

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024
NAME OF PROVIDER OR SUPPLIER Buffalo Valley Lutheran Villag		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>20725</p> <p>Based on clinical record review and staff and family interview, it was determined that the facility failed to ensure that the resident and the resident representative received written notice that specified the duration of the bed-hold policy for one of seven residents reviewed for hospitalization s (Resident 7).</p> <p>Findings include:</p> <p>Interview with Resident 7's sister on August 27, 2024, at 10:29 AM revealed that Resident 7 had been to the hospital. Resident 7's sister stated that all communication from the facility regarding the hospitalization was verbal, and she did not receive any written notices.</p> <p>Clinical record review for Resident 7 revealed nursing documentation dated June 28, 2024, at 8:45 PM that staff found Resident 7 on the floor in her room. Staff assessed swelling to Resident 7's forehead, notified the physician, and obtained instructions to send her to the emergency department for testing. The documentation noted, RP (responsible party) aware and gave verbal request for bed hold.</p> <p>The surveyor requested evidence of written information to Resident 7's responsible party that specified the duration of the state bed-hold policy during an interview with the Nursing Home Administrator and the Director of Nursing on August 28, 2024, at 1:00 PM.</p> <p>Information provided by the facility the morning of August 29, 2024, indicated that staff sent a copy of the bed-hold notice with Resident 7 when she went to the hospital. Her sister, her responsible party, was to meet her at the hospital and would have received the papers there.</p> <p>The facility had no evidence that Resident 7's responsible party received the written information.</p> <p>483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Transfer</p> <p>Previously cited deficiency 9/1/23</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.29(f) Resident rights</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19719</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure complete and accurate Minimum Data Set assessments for two of 19 residents reviewed (Residents 2 and 88).</p> <p>Findings include:</p> <p>Review of Resident 88's closed clinical record revealed a Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated May 29, 2024, that indicated the facility indicated that Resident 88 was discharged from the facility to a hospital setting.</p> <p>Nursing documentation dated May 29, 2024, at 10:58 AM indicated that Resident 88 was discharged home with her husband.</p> <p>Interview with the Administrator and Director of Nursing on August 29, 2024, at 10:26 AM confirmed that Resident 88's discharge location was coded in error on the MDS dated [DATE].</p> <p>Review of Resident 2's clinical record revealed an MDS dated [DATE], that indicated that staff assessed Resident 2 as being on an antibiotic. Further review of Resident 2's clinical record revealed no evidence that Resident 2 received an antibiotic during the assessment period for the MDS.</p> <p>Interview with the Nursing Home Administrator on August 29, 2024, at 2:03 PM confirmed that Resident 2 did not receive an antibiotic and the data entered into the MDS was an error.</p> <p>483.20(g) Accuracy of Assessments</p> <p>Previously cited 9/1/23</p> <p>28 Pa. Code 211.5(f)(ix) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>20725</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide the highest practicable care regarding physician ordered weight assessments for one of 19 residents reviewed (Resident 43).</p> <p>Findings include:</p> <p>Interview with Resident 43 on August 27, 2024, at 11:36 AM revealed that he often has swelling of his lower extremities and weight gain due to fluid retention. Resident 43 stated that he is to abide by a physician ordered fluid restriction.</p> <p>Clinical record review for Resident 43 revealed active physician orders as follows:</p> <p>Fluid restriction, 1800 ml (milliliters) related to congestive heart failure (inefficient ability of the heart to pump blood and oxygen through the body; causes blood and fluids to collect in inappropriate areas like the lungs and legs over time)</p> <p>Lasix (Furosemide, diuretic medication used to remove excess fluid from the body) oral tablet 80 MG (milligrams) by mouth one time a day related to acute and chronic respiratory failure (insufficient oxygenation of the body)</p> <p>Physician orders instructed staff to assess Resident 43's weight as follows:</p> <p>Weigh on admission daily for two days, then weekly for four weeks from April 20, 2024, to May 3, 2024.</p> <p>Weigh on admission daily for two days, then weekly for four weeks from May 4, 2024, to May 31, 2024.</p> <p>Weigh on admission daily for two days, then weekly for four weeks from June 1, 2024, to July 1, 2024.</p> <p>Weigh on admission daily for two days, then weekly for four weeks from July 9, 2024, to August 8, 2024.