

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

January 9, 2025

[REDACTED]
WARWICK BRIDGES LLC

[REDACTED]
ATTN BILL SNOW
[REDACTED]

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

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/23/2024, 10/24/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE BRIDGES AT WARWICK License #: 14316 License Expiration: 10/31/2025
 Address: 1600 ALMSHOUSE ROAD, JAMISON, PA 18929
 County: BUCKS Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: WARWICK BRIDGES LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-1 Date: 12/18/2016 Issued By: warwick township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 144 Waking Staff: 108

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 10/24/2024

Inspection Dates and Department Representative

10/23/2024 - On-Site: [REDACTED]
 10/24/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 130 Residents Served: 94

Secured Dementia Care Unit
 In Home: Yes Area: Lilac Terrace Capacity: 31 Residents Served: 26

Hospice
 Current Residents: 14

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 94
 Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 50 Have Physical Disability: 0

Inspections / Reviews

10/23/2024 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 11/24/2024

12/03/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 12/27/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/09/2024

Inspections / Reviews (*continued*)

12/24/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/27/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 12/29/2024

01/09/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/27/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

65f - Training Topics

1. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2023.

Direct care staff person B did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2023.

Plan of Correction

Accept (████) 12/24/2024)

Correction: (Document #1 65f) Upon immediate knowledge of this violation, direct care staff A and B were in serviced by Wellness Director on 10/24/24 on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan. I

Correction: (Document #2 -65f) New training has been implemented to meet the requirements of 2600.65f.

Training: (Document #3-65f) All current staff was in-serviced on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan .

Audit: (Document #4-65f) The Business Office Director or designee will audit all direct care staff's charts to ensure compliance with 2600.65f starting on 10/29/24 through 12/29/24

Quality Assurance: (Document #5-65f) The Executive Director and/or designee will review audits for regulation 2600.65f monthly at our Quality Assurance meeting until December 29, 2024 to ensure compliance with this regulation.

Proposed Overall Completion Date: 02/18/2025

Proposed Overall Completion Date: 12/29/2024

Licensee's Proposed Overall Completion Date: 12/29/2024

Implemented (████) - 01/09/2025)

66b - Training Plan Content

2. Requirements

2600.

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

66b Training Plan Content (continued)

Description of Violation

The home's staff training plan does not include the topic: Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Plan of Correction

Accept [REDACTED] - 12/24/2024)

Correction: (Document #1 66.b) Upon immediate knowledge of this violation, the training plan for 2024 was updated.

Training: (Document #2 66.b) Executive Director updated training plan for 2025 so that meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan are included in plan.

Audit: (Document #3 66.b) The Executive Director or designee will audit staff training logs, beginning on 10/29/24 and ending on 12/29/24 for compliance with regulation 2600.66.b

Quality Assurance: (Document #4 66.b) The Executive Director and/or designee will review audits for regulation 2600.66.b monthly at our Quality Assurance meeting until 12/29/24 to ensure compliance with this regulation.

Proposed Overall Completion Date: 02/18/2025

Proposed Overall Completion Date: 12/29/2024

Licensee's Proposed Overall Completion Date: 12/29/2024

Implemented [REDACTED] - 01/09/2025)

81b - Resident Personal Equipment

3. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On [REDACTED], resident [REDACTED] bedside mobility device was not secured to the bed frame.

On [REDACTED], resident [REDACTED] bedside mobility device was not secured to the bed frame.

On [REDACTED], resident [REDACTED] bedside mobility device was not secured to the bed frame.

Plan of Correction

Accept [REDACTED] - 12/24/2024)

Correction: (Document #1 81.b) Upon immediate knowledge of this violation, bed mobility devices were removed.

Correction: (Document #2 81.b) New mobility devices were ordered on 11/11/24 for resident [REDACTED] and [REDACTED] Maintenance installed new mobility devices to comply with regulation 81B on 11/15/24

Training: (Document #3 81.b) Executive Director in serviced Director of Engineering, Wellness Director and Memory Care director on 10/29/24 on requirement 2600.81.b and mobility devices that comply with regulation.

Audit: (Document #4 81.b) The Executive Director or designee will inspect 10 random rooms weekly starting 10/28/24 through 12/29/24 for compliance with regulation 2600.81.b

Quality Assurance: (Document #5 81.b) The Executive Director and/or designee will review audits for regulation 2600.81.b monthly at our Quality Assurance meeting until 12/29/24 to ensure compliance with this regulation.

81b - Resident Personal Equipment (continued)

Proposed Overall Completion Date: 02/18/2025

Proposed Overall Completion Date: 12/29/2024

Licensee's Proposed Overall Completion Date: 12/29/2024

Implemented (████) 01/09/2025)

183e - Storing Medications

4. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On ██████, there was an unopened ██████ belonging to resident ██████ in the medication cart. According to the manufacturer's instructions ██████ should be stored in refrigerator until opened.

On ██████, ██████ belonging to resident ██████ was on the medication cart opened without an open date on the label. According to the manufacturer's instructions ██████ expires after being opened for 42 days.

