

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395252	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: GARDENS AT YORK TERRACE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE: 2401 WEST MARKET STREET POTTSVILLE, PA 17901
STATE LICENSE NUMBER: 510202	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0692 SS=D	Based on a Medicare/Medicaid Recertification survey, State Licensure survey, and a Civil Rights Compliance survey completed on December 5, 2024, it was determined that The Gardens at York Terrace, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0692		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395252	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: GARDENS AT YORK TERRACE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE: 2401 WEST MARKET STREET POTTSVILLE, PA 17901		
STATE LICENSE NUMBER: 510202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0692 SS=D	Continued from page 1 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	Resident 5 weights to be reviewed for accuracy. Resident 5 assessment to be completed by dietician. All resident weights and assessments to be reviewed for accuracy and timeliness for all current residents with a lookback review. Resident weights to be reviewed to ensure follow up completed according to the facility policy. A random monthly audit of weights to be completed by nursing administration or designee monthly. Education provided to licensed nursing staff and dietician regarding the weight policy. Findings from the audits will be reported to QAPI for 3 months.	Completion Date: 12/31/2024 Status: APPROVED Date: 12/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395252	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024	
NAME OF PROVIDER OR SUPPLIER: GARDENS AT YORK TERRACE, THE STATE LICENSE NUMBER: 510202		STREET ADDRESS, CITY, STATE, ZIP CODE: 2401 WEST MARKET STREET POTTSVILLE, PA 17901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0692 SS=D	Continued from page 2 Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to adequately monitor and assess weight loss for one of three sampled residents at risk for weight loss. (Resident 5) Findings include: Review of the facility policy entitled, "Weight Assessment and Intervention," last reviewed January 18, 2024, revealed that any weight change of five pounds (lbs.) or more from the last weight assessment would be retaken for confirmation. If the weight was verified, nursing staff would notify the dietitian. The dietitian or Certified Dietary Manager would review the individual weight records and make recommendations as appropriate. Clinical record review revealed that Resident 5 had diagnoses that included osteoporosis and dementia. Review of the care plan revealed that the resident had a history of weight loss. On March 1, 2024, the resident weighed 127 lbs. On April 5, 2024, the	F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395252	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024	
NAME OF PROVIDER OR SUPPLIER: GARDENS AT YORK TERRACE, THE STATE LICENSE NUMBER: 510202		STREET ADDRESS, CITY, STATE, ZIP CODE: 2401 WEST MARKET STREET POTTSVILLE, PA 17901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0692 SS=D	Continued from page 3 resident weighed 117 lbs. The resident was reweighed on April 7, 2024, and weighed 120 lbs., which verified a weight loss of 7 lbs., (5.5 percent). There was a lack of evidence to support that staff notified the dietitian, or that the dietitian assessed the weight loss or resident's nutritional status until April 30, 2024, during a regularly scheduled quarterly assessment. In an interview on December 5, 2024, the Administrator confirmed that there was no evidence that the dietitian was notified of the verified weight loss and that the dietitian should have assessed the resident prior to April 30, 2024. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0692		



Certified End Page

GARDENS AT YORK TERRACE, THE
STATE LICENSE NUMBER: 510202
SURVEY EXIT DATE: 12/05/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY