STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: __--_____ B. WING: _____	12/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on December 18, 2024, at The Gardens at York Terrace, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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.

Certified End Page

GARDENS AT YORK TERRACE, THE

STATE LICENSE NUMBER: 510202

SURVEY EXIT DATE: 12/18/2024

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: 01 B. WING:	12/18/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0000	INITIAL COMMENT Facility ID #510202 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 18, 2024, it was determined that The Gardens at York Terrace was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type V (000), unprotected wood frame structure, with a partial basement, which is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

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.

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GARDENS AT YORK TERRACE, THE STATE LICENSE NUMBER: **510202**	**2401 WEST MARKET STREET POTTSVILLE, PA 17901**

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K 0100 SS=C	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	The facility provided current layout and drawings that were to scale accounting for all information (including door swings, compartment labeling, fire wall boundaries, smoke wall boundaries, hazardous areas, width of zones and travel distances). The facility to install Carbon Monoxide detectors, in the required designated areas, with linking alarm devices in manned locations. The facility will audit all current detectors and remove devices in areas not needed. The facility to ensure preventative maintenance and auditing of the carbon monoxide devices, as per manufacturers guidance. The facility to provided education to maintenance on Act 48 PA Carbon Monoxide Requirements. Maintenance to report findings to QAPI for 3 months.	Completion Date: **06/18/2025** Status: **APPROVED** Date: **01/10/2025**

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K 0100 SS=C	Continued from page 2 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on document review, observation and	K 0100		

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K 0100 SS=C	Continued from page 3 interview, it was determined the facility failed to meet the minimum standards for the operation of a facility, as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents within the component. Findings include: 1. Review of documentation and observation on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility life safety drawings lacked door swings, compartment labeling, fire wall boundaries, smoke wall boundaries, hazardous areas, width of zones and travel distances, which is information required by CMS for the active FSES. Interview at the time of the exit conference with the Administrator and Director of Maintenance December 18, 2024, at 1:15 PM, confirmed the facility floor plans lacked information required for a facility with an active FSES. 2. Review of documentation, observation and	K 0100		

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K 0100 SS=C	Continued from page 4 interview on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility lacked documentation of annual testing and inspection of installed Carbon Monoxide Alarms, per manufacturer's instructions, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the annual inspections were not performed, per manufacture's instructions. 3. Review of documentation, observation and interview on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility could not verify the installed carbon monoxide alarms could be heard by on duty staff, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act.	K 0100		

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K 0100 SS=C	Continued from page 5 Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility could not verify carbon monoxide detectors could be heard by on duty staff.	K 0100		
K 0211 SS=B	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	The facility requests DSI to conduct a FSES survey.	Completion Date: **02/18/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0211 SS=B	Continued from page 6 Based on observation and interview, it was determined the facility failed to provide two exits remote from one another, affecting one of four smoke compartments within the component. Findings include: 1. Observation on December 18, 2024, at 11:00 AM, revealed a single means of egress from the partial basement. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the basement did not have two acceptable exits.	K 0211		
K 0223 SS=E		K 0223		

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K 0223 SS=E	Continued from page 7 NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:	K 0223	The facility to inspect the attic doors noted as doors a, b, c, and d to render as non-rated to match the building rating assembly, consistent with the Type V (000) unprotected wood frame structure. The facility will audit all horizontal fire doors to ensure compliance to building structure. The facility to audit attic door compliance quarterly. The findings from the audits will be reported to QAPI for 3 months by maintenance staff.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

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K 0223 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to maintain the rated horizontal fire doors, to self-close and positively latch within the frame, in four of four smoke compartments within the component. Findings include: 1. Observation on December 18, 2024, between 12:05 PM and 12:30 PM, revealed horizontal fire rated doors required springs be attached to self-close and positively latch in the frame, at the following locations: a) 12:05 PM, 1st floor, Kitchen, Attic door; b) 12:15 PM, 1st floor, outside Kitchen, Attic door; c) 12:25 PM, 1st floor, by Activity Room, Attic door; d) 12:30 PM, 1st floor, Rainbow Hall, by Resident Room 135, Attic door. Interview at the time of the exit conference with the Administrator and Director of Maintenance on	K 0223		