</p> <p>The physician orders above did not provide additional information to staff regarding what fluctuations in weight should be considered significant or what to do when Resident 43's assessed weight fluctuated significantly.</p> <p>A review of Resident 43's weight assessments revealed the following:</p> <p>April 20, 2024, 190.6 pounds</p> <p>May 5, 2024, 193.4 pounds</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>May 6, 2024, 197.4 pounds, a four-pound increase in one day</p> <p>May 13, 2024, 205.6 pounds, an 8.2-pound increase in one week</p> <p>May 20, 2024, 203.2 pounds, a 12.6-pound, 6.61 percent, significant increase in one month</p> <p>Nursing documentation dated May 27, 2024, at 4:47 AM revealed that Resident 43 was calling out with complaints that he was not able to breathe. Resident 43 was pale, diaphoretic (sweaty), and had audible wheezing in his upper lung areas and had diminished breathing sounds in his lower lung areas. His oxygen saturation (percentage of oxygen in a person's blood; for most healthy adults, a normal oxygen saturation level is greater than 90 percent) was 84 percent while wearing oxygen at two liters per minute. He was belly breathing (using abdominal muscles to assist with respirations) and his nostrils were flaring. Resident 43's daughter, physician, and emergency services were notified.</p> <p>Nursing documentation dated May 28, 2024, at 9:07 AM revealed that the hospital admitted Resident 43 with a diagnosis of CHF.</p> <p>A physician's order dated July 25, 2024, instructed staff to implement daily weight assessments and notify the physician if Resident 43's weight increased by more than five pounds in one week.</p> <p>Resident 43's weight assessments revealed the following:</p> <p>August 2, 2024, 207.2 pounds</p> <p>August 9, 2024, 213 pounds (a 5.8-pound increase in one week)</p> <p>August 16, 2024, 217 pounds (an additional four-pound increase in one week; 9.8-pound increase in two weeks)</p> <p>There was no evidence in Resident 43's clinical record that staff implemented daily weight assessments or notified the physician of the above weight increase, at the time of the assessments.</p> <p>Nursing documentation dated August 19, 2024, at 3:06 PM indicated that staff assessed that Resident 43 had wheezing from his lungs and noted that Resident 43 had a 10-pound weight gain in two weeks. Staff notified the physician and nursing documentation dated August 19, 2024, at 6:01 PM indicated that the physician instructed staff to increase Resident 43's Lasix medication to 80 mg daily (was ordered as Furosemide Oral Tablet 40 mg daily at the time) and to obtain bloodwork on August 22, 2024.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on August 30, 2024, at 9:30 AM confirmed the above findings for Resident 43.</p> <p>483.25 Quality of Care</p> <p>Previously cited deficiency 9/1/23</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide physician ordered services to maintain a resident's range of motion for one of five residents reviewed (Resident 23) and failed to provide services to maintain a resident's range of motion for one of five residents reviewed (Resident 40).</p> <p>Findings include:</p> <p>Clinical record review for Resident 23 revealed a current physician's order dated October 15, 2023, where occupational therapy indicated that staff should place a palmar roll (foam cushioning) on her right hand every evening at bedtime (HS) for contracture prevention. Resident 23 was to wear the palmar roll per her tolerance at HS with staff completing skin checks each shift while the palmar roll was worn.</p> <p>There was no documentation available that indicated staff placed the palmar roll nightly or completed skin checks while the palmar roll was placed.</p> <p>Observation and concurrent interview with Resident 23 on August 27, 2024, at 10:12 AM revealed that her right hand was contracted. Resident 23 indicated that she did her own physical therapy program on it. No palmar roll was noted in Resident 23's room.</p> <p>The surveyor reviewed the above information on August 29, 2024, at 1:00 PM with the Director of Nursing.</p> <p>Clinical record review revealed an MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated June 4, 2024, noting staff assessed Resident 40 as having no lower extremity impairments.</p> <p>Further review of Resident 40's clinical record revealed his next quarterly MDS assessment dated [DATE], revealed that nursing staff assessed Resident 40 as having bilateral lower extremity impairment.</p> <p>Interview with the Director of Nursing on August 30, 2024, at 10:14 AM confirmed there was no evidence that the facility assessed Resident 40's decline in her lower extremity range of motion (ROM, movement of the body to maintain a resident's ability).</p> <p>The facility failed ensure Resident 40 received appropriate treatment and services to increase her range of motion and to prevent further decrease in range of motion.