

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 09/26/2025
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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>(continued on next page)</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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to provide timely notification to a resident whose payment coverage changed for two of three residents reviewed (Residents 93 and 57). Findings include: A review of the form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123, (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNF ABN, CMS-10055) is issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare. It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services. Key elements of compliance with the provision of the notice include that the facility notified an eligible resident in writing of the items and services which are/are not covered under Medicaid or by the facility's per diem rate, including the cost of those items and services as soon as reasonably possible when a change in coverage occurs. The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows Beginning on ., the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. Clinical record review for Resident 93 revealed census information that the facility provided services primarily paid for by Medicare A starting [DATE]. Resident 93's Medicare payment for services ended [DATE]. Resident 93 discharged out of the facility on [DATE]. Physical therapy documentation dated [DATE], at 11:59 AM indicated that therapy was provided; and that Resident 93 was scheduled for discharge on [DATE]. Physical therapy documentation dated [DATE], at 12:26 PM revealed that Resident 93 had no further skilled therapy needs and would discharge home the next day with home health services. The surveyor reviewed concerns that the facility did not provide a CMS-10123 notice to Resident 93 two days before the discontinuation of her Medicare A services during an interview with the Director of Nursing and the Nursing Home Administrator on [DATE], at 2:00 PM. The interview confirmed that Resident 93 did not leave the facility against medical advice (AMA). Clinical record review for Resident 57 revealed that the facility admitted her on [DATE], to receive services primarily paid for by Medicare A. Review of census information for Resident 57 revealed that the last day of Medicare A payment for services was [DATE]. Resident 57 began private payment for services beginning [DATE]. Resident 57 remained in the facility until she expired on [DATE]. Review of a CMS-10123 form for Resident 57 confirmed that Medicare A coverage for services ended [DATE]. The notice included documentation that facility staff discussed the notice and change in payment coverage with the responsible party on [DATE]. Resident 57's responsible party signed the notice on [DATE] Review of a CMS-10055 form for Resident 57 indicated that beginning on [DATE], Resident 57 would be responsible for an estimated cost per day. Resident 57's responsible party signed the notice on [DATE] (one day before). The notice did not include documentation that facility staff attempted to discuss the change in payment for services that included the estimated cost per day with Resident 57's responsible party as soon as reasonably possible when a change in coverage was anticipated (e.g., during the discussion on [DATE]). The surveyor reviewed the above concerns regarding Resident 57's CMS-10055 notice with the Nursing Home Administrator on [DATE], at 10:09 AM. 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on review of select facility policy and procedures, observations, and staff interview, it was determined that the facility failed to ensure a resident's rights to secure and confidential personal and medical information in the facility's main lobby for one of one resident reviewed for privacy concerns (Main Lobby Area; Resident 94). Findings include: A review of the facility policy titled, Confidentiality, last reviewed without changes on April 7, 2025, revealed a policy statement to ensure that a resident's confidential health information is protected from use or disclosure that is in violation of the Health Insurance Portability and Accountability Act (HIPAA) or other applicable federal or state requirements. Further review of the policy revealed that an individual's protected health information (PHI) should not be discussed with those not entitled to the information. Observation of the main lobby of the facility on September 26, 2025, at 9:30 AM revealed a binder titled Department of Health Surveys. The binder contained the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. Review of the contents of the binder revealed that the facility placed the full health survey and complaint survey results in the binder. Further review of the binder revealed a complaint deficiency letter and associated Statement of Deficiencies (Form CMS-2567) for a complaint investigation on June 12, 2025. The letter noted the name and associated specific resident identifier for Resident 94. The facility failed to ensure Resident 94's right to privacy of their personal and medical information. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 26, 2025, at 1:35 PM. 28 Pa. Code: 201.18(e)(1) Management</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop baseline care plans within 48 hours of admission for two of 18 residents reviewed (Residents 5 and 33). Findings include: Clinical record review for Resident 5 revealed that the facility admitted him on September 5, 2025. Hospital transfer documentation dated September 5, 2025, revealed that his medication regime included the administration of Warfarin (anticoagulant medication used to prevent and treat blood clots) daily at 3:00 PM. Nursing documentation dated September 5, 2025, at 5:00 PM revealed that Resident 5 arrived at the facility after hospitalization for left lower extremity cellulitis (common bacterial infection of the layers of the skin) from a venous stasis ulcer (wound that occurs due to poor blood flow in the veins). Resident 5's medication administration record (MAR, electronic documentation of the administration of medications) dated September 2025 revealed that Resident 5 received the Warfarin medication on September 6, 2025, at 9:00 PM. Review of Resident 5's baseline care plan (developed by the facility within 48 hours of admission) did not include the use or complications of anticoagulant therapy. A plan of care (initiated September 13, 2025, one week after Resident 5's admission) noted that Resident 5 was on anticoagulant therapy. Review of diagnoses listed for Resident 5 revealed that he was diagnosed with prediabetes (higher than normal blood sugar assessments, but not high enough to meet the criteria for a diabetes diagnosis) on his admission date of September 5, 2025. Nursing documentation dated September 8, 2025, at 6:01 PM revealed that the practitioner provided an order to perform an Accu-Chek assessment (glucose testing of a drop of blood obtained from a finger prick) at breakfast and supper and implement a sliding scale of insulin administration doses (the hormone insulin is injected in dosages based on the blood sugar level of the Accu-Chek assessment). An admission MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], noted that Resident 5 received insulin injections on three of the seven days reviewed. Review of the care plans developed by the facility for Resident 5 revealed no evidence that staff included Resident 5's use of insulin for his elevated blood sugars. The surveyor reviewed the above concerns regarding Resident 5's care plan development during an interview with the Nursing Home Administrator and the Director of Nursing on September 25, 2025, at 2:00 PM. Clinical record review for Resident 33 revealed hospital documentation dated August 12, 2025, by an infectious disease practitioner that indicated Resident 33 was admitted to the hospital on [DATE] for a pressure ulcer (wound that progresses through several stages from a simple break in the skin to depths that may expose bone or muscle) on her sacrum (tailbone) that presented with sacral osteomyelitis (infection that spread to the bone). The treatment recommendations for Resident 33 included the use of the intravenous antibiotic, Unasyn. Nursing documentation dated August 13, 2025, at 5:13 PM revealed that the facility admitted Resident 33 with a PICC line (peripherally inserted central catheter, a long, thin tube that's inserted through a vein in your arm and passed to the larger veins near your heart); and that she would receive the antibiotic, Unasyn. A medical diagnoses list for Resident 33 dated August 13, 2025, included osteomyelitis of the sacral region and pressure ulcer of the sacral region. admission nursing documentation dated August 13, 2025, at 5:13 PM assessed a pressure ulcer, Stage 4 (full thickness skin and tissue loss with exposed bone, tendon, or muscle) to Resident 33's sacrum that measured 13 cm (centimeters) by 7 cm by 3 cm. Review of Resident 33's care plans revealed that the facility did not initiate a plan of care to address interventions implemented for her skin integrity impairment (Stage 4 sacral pressure ulcer) until August 28, 2025 (more than two weeks after her admission). The plans of care available in Resident 33's medical record contained no plan of care to address the care and potential complications of a PICC site. Interview with the Director of Nursing on September 26, 2025, at 11:13 AM confirmed that Resident 33's baseline plan of care did not address the care and services for her Stage 4 pressure ulcer or the care and potential complications for her PICC line intravenous access. 