

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

October 20, 2026

[REDACTED], ADMINISTRATOR
LUTHERAN SENIOR SERVICES EAST
305 E TRESSLER BLVD
LEWISBURG, PA, 17837

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

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/18/2026 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: 08/15/2027

Address: 305 E TRESSLER BLVD, LEWISBURG, PA 17837

County: UNION

Region: NORTHEAST

Administrator

Name:

Phone:

Email:

Legal Entity

Name: LUTHERAN SENIOR SERVICES EAST

Address: 305 E TRESSLER BLVD, LEWISBURG, PA, 17837

Phone:

Email:

Certificate(s) of Occupancy

Type: C-2 LP

Date: 11/07/1988

Issued By: DLI

Staffing Hours

Resident Support Staff: 0

Total Daily Staff: 44

Waking Staff: 33

Inspection Information

Type: Full

Notice: Unannounced

BHA Docket #:

Reason: Renewal

Exit Conference Date: 08/18/2026

Inspection Dates and Department Representative

08/18/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 50

Residents Served: 37

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: 37

Diagnosed with Mental Illness: 2

Diagnosed with Intellectual Disability: 0

Have Mobility Need: 7

Have Physical Disability: 0

Inspections / Reviews

08/18/2026 Full

Lead Inspector:

Follow-Up Type: POC Submission

Follow-Up Date: 09/19/2026

09/30/2026 - POC Submission

Submitted By:

Date Submitted: 10/14/2026

Reviewer:

Follow-Up Type: Document Submission Follow-Up Date: 10/14/2026

Inspections / Reviews *(continued)*

10/20/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/14/2026

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 6/2/26 the Department received an incident report that Resident #1's Breztri inhaler was not available for administration of the 2nd dose on 5/27/26 and for administration of both doses on 5/28/26. The home did not report the incident timely.

Plan of Correction

Accept () - 09/30/2026)

One reportable was submitted 6 days late. The requirement is that they are to be submitted within 24 hours.

Staff responsible were re-educated on this regulation on 9/10/26 at the monthly staff meeting. Re-education was given on completing a reportable within 24 hours, how to properly complete a DHS reportable online, to email it to the State and EverTrue reportable hotline. A copy of the RCG Appendix B list reportable incidents will be available for them to reference.

PCHA and CSM will read the 24 hour report Mon-Fri to see if any events warranted a reportable x 4 weeks and then monthly x 2. Weekend staff will be required to call CSM or PCHA if any events occur over the weekend for guidance and to ensure timely reporting of the reportable events.

Audit findings will be reported to QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026

Implemented () - 10/20/2026)

17 - Record Confidentiality

2. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

At approximately 9:00 a.m. the computer on the medication cart was unlocked, unattended and accessible, the information on the computer was confidential information of the residents.

Repeated Violation: 7/12/25

Plan of Correction

Accept () - 09/30/2026)

A nurse had the medication cart facing away from the resident doorway and had secured the screen as () has been trained to do. The DHS surveyor was able to hit "back" and the screen opened up exposing a resident's private information.

Surveyor educated LPN on the spot that staff need to completely log out before walking away from the laptop.

Staff were re-educated on regulation 17 at the staff meeting on 9/10/26 and the obligation we all have to keep a resident's information confidential. Staff will be educated to log out when finished with the laptop.

CSM and PCHA will conduct random audits on all 3 shifts weekly x 4 and monthly x 2, to ensure staff are logging

17 - Record Confidentiality (continued)

*off prior to walking away from laptop containing resident information.
Audit findings will be reported to QAPI for review and recommendation.*

Licensee's Proposed Overall Completion Date: 10/14/2026

Implemented () - 10/20/2026)

42s - Privacy**3. Requirements**

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

The facility utilizes cameras with recording capabilities by the front entrance and emergency exits of the building. The residents of the facility have not been informed that these areas are subject to video recording and there are no signs indicating that those images are being recorded.

Plan of Correction

Accept () - 09/30/2026)

Sign was ordered and installed to the right of the main door notifying all who enter, that a camera is on the premises. PCHA will have a document added to the admission packet, notifying the resident and resident representative of the cameras. Resident and/or resident representative will be asked to sign it for acknowledgement. It will be kept with the admission paperwork.

A letter will go out to the existing residents and POAs to ensure they are aware of the cameras.

PCHA, ED and Maintenance supervisor were educated on this regulation on 8/18/26 and the need to notify anyone entering our building, that there are cameras onsite and they are being recorded.

All entrance/exit doors were audited to ensure signs were present.

Audit findings will be reported to QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026

Implemented () - 10/20/2026)

89b - Hot Water Temperature

4. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

At approximately 1:51 p.m., the hot water temperature in the bathroom of room 303 measured 124 degrees Fahrenheit.

Plan of Correction

Accept () - 09/30/2026)

Staff were notified immediately and asked to be sure they did not turn the faucet all the way to the hot. Also informed them to temp the water each time they perform care on a resident. An announcement was made at lunch time to all the residents re: being cautious with the hot water spigot. Maintenance was notified. They called Quality Air who arrived on 9/2 to replace the mixing valve. The temperature was 114 degrees after the new mixing valve was installed.

Maintenance will check water temperatures in different locations throughout PC, once weekly, and ongoing. PCHA or CSM will review them for compliance weekly x 4 and monthly x 2.

Staff were re-educated in the 9/10 staff meeting, to always feel the water before exposing a resident and if it feels too warm, temp it. Thermometers are available in the nursing station area.

Audit findings will be reported to QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026

Implemented () - 10/20/2026)

132g - Fire Drills Days/Times**5. Requirements**

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds sleeping hours fire drills at the beginning or end of 3rd shift as evidenced by the following drills: 11/1/25 at 6:03 a.m. and 4/29/26 at 11:46 p.m.