</p> <p>28 Pa. Code 211.10(a)(c)(d) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>20725</p> <p>Based on a review of select facility policies and procedures, clinical record review, and family and staff interview, it was determined that the facility failed to thoroughly investigate resident incidents and implement individualized interventions to prevent falls for one of seven residents reviewed for fall concerns (Resident 7).</p> <p>Findings include:</p> <p>The facility policy entitled, Fall Management, last reviewed without changes on January 25, 2024, revealed that the definition of a fall includes that unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. The purpose of the procedure is to provide assessment, after care, and identify new interventions to prevent further falls. As soon as possible after caring for the resident, the nurse will complete an Incident and Investigation Report and a Post Fall Investigation form. Staff document pertinent information regarding the fall in the resident's electronic health record.</p> <p>Interview with Resident 7's sister on August 27, 2024, at 10:26 AM revealed that Resident 7 fell approximately two months ago. Resident 7 hit her head on her bed frame, her face was black and blue, and she bruised her left leg. Resident 7's sister stated that Resident 7 would recount a story that would make no sense. Resident 7's sister indicated that Resident 7 has had many falls because she tries to get herself up from her chair. Resident 7's sister stated that the facility is currently trying a video alarm, to alert staff that Resident 7 is getting up from her chair.</p> <p>Clinical record review for Resident 7 revealed admission documentation dated December 6, 2023, at 3:10 PM that Resident 7 arrived at her room. Resident 7 had recent falls with the most recent one resulting in a right forehead hematoma (swelling due to the accumulation of blood under the skin).</p> <p>A review of Resident 7's clinical record revealed evidence that Resident 7 sustained a fall on 11 occasions in the 10 weeks from June 1, 2024, to August 11, 2024.</p> <p>A plan of care developed by the facility to address Resident 7's risk for falls identified that Resident 7 was non-compliant with her transfer status.</p> <p>Interventions listed on the plan of care included the following:</p> <p>PSA (pressure sensitive alarm, used to monitor residents who may be prone to wandering or falls; alerts caregivers when a resident gets out of a chair or bed) to recliner until VST (VSTAlert, an artificial intelligence-based fall prevention sensor that detects when residents intend to exit a chair or bed without assistance and alerts care staff to help. The device is to alert care staff before a resident stands, allowing a team member to arrive before a fall can occur. The device calibrates the room: the floor, the wall, the bed, and the chair. Once calibrated the device can either monitor in bed mode or chair mode.) available; active from January 28, 2024, to February 6, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>VST alert monitor to chair; may apply chair alarm if VST not working and notify DON (Director of Nursing); active from February 6, 2024, to May 2, 2024.</p> <p>PSA sensor alarm to recliner active from February 9, 2024, to February 22, 2024</p> <p>Sensor alarm to chair active from May 2, 2024, to May 28, 2024</p> <p>VST alert monitor to chair, check function every shift, active from May 28, 2024, to May 29, 2024</p> <p>VST alert monitor to chair (without the directive to check the function every shift) active since May 30, 2024</p> <p>Nursing documentation dated June 1, 2024, at 8:30 AM revealed that the licensed practical nurse alerted the registered nurse that Resident 7 fell . The incident documentation specifically noted that the VST did not alarm.</p> <p>Review of the nurse aide staff statement included with the facility's investigation dated June 1, 2024, noted that while two nurse aides served breakfast, a nurse stated Resident 7 was on the floor.</p> <p>Review of the interdisciplinary team documentation dated June 3, 2024, noted that the, VST in place and functioning. Staff responded timely .</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on August 29, 2024, at 10:00 AM revealed that the VST device initially alerts the nurse aide, then the licensed nurse if the nurse aide does not respond via a facility cell phone. The interview indicated that the facility could not provide information regarding how long the alert would sound after activation to the nurse aide before referral to the licensed nurse. The interview indicated that the facility believed that a report would indicate how long an alert sounded before staff responded; however, the facility had no reports to provide to the surveyor. The interview confirmed that a nurse aide may be providing care elsewhere on another hallway during an alert activation and no staff potentially near Resident 7's room would receive an alert to respond until some time passed after activation.