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K 0223 SS=E	Continued from page 9 December 18, 2024, at 1:15 PM, confirmed the horizontal fire-rated doors would not self-close and positively latch.	K 0223		
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K 0321	The facility to correct the kitchen door by utilizing a door adjustor to meet the gap requirement. An audit of all hazardous doors will be audited to ensure compliance. The facility will complete a random audit of the hazardous doors quarterly. Education provided to maintenance staff regarding hazardous door requirements. The findings from the audits will be reported to QAPI for 6 months.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

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K 0321 SS=E	Continued from page 10 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0321 SS=E	Continued from page 11 Based on observation and interview, it was determined the facility failed to maintain hazardous area doors, to be within the allowed gap margins, on one of four smoke zones within the component. Findings include: 1. Observation on December 18, 2024, at 12:10 PM, revealed the Kitchen Storage Room door exceeded minimum gap margins, at the top, by 3/16-inch. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the hazardous area door exceeded minimum gap requirements.	K 0321		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 12 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	The facility reviewed sprinkler inspection reports to establish the last completed 3 year full trip test. The 3 year full trip test was completed on 5/10/2023 with the annual sprinkler inspection that year. This documentation is filed in the life safety survey book for review. The facility reviewed the deficiencies from the 5 year hydrostatic fire department connection testing inspection. This 5 year testing was completed on 11/20/24. The facility developing a plan of action for the 5 year testing inspection cited summary. The facility is actively working with the sprinkler contractor and the local fire department to determine the best corrective action. In the interim, the facility will meet with the local fire chief to review the concerns from the testing for both awareness and planning, should the FDC be needed. The facility to request a TLW to address these concerns. The facility sprinkler system is a pipe system and will be labeled as a pipe	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/22/2025**

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K 0353 SS=F	Continued from page 13	K 0353	system, by the sprinkler system vendor, by 2/04/2025. The facility will complete an audit of the sprinkler inspection reports from 2024 to ensure deficiencies have been addressed. The sprinkler inspections occurred on the following dates: 1/8/24 quarterly, 4/2/24 annual, 7/3/24 quarterly, 10/3/24 quarterly, and 1/6/25 quarterly. The annual sprinkler inspection for 2025 is anticipated completion by 4/30/2025. The reports will be filed in the facility life safety book. The facility requesting a TLW for completion of the work that is needed for the FDC. Anticipated completion of this work would be 6/18/2025, as it is seasonal and greater external planning needed due to the location and correction of the FDC. Quarterly audits of the sprinkler reports will be completed by maintenance. Finding of the audits will be reported to QAPI for 9 months.	

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GARDENS AT YORK TERRACE, THE STATE LICENSE NUMBER: **510202**	**2401 WEST MARKET STREET POTTSVILLE, PA 17901**

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K 0353 SS=F	Continued from page 14 Based on document review, observation and interview, it was determined the facility failed to provide 3-year sprinkler maintenance documentation, maintain the fire department connection and lacked hydraulic nameplates, which affects the entire component. Findings include: 1. Review of documentation on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility lacked documentation for the 3-year full trip test. Last document full trip test was June 2021. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility could not provide documentation for 3-year full trip test. 2. Review of documentation on December 18, 2024, between 9:15 AM and 11:00 AM, revealed	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: 01 B. WING:	12/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 0353 SS=F	Continued from page 15 the facility lacked documentation for repairs of the fire department connection, which was reported deficient during the 5-year internal inspection, on November 20 2024. The deficiency reported the fire department connection could not pressurize the system, due to deterioration. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility could not provide documentation for repairs to the fire department connection. 3. Observation and interview on December 18, 2024, at 11:50 AM, revealed the sprinkler piping system lacked hydraulic nameplate for the installed system. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility could not provide a hydraulic nameplate.	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: __01_____ B. WING: _____	12/18/2024

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

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K 0371 SS=B	NFPA 101 Subdivision of Building Spaces - Smoke Compar Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by:	K 0371	The facility requests DSI to conduct a FSES survey.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/08/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: __01_____ B. WING: _____	12/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 0371 SS=B	Continued from page 17 Based on observation and interview, it was determined the facility failed to provide smoke compartments, not larger than 22,500 square feet, affecting one of four smoke compartments within the component. Findings include: 1. Observation on December 18, 2024, at 12:00 PM, revealed 1st floor, grade level, Zone 2, exceeded 22,500 square feet. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the square footage of Zone 2 exceeded 22,500 square feet.	K 0371		
K 0521 SS=C		K 0521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: __01_____ B. WING: _____	12/18/2024

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

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K 0521 SS=C	Continued from page 18 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	The facility to complete a 4 year fire damper HVAC inspection, by the facility HVAC external service provider. This inspection is scheduled for 1/15/2025. The vendor will draft a report, including the fire damper and fusible link status. The facility maintenance staff will audit annually to ensure the fire damper documentation is available in the life safety survey book for reference. The facility maintenance staff will monitor for the next scheduled inspection, anticipated on or before, January 2029. Findings from the inspection to be reported to QAPI for 3 months.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: __01_____ B. WING: _____	12/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 0521 SS=C	Continued from page 19 Based on document review and interview, it was determined the facility failed to provide documentation, verifying the 4-year fire damper maintenance and exercise was performed, affecting the entire component. Findings include: 1. Review of documentation on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility failed to provide documentation, verifying the 4-year fire damper exercise and maintenance was performed. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility failed to provide documentation for the 4-year fire damper maintenance.	K 0521		

Certified End Page

GARDENS AT YORK TERRACE, THE

STATE LICENSE NUMBER: 510202

SURVEY EXIT DATE: 12/18/2024

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: 02 B. WING:	12/18/2024

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

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K 0000	INITIAL COMMENT Facility ID #510202 Component 02 Lounge/Dayroom Building Based on a Medicare/Medicaid Recertification Survey completed on December 18, 2024, it was determined that The Gardens at York Terrace was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type V (111), protected wood frame structure, without a basement, which is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: 02 B. WING:	12/18/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0100 SS=C	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	The facility provided current layout and drawings that were to scale accounting for all information (including door swings, compartment labeling, fire wall boundaries, smoke wall boundaries, hazardous areas, width of zones and travel distances). The facility to install Carbon Monoxide detectors, in the required designated areas, with linking alarm devices in manned locations. The facility will audit all current detectors and remove devices in areas not needed. The facility to ensure preventative maintenance and auditing of the carbon monoxide devices, as per manufacturers guidance. The facility to provided education to maintenance on Act 48 PA Carbon Monoxide Requirements. Maintenance to report findings to QAPI for 3 months.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: 02 B. WING:	12/18/2024

