STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395311	A. BLDG: __--_____ B. WING: _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR EXTENDED CARE CENTER STATE LICENSE NUMBER: **032002**	**956 RAILROAD AVENUE 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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on April 15, 2025, at Bryn Mawr Extended Care, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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.

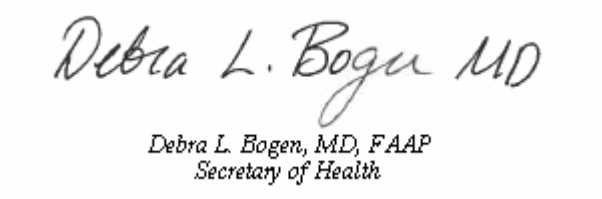
Certified End Page

BRYN MAWR EXTENDED CARE CENTER

STATE LICENSE NUMBER: 032002

SURVEY EXIT DATE: 04/15/2025

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395311	A. BLDG: 01 B. WING:	04/15/2025

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K 0000	INITIAL COMMENT Facility ID# 032002 Component 01 Based on a Medicare/Medicaid Recertification Survey completed on April 15, 2025, it was determined that Bryn Mawr Extended Care Center was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a two-story, Type II (000), unprotected non-combustible building, with a partial basement, that is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

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.

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	395311	A. BLDG: __01_____ B. WING: _____	04/15/2025

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BRYN MAWR EXTENDED CARE CENTER	**956 RAILROAD AVENUE BRYN MAWR, PA 19010**
STATE LICENSE NUMBER: **032002**	

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K 0100 SS=C	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	1)Our vendor will submit plans to Plan Review Department for approval of modifications to the fire suppression system. 2)No other areas affected. 3)To prevent the potential for reoccurrence the Administrator and/or designee educated Maintenance Director and/or designee on importance of making sure all plans are approved prior to initiating alterations and renovations. 4)To monitor and maintain on-going compliance the Administrator and/or designee will review all plans to make alterations and/or renovations and will seek approval from DOH as required prior to following through with said plans. Findings will be reported at the facility QAPI for continued review and recommendations as changes occur.	Completion Date: **05/07/2025** Status: **APPROVED** Date: **05/09/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0100 SS=C	Continued from page 2 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on observation and interview, it was	K 0100		

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K 0100 SS=C	Continued from page 3 determined the following item(s) did not meet the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents within the facility. Findings include: Document review on April 15, 2025, at 11:30 a.m., revealed in the basement, inside the Main Electrical (switchgear) Room, two heat detectors were programmed into the fire panel and four Halotron fire extinguishers were installed on January 27, 2025, after the existing ADX Halon units were removed. Exit Interview with the Administrator, Maintenance Director, and Regional VP of Operations on April 15, 2025, at 2:45 p.m., confirmed the facility failed to obtain Department-approved plans prior to initiating alterations and renovations. ***28 Pa Code § 51.3. Notification (d)***	K 0100		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR EXTENDED CARE CENTER	**956 RAILROAD AVENUE BRYN MAWR, PA 19010**
STATE LICENSE NUMBER: **032002**	

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K 0100 SS=C	Continued from page 4	K 0100		
K 0321 SS=E		K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0321 SS=E	Continued from page 5 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 0321	1)A. Food Service Office Door and frame was replaced and latches as required. B.Dry Storage door closure was repaired and closes properly C.2nd Fl. D Wing storage closet, hardware was replaced and the door latches as required 2)The Maintenance Director and/or designee inspected all self-closing doors in hazardous locations to ensure that the doors latch and close as required. 3)To prevent the potential for reoccurrence the Administrator and/or designee educated the Maintenance Director and/or designee on the importance of self-closing doors in hazardous locations close and latch as required. 4)To monitor and maintain on-going compliance, the Administrator and/or designee will audit all self-closing doors in hazardous locations monthly for 3 months to ensure compliance. If an issue is identified the door/s will be fixed immediately and the Maintenance Director and/or designee will be	Completion Date: **05/07/2025** Status: **APPROVED** Date: **05/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0321 SS=E	Continued from page 6 This REQUIREMENT is not met as evidenced by:	K 0321	reeducated. Findings will be reported to facility QAPI for continued review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0321 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain self closing doors at hazardous locations, affecting one of three levels in the facility. Findings Include: Observation on April 15, 2025, at the following times and location revealed the following: a) 12:40 p.m., at Food Services office, door was binding in frame, preventing the door to from latching; b) 12:45 p.m., at Dry Storage, door closure broken preventing door from closing; c) 2:10 p.m., at 2nd floor D wing's storage closet, hardware was broken, preventing the door from latching. Exit Interview with the Administrator, Maintenance Director, and Regional VP of Operations on April 15, 2025, at 2:45 p.m., confirmed the door deficiencies.	K 0321		