</p> <p>Although the clinical record documentation and nurse aide statement following Resident 7's June 1, 2024, fall indicated that the VST did not alert staff to respond, the interdisciplinary team did not investigate the discrepancy regarding the functioning of the VST alarm. The facility did not provide evidence of any new intervention to improve the reliability of the alert system should Resident 7 attempt to self-transfer.</p> <p>Nursing documentation dated June 6, 2024, at 10:59 PM revealed that the unit licensed practical nurse notified the registered nurse that Resident 7 fell while ambulating without assistance. The documentation specified that the, VST did not alarm at the time of the fall.</p> <p>The facility's investigation of the fall on June 6, 2024, substantiated that no alarm activated to alert staff that Resident 7 was attempting to ambulate without assistance. The facility interdisciplinary documentation dated one week later (on June 13, 2024) indicated that the VST was not working properly and that a chair alarm was added until a new VST arrived.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Incident Note documentation dated June 10, 2024, at 1:52 PM indicated that a chair alarm was discontinued due to the arrival of a new VST.</p> <p>Nursing documentation dated June 14, 2024, at 9:56 PM revealed that the licensed practical nurse (LPN) and the nurse aides (NA) were in the opposite hall when another staff member was on unit, walked past Resident 7's room doorway, and saw her on the floor. He alerted the LPN and NAs. The documentation indicated that Resident 7's VST did not alert the LPN or RN's (registered nurse) phones at the time of the incident.</p> <p>The documentation available did not indicate if the VST did or did not alert NA staff of Resident 7's attempt to ambulate independently. There was no evidence that the facility attempted to obtain a report of the device's activation to determine if, or for how long, the VST alerted NA staff before staff discovered Resident 7 on the floor. The facility intervention after the fall included to educate staff regarding the calibration of the VST device; however, no information provided indicated that it was the calibration of the device that resulted in a device failure.</p> <p>Nursing documentation dated June 26, 2024, at 2:50 PM revealed that nurse aide staff lowered Resident 7 to the floor.</p> <p>The interdisciplinary documentation dated June 27, 2024, indicated that therapy would screen Resident 7.</p> <p>The facility did not provide evidence that skilled therapy evaluated Resident 7 after the June 26, 2024, fall.</p> <p>Nursing documentation dated June 28, 2024, at 8:45 PM revealed that staff found Resident 7 on the floor. Staff assessed, a large knot of swelling, to the top of Resident 7's forehead. The physician directed staff to send Resident 7 to the emergency department for evaluation.</p> <p>Nursing documentation dated June 28, 2024, at 9:00 PM assessed the large knot, as 5 cm (centimeters) wide by 5 cm long by 3 cm high, with an abrasion over the site.</p> <p>Review of the Event Report System (ERS, an electronic method used by facilities to notify the Department of incidents/accidents that require a resident's transfer to the hospital) notification submitted July 1, 2024, noted that Resident 7 sustained a fall on June 28, 2024, at 8:25 PM. The information provided indicated that Resident 7 was non-compliant with her transfer status and fell while attempting to stand from her recliner. The information specifically noted that Resident 7's, .POC (plan of care) followed. The facility's follow-up action again noted that skilled therapy would screen Resident 7.</p> <p>Review of the facility's investigation of Resident 7's fall on June 28, 2024, indicated that staff included in a witness statement that, VST did not go off. Other staff statements noted that Resident 7 was previously in her recliner, the VST was set to chair, and the VST did not go off.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no indication that the facility investigated the failure of the VST alarm to alert staff of Resident 7's attempt to ambulate or transfer independently before discovering Resident 7 on the floor. No evidence provided indicated that the facility investigated the availability of a report to determine if, or for how long, the VST alarmed before staff found Resident 7 on the floor. The facility did not report the failure of the plan of care intervention in the details of the ERS notification.</p> <p>Nursing documentation dated July 16, 2024, at 2:20 PM revealed that the LPN called the RN to the unit where staff observed Resident 7 on the floor in the hallway between her room and her bathroom. The documentation noted, .all interventions in place at time of fall.</p> <p>Review of the facility's investigation of Resident 7's fall on July 16, 2024, reiterated details that Resident 7 was in the hallway by her bathroom. A signed statement from staff noted that Resident 7 was sitting in her wheelchair in the little hallway that connects two resident rooms. Resident 7 refused staff assistance and the staff left the room to assist another resident to her room when there was a loud bang. This staff returned to Resident 7's room and saw Resident 7 on the floor. The LPN also provided a signed statement that there was a loud bang, a resident called out, and Resident 7 was on the floor in the hallway between her bathroom and her bedroom. The LPN noted that there was no one in Resident 7's or her neighbor's room. No staff attested to the functioning of the VST alarm; however, the interdisciplinary team noted that the plan of care was followed and that appropriate fall interventions were in place.</p> <p>Interview with the Director of Nursing on August 30, 2024, at 9:30 AM confirmed that Resident 7's VST would not detect her attempt to rise from her wheelchair if she was positioned in the hallway near her bathroom. The interview confirmed that the statement from the staff indicated that staff left Resident 7 unattended while she was in the hallway and not in an area that provided VST monitoring.</p> <p>Even though Resident 7's VST was not calibrated to function when Resident 7 was not in her recliner chair or in her room and Resident 7 was outside the calibrated area when in the hallway near her bathroom, the interdisciplinary team noted that the plan of care was followed, and all the appropriate fall interventions were in place.</p> <p>Nursing documentation dated July 23, 2024, at 2:52 PM revealed that staff observed Resident 7 on the floor in front of her recliner. The documentation indicated that the VST sounded.</p> <p>The facility provided one staff statement included in the facility's investigation of the July 23, 2024, fall. The statement indicated that the staff was, busy attending with other resident. The investigation did not determine which staff was first to receive the VST alert, how long Resident 7's VST alarm activated before the second staff received or responded to Resident 7's VST alert, or if any new plan of care interventions were implemented in response to this fall.</p> <p>Nursing documentation dated July 29, 2024, at 6:15 AM revealed that NA staff called the writer because Resident 7 was on the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's investigation of the July 29, 2024, fall revealed that Resident 7 sustained a bruise to her left inner, posterior, thigh that measured 9 inches by 2.2 inches. The one staff statement provided with the facility's investigation indicated that a staff member received a notification that Resident 7, was ringing . and that the, .bell was on for 11 m 49 s (eleven minutes and 49 seconds). No staff attested that there was an initial VST alert to the NA, or a secondary VST alert to the licensed staff.</p> <p>Interview with the Director of Nursing on August 30, 2024, at 9:30 AM confirmed that the statement from the staff indicated a bell, not a VST, alert. The interview also confirmed that there was no evidence that the facility obtained a VST report that indicated the alert continued for almost 12 minutes or that a second staff received an alert (while the nurse aide was caring for another resident) as is intended for the device.</p> <p>Despite the unclear information as noted above for Resident 7's fall on July 29, 2024, the interdisciplinary team documented on July 31, 2024, that, Appropriate fall interventions in place; and POC followed.</p> <p>Nursing documentation dated August 11, 2024, at 7:05 PM indicated that the LPN found Resident 7 sitting on the floor in front of her recliner.</p> <p>Documentation by the RN (who responded to the scene following the LPN notification to her) dated August 11, 2024, at 8:12 PM indicated that Resident 7 has a VST in place that was sounding at the time of the incident.</p> <p>Review of the facility's investigation of Resident 7's fall on August 11, 2024, revealed that the facility obtained two staff statements. One staff statement indicated, was giving a shower when incident occurred. The second staff statement noted, I was assisting resident in (another room) with supper when I heard charge nurse alerted staffs that resident was on the floor inside her room.</p> <p>There was no indication from either staff that a VST alarm activated for Resident 7. The documentation in Resident 7's electronic medical record and the incident investigation initiated by the LPN on the unit did not indicate a VST alarm activated for Resident 7. The LPN noted on the incident investigation that while standing at the medication cart outside the nurses' station, Resident 7 called out, help, and set off her call bell. Upon entering the room, the LPN found Resident 7 on the floor.</p> <p>The interdisciplinary documentation on the investigation dated August 12, 2024, noted, MD (physician) and RP (responsible party) aware POC (plan of care) was followed.