Plan of Correction

Accept (████) - 12/24/2024)

Correction: (Document #1-183) In Immediate response to violation #1, the bottle on the cart unopened was disposed of and reordered. The medication was delivered that evening, opened and dated.

Correction: (Document #2 -183) In immediate response to violation #2, the opened undated bottle of Latanoprost was destroyed using drug buster and reordered from pharmacy. This medication was promptly stored in the refrigerator upon its arrival from pharmacy.

Training: (Document #3 -183) The Executive Director educated the Director of Wellness and Memory Care Director on 10/25/24 on the importance of adherence to regulation 2600.183 (E)

Training: (Document #4 -183) On 10/28/24 the Director of Wellness in-serviced appropriate staff directly involved with assisting with monitoring the adherence to regulation 2600.183 (E)

Action: (Document #5 -183) The Director of Wellness and/or Designee will perform weekly audits starting on 10/28/24 through 12/29/24 of all current Medication carts to ensure manufacturer guidelines are being followed ie: proper storage and dates until 12/29/24.

Action: (Document #6 -183) The Executive Director and/or Designee shall review all cart audits at our Monthly Quality Assurance Meeting to ensure adherence to regulation 2600.183 (E) until December 29, 2024.

Proposed Overall Completion Date: 02/18/2025

Proposed Overall Completion Date: 12/29/2024

Licensee's Proposed Overall Completion Date: 12/29/2024

Implemented (████) 01/09/2025)

185a - Implement Storage Procedures

5. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] as needed. On [REDACTED], the medication was not available in the home.

On [REDACTED], at bedtime, resident [REDACTED] s [REDACTED] had no reading; however the home documented [REDACTED] on the medication administration record.

On [REDACTED] at bedtime, resident [REDACTED] had no reading; however the home documented [REDACTED] on the medication administration record.

On [REDACTED] at bedtime, resident [REDACTED] had no reading; however the home documented [REDACTED] on the medication administration record.

On [REDACTED] at bedtime, resident [REDACTED] had no reading; however the home documented [REDACTED] on the medication administration record.

On [REDACTED] at bedtime, resident [REDACTED] s [REDACTED] had no reading; however the home documented [REDACTED] on the medication administration record.

On [REDACTED] at bedtime, resident [REDACTED] had no reading; however the home documented [REDACTED] on the medication administration record.

On [REDACTED], at bedtime, resident [REDACTED] [REDACTED] had no reading; however the home documented [REDACTED] on the medication administration record.

Resident [REDACTED] is prescribed blood sugar checks 4 times daily in the morning, afternoon, evening, and bedtime.

On [REDACTED], and [REDACTED] the resident's [REDACTED] was not checked and documented in the afternoon.

On [REDACTED], and [REDACTED] the resident's blood sugar was not checked and documented in the evening.

Plan of Correction

Accept ([REDACTED] - 12/24/2024)

#1 Correction: (Document #1- 185a) In immediate response to violation #1, the family and PCP were made aware. The medication was ordered for STAT delivery and was delivered the evening of 10/23/2024.

#1 Training: (Document #2 -185a) The Director of Wellness has reviewed weekly cart audit tools to ensure PRN medication refills are included in the audit process. This audit tool was reviewed with the appropriate staff responsible for always keeping medications available for our residents.

#1 Audit: Document #3-185a) The Director of Wellness and/or designee audited the PRN medications ordered and available to ensure adherence to regulation 2600.185a on 10/26/24

185a - Implement Storage Procedures (continued)

- #1 Audit: (Document #4 – 185a) The Director of Wellness and/or designee will audit each PRN medication weekly to ensure compliance with regulation 2600.185a starting 10/28/24 through 12/29/24.
- #1 Quality Assurance: (Document #5- 185a) The Executive Director and/or Designee will review weekly cart audits at our monthly Quality Assurance meetings until 12/29/24.
- #2-#8 Correction: (Document #6-185a) Upon immediate response, this residents PCP and family were made aware of the missing blood sugar readings. The second glucometer for this resident was removed from the cart and returned to the family to avoid confusion with what device blood sugars are recorded in. This resident was also changed to a Libre Sensor for blood glucose checks that is managed by a nurse for insertion and removal of device.
- #2-#8 Correction: (Document #7-185a) Missing blood sugar numbers were verified in the second glucose machine and the missing glucose numbers were added to the progress notes. We were unable to add the missing values to the current system because we have changed our electronic medical records system since our state inspection.
- #2-#8 Training: (Document #8-185a) On 10/25/24 the Executive Director educated the Director of Wellness and the Memory Care Director on the importance of adherence to regulation 2600.185a
- #2-#8 Training: (Document #9-185a) On 10/28/24 the Director of Wellness and/or Designee in-serviced appropriate staff responsible for the input of data to residents EMAR.
- #2-#8 Action: (Document #10- 185a) The Wellness Director and/or designee will audit the glucometer weekly starting 10/28/24 through 12/29/24 to ensure adherence to regulation 2600.185a.
- #2-#8 Action: (Document #11-185a) The Executive Director and/or designee will review audit results monthly at our Quality Assurance meetings. The Executive Director will review more often IF any violation is found during the weekly audits of this resident's glucometer until 12/29/24.