Plan of Correction

Accept () - 09/30/2026)

Our contracted fire drill company has been notified of the violation and will perform future drills closer to the recommended time of 2:00 a.m. and 4:00 a.m.

PCHA will ask the maintenance supervisor who has knowledge of the drills, to ensure they are being planned at the above mentioned times.

PCHA/CSM will audit fire drill log to ensure no patterns are detected, monthly x 4 and quarterly x 2.

Audit findings will be reported to Qapi for review and recommendation.

132h All residents are required to evacuate during a fire drill unless they are on hospice and have an order that

132g - Fire Drills Days/Times (continued)

they are actively dying.

A resident was on hospice but not actively dying. ■■■ had an extreme condition of anxiety and began screaming when staff attempted to assist ■■■ to evacuate.

Resident was educated, as well as ■■■ POA, on the house rules and the reason why all residents must participate in fire drills. ■■■ was present at one of the drills and was able to help evacuate resident. Resident has since passed.

Staff will be re-educated on the purpose of fire drills and the need to ensure all residents are evacuated from their rooms. Residents will also be educated at town meetings about the importance of evacuating all residents during a drill unless they are on hospice and actively dying.

PCHA and CSM will review monthly fire drills monthly x 6 months to note if any resident refused to evacuate. If they did, they will educate that resident

Audit findings will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026

Implemented (■■■ - 10/20/2026)

132h - Designated Meeting Place**6. Requirements**

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill conducted on 10/17/25 at 6:48 p.m., 11/1/25 at 6:03 a.m., and on 12/14/25 at 1:00 p.m. Resident #2 refused to evacuate.

Plan of Correction

Accept (■■■ - 09/30/2026)

A resident was on hospice but not actively dying. ■■■ had an extreme condition of anxiety and began yelling when staff attempted to assist ■■■ to evacuate.

The resident was educated, as well as ■■■ POA, on the house rules and the reason why all residents must participate in fire drills. ■■■ was present at one of the drills and was able to convince the resident to evacuate. The resident has since passed.

Staff were re-educated on the purpose of fire drills and the need to ensure all residents are evacuated from their rooms. Residents will also be educated at the town meeting on September 3, 2026 about the importance of evacuating all residents during a drill unless they are on hospice and actively dying.

PCHA and CSM will review monthly fire drills monthly x 6 months to note if any resident refused to evacuate. If they did, they will educate that resident.

Audit findings will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026

Implemented (■■■ - 10/20/2026)

141b1 - Annual Medical Evaluation**7. Requirements**

141b1 - Annual Medical Evaluation (continued)

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #3's medical evaluation dated [REDACTED] does not indicate that the resident's needs can be met safely in a personal care home.

Plan of Correction**Accept [REDACTED] - 09/30/2026)**

CSM will call the office to receive verbal permission to check the box and record the initials of the physician or physician's assistant who approved the correction.

Staff responsible for ensuring completion of DMEs were re-educated on 9/10 to review DME's upon receipt from the physician's office, to ensure all areas have been addressed. If they have not, a call will be placed to the office to receive a verbal solution and will log the initials of the approver.

CSM and PCHA will audit 10% of DME's weekly for 4 weeks.

Audit findings will be reviewed at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026**Implemented [REDACTED] - 10/20/2026)****183e - Storing Medications****8. Requirements**

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #4 has an order for Novolog Injection Pen Solution 100 unit. The pen was opened on 7/20/26. The manufacturer label indicates to discard after 28 days. The pen should have been discarded on 8/17/26.

Resident #5 has an order for Novolog Injection Pen Solution 100 unit. The pen was opened on 7/20/26. The manufacturer label indicates to discard after 28 days. The pen should have been discarded on 8/17/26.

Plan of Correction**Accept [REDACTED] - 09/30/2026)**

Staff immediately discarded the pens. Resident had refills in the cupboard.

CMT's were re-educated on 9/10 at the staff meeting on the medication guidelines provided by Omnicare to ensure meds are not being kept and used past the suggested timeframe. Guidelines are posted in the nursing office.

CSM and PCHA will audit the cart 1 x week x 4 weeks and then once monthly for 2 months to ensure all insulin pens are in compliance and not expired.

Audit findings will be reported to QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026

183e - Storing Medications (*continued*)*Implemented () - 10/20/2026)*

190c - Record of Training

9. Requirements

2600.

190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

Staff person C's annual practicum dated 10/27/25 does not have their original qualification date.

Plan of Correction*Accept () - 09/30/2026)*

Med tech was notified and signed the review. Med trainer was also notified of the oversight.

Med trainer received re-education on the process of conducting a med review and to complete all items at the time of the review. CMT's were re-educated at the staff meeting on 9/10, that they must sign each review at the time of the review.

CSM and PCHA will audit the med training book monthly x 6 months to ensure all elements are complete.

Audit findings will be reported to QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026

Implemented () - 10/20/2026)

225c - Additional Assessment

10. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #3's most recent assessment was completed () the resident's previous assessment was completed on ()

Resident #6's assessment dated () does not include that the resident utilizes a bed enabler to assist with transferring out of bed.

Plan of Correction*Accept () - 09/30/2026)*

Rasp was corrected day of the survey, by the CSM.

CSM will review all RASPS of those who have enablers to ensure they are noted on the rasp.

Staff responsible for completing RASPS were re-educated on the importance of capturing mobility devices on the RASP to ensure they can be audited by maintenance for safety and nursing staff to ensure they are used by the

225c Additional Assessment (continued)

resident for mobility.

PCHA/CSM will audit the RASP when a new enabler bar is added to the bed, to ensure it is noted on the RASP weekly x 4 monthly x 2.

Audit findings will be reported to QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: 10/14/2026

Implemented (█ - 10/20/2026)