from page 34 ability to roll from lying on back to left and right side, and return to lying on back on the bed. Further review revealed in section M0150, Resident R1 at risk of developing pressure ulcers/ injuries. Continued review revealed in section M0100, Resident R1 does not have a pressure ulcer/injury, a scar over bony prominence, or a non-removeable dressing/device (as of February 10, 2025). Review of Resident R1's care plan February 8, 2025, revealed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. Further review of Resident R1's care plan, initiated February 3, 2025, revealed resident has bowel incontinence and resident at risk for skin breakdown related to immobility. Review of Resident R1's "wound note" dated February 12, 2025, revealed the resident acquired DTPIs (Deep Tissue Pressure Injury) on sacrum, left heel and right heel while under care of facility.	F 0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0686 SS=D	Continued from page 35 Review of Resident R1's "wound note" dated February 19, 2025, revealed the resident acquired Stage 1 pressure injury to right great toe- medial while under care of facility. Review of Resident R1's entire clinical record revealed no documented evidence that a turning and positioning program was implemented to prevent the development of pressure ulcers. Interview with Unit Manager Employee E3 conducted on March 5, 2025 at 11:02 am confirmed that there was no documented evidence for turning and positioning to prevent development of pressure ulcer. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services.	F 0686		
F 0692 SS=D		F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0692 SS=D	Continued from page 36 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Resident immediately weighed per physicians' orders. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit of current will be conducted to ensure physician orders for obtaining weights are followed. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing staff and Interdisciplinary Team regarding the components of this regulation.	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0692 SS=D	Continued from page 37	F 0692	(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five clinical records to ensure that physician orders for weights are being followed Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0692 SS=D	Continued from page 38 Based staff interviews and review of clinical records, it was determined that the facility failed to ensure that weekly weights were obtained as ordered by physician for 2 out of 13 residents reviewed (Resident R1, Resident R33). Findings include: Review of Resident R1's clinical record revealed that Resident R1 was admitted to the facility on February 3, 2025 with diagnoses that included but not limited to fracture of lower end of left femur (break in the thigh bone), closed fracture with routine healing, and muscle weakness. Review of Resident R1's clinical record revealed a physician's order dated February 12, 2025 for resident to be weighed weekly x 4 weeks, then monthly. Review of Resident R1's weight record revealed the the resident was weighted at the time admission on	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0692 SS=D	Continued from page 39 February 3, 2025- 129.0 pounds. Continued review of weight record revealed no documented evidence that the resident was weighted weekly as ordered by the physician. Review of Resident R1's clinical record revealed no documented evidence that Resident R1 had refused to be weighed. Interview with Unit Manager Employee E3 conducted on March 4, 2025 at 2:00 pm confirmed that if weight is not obtained for a resident or resident refuses, it should be noted in the progress note and care plan should be created. Further interview with Employee E3, confirmed Resident R1's clinical record revealed no documented evidence of an attempt to obtain weights or refusal by resident. Review of Resident R33's clinical record revealed that Resident R33 was admitted to the facility on December 6, 2024 with diagnoses that included but not limited to Pleural effusion (build up of fluid in	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0692 SS=D	Continued from page 40 lungs), muscle weakness, dysphagia (difficulty swallowing) and cognitive communication deficit. Review of Resident R33's clinical record revealed a physician's order on December 11, 2024 for resident to be weighed weekly x 4 weeks, then monthly. Continued review of the resident's clinical record revealed that the resident was discharged to the hospital on December 12, 2024. Review of Resident R33's clinical record revealed that Resident R33 was readmitted to the facility on December 21, 2024. Review of Resident R33's weight record revealed that the resident weighted 180 pounds at admission on December 6, 2024. The next available weight was on January 2, 2025 -147 lbs. There was no documented evidence that the resident was weighted at the time of readmission on December 21, 2024.	