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

November 21, 2024

[redacted], COO
THREE READING, LP
[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 10/16/2024, 10/17/2024 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE MANOR AT MARKET SQUARE* **License #**: *20589* **License Expiration**: *10/20/2024*

Address: *803 PENN STREET, READING, PA 19601*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *THREE READING, LP*

Address: [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**: *93* **Waking Staff**: *70*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *10/17/2024*

Inspection Dates and Department Representative

10/16/2024 - On-Site: [redacted]

10/17/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *18* **Residents Served**: *14*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *21* **Have Physical Disability**: *0*

Inspections / Reviews

10/16/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/09/2024*

Inspections / Reviews *(continued)*

11/12/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/19/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/19/2024*

11/21/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/19/2024*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

65g - Annual Training Content

1. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff person A, B, and C did not complete annual fire safety education by a fire safety expert or person trained by a fire safety expert for the training year 2023.

Plan of Correction ***Accept (- 11/12/2024)***

1. Immediate Corrective Action: Staff members A, B, C will complete fire safety training by a fire safety expert by 11/15/2024.

2. Additional Corrective Action: To prevent further occurrence, The Maintenance Director who is a trained fire safety expert, created an annual training video that will be utilized for all staff fire safety training yearly. Fire safety training will occur yearly within the 1st quarter of 2025.

3. Ongoing Quality Assurance Actions: The Executive Director will ensure that all staff have completed fire safety annual training for year 2024 by 12/15/2024 and will verify that fire safety annual training is completed at all new hire orientation. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 11/21/2024)

91 - Telephone Numbers

2. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

The phone located in the main lobby area did not have the required emergency numbers posted on or near the phone.

Plan of Correction ***Accept (- 11/12/2024)***

1. Immediate Corrective Action: Required emergency numbers were placed above the phone located in the main lobby on 10/17/2024.

2. Additional Corrective Action: To prevent further occurrence, Department managers within marketing, maintenance, resident life, nursing, and dietary will audit all resident apartments and common areas on a weekly basis beginning on 11/12/2024 to ensure that emergency telephone numbers are placed in an accessible area for residents by 12/31/2024.

3. Ongoing Quality Assurance Actions: Audits will be conducted using the "room check audit tool" and will be given

91 - Telephone Numbers (continued)

to the Executive Director weekly. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 11/21/2024)

103e - Left Overs

3. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

The main kitchen freezer contained a 10-pound box of sausage links. The plastic bag within the box contained an open bag of sausage that was not dated when opened.

Plan of Correction ***Accept (- 11/12/2024)***

1. Immediate Corrective Action: All expired and improperly labeled food has been removed by the Resident Care Director and discarded on 10/18/2024 and no residents were affected by the deficient practice.

2. Additional Corrective Action: To prevent further occurrence, the Dietary staff were provided education on label and dating food items on 10/18/2024 by the Dietary Services Manager.

3. Ongoing Quality Assurance Actions: Utilizing the "Kitchen label and dating audit tool" the Dietary Services Director will audit food and beverage for proper labeling and dating daily beginning 11/12/2024. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented (- 11/21/2024)

132d - Evacuation

4. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

Fire drills that were conducted on 10/19/23, 11/30/23, 12/26/23, and 1/9/23 indicated more residents were in the home than were evacuated. The record does not indicate why all the residents were not evacuated.

Plan of Correction ***Accept (- 11/12/2024)***

1. Immediate Corrective Action: The Maintenance Director was educated on fire drill documentation and accuracy by the Executive Director on 10/17/2024.

132d - Evacuation (continued)

2. Additional Corrective Action: The Maintenance Director will conduct monthly fire drills with all residents and staff and will ensure that all residents are evacuated to a fire-safe area and that it is documented beginning 11/01/2024.

3. Ongoing Quality Assurance Actions: Utilizing our TELS system the Maintenance Director will audit to ensure all documentation is accurate beginning 10/17/2024. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented [redacted] - 11/21/2024)

183b - Meds and Syringes Locked

5. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 10/17/24, at approximately 9:30am, the medication cart located in the nursing office, was unlocked and unattended. The nursing office door was also unlocked.

Plan of Correction ***Accept ([redacted] - 11/12/2024)***

1. Immediate Corrective Action: The Resident Care Director locked the medication cart on 10/17/2024 and educated Resident Care staff (med techs) on company policy to ensure cart is locked at all times.

2. Additional Corrective Action: The Clinical Care Coordinator educated all Med Techs to lock medication carts at all times on 10/23/2024.

3. Ongoing Quality Assurance Actions: The Resident Care Director and Clinical Care Coordinator will routinely audit all medication carts daily on random shifts utilizing the "Medication Cart Audit Form" to ensure medication carts are locked at all times beginning 11/12/2024. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented ([redacted] - 11/21/2024)

183e - Storing Medications

6. 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 [redacted], at approximately [redacted] Resident #1's [redacted], Resident #2's and Resident #3's [redacted] were located in the medication cart. The instruction on the pens indicated to refrigerate until opened. None of the pens had been opened.