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K 0100 SS=C	Continued from page 2 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on document review, observation and	K 0100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0100 SS=C	Continued from page 3 interview, it was determined the facility failed to meet the minimum standards for the operation of a facility, as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents within the component. Findings include: 1. Review of documentation and observation on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility life safety drawings lacked door swings, compartment labeling, fire wall boundaries, smoke wall boundaries, hazardous areas, width of zones and travel distances, which is information required by CMS for the active FSES. Interview at the time of the exit conference with the Administrator and Director of Maintenance December 18, 2024, at 1:15 PM, confirmed the facility floor plans lacked information required for a facility with an active FSES. 2. Review of documentation, observation and	K 0100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0100 SS=C	Continued from page 4 interview on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility lacked documentation of annual testing and inspection of installed Carbon Monoxide Alarms, per manufacturer's instructions in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the annual inspections were not performed, per manufacture's instructions. 3. Review of documentation, observation and interview on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility could not verify the installed carbon monoxide alarms could be heard by on duty staff, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act.	K 0100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0100 SS=C	Continued from page 5 Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility could not verify carbon monoxide detectors could be heard by on duty staff.	K 0100		
K 0353 SS=F		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0353 SS=F	Continued from page 6 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	The facility reviewed sprinkler inspection reports to establish the last completed 3 year full trip test. The 3 year full trip test was completed on 5/10/2023 with the annual sprinkler inspection that year. This documentation is filed in the life safety survey book for review. The facility reviewed the deficiencies from the 5 year hydrostatic fire department connection testing inspection. This 5 year testing was completed on 11/20/24. The facility developing a plan of action for the 5 year testing inspection cited summary. The facility is actively working with the sprinkler contractor and the local fire department to determine the best corrective action. In the interim, the facility will meet with the local fire chief to review the concerns from the testing for both awareness and planning, should the FDC be needed. The facility to request a TLW to address these concerns. The facility sprinkler system is a pipe system and will be labeled as a pipe	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/22/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0353 SS=F	Continued from page 7	K 0353	system, by the sprinkler system vendor, by 2/04/2025. The facility will complete an audit of the sprinkler inspection reports from 2024 to ensure deficiencies have been addressed. The sprinkler inspections occurred on the following dates: 1/8/24 quarterly, 4/2/24 annual, 7/3/24 quarterly, 10/3/24 quarterly, and 1/6/25 quarterly. The annual sprinkler inspection for 2025 is anticipated completion by 4/30/2025. The reports will be filed in the facility life safety book. The facility requesting a TLW for completion of the work that is needed for the FDC. Anticipated completion of this work would be 6/18/2025, as it is seasonal and greater external planning needed due to the location and correction of the FDC. Quarterly audits of the sprinkler reports will be completed by maintenance. Finding of the audits will be reported to QAPI for 9 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0353 SS=F	Continued from page 8 Based on document review, observation and interview, it was determined the facility failed to provide 3-year sprinkler maintenance documentation, maintain the fire department connection and lacked hydraulic nameplates, which affects the entire component. Findings include: 1. Review of documentation on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility lacked documentation for the 3-year full trip test. Last document full trip test was June 2021. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility could not provide documentation for 3-year full trip test. 2. Review of documentation on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility lacked documentation for repairs of the	K 0353		

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K 0353 SS=F	Continued from page 9 fire department connection, which was reported deficient during the five year internal inspection on November 20 2024. The deficiency reported the fire department connection could not pressurize the system, due to deterioration. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the the facility could not provide documentation for repairs to the fire department connection. 3. Observation and interview on December 18, 2024, at 11:50 AM, revealed sprinkler piping system lacked hydraulic nameplate for the installed system. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility could not provide a hydraulic nameplate.	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 0521 SS=C	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	The facility to complete a 4 year fire damper HVAC inspection, by the facility HVAC external service provider. This inspection is scheduled for 1/15/2025. The vendor will draft a report, including the fire damper and fusible link status. The facility maintenance staff will audit annually to ensure the fire damper documentation is available in the life safety survey book for reference. The facility maintenance staff will monitor for the next scheduled inspection, anticipated on or before, January 2029. Findings from the inspection to be reported to QAPI for 3 months.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395252	A. BLDG: __02_____ B. WING: _____	12/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
K 0521 SS=C	Continued from page 11 Based on document review and interview, it was determined the facility failed to provide documentation, verifying the 4-year fire damper maintenance and exercise was performed, affecting the entire component. Findings include: 1. Review of documentation on December 18, 2024, between 9:15 AM and 11:00 AM, revealed the facility failed to provide documentation, verifying the 4-year fire damper exercise and maintenance was performed. Interview at the time of the exit conference with the Administrator and Director of Maintenance on December 18, 2024, at 1:15 PM, confirmed the facility failed to provide documentation for the 4-year fire damper maintenance.	K 0521		

Certified End Page

GARDENS AT YORK TERRACE, THE

STATE LICENSE NUMBER: 510202

SURVEY EXIT DATE: 12/18/2024

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
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