



November 19, 2019

Ms. Holly Schade
Senior VP Home & Health Services
ACTS Retirement – Life Communities, Inc.
375 Morris Road
West Point, Pennsylvania 19486

RE: Oakbridge Terrace at Spring House Estates
728 Norristown Road
Lower Gwynedd, Pennsylvania 19002
License #: 139010

Dear Ms. Schade:

As a result of the Department's Bureau of Human Services Licensing annual inspection on September 10, 2019 of the above facility, the violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence) must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Hancock", is written over a light blue horizontal line.

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: OAKBRIDGE TERRACE AT SPRING HOUSE ESTATES
Address: 728 NORRISTOWN ROAD, LOWER GWYNEDD, PA 19002
County: MONTGOMERY Region: SOUTHEAST

License Number: 13901

Administrator

Name: Susan Leisey Phone: 2156288110 Email: SLEISEY@ACTSLIFE.ORG

Legal Entity

Name: ACTS RETIREMENT-LIFE COMMUNITIES INC
Address: 375 MORRIS ROAD, WEST POINT, PA, 19486

Certificate(s) of Occupancy

Type: C-2 LP Date: 10/16/2001 Issued By: COPA L & I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 70 Waking Staff: 53

Inspection

Type: Full Reason: Renewal BHA Docket #: Notice: Unannounced

Inspection Dates and Department Representative

09/10/2019 - On-Site: Denise Gillespie, Dean Gray

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 54 Residents Served: 44

Special Care Unit

In Home: Yes Area: SCU Capacity: 30 Residents Served: 26

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 44
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 26 Have Physical Disability: 2

18 Other laws, regs, ordins.

Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Per Pennsylvania Statutes Title 35 P.S. Health and Safety § 7243. Facility powers and duties....
An approved carbon monoxide alarm at a care facility shall be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance.

On, 9/10/19 Boiler # 2 did not have a carbon monoxide alarm installed in close proximity to it.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

POC: Preparation and/or execution of this plan of correction does not constitute admission or agreement by the providers of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely as a matter of compliance with federal and state law.

Our vendor, Electronic Security Solutions was contacted. On 9/11/19 they installed an appropriate carbon monoxide alarm in "close proximity of not less than 15 feet" of boiler #2. Daily inspections of boilers and carbon monoxide alarms will be performed by the maintenance department and monitored by the Director of Physical Plant. The results of the audits will be reported to the Quality Assurance Committee for six months.

Administrator or designee will ensure all fossil fuel burning appliances and devices have a carbon monoxide detector within 15 feet. Inspections and Audits performed by home to be made available for Department review.
SP 10-25-19

Legal Entity Representative

Handwritten signature of Susan Leisey RW DAL
Signature

Susan Leisey RW DAL 10/24/19
Printed Name and Title Date

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The above plan of correction is approved as of 10-25-19 (Date)

Plan of correction implementation status as of 10-25-19 (Date)

The above plan of correction was approved by SP (Initials)

- Fully Implemented
Partially Implemented - Adequate Progress
Partially Implemented - Inadequate Progress
Not Implemented

2600.65a

Administrator or designee will ensure prior to or during first day of work all new employees will be trained in the areas specified in regulation 2600.65a. Home did send in verification via Relias transcript that staff person A had a fire safety course 04-05-19. It is the responsibility of the home to ensure dates recorded correlate with the dates of the actual training. Training records will be kept in employee files and made available for Department review.

SP 10-25-19

95 Furniture & Equipment

Requirements

2800. 95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

Resident Bedroom 108 has an enabler bar on the bed that is uncovered and poses a safety risk.

Resident Bedroom 2 has an enabler bar on the bed that was uncovered until day of inspection.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

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Bedroom 108 enabler cover was soiled on the morning of survey, 9/10/19. It was removed to be sanitized and replaced that same day by the CNA. Bedroom 2 enabler cover was shown to be in place during 9/5/19 audit. Because enabler bar covers become soiled from time to time and must be removed and sanitized the Director of Assisted Living will make extra covers available so that any enabler cover removed is replaced in a reasonable time frame. Effective by 10/23/19 enabler covers will be audited daily and per shift to ensure compliance. The Director of Assisted Living or designee will report the results of these audits quarterly to the Quality Assurance Committee for six months.

Administrator or designee will ensure all furniture and equipment is in good repair, clean and free of hazards. Enabler bars will be evaluated to ensure they don't pose a hazard to residents. Home did verify cover was washed and placed back over enabler the date of inspection.

SP 10-25-19

Legal Entity Representative

Signature: Susan Hensley RN, DAL Printed Name and Title: Susan Hensley RN, DAL Date: 10/24/19

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The above plan of correction was approved by SP (Initials) [] Fully Implemented [x] Partially Implemented - Adequate Progress [] Partially Implemented - Inadequate Progress [] Not Implemented

144c1 Smoking area guidelines

Requirements

2800.
144.c. A residence that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the residence, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The residence's designated smoking area had cushions present on the furniture in the area. The cushions were not fire resistant.

Plan of Correction (POC)

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Effective 9/10/19 the smoking policy was changed to reflect that the OBT West courtyard was no longer a designated smoking area. All signage and ash receptacles were removed. Staff were notified and a meeting was held with community residents to review this smoking policy and change in designated areas. The Director of Assisted Living will continue to monitor monthly to ensure compliance with smoking policy.

Administrator or designee will ensure that no combustible chairs, cushions or other items are present in any designated smoking areas of the home and that smoking policys and procedures are being followed

SP 10-25-19.

Legal Entity Representative

Susan Heisey RN, DAL
Signature

Susan Heisey RN DAL 10/24/19
Printed Name and Title Date

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(Date)

Plan of correction implementation status as of 10-25-19
(Date)

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(Initials)

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- Partially Implemented - Inadequate Progress
- Not Implemented

1 85a Storage procedures

Requirements

2800. 185.a. The residence 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 # 1 is prescribed Guffessin as needed. On 9/10/19, this medication was not available in the residence.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

DISPUTE: Resident #1 medication Guaifenesin was removed from the Med Cart at 2 am on 9/10/19 (the date of the survey) and reordered because it was due to expire 09 2019, denoting end of the month. (See exhibit #2). The removed medication was placed in a locked cabinet for the Director of Assisted Living to destroy once the new medication arrived from the pharmacy. Nursing staff had knowledge, keys and access to the expiring Guaifenesin medication in the event a dose was required prior expiration and before the new Guaifenesin medication arrived. While not on the Med Cart the medication was retained in the community and available to the resident. The Guaifenesin removed from the cart the morning of 9/10/19 was ordered that same morning and arrived from the pharmacy just after 5:00 pm on 9/10/19, the same day. It was immediately placed on the on the Med Cart. The expiring Guaifenesin was subsequently destroyed.

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An audit of Med Carts will be performed bi-weekly during the 11pm to 7am shift to ensure resident medications are available. Staff will be in-serviced not to remove expiring medications from the cart until the replacement medication has arrived from the pharmacy unless the medication itself has reached expiration. Audits will be completed by CNA or LPN staff. Director of Assisted Living will monitor audits for compliance. The results of the audits will be reported to the Quality Assurance Committee for one year. Please see attached.....

Legal Entity Representative

Signature: Susan Reisey RN DAC; Printed Name and Title: Susan Reisey, RN DAC; Date: 10/24/19

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2600.185a

Staff in-service to take place within 30 days receipt of POC. Documentation of in-service and audits to be made available for Department review. Home did verify medication arrived after 5:00pm date of inspection. Administrator will ensure procedures are implemented to ensure all resident medications are received and in-house in a timely manner.

SP 10-25-19