

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

April 29, 2025

[REDACTED]
LUTHERAN SENIOR SERVICES EAST
[REDACTED]

RE: BUFFALO VALLEY PERSONAL CARE
305 E TRESSLER BLVD
LEWISBURG, PA, 17837
LICENSE/COC#: 20212

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/14/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: BUFFALO VALLEY PERSONAL CARE License #: 20212 License Expiration: 08/15/2025
Address: 305 E TRESSLER BLVD, LEWISBURG, PA 17837
County: UNION Region: NORTHEAST

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: LUTHERAN SENIOR SERVICES EAST
Address: [Redacted]
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 40 Waking Staff: 30

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Incident Exit Conference Date: 03/14/2025

Inspection Dates and Department Representative

03/14/2025 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information License Capacity: 50 Residents Served: 38
Secured Dementia Care Unit In Home: No Area: Capacity: Residents Served:
Hospice Current Residents: 0
Number of Residents Who:
Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 38
Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 2 Have Physical Disability: 0

Inspections / Reviews

03/14/2025 Partial
Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 04/14/2025

04/18/2025 - POC Submission
Submitted By: [Redacted] Date Submitted: 04/29/2025
Reviewer: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 04/25/2025

Inspections / Reviews (*continued*)

04/29/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/29/2025

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document
Submission*

04/29/2025 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/29/2025

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

42c - Treatment of Residents

1. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

According to staff interviews, Resident [redacted] frequently marks off the current date on the calendar in the lobby. Staff person B witnessed Staff person A violently slam down their personal cell phone on the nurses' station desk and state in a low voice, "I'm going to beat your [redacted]" when Staff person A noticed Resident [redacted] was marking off future days on the calendar in the lobby on [redacted] between 3:30 p.m. and 4:00 p.m. Staff person C stated it was Staff person A's tone that made Staff person C turn around from the task they were completing. Staff person C saying the tone was, "sarcastic, or like Staff person A was repeating themselves to a toddler." Staff person D from dietary stated they entered the lobby area as Staff person A "rip the calendar off the wall after Resident [redacted] marked off future dates."

Plan of Correction

Accept [redacted] 04/29/2025)

1. All residents living in a Personal Care Home deserve to be treated with dignity and respect. It is one of the many resident rights they have.
2. Staff person A disrespected a resident by [redacted] tone, words and actions during an interaction.
3. Staff person A was suspended after PCHA was made aware of the incident by staff person B. PCHA started internal investigation, after reporting abuse to DHS and AAA. PCHA met with ED, HR and CSM. It was decided to terminate staff person A based on this incident and previous disciplines [redacted] had received. [redacted] was terminated 3/17/25.
4. Staff were re-educated on 3/19/25 about all the rights residents have, as well as a review of the abuse policy. PCHA emphasized that any staff member suspecting abuse or witnessing abuse, is mandated to report it IMMEDIATELY. Failure to do so may result in written discipline and/or termination. That failure to do so may jeopardize a resident in their care.
5. PCHA/CSM will monitor staff interactions and meet with 10% of residents quarterly to ensure their rights have not been violated and they are free from abuse. Findings will be reported to QAPI quarterly for review and recommendation.

Licensee's Proposed Overall Completion Date: 04/21/2025

Implemented [redacted] - 04/29/2025)