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0692 SS=D	Continued from page 41 Review of Resident R33's clinical record revealed the resident was weighted on, January 2, 2025 and the next available weight was not until January 15, 2025 which is greater than 7 days. Review of Resident R33's clinical record revealed that the next weight from January 15, 2025 was on January 27, 2025 which is greater than 7 days Review of Resident R33's clinical record revealed no documented evidence that Resident R33 had refused to be weighed. Interview with Unit Manager Employee E3 conducted on March 4, 2025 at 2:00 pm confirmed that if weight is not obtained for a resident or resident refuses, it should be noted in the progress note and care plan should be created. Further interview with Employee E3, confirmed R33's clinical record revealed no documented evidence of an attempt to weight or refusal by resident. 28 Pa. Code 211.5(ix) Clinical findings	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0692 SS=D	Continued from page 42 28 Pa. Code 211.12(d)(1)(3) Nursing services	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0692 SS=D	Continued from page 43	F 0692		
F 0693 SS=D		F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0693 SS=D	Continued from page 44 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 0693	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident R148 tube feeding orders were reviewed with physician to updated to reflect current needs. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit will be conducted for current Residents to ensure that all tube feeding orders are current and are being followed. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing staff regarding the components of this regulation. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0693 SS=D	Continued from page 45	F 0693	assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five residents to ensure that tube feeding orders updated and are being followed. Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0693 SS=D	Continued from page 46 Based on clinical record review and staff interviews, it was determined that the facility failed to follow recommendations to maintain acceptable parameters of nutrition for a resident receiving enteral nutrition for one of two residents reviewed. (Resident R33) Findings include: Review of Resident R33's clinical record revealed that Resident R33 was admitted to the facility on December 6, 2024 with diagnoses that included but not limited to Pleural effusion (build up of fluid in lungs), muscle weakness, dysphagia (difficulty swallowing) and cognitive communication deficit. Review of Resident R33's care plan revealed that resident requires tube feeding related to dysphagia (difficulty swallowing) and intervention initiated for Registered Dietitian to evaluate quarterly and as needed, monitor caloric intake, estimate needs and make recommendations for changes to tube feeding as needed.	F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0693 SS=D	Continued from page 47 Review of Resident R33's clinical record revealed a physician order dated December 30, 2024 for one time a day Jevity 1.5 (tube feed) at 20 ml/hour up at 7pm. No total volume listed in physician order. Review of Resident R33's clinical record revealed a physician order dated January 2, 2025 one time a day Jevity 1.5 (tube feed) at 30 ml/hour up at 7pm. No total volume listed in physician order. Review of Resident R33's clinical record revealed a physician order dated January 8, 2025, increase tube feed by 10 ml every 8 hours until goal of 65ml/hour is reached. Review of Resident R33's clinical record revealed a physician order dated January 11, 2025 for two times a day for Nutrition Jevity 1.5 (tube feed) 65ml/ hour for 22 hours TV (total volume) 1430 ml. Review of Resident R33's nutritional assessment review dated January 2, 2025 revealed	F 0693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0693 SS=D	Continued from page 48 recommendation from Registered Dietitian for tube feed to run at 65ml/hour over 22 hours for TV (total volume) of 1430ml daily. Further review of Resident R33's clinical record revealed no documented rationale from physician for delay in meeting resident's caloric needs as recommended by the Registered Dietician. 28 Pa. Code 211.10(c) Resident care policies	F 0693		