</p> <p>Interview with the Director of Nursing on August 30, 2024, at 9:30 AM confirmed that the VST device was not set up to alert the RN first; however, the RN was the only staff that noted a VST activated. The interdisciplinary team documentation did not indicate that anyone identified the irregularity regarding the available information pertaining to the functioning of the VST device.</p> <p>Inservice attendance provided by the facility dated August 18, 2024, in response to the surveyor's questions regarding Resident 7's falls, instructed staff to, Please ensure VST in (Resident 7's roommate's room, not Resident 7's room number) is on, functioning, and setting in appropriate location of resident (bed or chair); make LPN aware if not functioning so a different form of monitoring can be put in place. A handwritten note at the bottom of the attendance sheet noted, VST was not working.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility provided the evidence of in-service education in response to the surveyor's questions regarding Resident 7's falls; however, the evidence indicated an issue with VST use for Resident 7's roommate.</p> <p>The facility failed to thoroughly investigate Resident 7's incidents to ensure that the intervention intended to alert staff of her non-compliance with requesting staff assistance functioned as intended.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>20725</p> <p>Based on clinical record review, observation, and staff, resident, and family interview, it was determined that the facility failed to implement interventions, consistent with physician orders and resident preferences, for two of two residents reviewed for nutrition and hydration concerns (Residents 43 and 66).</p> <p>Findings include:</p> <p>Interview with Resident 43 on August 27, 2024, at 11:28 AM revealed that he was to abide by a physician ordered fluid restriction. Resident 43 stated that he was not sure how much fluid he was allowed and, they (staff) take care of it.</p> <p>Clinical record review for Resident 43 confirmed that the physician ordered an 1800 ml (milliliter) fluid restriction within which dietary would provide 360 ml per each day shift meal.</p> <p>Interview with Resident 43 during observation of the lunch meal on August 27, 2024, at 1:19 PM revealed that he did not receive milk as per his meal tray ticket. Resident 43 stated that he requested cranberry juice and milk. Review of Resident 43's tray ticket confirmed that he circled cranberry juice and milk as his beverage choices. Resident 43 requested two, four-ounce, cranberry juices and one, four-ounce, milk. Resident 43 received only the two, four-ounce, cranberry juices.</p> <p>Interview with Employee 4 (nurse aide) on August 27, 2024, at 1:30 PM confirmed that she delivered Resident 43's lunch meal after she obtained his beverages. Employee 4 confirmed that Resident 43 should have received his three, four-ounce, beverage choices; however, she failed to provide milk per his choice.</p> <p>Clinical record review for Resident 66 revealed the following weight assessments:</p> <p>July 9, 2024, 170 pounds</p> <p>July 10, 2024, 168.2 pounds</p> <p>July 15, 2024, 163.2 pounds</p> <p>July 16, 2024, 161.2 pounds</p> <p>July 22, 2024, 159.4 pounds</p> <p>July 29, 2024, 156.4 pounds</p> <p>August 5, 2024, 153.2 pounds (a 9.88 percent significant weight loss in one month)</p> <p>A physician's order dated July 15, 2024, instructed staff to provide extra gravy/sauce with meat. A physician's order dated July 17, 2024, instructed staff to provide fortified food during the lunch meal.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nutrition progress note documentation dated July 16, 2024, at 2:02 PM revealed Resident 66 presented with a weight loss since her admission and there was a new order for fortified mashed potatoes at lunch.</p> <p>Nutrition progress note documentation dated July 30, 2024, at 2:57 PM revealed that staff monitored Resident 66 for weight loss of eight percent in one month, and Resident 66 received fortified mashed potatoes at the lunch meal.</p> <p>Nutrition progress note documentation dated August 7, 2024, at 11:23 PM again noted that staff monitored Resident 66 for weight loss of eight percent in one month, and Resident 66 received fortified mashed potatoes at the lunch meal.</p> <p>Observation of the lunch meal on August 27, 2024, at 12:47 PM revealed Resident 66 at a table with her daughter who was cutting her food items and assisting her mother to eat. Interview with Resident 66's daughter while reviewing Resident 66's meal ticket confirmed that Resident 66 was to receive extra gravy on her meat; however, Resident 66 received no gravy with her meal that included chicken.</p> <p>Interview with Employee 5 (dietary aide) on August 27, 2024, at 12:49 PM confirmed that she did not provide gravy on Resident 66's chicken. Employee 5 confirmed that Resident 66's tray ticket indicated that she was on a fortified diet; however, Employee 5 stated that she did not know what made Resident 66's fortified diet different than other residents' regular meal. The surveyor pointed to a sign posted on the lunch steam table that indicated a fortified food at the lunch meal was mashed potatoes. Employee 5 confirmed that she did not provide mashed potatoes on Resident 66's lunch meal tray. Employee 5 then portioned a serving of mashed potatoes with gravy for Resident 66.