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>Based on clinical record review and staff interview, it was determined that the facility failed to provide the highest practicable care regarding wound assessment for one of three residents reviewed for skin concerns (Resident 58). Findings include: Clinical record review for Resident 58 revealed a diagnosis list that included dementia (general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons). Further clinical record review for Resident 58 revealed a quarterly Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated August 28, 2025, that noted facility staff assessed the resident as rarely/never understood. A review of the task list (located in the electronic health record where staff document specific care related events for a resident) for Resident 58 revealed that staff were to apply a moisture barrier to the buttocks with incontinence care. Resident 58's care plans revealed that the resident was at risk for altered skin integrity and the resident had bladder incontinence related to activity intolerance. Braden Score documentation for Resident 58 dated June 3, 2025, at 6:18 PM revealed a Braden Score of 12.0 (a clinical tool used to assess the risk of developing pressure ulcers; a score of 12 indicates a high risk). A skin/wound note dated June 6, 2025, at 2:46 AM revealed that Resident 58 is developing MASD (moisture associated skin damage) on the sacrum. A fax was sent to the medical provider to update. Clinical documentation for Resident 58 dated June 6, 2025, at 2:47 AM revealed a skin check note that indicated a new skin issue on the middle sacrum that was inquired in-house. The skin issue was documented as MASD and was measured at 1.3 centimeters (cm) in width and 0.9 centimeters in depth. It was noted as, New Skin Issue. A skin/wound note for Resident 58 dated June 6, 2025, at 11:03 AM revealed documentation that the resident had Sacral MASD noted measuring 1.5 cm x 0.5 cm, treatment in place. A health status note for Resident 58 dated June 23, 2025, at 2:24 PM revealed that a three day bowel and bladder diary noted the resident is incontinent of bowel and bladder. Skin check documentation for Resident 58 revealed that the resident had MASD; however, the documentation noted Skin issue has not been evaluated, and staff continued to document, Wound is new, for the following dates: June 12, 2025, at 7:28 PM June 19, 2025, at 8:34 PM June 26, 2025, at 4:34 PM July 3, 2025, at 5:13 PM July 10, 2025, at 4:25 PM July 17, 2025, at 9:34 AM July 24, 2025, at 7:21 PM July 31, 2025, at 4:11 PM August 7, 2025, at 6:06 PM August 14, 2025, at 4:04 PM August 21, 2025, at 6:07 PM August 28, 2025, at 3:45 PM September 4, 2025, at 4:36 PM September 11, 2025, at 3:48 PM September 18, 2025, at 3:59 PM September 25, 2025, at 3:30 PM A long term care evaluation for Resident 58 dated August 28, 2025, at 9:28 AM revealed that Z-guard (a topical medication to protect the skin) continues related to incontinence. The documentation revealed that the resident had MASD; however, the documentation noted Skin issue has not been evaluated, and staff continued to document the wound as new. Further clinical record review for Resident 58 revealed no evidence that the resident's MASD was routinely or comprehensively assessed after the initial assessment on June 6, 2025, to determine if the wound was improving or worsening. An interview with the Director of Nursing on September 26, 2025, at 2:10 PM revealed the facility could provide no further evidence that Resident 58's MASD was routinely or comprehensively assessed. 483.25 Quality of Care Previously cited deficiency 8/30/2024 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on clinical record review, review of select facility policies and procedures, and staff interview, it was determined that the facility failed to assess and implement treatment and services to promote the healing of pressure ulcers for one of three residents reviewed for pressure ulcer concerns (Resident 63). Findings include: The policy entitled Pressure Injury Treatment Protocol, last reviewed without changes April 7, 2025, revealed the purpose of this procedure is to provide guidelines for the care of existing pressure injuries. All pressure injuries will be assessed every week and as needed using the 52 Week Wound Assessment. If the wound does not improve in 14 days, the facility is to notify the physician, re-evaluate nutritional support, offloading or redistribution devices, and advanced wound product changes. Clinical record review revealed the facility admitted Resident 63 on April 15, 2025. Nursing documentation dated April 15, 2025, at 5:08 PM revealed Resident 63 was admitted with a Stage 2 (partial thickness loss of skin with exposed dermis) on her sacrum, measuring 2 centimeters (cm) by 0.5 cm by 0.1 cm. Further review of Resident 63's clinical record revealed the following assessments of Resident 63's sacrum completed by a wound care specialist: April 17, 2025, Stage 2 measuring 3.6 cm by 1.5 cm by 0.1 cm April 24, 2025, Stage 2 measuring 3.3 cm by 1.4 cm by 0.1 cm May 1, 2025, the wound care specialist rescheduled Resident 63's appointment May 8, 2025, the wound care specialist rescheduled Resident 63's appointment Resident 63's wound was not assessed again until May 16, 2025, when the wound care specialist noted the open area on Resident 63's sacrum was now a Stage 3 (full thickness skin loss, exposing the fatty tissue beneath) pressure ulcer, measuring 1.2 cm by 0.8 cm, by 0.3 cm There was no assessment of Resident 63's sacral pressure ulcer from April 24 to May 16, 2025 (three weeks), going from a Stage 2 to Stage 3 pressure ulcer. Interview with the Director of Nursing on September 26, 2026, at 1:49 PM confirmed Resident 63's pressure ulcer was not assessed at least weekly, with an evaluation including the date observed, location and staging, and size. 