

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

December 1, 2025

[REDACTED]
ACTS RETIREMENT-LIFE COMMUNITIES INC
[REDACTED]
[REDACTED]

RE: OAKBRIDGE TERRACE AT
NORMANDY FARMS ESTATES
9000 TWIN SILO DRIVE
BLUE BELL, PA, 19422
LICENSE/COC#: 13898

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/28/2025 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: OAKBRIDGE TERRACE AT NORMANDY FARMS ESTATES **License #:** 13898 **License Expiration:** 07/17/2026
Address: 9000 TWIN SILO DRIVE, BLUE BELL, PA 19422
County: MONTGOMERY **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: ACTS RETIREMENT-LIFE COMMUNITIES INC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: Other **Date:** 03/24/2000 **Issued By:** CWOPA L&I
Type: Other **Date:** 04/20/2000 **Issued By:** Upper Gwynedd Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 59 **Waking Staff:** 44

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 08/28/2025

Inspection Dates and Department Representative

08/28/2025 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity: 58	Residents Served: 48		
Special Care Unit			
In Home: Yes	Area: Cranberry	Capacity: 12	Residents Served: 11
Hospice			
Current Residents: 0			
Number of Residents Who:			
Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 48		
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 0		
Have Mobility Need: 11	Have Physical Disability: 1		

Inspections / Reviews

08/28/2025 Partial
Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/09/2025

11/12/2025 - POC Submission
Submitted By: [REDACTED] **Date Submitted:** 11/28/2025
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/17/2025

Inspections / Reviews *(continued)*

11/20/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/28/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 11/28/2025

12/01/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/28/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c Incident reporting

1. Requirements

2800.

16.c. The residence shall report the incident or condition to the Department’s assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] resident [redacted] had a fall that resulted in pain in bilateral arms and lower extremities. Resident [redacted] was sent to the hospital and was diagnosed with [redacted]. The residence did not report this incident to the Department until [redacted]

Plan of Correction

Accept ([redacted] - 11/20/2025)

Director of Assisted Living provided in-service to both Registered Nurses and Licensed Practical Nurses on 9/5/25 on how to correctly fill out the Reportable Incident Report and the required 24-hour time frame to send the Reportable Incident Report. The pool staff LPN that failed to send the Reportable Incident Report within the required 24 hour time frame was counseled on 9/16/25 for failure to send it as required and educated on what the DHS requirements were for filling out and sending a Reportable Incident Report. Director of Assisted Living set up a binder in each nurses station with a copy of the in-service and instructions for quick reference if needed.

Director of Assisted Living will provide an additional in-service on the new form that will be included in the binder, which will explain how the new documentation form is to be used to document all Reportable Incident Reports when they happen and then for each of the next 2 shifts following the incident to confirm that the Reportable Incident Report was sent to DHS. This form will also be used to acknowledge that the Director of Assisted Living or in [redacted] absence, [redacted] designee, was notified at the time of incident that the Reportable Incident Report was sent to DHS.

The Director of Assisted Living or designee will review Reportable Incident Report binder daily for completeness and compliance. This form will be used for ongoing monitoring by Director of Assisted Living or designee and reported to QAPI in January for further discussion and review.

Proposed Overall Completion Date: 11/09/2025

Licensee's Proposed Overall Completion Date: 11/25/2025

Implemented ([redacted] - 12/01/2025)

42b Abuse/Neglect

2. Requirements

2800.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [redacted], at approximately 6:00 am, resident # [redacted], who resides in the secured dementia unit and has a primary diagnosis of severe vascular dementia, was found lying on the ground face down outside on the patio in the dementia unit. The resident had dried blood on their face and a bruise on their left hand. The resident was sent out to the hospital, diagnosed with traumatic abrasion and laceration on the nose bridge. The staff member A reported they did not notice the resident in the patio at 5:30am as it was dark outside and not lighted.

On [redacted] at approximately 12:35 pm, resident #1 was found on the patio laying on their left side, covered in blood. Despite resident [redacted] on hourly checks following their previous fall in the patio, the resident continued to go in and out of the patio doors. According to Staff member B they continued to reset the alarm on the patio doors and did not

42b Abuse/Neglect (continued)

provide supervision to the resident when they were on the patio as a method of promoting independence.

Plan of Correction

Accept [REDACTED] - 11/20/2025)

On 11/6/2025 the Director of Assisted Living spoke on phone with [REDACTED] Human Services Licensing Supervisor, to discuss my dispute of this violation. [REDACTED] stated that [REDACTED] would review the documents provided by [REDACTED] discuss with [REDACTED] and respond back to me. As of 11/9/25 this Director of Assisted Living has not heard back from [REDACTED] as discussed. As of 11/17/2025, [REDACTED] was called again by Director of Assisted Living and message was left to return my call. [REDACTED] did not return my call today.