</p> <p>The surveyor reviewed the above findings for Residents 43 and 66 during an interview with the Nursing Home Administrator and the Director of Nursing on August 28, 2024, at 1:00 PM.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29512</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to receive informed consent and assess for the risk of side rail entrapment for two of six residents reviewed for accident hazards (Residents 12 and 66).</p> <p>Findings include:</p> <p>Observation of Resident 12's room on August 27, 2024, at 9:57 AM and August 28, 2024, at 10:53 AM revealed that there were bilateral one-quarter enabler bars (side rails) on the bed.</p> <p>Clinical record review for Resident 12 revealed a nursing enabler bar assessment dated [DATE], that indicated Resident 12 was assessed by therapy for enabler bars. Therapy indicated that Resident 12 did not need enabler bars. On August 13, 2024, maintenance staff evaluated the one-quarter enabler bars on Resident 12's bed and indicated that they passed for potential entrapment. There was no documentation that indicated the facility received consent from Resident 12 or their responsible party to utilize enabler bars, that the facility provided education to Resident 12 and their responsible party regarding the potential risks of utilizing enabler bars, or that nursing staff assessed Resident 12 for the need to utilize enabler bars for entrapment zones.</p> <p>The surveyor reviewed the above information during an interview with the Nursing Home Director and the Director of Nursing on August 29, 2024, at 2:00 PM.</p> <p>In a facility note received on August 30, 2024, at 9:00 AM the facility indicated that (Resident 12) - bilateral rails - should not have been on bed. (Resident 12) expressed desire to staff to have enabler rails for bed mobility. This request was not passed on to nursing or therapy.</p> <p>On August 20, 2024, at 9:30 AM the Director of Nursing confirmed the facility note that Resident 12 should not have enabler bars.</p> <p>Observation of Resident 66 on August 28, 2024, at 10:43 AM revealed she was in a bed that was equipped with a side rail on her left side.</p> <p>Nursing documentation dated July 10, 2024, at 11:41 AM indicated that staff obtained consent from Resident 66 for an enabler bar on the left side of her bed.</p> <p>A physician's order dated July 19, 2024, noted that Resident 66 was not capable of understanding her rights and responsibilities.</p> <p>The surveyor requested any evidence that the facility obtained informed consent from Resident 66's responsible party for the use of the side rail and any side rail entrapment risk assessments for Resident 66 during an interview with the Nursing Home Administrator and the Director of Nursing on August 28, 2024, at 1:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Enabler Evaluation dated July 10, 2024, noted, left per therapy, in the section labeled for, Resident/ Responsible Party Signature and Date.</p> <p>Review of census information for Resident 66 revealed that she resided on the [NAME] nursing unit from her admission on July 9, 2024, to August 16, 2024, when she moved to the Chestnut nursing unit.</p> <p>A Bed System Measurement Device Test Results Worksheet provided by the facility for Resident 66 revealed there was a left-sided bed rail assessed on July 5, 2024, for the bed she currently utilized on the Chestnut nursing unit. This date was before Resident 66's admission to the facility. The document did not include a resident's name, type of bed, or type of mattress.</p> <p>A Bed System Measurement Device Test Results Worksheet provided by the facility for Resident 66 revealed that there was a left-sided bed rail assessed on August 13, 2024, for the bed she currently utilized on the Chestnut nursing unit; however, Resident 66 resided on the [NAME] nursing unit on that date.</p> <p>The surveyor reviewed the above findings for Resident 66 during an interview with the Director of Nursing and the Nursing Home Administrator on August 29, 2024, at 1:00 PM. The interview confirmed that the Bed System Measurement Device Test Results Worksheets do not become a permanent part of the residents' medical record. The information contained on the forms provided was insufficient to determine what resident was assessed in a particular type of bed model.</p> <p>The facility was unable to provide clarification how the staff document evidence that a bed's dimensions are appropriate for a particular resident's size and weight when the documentation provided does not include a resident name or type of bed/mattress.