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K 0321 SS=E	Continued from page 8	K 0321		
K 0351 SS=F	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	K 0351	1)The facility contractor is submitting plans to the Plan Review Department for approval of modifications to the fire suppression system for approval. 2)The Maintenance Director and/or designee will inspect the Main Electrical Room once a suitable fire suppression system is installed. 3)To prevent the potential for reoccurrence the Administrator will educate the Maintenance Director and/or designee on the importance of a suitable fire suppression system is installed. 4)To monitor and maintain on-going compliance the Administrator and/or designee will check the fire suppression system is in place as required monthly for 3 months. Findings will be reported to facility QAPI for continued review and recommendations.	Completion Date: **05/07/2025** Status: **APPROVED** Date: **05/09/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0351 SS=F	Continued from page 9 Based on observation and interview, it was determined the facility failed to install required sprinkler system components, affecting one of three levels. Findings include: Observation made on April 15, 2025, at 11:25 a.m., revealed inside the basement, the Main electrical (switchgear) Room lacked an automatic sprinkler system. Exit Interview with the Administrator, Maintenance Director, and Regional VP of Operations on April 15, 2025, at 2:45 p.m., confirmed the facility lacked complete automatic sprinkler protection.	K 0351		

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K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	1)A. Wet System – The tampers in the report to the alarm panel. B. Dry System – The maintenance Director or Designee will ensure to FDC hydrotest date is confirmed and completed. 2)The Maintenance Director and/or designee inspected the tampers, confirmed reporting to the alarm system, and the pit does not have accumulating water. 3)To prevent the potential for reoccurrence the Administrator educated the Maintenance Director and/or designee on the importance of ensuring the tampers report to the alarm system and the pit does not have accumulating water. 4)To monitor and maintain on-going compliance the Maintenance Director and/or designee will inspect the pit weekly for one month, and monthly for the next two months. If an issue is identified the vendor will be contacted to restore the tamper connection to the alarm and assure there is no accumulation of water in the pit. Findings will be reported to facility QAPI for continued review and recommendations.	Completion Date: **05/07/2025** Status: **APPROVED** Date: **05/08/2025**

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K 0353 SS=F	Continued from page 11 Based on document review and interview, it was determined the facility failed to maintain automatic sprinkler system components, affecting the entire facility. Findings include: Document review on April 15, 2025, at 10:30 a.m., revealed the April 2, 2025 sprinkler inspection report listed the following deficiencies: a) Wet System - The tamper in the pit did not report to the panel at the time of inspection. The following was noted: The pit constantly fills with water. The customer needs to monitor water accumulation in the pit and keep it pumped out for inspection and maintenance of the devices in the pit; b) Dry System - The date of the last FDC hydrotest is unknown and needs to be performed ASAP. Exit Interview with the Administrator, Maintenance Director, and Regional VP of Operations on April	K 0353		

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K 0353 SS=F	Continued from page 12 15, 2025, at 2:45 p.m., confirmed the sprinkler system deficiencies.	K 0353		
K 0374 SS=E		K 0374		

