Department of Human Services
Bureau of Human Service Licensing

September 12, 2022

[redacted]
WARWICK BRIDGES LLC
[redacted]

RE: THE BRIDGES AT WARWICK
1600 ALMSHOUSE ROAD
JAMISON, PA, 18929
LICENSE/COC#: 14316

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/11/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Shawn Parker

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY

Facility Information

Name: *THE BRIDGES AT WARWICK* **License #**: *14316* **License Expiration**: *10/31/2022*

Address: *1600 ALMSHOUSE ROAD, JAMISON, PA 18929*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *215-600-3747* **Email**: [redacted]

Legal Entity

Name: *WARWICK BRIDGES LLC*

Address: *1000 LEGION PLACE, SUITE 1600, ATTN BILL SNOW, ORLANDO, FL, 32801*

Phone: *215-600-3747* **Email**: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *86* **Waking Staff**: *65*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Complaint* **Exit Conference Date**: *03/11/2022*

Inspection Dates and Department Representative

03/11/2022 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *130* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Vista - 1st floor* **Capacity**: *31* **Residents Served**: *20*

Hospice

Current Residents: *NM*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *31* **Have Physical Disability**: *1*

Inspections / Reviews

03/11/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/18/2022*

Inspections / Reviews *(continued)*

05/11/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/16/2022*

09/12/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

85a - Sanitary Conditions

1. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

The following unsanitary conditions were observed on 3/11/22:

- *no toilet paper - bathroom across from activities room.*
- *no paper towels - bathroom by nurse station and bathroom across from activities room.*
- *toilet soiled and unsanitary - bathroom by nurse station.*
- *PTAC heating unit vents contained dust and needed to be cleaned in bedroom(s) 134, 139, 141 and 142.*

Plan of Correction ***Accept***

Correction-In response to this violation, the toilet in common bathroom A located in the SDCU was flushed and cleaned, room was stocked with paper towels and toilet paper by 3/11/22. PTAC vents in units 134, 139, 141 and 142 were cleaned by 3/11/2022.(Document A1)

Training- Vice President of Clinical Services (VPCS) to in-service Executive Director on regulation 2600.85a by 3/15/2022. (Document A2)

Training-Executive Director in-serviced applicable staff, on regulation 2600.85a by 3/18/2022. (Document A3)

Training-Executive Director inspected all common bathrooms to ensure compliance with 2600.85a by 3/16/2022. (Document A4)

Audit Tool (1 of 6) Executive Director and designee inspected all common bathrooms to ensure compliance with 2600.85a by 3/16/2022. (Document A4)

Audit Tool (2 of 6)-Executive Director and/or designee has and will continue to inspect common bathrooms daily to ensure compliance with 2600.85a until 6/30/2021. (Document A5)

Audit Tool (3 of 6) Audit results for bathrooms will be reviewed at monthly QA meeting until 6/30/2022. The Committee will direct further interventions as required to maintain/sustain compliance. (Document A6)

Audit Tool (4 of 6)-Executive Director or designee inspected all PTACs to ensure compliance with 2600.85a by 3/16/2022. (Document A7)

Audit Tool (5 of 6) Executive Director and/or designee has and will continue to inspect all PTACs monthly to ensure compliance with 2600.85a. (Document A8)

Audit Tool (6 of 6) Audit results for PTACS will be reviewed at monthly QA meeting until 6/30/2022. The Committee will direct further interventions as required to maintain/sustain compliance. (Document A9)

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an

85a - Sanitary Conditions (continued)

admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Completion Date: *06/30/2022*

Document Submission ***Implemented***

Update: *09/12/2022*

see attached

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The thermostat in resident #1's bedroom (room #130) was not covered. The uncovered thermostat had exposed wires which is a potential safety hazard to the resident on the SDCU.