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** Based on clinical record review, and family and staff interviews, it was determined that the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase and/or prevent further decrease in range of motion for one of two residents reviewed for range of motion concerns (Resident 7). Findings include: Interview with Resident 7's family on September 23, 2025, at 10:23 AM revealed Resident 7 was struggling to walk now. She stated that Resident 7 has been unsteady and has a difficult time lifting his right foot. Clinical record review revealed the facility admitted Resident 7 on October 18, 2022. Review of Resident 7's MDS (Minimum Data Set, an assessment completed at specific intervals to determine resident care needs) dated April 3, 2025, revealed Resident 7 had no limitations to his range of motion, and was able to walk 150 feet with supervision of staff, or touching assistance. Review of a therapy referral form dated June 7, 2025, revealed Resident 7's wife requested a physical therapy screen due to his shuffling and unsteady gait, and difficulty with transfers. There was an undated note at the bottom of the therapy referral form indicating no skilled therapy needs, no change in function. Resident 7's next MDS dated [DATE], revealed staff now assessed Resident 7 as having upper extremity limitations to his one side, and needed partial to moderate staff assistance to walk 150 feet. Review of a therapy referral form dated June 30, 2025, revealed after staff interview, it was determined that Resident 7 is partial to moderate assistance with toileting hygiene, substantial assistance with upper body dressing, and dependent on staff assistance for lower body dressing. A therapy referral was placed for the significant decline in Resident 7's activities of daily living functional abilities. Review of Resident 7's occupational therapy documentation revealed an evaluation dated July 17, 2025, due to the decline in his activities of daily living. Resident 7 and family were present for the evaluation and stated no change in Resident 7's functional status indicating Resident 7 frequently has bad days. Resident 7's family reported shaking in Resident 7's lower right extremity with difficulty lifting his foot during ambulation. Occupational therapy noted no further needs identified for Resident 7 and made a referral to physical therapy for ambulation training. Review of physical therapy documentation revealed they did not assess Resident 7 until August 14, 2025, and he remained on caseload until September 1, 2025. Review of physical therapy's discharge recommendations dated September 1, 2025, revealed Resident 7 is to continue ambulation via restorative nursing program as nursing staff have been doing. A restorative ambulation program was established. Physical therapy revealed Resident 7's prognosis to maintain his current level of function would be excellent with consistent staff support and participation in restorative nursing program. The facility was unable to provide any documentation of a restorative nursing program for Resident 7's decline in ambulation. There was no evidence of the restorative nursing ambulation program referenced by physical therapy Interview with the Nursing Home Administrator and Director of Nursing on September 26, 2025, at 1:39 PM confirmed the delay in Resident 7 receiving therapy services and no evidence of a restorative nursing ambulation program for Resident 7. 28 Pa. Code 211.12 (d)(1)(2)(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>(continued on next page)</p>

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Observation of Resident 6's bedroom on September 23, 2025, at 12:35 PM, September 24, 2025, at 2:55 PM, and September 25, 2025, at 11:40 AM revealed the resident was lying in bed and the bed was not in a low position. Interview with Employee 13, licensed practical nurse, on September 25, 2025, at 11:40 AM revealed that the resident bed had been elevated for resident care and was not returned to a low position. Clinical record review for Resident 6 revealed a physician's order active since May 5, 2025, for a low bed. The care plan initiated on June 21, 2025, lists a low bed as an intervention related to fall prevention. The facility failed to implement the planned accident interventions for Resident 6 indicated by the physician's order and care plan. The above information was reviewed with the Nursing Home Administer and the Director of Nursing on September 25, 2025, at 2:45 PM. The State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, defines elopement as a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. Clinical record review for Resident 4 revealed that the facility admitted her on July 17, 2025, to the first-floor [NAME] nursing unit. A physician's order dated July 17, 2025, instructed staff to ensure that a wander guard (wander guard is a wireless system that protects