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0695 SS=D	Continued from page 49 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents R146 and R149 were provided with respiratory care and supplemental oxygen as ordered by the physician (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: Residents on oxygen will be audited to ensure they are MD orders are being followed. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing staff regarding the components of this regulation. (4) How the corrective action(s) will	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0695 SS=D	Continued from page 50	F 0695	be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five clinical records to ensure that pain medications are in place and are being given as ordered. Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0695 SS=D	Continued from page 51 Based on observations and interviews with staff, it was determined that the facility failed to provide appropriate respiratory care services related to changing and labelling respiratory equipment's and administering oxygen as ordered by the physician for two of thirteen residents reviewed. (Residents R146 and R149). Findings Include: A review of the facility policy titled "Oxygen Administration" "The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review of Resident R146's clinical record revealed that Resident R146 was admitted to the facility February 23, 2025, with diagnoses of but not limited to Acute Respiratory Failure, COPD (Chronic Obstructive Pulmonary Disease), and Anemia (low blood count)	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0695 SS=D	Continued from page 52 Review of Resident R146's physician orders revealed an order for O2 (Oxygen) at 2L (liters)/min via NC (nasal Cannula), continuously every shift for SOB (shortness of breath). Observation conducted on March 3, 2025, at 09:17 a.m. during tour of the facility revealed that Resident R146 was in bed awake on oxygen concentrator via nasal cannula. Further observation revealed that the resident's tubing with a label w "2.20" written on it. Further observation revealed that the oxygen flow meter on the oxygen concentrator was at 5 liters/minute. Interview with the Director of Nursing Employee E3 conducted during a follow up observation together with Employee E2 on March 3, 2025, at 09:31 a.m., confirmed that Resident R146's oxygen flow meter was at 5 liters/minute. Further, Employee E3 confirmed that the physician's order was for O2 (Oxygen) at 2L/min via NC (nasal Cannula)	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0695 SS=D	Continued from page 53 continuously every shift for SOB (shortness of breath). Review of Resident R149's clinical record revealed that Resident R149 was admitted to the facility on February 23, 2025, with diagnoses of but not limited to COPD (Chronic Obstructive Pulmonary Disease), Centrilobular Emphysema, Generalized Anxiety Disorder, and Anemia. Review of Resident R149's physician's orders revealed that there was no order for oxygen therapy. Observation conducted on March 3, 2025, at 09:44a.m. revealed that Resident R149 was in bed, oxygen concentrator via nasal cannula. Further observation revealed that Resident R149's oxygen tubing and the humidification bottle did not have a date affixed to it. Further observation revealed that the oxygen concentrator's flow meter reading was 5	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0695 SS=D	Continued from page 54 liters/minute. Interview with Resident R149 conducted at the time of the observation revealed that he told the staff about it but they didn't do anything about it. Interview with Director of Nursing, Employee E2 conducted on March 3, 2025, at 09:53 a.m. during a follow up observation Unit Manager, Employee E3 confirmed that Resident R149's oxygen flow meter reading was 5 liters/minute. Interview with Unit Manger Employee E3, conducted on March 3, 2024, at 09:55 a.m. confirmed that there was no physician's order in place for oxygen for Resident R149. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0697 SS=D		F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0697 SS=D	Continued from page 56 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident R148's pain medication were delivered and she has been receiving it as per Physician orders. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit will be conducted of residents that have an order for pain medications to ensure that they are being given per physician order. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing staff regarding the components of this regulation. (4) How the corrective action(s) will be monitored to ensure the practice	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0697 SS=D	Continued from page 57	F 0697	will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five clinical records to ensure that pain medications are in place and are being given as ordered. Audits will be conducted weekly x for four weeks and then monthly for two months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0697 SS=D	Continued from page 58 Based on review of facility policy, review of clinical record, and staff interview, it was determined that the facility failed to ensure that appropriate pain management was provided to a resident consistent with standards of professional practice for one of thirteen residents reviewed (Resident R148). Findings