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K 0374 SS=E	Continued from page 13 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	1)A. Immediately upon observation on April 15, 2025, the wheelchair next to room 112 was removed so as not to prevent the door to close smoke tight. B. Chateau Dining the smoke barrier door was repaired so that it does not drag the floor, preventing the door from closing smoke tight. 2)The Maintenance Director and/or designee audited all smoke doors for obstructions and door dragging the floor preventing the door from closing smoke tight. 3)To prevent the potential for reoccurrence the Administrator and/or designee educated the Maintenance Director and/or designee and staff on the importance of all smoke doors closing smoke tight without obstructions. 4)To monitor and maintain on-going compliance the Maintenance Director and/or designee will audit 3 smoke doors for closing smoke tight without obstruction for the next 3 months. If an issue is identified the Maintenance Director or designee will immediately notify the	Completion Date: **05/07/2025** Status: **APPROVED** Date: **05/06/2025**

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR EXTENDED CARE CENTER STATE LICENSE NUMBER: **032002**	**956 RAILROAD AVENUE** **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
K 0374 SS=E	Continued from page 14	K 0374	administrator and correct the problem. Findings will be reported to facility QAPI for continued review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395311	A. BLDG: __01_____ B. WING: _____	04/15/2025

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BRYN MAWR EXTENDED CARE CENTER STATE LICENSE NUMBER: **032002**	**956 RAILROAD AVENUE BRYN MAWR, PA 19010**

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K 0374 SS=E	Continued from page 15 Based on observation and interview, it was determined the facility failed to ensure doors in smoke barrierswere maintained to resist the passage of smoke, affecting one of three levels. Findings include: Observation on April 15, 2025, at the following times and locations revealed: a) 12:25 p.m., first floor, smoke barrier door next to room 112 was blocked by a wheel chair, preventing the door to close smoke tight; b) 12:50 p.m., Chateau Dining, the smoke barrier door was dragging on floor, preventing the door from closing smoke tight. Exit Interview with the Administrator, Maintenance Director and Regional VP of Operations on April 15, 2025, at 2:45 p.m., confirmed the door deficiencies.	K 0374		

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K 0374 SS=E	Continued from page 16	K 0374		
K 0521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	1)The facility vendor is in the process of identifying, repairing, and determining if the dampers are all necessary and if necessary to make modifications, will contact the Plan Review Department for approval of modifications to the fire suppression system. 2)The Maintenance Director and/or designee reviewed and confirmed the fire dampers are operable. 3)To prevent the potential for reoccurrence the Administrator and/or designee educated the Maintenance Director and/or designee on the importance of ensuring fire dampers are inspected and operable. 4)To monitor and maintain on-going compliance the Administrator and/or designee ensure fire dampers remain operable monthly for 3 months. Findings will be reported to facility QAPI for continued review and recommendations.	Completion Date: **05/23/2025** Status: **APPROVED** Date: **05/13/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR EXTENDED CARE CENTER STATE LICENSE NUMBER: **032002**	**956 RAILROAD AVENUE BRYN MAWR, PA 19010**

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K 0521 SS=F	Continued from page 17 Based on document review and interview, it was determined the facility failed to maintain inspection of Heating, Ventilating and Air Conditioning (HVAC) equipment at required intervals, affecting the entire facility. Findings include: Document review on April 15, 2025, at 9:00 a.m., revealed the May 9, 2022, the fire damper inspection report listed (73) dampers as deficient due to inaccessibility or damage. Evidence of repairs was unavailable at the time of survey. Exit Interview with the Administrator, Maintenance Director, and Regional VP of Operations on April 15, 2025, at 2:45 p.m., confirmed the fire damper deficiencies.	K 0521		

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	395311	A. BLDG: __01_____ B. WING: _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BRYN MAWR EXTENDED CARE CENTER	**956 RAILROAD AVENUE BRYN MAWR, PA 19010**
STATE LICENSE NUMBER: **032002**	

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K 0521 SS=F	Continued from page 18	K 0521		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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BRYN MAWR EXTENDED CARE CENTER STATE LICENSE NUMBER: **032002**	**956 RAILROAD AVENUE BRYN MAWR, PA 19010**