memory care residents from elopement with bracelets and door controllers) device was placed and blinking every shift. A baseline plan of care dated July 17, 2025, indicated that the facility identified Resident 4 had a risk for wandering and elopement. An elopement evaluation dated July 17, 2025, at 2:10 PM revealed that Resident 4 had a history of elopement while at home, and her wandering behavior had both a pattern/was goal-directed and that she wandered aimlessly (was non-goal-directed). Observation of the [NAME] nursing unit on September 23, 2025, at 10:25 AM revealed that entering and exiting the unit was possible by either waving a hand over a wall sensor or by using a push-bar on the door. Clinical record review for Resident 4 revealed nursing documentation dated July 17, 2025, at 3:09 PM that Resident 4 was ambulating on the unit with her walker stating, I'm not staying tonight; that she was exit-seeking, and that redirection was effective for short intervals. Nursing documentation dated July 18, 2025, at 12:52 PM revealed that Resident 4 was wandering and attempting to elope. Nursing documentation dated July 20, 2025, at 3:11 PM revealed that Resident 4 attempted to exit the nursing unit. Review of a fall incident investigation dated July 26, 2025, at 4:15 AM revealed that staff identified, Resident is new to SNF (skilled nursing facility). She is independent in the facility and wanders all around but is severely cognitively impaired Nursing documentation dated August 3, 2025, at 3:19 PM revealed that a licensed practical nurse notified the writer that Resident 4 left the facility and could not be redirected to return to the facility. Interview with the Nursing Home Administrator and the Director of Nursing on September 24, 2025, at 2:00 PM revealed that the facility interdisciplinary team did not have an incident investigation or report to the Department details related to the events of August 3, 2025, for Resident 4 because staff did not recognize the incident as elopement given staff were with Resident 4 when she left the building. The interview indicated that the facility did not recognize the area outside the [NAME] nursing unit as having potential accident hazards (an unsafe area). Resident 4's wander guard alerted staff of her attempt to exit when she reached the facility's front doors. Nursing documentation dated August 4, 2025, at 1:25 PM revealed that the facility moved Resident 4 to a second-floor nursing unit room due to safety concerns. Observation of the lobby area outside the [NAME] nursing unit on September 26, 2025, at 9:52 AM revealed no impediments that would prevent a confused and wandering resident from leaving the unit, making a left hand turn into a long hallway past the main kitchen area, to the unlocked and unmonitored doors of the personal care facility attached to the nursing care facility, and exiting an unlocked and</p>		

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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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to assess and implement individualized interventions to promote bowel continence for one of two residents reviewed for incontinence (Resident 7). Findings Clinical record review revealed a quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) assessment dated [DATE], that staff assessed Resident 7 as continent of his bowel. Further review of Resident 7's clinical record revealed an MDS assessment completed on April 3, 2025, noting staff assessed Resident 7 as now occasionally incontinent of bowel, and a significant change MDS completed on June 30, 2025, revealed staff assessed Resident 7's bowel continence declining to now being frequently incontinent of bowel. Interview with the Director of Nursing and Nursing Home Administrator on September 26, 2025, at 1:37 PM revealed the facility did not have a policy addressing bowel continence. Review of Resident 7's plan of care for toilet use initiated February 6, 2023, revealed Resident 7 requires assistance of one staff for his toileting needs. Further review of Resident 7's clinical record revealed a bowel and bladder three-day observation record for April 17, 18, and 19, 2025 and again on July 4, 5, and 6, 2025. There was no documented evidence that staff reviewed Resident 7's observation records to implement individualized interventions to promote bowel continence. Review of Resident 7's task documentation revealed on April 22, 2025, staff were to offer to assist Resident 7 to the bathroom daily at midnight, 3:00 AM, after breakfast, and at 5:00 PM. Review of task documentation dated July 17, 2025, revealed staff were now to only offer to assist Resident 7 to the bathroom at midnight and 3:00 AM. The facility failed to assess and implement individualized interventions to promote Resident 7's bowel continence. The findings were reviewed during a meeting with the Nursing Home Administrator and Director of Nursing on September 26, 2025, at 1:30 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with enteral tube feeding, who utilize a lift, catheter care, medication administration, transmission based