include: Review of thefacility policy entitled "Pain assessment and management" revealed that under section "Purpose": The purpose of this procedure is to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Under Section "General Guidelines": #1 The pain management program is based on facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan and the resident's choices related to pain management. #2. Pain management is defined as the	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0697 SS=D	Continued from page 59 process of alleviating the residents pain based on his or her critical condition and established treatment goals. #3. pain management is a multidisciplinary care process that includes the following #a. assessing the potential for pain. #b. recognizing the presence of pain. #c. identifying the characteristics of pain. #d. Addressing the underlying causes of pain, developing and implementing approaches to pain management. #f. Identifying and using specific strategies for different levels and sources of pain. #g. Monitoring for the effectiveness of interventions and #h. modifying approaches as necessary. #5. Acute pain or significant worsening of chronic pain should be assessed every 30 to 60 minutes after the onset and reassess as indicated and to relief is obtained. #6. For stable chronic pain, the resident pains and consequences of pain are assessed at least weekly. Under section "Implementing Pain Management Strategies": #2. Pharmacological interventions may be prescribed to manage pain; however, they do not usually address the cause of pain and can have adverse effects on the residents. Under section "Documentation": #1. Document the residents	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0697 SS=D	Continued from page 60 reported level of pain with adequate detail as necessary and in accordance with the pain management program. #2 Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record. Review of Resident R148's clinical record revealed that Resident R148 was admitted to the facility on February 28, 2025, with diagnoses of but not limited to: Spinal Stenosis, Low Back Pain, Pain in Leg, Chronic Pain Syndrome, Allergy. Review of Physician's orders revealed the following orders: Oxycodone HCl Oral (opioid) Tablet 5 MG (milligrams) give 1 tablet by mouth every 6 hours as needed for severe pain-date ordered 3/2/25 Tramadol HCl Oral (opioid) Tablet 50 MG give 1 tablet by mouth every 6 hours as needed for severe pain-date ordered 3.1.25 with date discharged order of 3/2/25 Tramadol HCl Oral (opioid) Tablet 50 MG Give 1	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0697 SS=D	Continued from page 61 tablet by mouth every 8 hours as needed for moderate pain-date ordered 3/2/25 Tylenol tablets 325 mg give 2 tablet by mouth every 4 hours as needed for pain do not exceed 3 gm/ day-date ordered: 2/28/25 Review or Resident R148's MAR (medication administration record) for March 3, 2025, revealed that during the day shift (unspecified time), Resident R148 had a documented pain at level 10. Further, Tylenol 650 mg was given at 04:20PM and at 10:25PM. Further review of Resident R148's MAR for March 3, 2025, revealed that Oxycodone HCl Oral (opioid) Tablet 5 MG give 1 tablet by mouth every 6 hours as needed for severe pain-date ordered 3.2.25 was not administered to Resident R148. Review or Resident R148's MAR (medication Administration Record) for March 4, 2025, revealed that during the day shift (unspecified time), Resident 148 had a documented pain at level 8.	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0697 SS=D	Continued from page 62 Further, Tylenol 650 mg was given at 5:53AM (night shift) but there was no documented evidence that Resident R148 received any pain medication during the day shift of March 4, 2025, when Resident R148 complained of pain at level 8. Further review of Resident R148's MAR for March 4, 2025, revealed that Oxycodone HCl Oral (opioid) Tablet 5 MG give 1 tablet by mouth every 6 hours as needed for severe pain-date ordered 3/2/25 was not administered to Resident R148. Interview with DON (Director of Nursing) Employee E2 conducted on March 5, 2025, at 01:10 Pp.m. revealed that the facility uses the numeric pain scale with 0 (zero)-for no pain, 1-3 for mild pain, 4-6 for moderate pain and 7 to 10 for severe pain. Review of Resident R148's list of allergies revealed that resident R148 was allergic to the following medications: Fentanyl, Hydrocode, Hydromorphone, Morphine, Oxycodone and	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0697 SS=D	Continued from page 63 Codeine. Further review of resident R148's clinical record revealed no documented rationale for not administering the Oxycodone HCl Oral (opioid) Tablet 5 mg give 1 tablet by mouth every 6 hours as needed for severe pain. Further, there was no documented evidence that the physician was made aware that the Oxycodone HCl Oral (opioid) tablet 5 mg 1 tablet as needed for severe pain was not administered for Resident R148's pain at level 10 on March 3, 2025, and level 8 on March 4, 2025, and there was no documented evidence that non-pharmacological technique for pain management was implimented. 