pennsylvania
DEPARTMENT OF PUBLIC WELFARE

NOV 0 8 2013

Mr. Jefferson D. Kaighn, Vice President
ACTS Retirement – Life Communities, Inc.
375 Morris Road
West Point, Pennsylvania 19486

RE: Oakbridge Terrace at Brittany Pointe Estates
1001 Valley Forge Road
Lansdale, Pennsylvania 19446
License #: 138930

Dear Mr. Kaighn:

As a result of the Department of Public Welfare's licensing inspection on July 18, 2013, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa.Code Ch. 2800 (relating to assisted living residences).

Your regular license for the period July 1, 2013 to July 1, 2014 was issued on April 11, 2013. Your regular license remains in good standing.

Sincerely,

Matthew J. Jones
Acting Director

Enclosure
Licensing Inspection Summary

Bureau of Human Services Licensing
625 Forster Street, Room 631 | Harrisburg, PA 17120 | 717.783.3670 | F 717.783.5662 | www.dpw.state.pa.us

LICENSING INSPECTION SUMMARY
Assisted Living Residences - 55 Pa.Code § 2800

Name of Residence: Oakbridge Terrace at Brittany Pointe Estates

Address:
1001 S Valley Forge Rd Lansdale, Pa. 19446

License Number: 460210

Type of Inspection:
Full

Reason(s) for Inspection: Annual

Notice:

On-site Inspection Dates and Department Representatives On-site:
7/18/13 – Israel Springs, Dale Rosenblat

Off-site Inspection Dates and Department Representatives, if Applicable:

Regulation: § 2800.121 (a) Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.
Violation: The patio door located near the parlor is used as an egress route but is locked at all times.

Plan of Correction

Dear Mr. Cody,

It was brought to our attention that because we did not have our 90 day review this issue was not discovered until our annual inspection on July 18, 2013. It was also discussed that if the issue was corrected while the inspectors were still at the facility it was possible the violation would not be included in the inspector's final report. I respectfully request consideration regarding this matter.

Plan of Correction for Reg. 2800.121(a)

This regulation is important because egress routes to and from the facility must be unlocked and unobstructed at all times.

This violation occurred because there was a turn mechanism deadbolt on the exit doors that required unlocking prior to being able to exit. The doors cited lead to a sidewalk which goes around the building to the courtyard outside the Dining Room. Our residents do not use this

This concern was corrected immediately while the inspectors were still on site and deemed acceptable. Our Plant Operations Director brought in our locksmith within an hour. He removed the deadbolt, leaving only a door handle to be turned in order to open the door. Each door has an opening of 36 inches so it meets all accessibility/exit requirements.

The removal of the deadbolt is permanent.

Both the Administrator of OakBridge Terrace [redacted] and the Director of Plant Operations [redacted] will be responsible for maintaining an unlocked and unobstructed egress.

Printed Name and Title of Legal Entity Representative (Required on all pages) MARGARET C WINTER, ADMINISTRATOR	
Signature of Legal Entity Representative (Required on all pages) Margaret C Winter	Date 8/27/13

DEPARTMENT USE ONLY – HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 10/28/13 (Date)	Plan of correction implementation status as of 10/28/13 (Date):
	☒ Fully Implemented
The above plan of correction was approved by NSC (Initials)	☐ Partially Implemented – Adequate Progress
	☐ Partially Implemented – Inadequate Progress
	☐ Not Implemented

Regulation: § 2800.187 (a) (14) A medication record shall be kept to include the name and initials of the staff person administering the medication.

Violation: On the MAR, the administration of the 8 AM dose of Digoxin for Resident #1 was not initialed by Staff Person A on Wednesday, 7/17/13 and Thursday, 7/18/13.

Plan of Correction

Plan of Correction for Reg. 2800.187(a)

This regulation is important because the medication record is to include the name and initials of the person administering the medication.

This regulation was violated because the nurse administering the medication did not initial the MAR.

The violation was caused by the omission of the nurses' initials in the proper space on the MAR. Prior to administering the medication the nurse checked the resident's pulse, which is the correct procedure for administering Digoxin. She recorded the pulse on her report sheet, but failed to document on the MAR.

Immediately after verification of administering of the medication the nurse documented her initials on the MAR.

The regulation and our policy on medication administration was reviewed with the nurse and she was counseled on the importance of following through on her documentation.

The Charge nurse on duty is responsible for charting on the MAR as she administers the resident's medications as ordered by the physician. After giving the last med pass for the shift, the Charge nurse is to go through the MARs and again check for accuracy and completeness.

Printed Name and Title of Legal Entity Representative (Required on all pages) MARGARET C WINTER, ADMINISTRATOR

Signature of Legal Entity Representative (Required on all pages) Margaret C Winter — Date 8/27/13

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