precautions, intravenous therapy, and dressing changes for four of four employees reviewed for competencies (Employees 2, 3, 4, and 5). Findings include: A review of the facility documentation revealed that the facility had a total of 87 residents receiving medications, 25 residents that utilize lifts, five residents with indwelling urinary catheters (insertion of a tube into the bladder to remove urine), 12 residents with dressing changes, 23 residents with enhanced barrier precautions, one resident with intravenous therapy (technique that delivers fluids, medications, and nutrients directly into a patient's bloodstream through a vein), and one resident with enteral tube feedings (device that allows liquid food to enter your stomach or intestine through a tube). A request for nursing staff competencies for the above-mentioned areas revealed the facility was unable to provide any competencies for Employees 2 and 3 (licensed practical nurses) and Employees 4 and 5 (registered nurses). The findings were reviewed with the Nursing Home Administrator and Director of Nursing on September 25, 2025, at 1:07 PM. They confirmed the facility could provide no documentation that ensured Employees 2, 3, 4, and 5 had specific competencies and skill sets to care for the residents needs listed above. 483.25(c)(1)-(3) Increase/prevent Decrease in ROM/mobility Previously cited deficiency 8/30/2024 28 Pa. Code 201.20 (a) Staff Development</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure medication security for two of 18 residents reviewed (Residents 4 and 62). Findings include: The facility policy entitled, Discarding and Destroying Medications, last reviewed without changes on April 7, 2025, revealed that non-controlled and Schedule V (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications. Should the facility contract with a DEA-registered collector, controlled substances may be disposed of in an authorized collection receptacle located at the facility. Both controlled and non-controlled substances may be disposed of in the collection receptacle. For unused, non-hazardous controlled substances that are not disposed of by an authorized collector, the steps include mixing the medication (either liquid or solid) with an undesirable substance (to include sand, coffee grounds, kitty litter, or other absorbent materials). Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage. Dispose with solid waste (i.e. regular trash) in the presence of two witnesses. Ointments, creams, and other like substances may be discarded into the trash receptacle in the medication room. Clinical record review for Resident 4 revealed nursing documentation created August 21, 2025, at 9:51 AM for an effective date of August 20, 2025, at 9:45 AM that staff found Resident 4 in her room taking two pills. The documentation indicated that the nurse did not know where the medication came from or how many pills Resident 4 took before discovered by staff. Resident 4 (who had the diagnosis of dementia and exhibited cognitive deficits) stated that she took a couple other pills. The writer indicated that they did not administer morning medications and did not know what medications Resident 4 had. Incident note documentation dated August 22, 2025, at 12:32 PM revealed that the writer was notified on August 21, 2025, at 4:00 PM that staff observed Resident 4 with unknown medications in her possession and an incident report was completed. It was reported that this incident occurred on August 20, 2025, at 12:00 PM and no documentation was completed. It was unclear if she ingested any of the medications or not. The medications were removed and disposed of by the unit licensed practical nurse. Review of the facility's incident investigation dated August 20, 2025, at 12:00 PM revealed notes dated August 22, 2025, that the interdisciplinary team discussed the incident and Whole house education started for all nursing staff to never leave medications unattended on the medication cart or in resident rooms. Interview with the Director of Nursing on September 25, 2025, at 11:03 AM revealed that the facility did not have evidence of completion of education with all house nursing staff regarding medication security. Observation of Resident 62's room on September 24, 2025, at 9:17 AM revealed a privately paid caregiver (Employee 7) at his bedside. Employee 7 stated that she observed a medication tablet on Resident 62's floor when she entered his room this morning, that she reported it to the nurse on the unit, and that the nurse on the unit disposed of it in the garbage receptacle in Resident 62's room. Observation of the area around Resident 62's room trash receptacle revealed an oblong, ruddy-colored, tablet on the floor near the garbage receptacle. Observation and interview with Employee 8 (licensed practical nurse) on September 24, 2025, at 9:46 AM confirmed that Employee 7 pointed out the tablet to her that morning and she disposed of it in the garbage in Resident 62's room. When compared to house stock Omeprazole (medication used to decrease stomach acid), it was determined that the tablet in Resident 62's room was delayed-release