183e Storing Medications *(continued)*

Plan of Correction ***Accept (- 11/12/2024)***

1. Immediate Corrective Action: The Resident Care Director discarded residents 1, 2, 3 insulin pens following HSL policies and procedures, and received replacements from pharmacy on 10/17/2024. No residents were impacted.

2. Additional Corrective Action: The Clinical Care Coordinator educated all Med Techs on storage procedures for insulin pens on 10/23/2024.

3. Ongoing Quality Assurance Actions: The Resident Care Director and Clinical Care Coordinator will routinely audit medication carts to ensure that insulin pens are refrigerated audits beginning 11/12/2024. All med techs follow proper storage policies and procedures and will ensure that insulin pends and placed in the refrigerator upon delivery from the pharmacy. beginning on 10/23/2024. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented - 11/21/2024)

185a - Implement Storage Procedures

7. 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

On at approximately , a narcotic count was conducted with Staff C. The narcotic counts were not accurate for Resident #5's . Through further investigation it was determined Staff D signed all the medications out on the Medication Administration Record but did not sign the controlled drug record.
The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #6 On the reading on the glucometer was but was not documented or noted on Medication Administration Record (MAR), on , resident #6's reading on glucometer was but was incorrectly transcribed as . Resident #7 The morning glucometer reading was but was incorrectly transcribed on the MAR as . The morning glucometer reading was but there was nothing in the glucometer. The morning glucometer reading was but was incorrectly transcribed on the MAR as . Resident # 8 bedtime glucometer reading on was . However, the resident's' medication administration record incorrectly transcribed the reading as

Plan of Correction ***Accept (- 11/12/2024)***

1. Immediate Corrective Action: On 10/17/2024 the Resident Care Director counted all medication cart narcotics to ensure accuracy and all counts were correct.

2. Additional Corrective Action: the Clinical Care Coordinator educated all Med Techs on company's narcotic policy and blood glucose monitoring policy on 10/23/2024.

3. Ongoing Quality Assurance Actions: The Resident Care Director and Clinical Care Coordinator will routinely audit all medications carts daily utilizing the "Medication Cart Audit Form" to ensure that all narcotics are documented

185a Implement Storage Procedures (continued)

on the Medication Administration record and signed out in the controlled drug record and that all blood sugar readings match between the Medication Administration Record and Glucometers beginning 11/12/2024. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented [redacted] - 11/21/2024)

187a - Medication Record

8. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
9. Administration times.

Description of Violation

Resident #6 is prescribed [redacted] by mouth every 8 hours. However, Resident #6 medication administration record (MAR)does not indicate this medication was given at [redacted] on [redacted], and [redacted] dose on [redacted] and [redacted]. Resident #6 is prescribed [redacted] three times a day. The MAR does not indicate this medication was given the morning dose on [redacted]. Staff interviews indicated that the medication was administered as prescribed.

Repeat Violation 10/17/23

Plan of Correction ***Accept ([redacted] - 11/12/2024)***

1. Immediate Corrective Action: Residents, their responsible parties, and PCPs were notified of the errors on 10/18/2024. There were no new orders from the PCP and no residents were negatively impacted.

2. Additional Corrective Action: The Clinical Care Coordinator provided education to all med techs on medication administration documentation on 10/23/2024.

3. Ongoing Quality Assurance Actions: Oversite to all MAR documentation is reviewed at daily clinical meeting by Executive Director, Resident Care Director, and Clinical Care Coordinator. The Resident Care Director and Clinical Care Coordinator will audit the MAR daily to ensure that medication administration is documented 11/12/2024. The Executive Director will oversee compliance with weekly audits beginning on 11/15/24. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented ([redacted] - 11/21/2024)

187d - Follow Prescriber's Orders

9. Requirements

187d - Follow Prescriber's Orders *(continued)*

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Department Representative was observing medication pass on 4th floor on [redacted]. Staff C was unable to administer[redacted] to Resident #7 and [redacted] to resident #8, due to the medications not available in the medication cart.

Plan of Correction ***Accept ([redacted] - 11/12/2024)***

1. Immediate Corrective Action: Upon discovery of medications not available the Executive Director notified Pharmacy on 10/17/24 and had medications delivered stat on 10/17/2024.

2. Additional Corrective Action: The Clinical Card Coordinator provided education to all med techs on re-ordering process and notifying pharmacy of medications that are not available but located on the MAR, on 10/23/2024.

3. Ongoing Quality Assurance Actions: The Resident Care Director and Clinical Care Coordinator will audit the MAR and medication carts daily to ensure that all medications are present and re-ordered in a timely manner beginning 11/12/2024, audits will be completed utilizing the "medication cart audit form" beginning 11/12/2024. Ongoing compliance will be reviewed at our quarterly QA review meetings beginning with the 2024 Q4 review, which will be held in January 2025.

Licensee's Proposed Overall Completion Date: *12/31/2024*

Implemented [redacted] - 11/21/2024)