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K 0918 SS=F	Continued from page 19 NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	1.) A. Upon observation on April 15, 2025, the Maintenance Director and/or Designee performed the monthly testing of battery electrolyte specific or conductance testing. B. Annual 90-minute load bank or report indicating unit meets 30% of name plate – was not due for annual testing; however, it was completed. C. Annual fuel sample report although not due was completed. D. In the basement, the emergency generator set location (transformer room) a battery back-up emergency light was installed. 2.) The Maintenance Director and/or designee although not due had the Annual 90-minute load bank and Annual fuel sample reports completed. 3.) To prevent the potential for reoccurrence the Administrator and/or designee educated the Maintenance Director and/or designee on the importance of ensuring all reports are completed timely and available for review. 4.) To monitor and maintain	Completion Date: **05/07/2025** Status: **APPROVED** Date: **05/06/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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BRYN MAWR EXTENDED CARE CENTER STATE LICENSE NUMBER: **032002**	**956 RAILROAD AVENUE** **BRYN MAWR, PA 19010**

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K 0918 SS=F	Continued from page 20 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	on-going compliance the Administrator and/or designee audit both the monthly and annual testing reports and ensure the back-up battery operated emergency lighting is in place and operable monthly for 3 months. Findings will be reported to facility QAPI for continued review and recommendations.	

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K 0918 SS=F	Continued from page 21 Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator, affecting the entire facility. Findings include: 1. Document review on April 15, 2025, at 11:00 a.m., revealed the facility could not produce documentation of the following tests and inspections: a) Monthly testing of battery electrolyte specific gravity or conductance testing; b) Annual 90 minute load bank or report indicating unit meets 30% of name plate; c) Annual fuel sample report. Exit Interview with the Administrator, Maintenance Director, and Regional VP of Operations on April 15, 2025, at 2:45 p.m., confirmed reports were unavailable to review at the time of this survey. 2. Observation made on April 15, 2025, at 12:45 p.m., revealed in the basement, the emergency	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0918 SS=F	Continued from page 22 generator set location (transformer room) lacked battery back-up emergency lighting. Exit Interview with the Administrator, the Maintenance Director and Regional VP of Operations on April 15, 2025 at 2:45 p.m., confirmed the emergency generator component was not installed.	K 0918		
K 0923 SS=E		K 0923		

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K 0923 SS=E	Continued from page 23 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	1.) Immediately upon observation on April 15, 2025 the one free standing oxygen cylinder on the first floor in the Med Room across from the conference room was immediately removed. 2.) The Maintenance Director and/or designee audited the number and location of oxygen tanks and confirmed they were being stored properly. 3.) To prevent the potential for reoccurrence the Administrator and/or designee educated the Maintenance Director and/or designee on the importance of ensuring all oxygen cylinders held in a holder and not free standing. 4.) To monitor and maintain on-going compliance the Administrator and/or designee audit all oxygen tanks monthly for 3 months. Findings will be reported to facility QAPI for continued review and recommendations.	Completion Date: **05/07/2025** Status: **APPROVED** Date: **05/06/2025**

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K 0923 SS=E	Continued from page 24 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

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K 0923 SS=E	Continued from page 25 Based on observation and interview, it was determined the facility did not properly store medical gases, affecting one of three levels in the facility. Findings include: Observation on April 15, 2025, at 12:20 p.m., revealed on the first floor, in the Med room across from the conference room, had one free standing oxygen cylinder stored. Exit Interview with the Administrator, Maintenance Director, and Regional VP of Operations on April 15, 2025, at 2:45 p.m., confirmed the free standing oxygen cylinder.	K 0923		

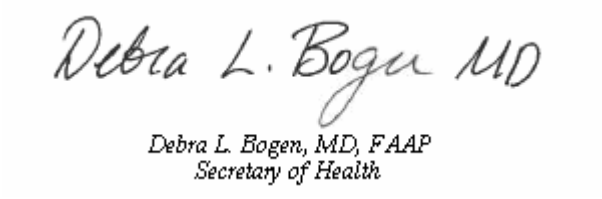
Certified End Page

BRYN MAWR EXTENDED CARE CENTER

STATE LICENSE NUMBER: 032002

SURVEY EXIT DATE: 04/15/2025

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

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