| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395261 | A. Building<br>B. Wing | 03/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Buffalo Valley Lutheran Villag | 189 East Tressler Boulevard<br>Lewisburg, PA 17837 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>20725<br><br>Based on a review of select facility policies and procedures, clinical record review, and resident family and staff interview, it was determined that the facility failed to ensure that a physical restraint was used for the treatment of medical symptoms for one of six residents reviewed (Resident 1).<br><br>Findings include:<br><br>The facility policy entitled, Abuse/Neglect/Mistreatment of Residents/Misappropriation of Resident Property, last reviewed without changes on January 25, 2025, revealed that the facility standard is that the facility protects each resident's right to be free from abuse, neglect, mistreatment or misappropriation of property through appropriate screening, training, prevention, identification, investigation, protection, and reporting/response procedures. Physical abuse includes, but is not limited to, hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. Prevention includes that through training, the facility will reinforce with employees their responsibility to identify, correct, and intervene in situations in which abuse, mistreatment, neglect, and/or misappropriation of resident property may occur. The facility will identify and develop appropriate plans of care for residents who are at risk of behavioral problems which may lead to conflict or neglect such as wandering and entering other residents' rooms. Investigation includes that the facility shall investigate all allegations of abuse, mistreatment, neglect, or misappropriation of resident property and all resident incidents/accidents, unusual occurrences, and injuries of unknown origin. Any employee alleged to have committed an act of abuse, neglect, mistreatment of residents or misappropriation of resident property shall be suspended immediately and not permitted on the premises until an investigation is completed.<br><br>The facility policy entitled, Abuse Prevention Program, last reviewed without changes on January 25, 2025, revealed that as part of resident abuse prevention, the administration will protect residents during abuse investigations.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy entitled, Restraints, last reviewed without changes on January 25, 2025, revealed that restraints will not be used to control resident behavior or as a punishment. An assessment will be completed by the interdisciplinary team (IDT) in collaboration with the physician to evaluate the need for the use of a restraint. A physician's order will be obtained prior to initiation of the restraint and the order will specify the period of time to use the restraint. The resident and representative will be fully informed on the use of the restraint. The facility will obtain informed consent from the resident or, in the case of a resident who is incapable of making a decision, the resident's representative may give informed consent. A restraint may only be applied by a person trained in the application of the restraint.<br><br>Interview with Resident 1's husband on March 21, 2025, at 12:17 PM revealed that facility staff made him aware of an incident when staff tied Resident 1 to her wheelchair with a shawl from her room. Resident 1's husband stated that he was aware of his wife's behaviors of constantly trying to stand up and down repeatedly and, wanting to go all the time.<br><br>Clinical record review for Resident 1 did not include evidence of a physician's order or plan of care for the use of a mechanical restraint.<br><br>Review of a facility investigation dated February 12, 2025, at 12:00 AM revealed that a nurse aide reported to the registered nurse supervisor that a nurse on the unit tied a resident to a wheelchair with a shawl. Information pertinent to the investigation included that Resident 1 was noncompliant with her transfer status, and she had behaviors of frequently placing herself on the floor.<br><br>A witness statement dated February 11, 2025, obtained from Employee 1 (registered nurse) during the investigation confirmed that Employee 1 took the ends of Resident 1's shawl, wrapped them around the back of her wheelchair, and loosely tied them together.<br><br>A witness statement dated February 11, 2025, obtained from Employee 4 (nurse aide) during the investigation indicated that Resident 1 stands and tries to sit on the floor anytime a staff member looks away from her, and she had fallen in the beginning of the shift. Resident 1 kept getting up and trying to sit on the floor. Employee 1 took Resident 1 to her room and when she came out of the room, Employee 1 showed Employee 4 that she had a blanket on Resident 1's lap that was tied around the back of the chair. Another nurse aide on the unit, Employee 3, identified the device as a restraint and untied the device. Employee 1 retied the device and Employee 3 made Employee 2 (registered nurse supervisor) aware of the device use when Employee 2 entered the unit around the time of the supper meal. After the supper meal, Employee 4 noted that the blanket was back and twisted around (Resident 1). Employee 4 heard Resident 1 state that she was stuck while trying to stand. Employee 4 stated that Employee 1 admitted to retying the blanket. Employee 4 reported the repeated use of the tied blanket to Employee 2.<br><br>A witness statement dated February 11, 2025, obtained from Employee 3 confirmed that she untied the blanket on Resident 1's lap, but Employee 1 tied it around Resident 1 again. Employee 3 notified her supervisor (Employee 2), who came to the unit at supper time, and the blanket was removed from Resident 1; however, after Employee 2 left the unit, Employee 1 tied the blanket behind Resident 1's wheelchair again. Employee 3 notified Employee 2 of the repeated use of the device that tied Resident 1 to her wheelchair.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A witness statement dated February 11, 2025, obtained from Employee 2 confirmed that she removed a checkered shawl that was on Resident 1's lap and tied around the back of her wheelchair. Employee 2's statement was that she educated Employee 1 against the use of the device that was restricting Resident 1's movement and Employee 1 untied the shawl. An hour later, Employee 2 observed Resident 1 with the shawl around her waist and tied behind the wheelchair. Employee 2 untied the shawl and took Resident 1 with her to her office. Employee 2's statement was that she informed Employee 1 that it was not okay to use restraints and Resident 1's shawl in a restraining manner.<br><br>The information available from the facility's investigation indicated that supervisory staff noted Employee 1 inappropriately restrained Resident 1 in her wheelchair; however, did not suspend Employee 1 immediately to not permit her on the premises until an investigation was completed. Employee 1 could utilize the inappropriate restraint a second time on Resident 1 and had the potential to inappropriately restrain other residents assigned to her care.<br><br>Interview with the Nursing Home Administrator and the Director of Nursing on March 21, 2025, at 3:45 PM confirmed that the facility had no evidence that Employee 2 was counseled regarding permitting Employee 1 on the premises after a known allegation of inappropriate restraint use while the facility completed an investigation. The facility also had no evidence of education provided to all staff after the incident to reinforce the facility's policies regarding restraint use and the protection of residents (via immediate suspension of alleged perpetrators) during abuse investigations.<br><br>28 Pa. Code 211.8(c.1)(2)(3)(d) Use of restraints<br><br>28 Pa. Code 211.12(d)(1)(5) Nursing services |