Proposed Overall Completion Date: 02/18/2025

Proposed Overall Completion Date: 12/29/2024

Licensee's Proposed Overall Completion Date: 12/29/2024

Implemented [REDACTED] - 01/09/2025)

227d - Support Plan Medical/Dental**6. Requirements**

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident [REDACTED] dated [REDACTED] was missing completed sections for Understanding Instructions, Managing Finances and supervision Assessment.

The assessment for resident [REDACTED] dated [REDACTED], was missing completed sections for medication self-administration.

Plan of Correction

Accept [REDACTED] - 12/24/2024)

Correction: (Document #1-227d) Upon immediate response to these violations, resident 7 and 8 RASPs were rectified.

Training: (Document #2-227d) On 10/25/24 the Executive Director educated the Director of Wellness and the

227d Support Plan Medical/Dental (continued)

Memory Care Director on the importance to adhere to regulation 2600.227d

Training: (Document #3 227d) On 10/28/24 the Director of Wellness educated the appropriate qualified staff on the importance of completion of RASPs as stated in regulation 2600.227d.

Audit: (Document #4 227d) The Director of Wellness and/or designee will audit all current resident RASPs starting on 10/28/24 through 12/29/24 to ensure adherence to regulation 2600.227d.

Audit: (Document #5 227d) The Director of Wellness will audit the RASPs of all new move ins from 11/18/2024 through 12/29/24 to ensure a routine has been established with adhering to regulation 2600.227d

Quality Assurance: (Document #6 227d) The Executive Director and/or designee will review all audits pertaining to regulation 2600.227d during monthly Quality Assurance meetings through 12/29/24. The Executive Director will be immediately notified if there is a violation found.

Proposed Overall Completion Date: 02/18/2025

Proposed Overall Completion Date: 12/29/2024

Licensee's Proposed Overall Completion Date: 12/29/2024

Implemented (█ - 01/09/2025)

231b - Medical Evaluation**7. Requirements**

2600.

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident █ was admitted to the Secure Dementia Care Unit (SDCU) on █; however, the resident's medical evaluation was completed on █.

Plan of Correction

Accept █ - 12/24/2024)

Correction: (Document #1 231b) Upon immediate knowledge of this violation, resident █ family and PCP were made aware. Resident █ PCP stated █ had dated the paperwork with the wrong year and issued a new DME dated properly for resident █ move in on █.

Training: (Document #2 231b) On 10/25/24 the Executive Director educated the Director of Wellness, Memory Care Director, Sales Director and the Business office Director on the importance of adherence to regulation 2600.231b.

Training: (Document #3 231b) On 10/28/24 the Director of Wellness educated the appropriately qualified staff on the importance of adhering to regulation 2600.231b.

Audit: (Document #4 231b) The Director of Wellness and/or Designee will audit all residents' charts living in our Secured Dementia Unit to ensure adherence to regulation 2600.231.b starting 10/28/24 through 12/18/24.

Audit: (Document #5 231b) The Director of Wellness and/or designee will audit all future Memory Care residents from 10/28/24 to 12/29/24 to ensure a pattern of compliance with regulation 2600.231b has been established.

Quality Assurance: (Document #6 231b) The Executive Director and/or designee will review audits for regulation 2600.231b monthly at our Quality Assurance meeting until 12/29/24 to ensure compliance with this regulation.

Proposed Overall Completion Date: 02/18/2025

Proposed Overall Completion Date: 12/29/2024

231b Medical Evaluation (continued)

Licensee's Proposed Overall Completion Date: 12/29/2024

Implemented [REDACTED] 01/09/2025)

233c - Key-Locking Devices

8. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The Secure Dementia Care Unit courtyard exit had the wrong code posted and did not operate when code posted was entered.

Plan of Correction

Accept [REDACTED] - 12/24/2024)

Correction: (Document #1 223.c) Upon immediate knowledge of this violation, correct signage was hung to notify of exit code for secure dementia care courtyard.

Training: (Document #2 223.c) On 10/28/24 Executive Director in serviced Director of Engineering and Memory Care director on requirement for signage to match the current code for exit from courtyard.

Training: (Document #3 223.c) On 11/6/24 Executive Director, Director of Engineering and Memory Care director executed simulation of changing electronic lock code

Audit: (Document #4 223.c) The Maintenance Director will audit secure memory care electronic locks weekly to ensure compliance with regulation 2600.223.c from 10/29/24 to 12/29/24

Quality Assurance: (Document #5 223.c) The Executive Director and/or designee will review audits for regulation 2600.223.c monthly at our Quality Assurance meeting until 12/29/24 to ensure compliance with this regulation.

Proposed Overall Completion Date: 02/18/2025

Proposed Overall Completion Date: 12/29/2024

Licensee's Proposed Overall Completion Date: 12/29/2024

Implemented [REDACTED] - 01/09/2025)