28 Pa. Code 211.9 (a)(1) Pharmacy services. 28 Pa. Code 211.12 (d)(5) Nursing services.	F 0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0755 SS=D		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0755 SS=D	Continued from page 65 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident R148 medications were reviewed with physician to identify any allergies and adjusted as needed. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: An audit will be conducted for current Residents to ensure that all medication allergies are being followed. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education will be provided by the DON/ and or designee to nursing staff regarding the components of this regulation. (4) How the corrective action(s) will be monitored to ensure the practice	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0755 SS=D	Continued from page 66 This REQUIREMENT is not met as evidenced by:	F 0755	will not recur, i.e., what quality assurance program will be put in place: Random audits will be conducted weekly by the DON/ and or designee of five residents to ensure that medication allergy orders are followed. Audits will be conducted weekly x for four weeks and then monthly for six months. Results of these audits will be reported to the monthly Quality Assurance Performance Improvement Committee until monthly and/or substantial compliance is met. Adjustments to the plan of corrections will be made by the Interdisciplinary team as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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 0755 SS=D	Continued from page 67 Based on record review and interview with resident and staff it was determined that the facility failed to ensure the safe and effective use of medications in a manner that minimizes medication-related adverse consequences or events related to drug allergies for one of thirteen residents reviewed. (Resident R148) Findings include: Review of Resident R148's clinical record revealed that Resident R148 was admitted to the facility on February 28, 2025 with diagnoses of but not limited to: Spinal Stenosis, Low Back Pain, Pain in Leg, Chronic Pain Syndrome, Allergy Review of Resident R148's list of allergies revealed that resident R148 was allergic to and the allergic reaction the following medications: Allergen: Fentanyl (opioid) Reaction Manifestation: Anaphylaxis, Hives, Shortness of breath, Angio-edema Severity: Severe Allergen: Hydrocodone (opioid) Reaction Manifestation: Hives, Itching Severity: Unknown	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0755 SS=D	Continued from page 68 Allergen: Hydromorphone (opioid) Reaction Manifestation: Anaphylaxis, Hives, SOB (shortness of breath), Angio-edema Severity: Severe Allergen: Morphine (opioid) Reaction Manifestation: none documented Severity: none documented Allergen: Oxycodone (opioid) Reaction Manifestation: none documented Severity: none documented Allergen: Codeine Reaction Manifestation: none documented Severity: none documented Review of Physician's orders revealed the following orders: Oxycodone HCl Oral (opioid) Tablet 5 MG Give 1 tablet by mouth every 6 hours as needed for severe pain-date ordered 3.2.25 Tramadol HCl Oral (opioid) Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for severe pain-date ordered 3.1.25 with date DC: 3.2.25 Tramadol HCl Oral (opioid) Tablet50 MG Give 1 tablet by mouth every 8 hours as needed for moderate pain-date ordered 3.2.25	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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 0755 SS=D	Continued from page 69 Tramadol HCl Oral (opioid) Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for moderate/Severe pain-dated 3.4.25 Interview with Resident R148 conducted on March 4, 2025, at 10:16 AM revealed that Resident R148 was allergic to Opioids. Further resident revealed that she develops hives, rashes and itching with Oxycodone and Morphine. Resident also revealed that she is possibly allergy to tramadol but not as bad as the morphine and Oxycodone. Interview with Physician Employee E5 conducted on March 5, 2025, confirmed that there was documented Opioids allergies on Resident R148's clinical records. Further Employee E5 revealed that he had discontinued the Oxycodone and that Resident R148 was only on Tramadol. Interview with Facility Administrator Employee E1 revealed that they did not have a policy addressing allergies.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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 0755 SS=D	Continued from page 70 28 Pa. Code 211.9 (a)(1) Pharmacy services.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD BRYN MAWR, PA 19010**