We are disputing this violation for these reasons:

Regarding 08 12 2025, The surveyor is making assumptions.

The written statement by the care giver stated: stated [REDACTED] saw the resident at 5:00am in bed during rounds. [REDACTED] then attended to other residents and issues. [REDACTED] spelled out [REDACTED] timeline for the care of others. [REDACTED] was not looking for this resident at 5:30am as the surveyor indicates. The staff member stated [REDACTED] next saw [REDACTED] at approximately 6:00am outside in the courtyard. The sunrise on 8/12/2025 in Bluebell PA was approximately at 5:53am. There is no evidence that the resident went outside while it was dark outside. The resident could have gone out at 5:53am when it was light out with the rising of the sun that day. [REDACTED] could have fallen on 8/12/25 as soon as [REDACTED] went out since it was noted that [REDACTED] was found near the main outside courtyard doors. Also, the PCA Med Tech statement said the blood was semi dry. PCA Med Tech is not a professional nurse to provide that assessment. The time line for when blood clots and dries is determined by many factors and the PCA Med Tech did not say that [REDACTED] had physically touched the blood to determine if it was wet or dry. It was [REDACTED] assumption/and or opinion and not based on physical facts that it was semi dry. The resident support plan states independence with ambulation. Ambulating throughout the neighborhood on [REDACTED] own and going into the courtyard was a normal daily behavior for this resident.

Regarding 08 16 2025, While onsite, and at time of exit, the surveyor never mentioned anything being wrong with what occurred on the 16th. Resident was on one hour checks on [REDACTED] return from the hospital on 8/15/2025. The hospital did not order physical therapy for [REDACTED] upon discharge, since [REDACTED] level of independence with ambulation had not changed during [REDACTED] hospitalization. Resident was free to move about independently as always on both the inside hallways of the unit and the outside courtyard of the unit. There is no evidence that there were any broken pieces of pavement or debris that could have caused the fall. As discussed with [REDACTED] [REDACTED] did not see any evidence of this when [REDACTED] reviewed the outside photos that were taken of the courtyard by [REDACTED] at the time of [REDACTED] visit. The main outside courtyard doors by the nurses station were not alarmed allowing [REDACTED] free access to the outside courtyard. This free access to the courtyard was in this residents support plan. Staff nurse placed a wanderguard on [REDACTED] upon admission per our policy(for 48 hours) when a resident is admitted to the memory care unit. The wanderguard would alert staff if [REDACTED] attempted to exit at either end of the hallway exit doors to the unit and at the far end of the Cranberry unit hallway where the doors to the courtyard were not visible to staff from the nurses station. The main outside courtyard doors were not alarmed. The wanderguard was not being used to prevent [REDACTED] from using the outside courtyard independently, since [REDACTED] had open access to the courtyard from the main courtyard doors by the nurses station as noted in [REDACTED] support plan. Resident was independent in ambulation on admission from the hospital and did not require supervision while outside in courtyard to promote [REDACTED] independence. At no time were we neglectful to the needs of this resident.

Plan of Correction

The Plant Director for Normandy Farms Estates enabled the Cranberry Memory Care Unit main outside courtyard

42b Abuse/Neglect (continued)

doors to be alarmed and locked for those residents that are wearing a wanderguard bracelet. This was completed on 9/5/2025. RFT Technology was called in to set a timer on doors so doors would be locked during hours that it was dark outside. Timer was installed on the one main outside courtyard doors which was set to have the courtyard doors locked from 5pm to 7am (adjusted for daylight savings time) to prevent any residents from accessing the courtyard overnight when it was dark outside. The main outside courtyard doors would be open for use by all residents from 7am 5pm and then continually adjusted to daylight savings time. The maintenance staff will continue to conduct weekly checks every Tuesday that all Cranberry Memory Care exit doors and outside locked courtyard doors are working properly and locking with use of the wanderguard bracelet. OBT staff will continue to check Q shift that each resident wearing wanderguard bracelet has their bracelet intact on their person. OBT staff will continue to check residents every Friday who are wearing a wanderguard that their wanderguard is functioning properly. The OBT staff will check the 2 outside courtyard doors every 1 hour from 5pm 7am to ensure that they have remained locked x 1 month, then every 2 hours x 2 weeks and then evening and night shift ongoing. The Director of Assisted Living or designee will monitor and report findings to QAPI for further review.

Director of Assisted Living will complete the in servicing of OBT staff on the new locked doors, the monitoring times and review the in place safety checks for those residents wearing the wanderguard bracelet, by 11/25/25

Proposed Overall Completion Date: 11/25/2025

Licensee's Proposed Overall Completion Date: 11/25/2025

Implemented (█) - 12/01/2025)