Plan of Correction ***Accept***

Correction-In response to this violation, the thermostat dial and cover in SDCU room #130 was repaired on 3/11/2022. (Document B1)

Training- Vice President of Clinical Services (VPCS) to in-service Executive Director on regulation 2600.85A by 3/15/2022. (Document B2)

Training-Executive Director in-serviced applicable staff on regulation 2600.85a by 3/18/2022. (Document B3)

Audit Tool (1 of 3)-Executive Director inspected all bedrooms in SDCU to ensure compliance with 2600.85a by 3/16/2022. (Document B4)

Audit Tool (2 of 3)-Executive Director and/or designee will inspect all bedrooms weekly to ensure compliance with 2600.85a until 06/30/2021. (Document B5)

Audit Tool (3 of 3)-Audit results will be reviewed at monthly QA meeting until 6/30/2022. The Committee will direct further interventions as required to maintain/sustain compliance. (Document B6)

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Completion Date: *06/30/2022*

Document Submission ***Implemented***

88a - Surfaces *(continued)*

Update: *09/12/2022*

see attached

89a - Water Pressure

1. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 3/11/22, at 9:30am, the home did not have hot or cold running water in the bathroom across from the activities room.

Plan of Correction ***Accept***

Correction-In response to this violation, the bathroom's motion sensor on the faucet was repaired on 3/12/2022. (Document C1)

Training- Vice President of Clinical Services (VPCS) in-serviced Executive Director on regulation 2600.89a by 3/15/2021. (Document C2)

Training-Executive Director in-serviced applicable staff on regulation 2600.89a by 3/18/2022. (Document C3)

Audit Tool (1 of 3) -Executive Director and designee inspected all resident rooms to ensure compliance with 2600.89a by 3/18/2022. (Document C4)

Audit Tool (2 of 3)-Executive Director and/or designee has and will continue to inspect each room weekly to ensure compliance with 2600.88a until 6/30/22. (Document C5)

Audit Tool (3 of 3) -Audit results will be reviewed at monthly QA meeting until 6/30/22. The Committee will direct further interventions as required to maintain/sustain compliance. (Document C6)

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Completion Date: *06/30/2022*

Document Submission ***Implemented***

Update: *09/12/2022*

see attached

101j5 - Bedside Table/Shelf

1. Requirements

101j5 - Bedside Table/Shelf *(continued)*

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf for resident(s) #2, #3 or #4's bed in bedroom(s) 128, 141 or 146.

Plan of Correction ***Accept***

Correction-In response to this violation, room 128, 141 and 146's bedside table was moved near the bedside. (Document D1)

Training- The Vice President of Clinical Services (VPCS) in-serviced the ED and Director of Wellness (DOW) on regulation 101J (5) on 3/14/2022. (Document 2)

Training- The Executive Director trained applicable staff on 2600.101J(5) regulation by 3/18/2022. (Document D3)

Audit Tool (1 of 3)-The Executive Director and/or designee inspected all resident rooms in SDCU to ensure that they had a bedside table located next to the bed as per the regulation. The audit will be completed by 3/18/202. (Document D4)

Audit Tool (2 of 3)-The Executive Director and/or designee has and will continue to inspect each room in SDCU weekly to ensure that they still has a bedside table near the bed until 6/30/20. (Document D5)

Audit Tool (3 of 3)-Audit results will be reviewed at the Monthly QA meeting until 6/30/21. The Committee will direct further interventions as required to maintain/sustain compliance. (Document D6)

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Completion Date: *06/30/2022*

Document Submission ***Implemented***

Update: *09/12/2022*

see attached

101j7 - Lighting/Operable Lamp

1. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident(s) #2, #3 and #4 do not have access to a source of light that can be turned on/off at bedside.

101j7 - Lighting/Operable Lamp (continued)

Plan of Correction ***Accept***

Correction-In response to this violation, room 128, 141 and 146's had a source of light affixed to wall near the bedside by 3/15/2022. (Care plans for identified resident's were updated to reflect that a moveable lamp was a hazard and that a wall-affixed light source was more appropriate at this time.) (Document E1)

Training- The Vice President of Clinical Services (VPCS) in-serviced the ED and Director of Wellness (DOW) on regulation 101J (5) on 3/14/2022. (Document E2)

Training- The Executive Director trained applicable staff on 2600.101J(7) regulation by 3/18/2022. (Document E3)

Audit Tool (1 of 3)-The Executive Director and/or designee inspected all resident rooms in SDCU to ensure that they had a bedside table located next to the bed as per the regulation by 3/18/2022. (Document E4)

Audit Tool (2 of 6) -The Executive Director and/or designee has and will continue to inspect each room in SDCU weekly to ensure that it still has a bedside table near the bed until 6/30/20. (Document E5)

Audit Tool (3 of3) -Audit results will be reviewed at the Monthly QA meeting until 6/30/21. The Committee will direct further interventions as required to maintain/sustain compliance. (Document E6)

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Completion Date: *06/30/2022*

Document Submission ***Implemented***

Update: *09/12/2022*

see attached

102h - Toilet Paper

1. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 03-11-2022 there was no toilet paper in the bathroom across from activities room.

