

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

January 10, 2023

[REDACTED]  
THREE READING, LP  
[REDACTED]  
[REDACTED]

RE: THE MANOR AT MARKET SQUARE  
803 PENN STREET  
READING, PA, 19601  
LICENSE/COC#: 20589

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/03/2022, 11/08/2022, 12/02/2022, 12/12/2022, 12/14/2022 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]  
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: THE MANOR AT MARKET SQUARE License #: 20589 License Expiration: 10/20/2023  
 Address: 803 PENN STREET, READING, PA 19601  
 County: BERKS Region: NORTHEAST

**Administrator**

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

**Legal Entity**

Name: THREE READING, LP  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: I 2 Date: 05/31/2019 Issued By: City of Reading  
 Type: C 2 LP Date: 08/01/2000 Issued By: L&I

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 79 Waking Staff: 59

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Incident Exit Conference Date: 12/14/2022

**Inspection Dates and Department Representative**

11/03/2022 On Site [REDACTED]  
 11/08/2022 Off Site [REDACTED]  
 12/02/2022 Off Site [REDACTED]  
 12/12/2022 Off Site [REDACTED]  
 12/14/2022 Off Site [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: 80 Residents Served: 60

**Secured Dementia Care Unit**  
 In Home: Yes Area: n/a Capacity: 16 Residents Served: 14

**Hospice**  
 Current Residents: 1

**Number of Residents Who:**  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 60  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 19 Have Physical Disability: 2

**Inspections / Reviews**

11/03/2022 - Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/26/2022

12/30/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2022

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/05/2023

01/10/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2022

Reviewer: [REDACTED]

Follow-Up Type: Not Required

## 42s - Privacy

## 1. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

## Description of Violation

The designated person for resident #1 had a video monitor (nanny cam) installed in resident #1's room. On [REDACTED]/22 video footage of the resident was recorded by the designated person and provided to the department on [REDACTED]/22. The video footage includes audio recording of both staff and the resident. The designated person confirmed that they were recording both video and audio with the installed camera during the time the resident was living at the home.

## Plan of Correction

Accept [REDACTED] - 12/30/2022)

What: The designated person for resident #1 had a video monitor (nanny cam) installed in resident #1 room. On [REDACTED] 22 video footage of the resident was recorded by the designated person and provided to the department on [REDACTED] 22. The video footage includes audio recording of both staff and the resident. The designated person confirmed that they were recording both video with installed camera during the time the resident was living at the home.

When: Resident had a designated person sign an agreement with the facility about Electronic Monitoring Policy. At the time of signing agreement, resident's designated person assured administrator that the camera is only placed in resident's room to communicate with the resident. Facility was not aware that resident's designated person is recording.

Who: Policy will continue to be reviewed with residents and their designees at the time of admission with the emphasis on non-recording.

How: During the weekly room housekeeping any possible recording devices noticed in rooms will be reported to Executive Director, who will then review the finding with the resident and their responsible party to ensure they understand and comply with the Electronic Monitoring Policy.

Licensee's Proposed Overall Completion Date: 12/26/2022

Implemented [REDACTED] - 01/10/2023)

## 81b - Resident Personal Equipment

## 2. 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

In a video recorded of resident #1 on [REDACTED]/22 the resident's bed with a bedrail attached to it could be seen on the video recording. The bed rail did not have a cover over it and the openings appeared to be wider than 4 3/4 inches. The bed rail posed an entrapment risk.

## Plan of Correction

Accept [REDACTED] - 12/30/2022)

What: In video recorded of resident #1 on [REDACTED]-22 the resident's bed with a bedrail attached to it could be seen on the video recording. The bed rail did not have a cover over it and the openings appeared to be wider than 4 3/4 inches. The bed rail posed an entrapment risk.

When: Enablers Bars are only put in place following assessment by PT/OT to ensure the resident is capable of using them for repositioning. Enablers are used only on one side of the bed. Enablers will have covers on openings upon

**81b - Resident Personal Equipment (continued)**

installation. New bed enablers with covers were purchased and installed to ensure regulatory compliance.

Who: Marketing Director and Resident Care Director and nursing staff were in-serviced as to approved bed enablers. During the daily routine rounds nursing staff will be checking enablers for covers. Those residents who will be using enablers will have appropriate note in the RASP.

How: At the time of admission the Marketing Director will inform families about the type of bed enablers that are permitted. Maintenance Assistant will spot check to ensure that any enablers are properly fastened to the bed and covered. Nursing staff was educated on the enablers requirement and will notify RCD or ED if they will see any discrepancies. RCD during the weekly room checks will be reviewing compliance.

Licensee's Proposed Overall Completion Date: 12/26/2022

Implemented (████) 01/10/2023)

**142a Secure Medical Care****3. Requirements**

2600.

142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

**Description of Violation**

On █████/22 resident #1 suffered a fall at approximately █████ am while self transferring from bed and rang their call bell for help. Staff are seen in video footage responding to the resident. The resident's designated person also viewed the video footage from their home and went to the home, █████

█████ Staff person A, the home's administrator acknowledged that they were unaware of the fall until approximately █████ am when the resident's designated person arrived at the home. An ambulance was called and the resident was transported to the hospital █████

█████ The home failed to assess the resident for injuries in a timely manner and as a result the resident did not receive medical care until approximately 2 hours after the fall.

**Plan of Correction**

Accept █████ - 12/30/2022)

What: On █████-22, resident #1 suffered a fall at approximately █████ am while self-transferring from bed and rang their call bell for help. Staff are seen in video footage responding to the resident. The resident's designated person also viewed the video footage from their residence and went to the home, █████

█████ Staff person A, the home's administrator acknowledged that they were unaware of the fall until approximately █████ am when the resident's designated person arrived at the home. An ambulance was called and the resident was transported to the hospital where they were diagnosed with █████

█████ The home failed to assess the resident for injuries in a timely manner and as a result, the resident did not receive medical care until approximately 2 hours after the fall.

When: Staff responded to the resident's call within 7 minutes of pulling the cord. The resident was found on the floor. Staff assisted resident to the armchair and left the resident's room. Resident's designated person arrived to alert staff to the resident's care needs █████. After assessment administrator sent resident for further evaluation to the hospital.

Who: Resident Care Director will re-educate nursing staff about immediate post fall assessment with the emphasis on not lifting resident until determination that the resident is safe to be moved. Training will be concluded by December 29th.

**142a - Secure Medical Care (continued)**

*How: The training will include all nursing staff. PT/OT who are working in the facility will provide additional training on safely moving resident from the floor. RCD will periodically provide refreshing training on post fall assessment and review of the training will be addressed in quarterly QA meetings with the Executive Director.*

Licensee's Proposed Overall Completion Date: 12/26/2022

Implemented [REDACTED] - 01/10/2023)