(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
P 5510	Nursing services. (2) Effective July 1, 2023, a minimum of 1 nurse aide per 12 residents during the day, 1 nurse aide per 12 residents during the evening, and 1 nurse aide per 20 residents overnight. This REGULATION is not met as evidenced by:	P 5510	Nursing schedules were reviewed to ensure the proper Nurse's Aide ratio on the morning, evening and overnight shifts. NHA/designee will reeducate the scheduler and Director of Nursing on the correct Nurse's Aide ratio. NHA/designee will audit the nursing schedules in advance daily x4 weeks to ensure Nurse Aids are being staffed at the proper ratio. Results will be shared at QA.	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5510	Continued from page 1 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) for every 10 residents on day shift, one nurse aide for every 11 residents on evening shift, and one nurse aide for every 15 residents overnight for 21 of 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility revealed the following staff scheduled for the resident census: Day shift (requires one NA per 10 residents) On February 13, 2025, 24 NA hours, with a census of 36 residents, required 28.80 NA hours. On February 14, 2025, 24 NA hours, with a census of 37 residents, required 29.60 NA hours.	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5510	Continued from page 2 On February 15, 2025, 24 NA hours, with a census of 40 residents, required 32 NA hours. On February 16, 2025, 24 NA hours, with a census of 42 residents, required 33.60 hours. On February 18, 2025, 24 NA hours, with a census of 41, required 32.80 hours. On February 19, 2025, 24 NA hours, with a census of 43, required 34.40 hours. On February 20, 2025, 24 NA hours, with a census of 45, required 36 hours. On February 21, 2025, 32 NA hours, with a census of 44, required 35.20 hours. On February 23, 2025, 42 NA hours, with a census of 62, required 49.60 hours. On March 01, 2025, 32 NA hours, with a census of 52, required 41.60 hours.	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5510	Continued from page 3 March 02, 2025, 32 NA hours, with a census of 51, required 40.80 hours. Evening shift (requires one NA per 11 residents) On February 13, 2025, 23 NA hours, with a census of 36 residents, required 26.18 NA hours. On February 14, 2025, 24 NA hours, with a census of 37 residents, required 26.91 NA hours. On February 15, 2025, 23 NA hours, with a census of 40 residents, required 29.09 NA hours. On February 16, 2025, 24 NA hours, with a census of 42 residents, required 30.55 hours. On February 17, 2025, 24 NA hours, with a census of 42 residents, required 30.55 hours. On February 18, 2025, 24 NA hours, with a census of 41, required 29.82 hours.	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5510	Continued from page 4 On February 19, 2025, 24 NA hours, with a census of 43, required 31.27 hours. On February 20, 2025, 24 NA hours, with a census of 45, required 32.73 hours. On February 21, 2025, 24 NA hours, with a census of 44, required 32 hours. On February 22, 2025, 24 NA hours, with a census of 44, required 32 hours. On February 23, 2025, 32 NA hours, with a census of 62, required 45.09 hours. On February 24, 2025, 40 NA hours, with a census of 60, required 43.64 hours. On February 25, 2025, 40 NA hours, with a census of 61, required 44.36 hours. On February 26, 2025, 40 NA hours, with a census	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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
P 5510	Continued from page 5 of 59, required 42.91 hours. On February 27, 2025, 38 NA hours, with a census of 55, required 40 hours. On February 28, 2025, 32 NA hours, with a census of 55, required 40 hours. On March 01, 2025, 32 NA hours, with a census of 52, required 37.82 hours. On March 02, 2025, 32 NA hours, with a census of 51, required 37.09 hours. March 03, 2025, 34.50 NA hours, with a census of 49, required 35.64 hours. March 04, 2025, 34 NA hours, with a census of 50, required 36.36 hours. March 05, 2025, 34.50 NA hours, with a census of 50, required 36.36 hours.	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5510	Continued from page 6 Overnight shift (requires one NA per 15 residents) February 13, 2025, 16 NA hours, with a census of 36, required 19.20 hours. February 23, 2025, 32 NA hours, with a census of 62, required 33.07 hours. February 25, 2025, 24 NA hours, with a census of 61, required 32.53 hours. February 26, 2025, 26 NA hours, with a census of 59, required 31.47 hours. February 27, 2025, 24 NA hours, with a census of 55, required 29.33 hours. February 28, 2025, 24 NA hours, with a census of 55, required 29.33 hours. On March 06, 2025 at approximately 11:00 a.m. Administrator, Employee E1, confirmed the facility did not meet the minimum NA to resident ratios for	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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