Omeprazole 20 milligrams (mg). Clinical record review for Resident 62 revealed no physician orders for staff to administer Omeprazole to Resident 62. The surveyor reviewed the above concerns regarding medication security with the Nursing Home Administrator on September 25, 2025, at 10:15 AM. 28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and staff interview, it was determined that the facility failed to store food items in a safe and sanitary manner and maintain the environment in a safe and sanitary condition in the facility's main kitchen. Findings included: Observation of the facility's main kitchen with Employee 6, dietary manager, on September 23, 2025, at 9:03 AM revealed the following: The splash guard on the wall adjacent to the dishwasher had a black, greasy build-up on it and the surrounding hoses. The dishwasher room had a rack holding various items. The bottom shelf of the rack held various cooking pans that were identified as clean by Employee 6. The cooking pans and the splash guard under them contained a significant number of debris, crumbs, and dirt and were not protected from the ambient environment. The floor of the walk-in cooler had debris, which included food debris and dirt, especially under the food storage racks. There were two red-colored puddles of fluid on the floor of the cooler. The bottom shelf of a rack held a box of chicken breasts with rib meat and had a puddle of unidentified fluid on it next to the food item. The walk-in freezer had a package of ravioli with a use by date of September 2, 2025, and waffles with a use by date of May 11, 2025. Two black-colored, wheeled carts had an extensive build-up of grease and dirt. A stainless-steel table that had a coffee machine on top of it had debris build-up in the shelving area underneath. There were brown colored dried stains on the wall next to the coffee machine. A storage area had a shelving rack that held various cooking pans on the bottom shelf. There was an extensive build-up of cobwebs between the cooking pans and the wall. There was no splash guard protecting the items on the bottom rack from mop splash. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 24, 2025, at 2:00 PM. 28 Pa. Code 201.14(a) Responsibility of licensee</p>

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<p>F 0814</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation and staff interview, it was determined that the facility failed to properly contain and dispose of garbage at two of two observed facility dumpsters. Findings include: Observation of the main dumpsters outside of the kitchen dock entrance with Employee 6, dietary manager, on September 23, 2025, at 9:30 AM revealed the following: There were discarded medical gloves, debris, paper products, and a washcloth around two of the dumpsters. The top of one dumpster had a discarded plastic apple sauce container and unidentified debris between the lids. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 24, 2025, at 2:00 PM. 28 Pa. Code 201.14(a) Responsibility of licensee</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, staff interview, and review of facility documentation, it was determined that the facility failed to maintain an effective pest control program so that the facility is free from pests in the main kitchen area. Findings include: Observation of the facility's main kitchen on September 23, 2025, at 9:03 AM with Employee 6, dietary manager, revealed the following: The wall of the dishwashing area contained multiple black colored, winged, smaller insects. At least four were observed on the wall. A concurrent interview with Employee 6 revealed that these insects have been present for at least one and a half weeks and the facility placed traps to help remedy the insects. Further observation of the main part of the kitchen revealed multiple additional black colored, winged insects located on the ceiling next to a vent. The ceiling area adjacent to the vent had unidentified splash stains. A large spider was observed walking across the floor in the area that held the heated meal delivery carts and proceeded to enter a floor drain. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on September 24, 2025, at 2:00 PM. Pest control documentation dated May 31, 2025, June 30, 2025, and July 9, 2025, revealed that pest management provided services to the facility for general pest control - maintenance, exterior insect perimeter treatment - maintenance, and bioremediation. This pest control documentation revealed no evidence that the pest control service was notified of the winged insects in the facility's main kitchen. Pest control documentation dated September 24, 2025, at 5:38 PM revealed a pest management visit that noted some phorid flies and fruit flies around the drains due to grease and food build up. Pest management treated around the drains and drain lines to help resolve the current issue and prevent future problems from occurring. The facility failed to maintain an effective pest control program so that the facility's main kitchen is free of pests. 28 Pa Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(3) Management</p>		