Plan of Correction ***Accept***

Correction-In response to this violation, toilet paper was placed in the bathroom across from the activities room in the SDCU on 3/11/2022. (Document F1)

102h - Toilet Paper (continued)

Training- Vice President of Clinical Services (VPCS) in-serviced Executive Director on regulation 2600.102h on 3/15/2022. (Document F2)

Training-Executive Director in-serviced applicable staff, on regulation 2600.102h on 3/18/2022. (Document F3)

Audit Tool (1 of 3)-Executive Director or designee inspected all toilets to ensure compliance with 2600.102h on 3/16/2022. (Document F4)

Audit Tool (2 of 3) -Executive Director and/or designee has and will continue to inspect common bathrooms and spot audit 5 different resident rooms daily to ensure compliance with 2600.102h until 6/30/2021. (Document F5)

Audit Tool (3 of 3) -Audit results will be reviewed at monthly QA meeting until 6/30/2022. The Committee will direct further interventions as required to maintain/sustain compliance. (Document F6)

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Completion Date: *06/30/2022*

Document Submission ***Implemented***

Update: *09/12/2022*

see attached

105g - Lint Removal and Duct Cleaning

1. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 3/11/22, two dryers on the SDCU were observed with lint in the lint trap. There were no clothes in the dryer at the time of inspection.

Plan of Correction ***Accept***

Correction-In response to this violation, all lint traps were cleaned by 3/11/2022. (Document G1)

Training-The Vice President of Clinical Services (VPCS) in-serviced the ED and Director of Wellness (DOW) on regulation 2600.105g on 3/15/2022. (Document G2)

Training- The Executive Director trained current staff on regulation 2600.105g by 3/18/2022. (Document G3)

Audit Tool (1 of 3)-The Executive Director and designee inspected all dryers in the community to ensure

105g - Lint Removal and Duct Cleaning (continued)

compliance with 2600.105g by 3/16/2022. (Document G4)

Audit Tool (2 of 3)-The Executive Director and/or designee has and will continue to audit lint trap log sheets in each laundry room weekly to ensure compliance with 2600.105g until 6/30/2022. (Document G5)

Audit Tool (3 of 3) Audit results will be reviewed at the Monthly QA meeting until 6/30/2022. The Committee will direct further interventions as required to maintain/sustain compliance. (Document G6)

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Completion Date: *06/30/2022*

Document Submission ***Implemented***

Update: *09/12/2022*

see attached

183d - Prescription Current

1. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 3/11/22, a bottle of Loperamide 2mg was observed with resident #5's medications. However, the medication was discontinued and resident #5 did not have a current order for the medication.

Plan of Correction ***Accept***

Correction-In response to this violation the discontinued medication for Resident #5 was removed from the medication cart on 3/11/2022. (Document H1)

Training- The Vice President of Clinical Services (VPCS) in-serviced the ED and Director of Wellness (DOW) on regulation 2600.183d on 3/15/2022. (Document H2)

Training-Director of Wellness in-serviced med techs on regulation by 3/18/2022. (Document H3)

Audit Tool (1 of 3)- Director of Wellness or designee audited all current medications to ensure compliance with 2600.183d on 3/18/2022. (Document H4)

Audit Tool (2 of 3)- Director of Wellness and/or designee has and will continue to audit all medication carts weekly to ensure compliance with 2600.183d until 6/30/2022. (Document H5)

183d - Prescription Current (continued)

Audit (3 of 3)-Audit results will be reviewed at monthly QA meeting until 6/30/22. The Committee will direct further interventions as required to maintain/sustain compliance. (Document H6)

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Completion Date: *06/30/2022*

Document Submission ***Implemented***

Update: *09/12/2022*

see attached