</p> <p>Following the surveyor's additional questioning, on August 29, 2024, at 2:10 PM the Director of Nursing provided an additional Bed System Measurement Device Test Results Worksheet dated August 13, 2024, for Resident 66's bed assignment on the [NAME] nursing unit. This form also did not include a resident name, make, and model of the bed, or make and model of the mattress.</p> <p>The facility failed to provide an informed consent signed by either Resident 66, or her responsible party, for the use of a side rail.</p> <p>483.25(n)(1)-(4) Bedrails</p> <p>Previously cited deficiency 9/1/24</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by three of three residents reviewed (Residents 52, 60, and 79).</p> <p>Findings include:</p> <p>Clinical record review for Resident 52 revealed the facility admitted her on February 24, 2021. A diagnosis of dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life) was added on November 8, 2022. A review of Resident 52's most recent annual Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated July 3, 2024, indicated that the facility assessed Resident 52 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 52's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>Clinical record review for Resident 60 revealed the facility admitted her on August 12, 2021. A diagnosis of dementia with agitation was added on May 30, 2023. A review of Resident 60's most recent annual MDS assessment dated [DATE], indicated that the facility assessed Resident 60 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 60's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>Clinical record review for Resident 79 revealed the facility admitted her on December 11, 2023, with a diagnosis of dementia with anxiety. A review of Resident 79's admission MDS assessment dated [DATE], indicated that the facility assessed Resident 79 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 79's care plan revealed that there was no indication that the facility had developed and implemented a person-centered care plan to address the resident's dementia and cognitive loss.</p> <p>Interview with the Director of Nursing on September 29, 2024, at 2:12 PM confirmed the facility had no further documentation that the facility developed and implemented individualized person-centered care plans to address Resident 52, 60, and 79's dementia and cognitive loss.</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>20725</p> <p>Based on clinical record review and staff interview it was determined that the facility failed to ensure a resident's medication regime was free from potentially unnecessary medication for one of five residents selected for medication regimen review (Resident 7).</p> <p>Findings include:</p> <p>Clinical record review for Resident 7 revealed a physician order dated March 13, 2024, for staff to administer Zyrtec (allergy medication) 10 mg (milligrams) by mouth one time a day for, .cold and runny nose.</p> <p>A consultant pharmacist review dated April 5, 2024, requested that the physician evaluate the need for Resident 7's continued daily use of Zyrtec. The physician accepted the recommendation with the direction to reassess the need for the medication in two weeks.</p> <p>Resident 7's clinical record contained no evidence that staff reassessed Resident 7's need for the Zyrtec medication after two weeks.</p> <p>The physician order for Resident 7's Zyrtec remained active until it was discontinued on July 3, 2024.</p> <p>A review of Medication Administration Records (MARs, electronic documentation of the administration of medication) dated April, May, June, and July 2024, confirmed that Resident 7 received the Zyrtec medication daily until July 3, 2024.</p> <p>Interview with the Director of Nursing on August 29, 2024, at 2:10 PM confirmed that staff did not complete a reassessment of Resident 7's use of the Zyrtec medication and the medication remained active for three months after the physician responded to the consultant pharmacist's recommendation.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>29512</p> <p>Based on review of facility staff education records and staff interview, it was determined that the facility failed to ensure that all nurse aide staff completed a minimum of 12 hours of in-service education training each year for two of three nurse aides reviewed (Employees 1 and 2).</p> <p>Findings include:</p> <p>During an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) on August 28, 2024, at 1:00 PM the surveyor requested evidence of annual in-service education for Employee 1, nurse aide, hired January 10, 2017, and Employee 2, nurse aide, hired June 5, 2023.</p> <p>Interview with the NHA on August 29, 2024, at 12:20 PM confirmed that Employee 1 only completed 7.25 hours and Employee 3 only completed 9.0 hours of the required 12 hours of annual in-service education, which included dementia training, abuse prevention training, and any areas of weakness or resident special care needs in the past year.</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 201.20(a)(d) Staff development</p> <p>28 Pa. Code 211.12(c) Nursing services</p>