STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395261	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Valley Lutheran Villag	189 East Tressler Boulevard 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on a review of select facility policies and procedures, facility grievance log documentation, clinical record review, and family and staff interview, it was determined that the facility failed to make a prompt effort to resolve resident grievances for one of six residents reviewed (Resident 1). Findings include: The facility policy entitled, Resident Grievance Report and Tracking Log, last reviewed April 7, 2025, revealed that the facility, upon receiving a concern or grievance, would actively seek a resolution and keep the resident/health care agent appropriately apprised of the findings towards resolution. Upon receipt of a grievance or concern, the community staff member receiving the grievance or concern will immediately initiate a Resident Concern/Grievance Report. All pertinent data will be gathered and documented to promptly investigate, follow through, and provide timely resolution to the grievance/concern. Resolution will be communicated to the resident, health care agent or surrogate, and documented on the Resident Concern/Grievance Report. The grievance officer will ensure that the complaint is investigated and that there is a resolution to the complaint. If satisfactory resolution has not occurred, the community grievance officer will enlist the assistance of the appropriate department head and/or Administrator to continue attempts toward resolution. The facility's grievance policy did not include that the resident/health care agent/or surrogate has the right to obtain the review in writing and the right to obtain a written decision regarding his or her grievance. Review of Resident/Resident Representative Grievance Forms revealed that Resident 1's son and daughter submitted a concern on June 2, 2025, at 8:00 AM pertaining to events that occurred on May 31, 2025, to June 1, 2025. The three-page typed Summary of Concern and Expectation for Resolution submitted by Resident 1's son and daughter included an allegation of unauthorized administrations of a narcotic pain medication, and Employee 1 (licensed practical nurse), proclaimed .that we were abusing (Resident 1) by forcing her to eat and not allowing her to receive needed narcotic pain medication. The family requested .a full explanation of what happened during the overnight of 5/31-6/1 (May 31, 2025, to June 1, 2025), including all vital signs taken during that period and all medications administered. We would also like a copy of the hospital discharge documents and records of all medications ordered and administered since her admission to this facility. Page two of the Grievance Form included the signatures of the Grievance Officer (Employee 3), the Director of Nursing, and the Nursing Home Administrator, that indicated completion of the form on June 5, 2025. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review for Resident 1 revealed that her daughter was recorded as her first emergency contact and that her son was recorded as her second emergency contact. An active physician order dated May 29, 2025, (the date of Resident 1's admission to the facility), stipulated that Resident 1 was not capable of understanding her rights and responsibilities. Interview with Resident 1's son and daughter on June 12, 2025, from 11:57 AM to 12:28 PM revealed that they did not consider their grievance resolved as they did not receive any requested written documentation that pertained to why nursing staff administered the narcotic pain medication, Morphine, when they believed their mother's condition did not meet the criteria for administration. Resident 1's son stated that he want(ed) it in writing why the nurse gave the Morphine. Resident 1's son stated that the facility did not thoroughly investigate his concern because staff never investigated if the nurse attempted anything else (non-medicinal interventions) before giving the Morphine. Resident 1's son indicated that the copy of the Grievance Form that he has only has the first page completed, and the sections on the second page are blank. The interview confirmed that the son and daughter present during the interview were the family present in the dining room when Resident 1 was screaming on June 1, 2025, but both Resident 1's son and daughter denied any action of force-feeding Resident 1. Interview with Employee 3 (social services coordinator identified by the facility as the facility's Grievance Officer) and Employee 4 (licensed practical nurse/clinical manager) on June 12, 2025, at 3:55 PM revealed that they were not aware of a regulatory requirement that pertained to issuing written grievance decisions to the resident/responsible party. The interview confirmed that the facility did not provide any written documentation to Resident 1's family as requested in the three-page typewritten grievance. The interview confirmed that although Resident 1's son documented in his grievance that Employee 1 alleged he abused his mother, the facility did not investigate the allegation or report the allegation of abuse to state and county agencies (Department of Health State Survey Agency and/or the county Area Agency on Aging). The interview indicated that Resident 1's family grievance was reopened, on this date prior to the surveyor's questioning as Employee 3 became aware that Resident 1's son did not consider his grievance resolved. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code: 201.18(b)(2)(3)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on a review of select facility policies and procedures, clinical record review, and staff and family interview, it was determined that the facility failed to thoroughly investigate and report to the appropriate agencies an incident of potential resident abuse for one of six residents reviewed (Resident 1). Findings include: The facility policy entitled, Abuse/Neglect Prevention and Response, last reviewed April 7, 2025, revealed that an allegation of potential or actual abuse, neglect, or exploitation will be immediately reported to the appropriate leadership and government agencies, the resident protected, and the allegation investigated. The definition of abuse includes willful intimidation with resulting pain or mental anguish. Physical abuse is defined as hitting, slapping, pinching, kicking, and the like. It also includes controlling a resident's behavior through physical punishment and/or intimidating behaviors such as shaking a finger in a resident's face. It is the facility's responsibility to investigate each concern that is raised and it is the Administrator who is responsible for overseeing the investigation. The Administrator may designate the investigation to be conducted by a designee. Staff will immediately see to the safety of an alleged resident victim upon an allegation of abuse. This includes, but is not limited to, removing accused person from contact with all residents. The measures necessary to provide for the safety of the alleged resident victim will remain in effect, modified as necessary, until no longer necessary for the safety of the alleged resident victim. Staff will immediately report to the Administrator, or Administrator's designee any actual, potential or alleged complaint of abuse regardless of source. Failure to immediately report any such allegation will not be tolerated and appropriate action will be taken. The facility documents each incident of possible abuse/neglect and immediately notifies the appropriate authorities in accordance with facility policy. The facility's active policy included state-specific guidelines for Illinois and Missouri; however, did not refer to Pennsylvania's regulatory agencies. Clinical record review for Resident 1 revealed nursing documentation by Employee 1 (licensed practical nurse) dated June 1, 2025, at 8:54 AM that Resident 1's grandson inappropriately speaks to the resident when providing care. When resident expresses that she no longer wants food and that she's going to throw up, the grandson 'shushes' her and tells her to be quiet while continuing to force feed her whichever meal she is currently eating. Grandson forces her head forward aggressively and shakes the resident's shoulder while yelling at her to 'wake up' to rouse her .Grandson states that when the resident says she is in pain, that she is not in pain, only he knows when the resident is in pain .This nurse is concerned the resident is being mistreated when she is capable of expressing her needs. Supervisor is aware and has spoken to family, care is ongoing. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing documentation by Employee 2 (registered nurse) dated June 1, 2025, at 10:00 AM revealed that there was a conversation with family at Resident 1's bedside regarding several concerns. The documentation stipulated that, This writer could hear resident moaning loudly from supervisor's office. Went to investigate and found resident in dining room with grandson and daughter attempting to feed resident breakfast. LPN (licensed practical nurse) was present and could be heard explaining to family that resident appears to be painful and would like to offer pain medication to help with symptoms. Family resistive to any intervention and were noted to be forcing resident to eat when she was clearly stating no. Daughter voiced concern over starving resident and states this is how resident has been for years. Explained that resident has the right to refuse and that forcing her to eat could cause more harm and discomfort. Resident had consumed approx (approximately) 50 percent of her meal. She was moaning loudly, and CNAs (nurse aides) assisted resident back to bed. Interview with Resident 1's daughter and son on June 12, 2025, at 11:57 AM confirmed that there was an incident in the dining room when Employee 1 approached them while feeding Resident 1 to suggest that she could administer pain medication to Resident 1. The interview indicated that they remained with their mother at her bedside following the incident. The interview indicated that it was her son and daughter who were present in the dining room, and Resident 1 does not have a grandson that visits her in the facility. Interview with the Director of Nursing on June 12, 2025, at 2:00 PM revealed that the facility did not complete an incident report regarding the above incident described by Employees 1 and 2 that recorded Resident 1's family was force-feeding her, forced her head forward aggressively, and shook her shoulder while yelling at her. The facility did not obtain witness statements from any staff, residents, or family present during the incident to refute or corroborate the described details of the interaction. The facility did not report the incident to the Department of Health or Area Agency on Aging. The facility did not remove the family to investigate the incident to ensure the residents' safety. The interview confirmed that Resident 1's son filed a grievance on June 2, 2025, that documented that Employee 1 alleged, .we were abusing (Resident 1) by forcing her to eat and not allowing her to receive needed narcotic pain medication. 28 Pa. Code 201.14(a)(c) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(2)(3)(e)(1)Management 28 Pa. Code 201.29(a) Resident rights