P 5510	Continued from page 7 21 of 21 days reviewed.	P 5510		
P 5530	Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	Nursing schedules were reviewed to ensure the proper LPN ratios on the day and evening shifts. NHA/designee will reeducate the scheduler Director of Nursing on the correct LPN ratio. NHA/designee will audit the nursing schedules in advance daily x4 weeks to ensure LPN's are being staffed at the proper ratio. Results will be shared at QA.	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5530	Continued from page 8 Based on a review of nursing staffing hours and staff interview, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) for every 25 residents on day shift and one LPN for every 30 residents on evening shift for 9 of 21 days reviewed. Findings include: Review of nursing staff care hours provided by the facility revealed the following staff scheduled for the resident census: Day shift (requires one LPN per 25 residents) On February 14, 2025, 8 LPN hours, with a census of 37 residents, required 11.84 hours. On February 15, 2025, 8.50 LPN hours, with a census of 40 residents, required 12.80 hours. On February 22, 2025, 8.50 LPN hours, with a	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5530	Continued from page 9 census of 44, required 14.08 hours. On February 23, 2025, 16.50 LPN hours, with a census of 62, required 19.84 hours. On February 24, 2025, 16 LPN hours, with a census of 60, required 19.20 hours. On March 01, 2025, 8.50 LPN hours, with a census of 52, required 16.64 hours. March 02, 2025, 8.50 LPN hours, with a census of 51, required 16.32 hours. Evening shift (requires one LPN per 30 residents) On February 13, 2025, 9.50 LPN hours, with a census of 36 residents, required 9.60 hours. On February 14, 2025, 8.50 LPN hours, with a census of 37 residents, required 9.87 NA hours. On February 15, 2025, 9 LPN hours, with a census	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5530	Continued from page 10 of 40 residents, required 10.67 NA hours. On February 20, 2025, 11 LPN hours, with a census of 45, required 12 hours. On February 21, 2025, 8.50 LPN hours, with a census of 44, required 11.73 hours. On February 23, 2025, 8.50 LPN hours, with a census of 62, required 16.53 hours. On March 06, 2025 at approximately 11:00 a.m. Administrator, Employee E1, confirmed the facility did not meet the minimum LPN to resident ratios for 9 of 21 days reviewed.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: **023402**	**773 E. HAVERFORD ROAD** **BRYN MAWR, PA 19010**

(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
P 5640	Continued from page 11 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	Nursing schedules were reviewed to ensure the total hours of general nursing care for each 24-hour period meets the requirement. NHA/designee will reeducate the scheduler and the Director of Nursing on the total hours of general nursing care for each 24-hour period. NHA/designee will audit the nursing schedules in advance daily x4 weeks to ensure total hours of general nursing care for each 24-hour period are met. Results will be shared at QA.	Completion Date: **04/21/2025** Status: **APPROVED** Date: **03/24/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: 00 B. WING:	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5640	Continued from page 12 Based on review of facility staffing sheets, it was determined that the facility failed to provide a minimum of 3.20 hours of direct resident care for each resident in a 24 period for 12 of 21 days reviewed. Findings include: Review of facility nursing staffing sheets for the weeks of February 13, 2025- February 19, 2025, February 20, 2025-February 26, 2025, and February 27,2025-March 5, 2025 revealed the following days where the staffing hours of direct resident care fell below the required 3.20 hours: - February 13, 2025- 3.17 hrs. - February 14, 2025- 3.07 hrs. - February 15, 2025- 3.09 hrs. - February 18, 2025- 3.18 hrs. - February 19, 2025- 3.19 hrs. - February 20, 2025- 2.93 hrs. - February 21, 2025- 3.13 hrs.	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395095	A. BLDG: __00_____ B. WING: _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR VILLAGE STATE LICENSE NUMBER: 023402	773 E. HAVERFORD ROAD BRYN MAWR, PA 19010

(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
P 5640	Continued from page 13 - February 23, 2025- 3.19 hrs. - February 25, 2025- 3.19 hrs. - February 27, 2025- 3.15 hrs. - February 28, 2025- 3.07 hrs. - March 02, 2025- 3.0 hrs. On March 06, 2025 at approximately 11:00 a.m. Administrator, Employee E1, confirmed the facility failed the nursing hour requirements for 12 of 21 days reviewed.	P 5640		

Certified End Page

BRYN MAWR VILLAGE

STATE LICENSE NUMBER: 023402

SURVEY EXIT DATE: 03/06/2025

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

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY