pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **FAITH FRIENDSHIP MINISTRIES INC**
LEGAL ENTITY

To operate **FAITH FRIENDSHIP VILLA OF MOUNTVILLE**
NAME OF FACILITY OR AGENCY

Located at **128 WEST MAIN STREET, MOUNTVILLE, PA 17554**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **74**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **October 17, 2023** until **April 17, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **322021**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: OCTOBER 17, 2023

Faith Friendship Ministries Inc
[redacted], 128 W Main Street
Mountville, Pennsylvania 17554

RE: Faith Friendship Villa of Mountville
128 West Main Street
Mountville, Pennsylvania 17554
License #: 322021

Dear Faith Friendship Ministries Inc:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on February 15-16, 2023 and February 22-23, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (322020) dated February 11, 2023 to February 11, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code §20.71(a)(2);(4);(5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600:	Class of Violation	Census at Inspection	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.15(a)	II	69	$5	$345	5 calendar days from mailing date of this letter
2600.15(d)	II	69	$5	$345	5 calendar days from mailing date of this letter
2600.42(b)	II	69	$5	$345	5 calendar days from mailing date of this letter
2600.57(b)	II	69	$5	$345	5 calendar days from mailing date of this letter
2600.57(d)	II	69	$5	$345	5 calendar days from mailing date of this letter
2600.88(a)	III	69	$3	$207	15 calendar days from mailing date of this letter
2600.132(d)	II	55	$5	$345	5 calendar days from mailing date of this letter
2600.141(a)	III	55	$3	$207	15 calendar days from mailing date of this letter
2600.141(b)1	III	55	$3	$207	15 calendar days from mailing date of this letter

2600.187(a)	III	55	$3	$207	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

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Sincerely,



Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *FAITH FRIENDSHIP VILLA OF MOUNTVILLE* **License #:** *32202* **License Expiration:** *02/11/2024*

Address: *128 WEST MAIN STREET, MOUNTVILLE, PA 17554*

County: *LANCASTER* **Region:** *CENTRAL*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *FAITH FRIENDSHIP MINISTRIES INC*

Address: [redacted] *128 W MAIN STREET, MOUNTVILLE, PA, 17554*

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *01/22/1986* **Issued By:** *Labor and Industry*

Type: *C-2 LP* **Date:** *09/10/2015* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *79* **Waking Staff:** *59*

Inspection Information

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *02/23/2023*

Inspection Dates and Department Representative

02/15/2023 - On-Site: [redacted]
02/16/2023 - On-Site:
02/22/2023 - On-Site:
02/23/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served:** *69*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *54* **Are 60 Years of Age or Older:** *38*

Diagnosed with Mental Illness: *52* **Diagnosed with Intellectual Disability:** *15*

Have Mobility Need: *10* **Have Physical Disability:** *1*

Inspections / Reviews

02/15/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/19/2023*

04/07/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/02/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/14/2023*

04/24/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/02/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/01/2023*

10/12/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/02/2023*

[redacted] **Follow-Up Type**: *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Resident 4's file contains a typed document detailing an incident that occurred on 01/23/2023. The incident describes that Resident 4 engaged in unwanted sexual behaviors/advances towards Resident 6. In the document, it is noted that if this inappropriate behavior continued, a DHS/ police and APS report would be filed. Interviews with staff indicated that the incident was not reported to the Department or AAA.

Repeated Violation - 8/22/22, et al

Plan of Correction ***Accept [redacted] - 04/24/2023)***

1) Staff have been informed and are required to immediately report to their supervisors, any suspicions or reports of abuse by residents or employees. Dates Employees have been informed are: At time of hire, 9/1/22, 9/2/22, 11/18/22, 2/20/23, 2/21/23, 4/13/23, ongoing.

2) Resident have been told and are encouraged to share any arguments, complaints, or inappropriate or violent behavior witnessed by residents or employees with any member of FFM Administration that is on duty. The dates that residents have been informed are: Beginning 11/15/22- FFM Administration has formally shared this message with residents on a monthly basis. Most recent 2/20/23-2/21/23 which resulted in one reportable incident. Another announcement was shared on 3/14/23 and 3/15/23. The next occurence will occur the last week in April.

3) On a monthly basis the Administrator and/or CEO will hold informal and random conversations with residents to determine the likelihood of reportable incidences that may have occurred but have not been reported. Started in January 2022, but became formal effective August 2022, and now formally includes the PCHA Administrator.

4) FFM will incorporate a customized Ministry Safe Abuse Prevention Program as assisted by APS experts. The implementation of a formal APS program will begin in May 2023, after new insurance policies become effective. Components of such program have are already being introduced and implemented.

5)The Administrator and/or CEO will review IR's on a monthly basis to identify residents and/or employees that may be at risk and need intervention. Start date 3/27/23 by Administrator.

6)The chart and regulations regarding reportable incidents from the RCG will be provided to and reviewed by the CEO/Administrator with every member of staff by the end of May 2023. This training will be co-presented by the Administrator and CEO.

7) The resident council will implement an anonymous way for residents to share complaint/suggestions with staff by placing locked suggestion boxes throughout the home. Residents will be trained on how to complete the forms or have someone help them. July 2023

FFM administration was made aware that the incident involving Resident 4 and Resident 6 was not reported. Upon discovery of this incident not being reported, FFV staff was instructed by BHSL staff to report this incident

15a - Resident Abuse Report (continued)

immediately to The Department as well as AAA. Report was submitted and fax to both DHS and AAA on 02/16/2023."

Thank you. [redacted]

Licensee's Proposed Overall Completion Date: *04/18/2023*

Not Implemented [redacted] ***- 10/12/2023)***

15d - Resident Abuse-Notification

2. Requirements

2600.
15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

Resident 4's file contains a typed document detailing an incident that occurred on 01/23/2023. The incident describes that Resident 4 engaged in unwanted sexual behaviors/advances towards Resident 6. In the document, it was noted that if this inappropriate behavior continued, a DHS/ police and APS report would be filed. Interviews with staff indicated that the incident was not reported to the Department or AAA. Staff also reported that no notification of suspected abuse was reported to the resident's designated person.

Repeated Violation - 8/22/22, et al

Plan of Correction ***Accept*** [redacted] ***- 04/24/2023)***

A former employee made a decision to not report this incident thinking [redacted] *was giving Resident 4 a second chance, but* [redacted] *was also using the incident as behavioral leverage.*

This was not the right or compliant course of action to take. The current PCHA and CEO/ED were not aware of this incident or the decision. That PCHA is no longer an employee of FFM. However, the current PCHA has 30 years of experience, and both is fully aware and is skillful in handling such matters.

The CEO/ED also prepares IR's when it involves any member of FFV management and conducts the required internal investigation. FFM will do everything in our power to prevent this from happening again.

1) Training is being scheduled for staff in partnership with Adult Protective Services, for the Act 13 portion and FFM will cover the 55.2600 (15 a,d and 16c) portion of the training.

2) The Administrator and CEO are meeting with staff to share the regulations as they pertain to RI's and asking them to sign a statement affirming, they are aware of the regulations surrounding reportable incidents starting March 27, 2023.

One on ones' and/or group sessions will be completed by the end of April 2023. The Administrator will periodically review the incident reporting to identify patterns and areas for improvement/training.

The all-staff training on Regulation 55.2600.15d started on March 27, 2023 and was provided on April 13, 2023

Resident 6's designated person was notified of the suspected abuse that occurred on [redacted] ***2023 by PCHA***

15d - Resident Abuse-Notification (continued)

Administrator/CMD on [redacted], 2023 via phone.

Thank you - [redacted]

Licensee's Proposed Overall Completion Date: *04/18/2023*

Not Implemented [redacted] ***- 10/12/2023)***

16c - Written Incident Report

3. 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 01/23/2023, Resident 4 made unwanted sexual gestures and kissed Resident 6. This incident was never reported to the Department and AAA.

Plan of Correction ***Accept*** [redacted] ***- 04/24/2023)***

A former employee (PCHA) made a decision to not report this incident thinking [redacted] *was giving Resident 4 a second chance but* [redacted] *was also using the incident as behavioral leverage. This was not the right or compliant course of action to take. Current PCHA and CEO/ED were not aware of this incident or the decision. That PCHA is no longer an employee of FFM. However, the current PCHA is fully aware and is skillful in handling such matters.*

The CEO/ED is also now involved in preparing IR's when it involves any member of management and conducts the required internal investigation. We will do everything in our power to prevent this from happening again. The following steps should help ensure compliance.

1) Training is being scheduled for staff in partnership with Adult Protective Services, for the Act 13 portion and FFM will cover the 55.2600 (15 a,d and 16c) portion of the training. Additional training has been provided on April 13, 2023 and will be provided for new staff during orientation. This training is for all staff and will also be provided in person two times per year. The next all-staff IR training session will be conducted in August 2023 and will be conducted by the Administrator or Executive Director.

2) The Administrator and CEO are meeting with staff to share the regulations as they pertain to RI's/Act13 and asking them to sign a statement affirming, they are aware of the regulations surrounding reportable incidents. These one on one's and/or group sessions will be completed by the end of April 2023. The Administrator will periodically review the incident reporting to identify patterns and areas for improvement/training. The auditing of IR's started on March 27, 2023.

FFM Administration became aware that the incident involving Resident 4 and Resident was not reported. FFV staff was instructed by BHSL to report this incident to BHSL staff and AAA. The reports were filed on February 16, 2023

Thank you [redacted]

16c - Written Incident Report *(continued)*

Licensee's Proposed Overall Completion Date: *04/17/2023*

Not Implemented [redacted] 10/12/2023)

18 - Compliance With Laws

4. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Standards Act requires that an approved carbon monoxide alarm be operable in close proximity of fossil fuel-burning devices. The basement boiler room has a CO detector labeled 1/21/19; however, the CO detector doesn't work when the test button is pressed.

Plan of Correction ***Accept [redacted] - 04/24/2023)***

FFM Administrator and CEO with the Property/maintenance manager have reviewed and revised the monthly checklist for preventative maintenance and fire safety policy on March 16, 2023. The CO2 Detector was fixed and the others added on 2/22/23. The revised checklist became effective 3/17/2023

FFM has revised it to include routine monthly CO2 detector testing by the Property Manager (PM). The Administrator will review the logs on a quarterly basis to ensure compliance starting May 2023. The PM manager has identified other areas where a CO2 detector should be installed and is completing that work. See attached checklist and images. - ***Thank you*** [redacted]

Licensee's Proposed Overall Completion Date: *04/19/2023*

Not Implemented [redacted] - 10/12/2023)

20b5 - No Commingling

5. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
5. Commingling of resident funds and home funds is prohibited.

Description of Violation

The personal care home is Rep Payee for numerous residents as well as holds money over $200 for residents. All resident money is stored in one account at a local financial institution. The account used for all the resident money is under the name, Faith Friendship Ministries Inc. This account is not interest bearing.

Plan of Correction ***Accept [redacted] - 04/24/2023)***

FFM has consulted with two other PCH's in South Central PA. We have reviewed their processes for preventing the commingling of resident funds and have decided to adopt them.

To clarify FFM currently does have a separate bank account named ***Resident Funds***

20b5 - No Commingling (continued)

. We do not use one account for all banking. To comply with the concerns of commingling, FFM will implement an internal envelope system to keep residents' spending money separate. For SSI recipients that we are rep payee for, their benefits go directly into the FFM Resident Funds Account. on a monthly basis FFM will withdraw their spending money and put it into their individual envelope to be held in our safe under lock and key, until each banking session and/or a resident requests his/her funds. Each withdraw will continue to be documented and attested to by the signing of each resident. This envelope system will officially begin April 1, 2023, when the new benefits are deposited. The Buisness Manager will add funds to each resident's envelope and the BM Assistant and Care Managers will distribute funds to the Residents during banking sessions.

Thank you - [redacted]

Licensee's Proposed Overall Completion Date: *04/17/2023*

Not Implemented [redacted] ***- 10/12/2023)***

42b - Abuse

6. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Staff Member D was hired by the home on [redacted] */2007. During* [redacted] *employment, Staff Member D sexually abused Residents 3, 7, 9, 10, 11, 12, 13, 14, 15, 16 and 17 at various times, both at the personal care home and at other locations in the community. At present, Staff member D has been charged by police with 329 counts of institutional sexual assault, 333 counts of indecent assault and 1 count of disorderly conduct.*

On 02/17/2023, Staff Member C and Resident 18 engaged in a verbal altercation in which the staff member directed profanities toward the resident. Resident 18 reported feeling disrespected, verbally abused, and scared of the staff member.

On 01/23/2023, Resident 4 made unwanted sexual gestures and kissed Resident 6. This incident was not reported to the Department and AAA.

On 01/09/2023, Resident 7 grabbed Residents 2 and 8 from behind on separate occasions and made unwanted sexual gestures.

Repeated Violation - 8/22/22, et al

Plan of Correction ***Accept (*** [redacted] ***- 04/24/2023)***

FFM's investigations, internal and external responses to this has been extensive and would not be appropriate to list in this POC due to length.

Any instances of abuse are difficult. This has been devastating. FFM does not condone resident abuse in any form. We also have clear and firm policies on expected conduct of our residents. So, to learn over 11 residents alleged being abused by any staff (member D), was and is unfathomable to us. As a faith-based non-profit we rely heavily on our faith in God, regulations and best practices to guide our decisions and help us achieve excellence in all we do.

We had no idea that for over 15 years we had a trusted, beloved, member of our team that would become an

42b - Abuse (continued)

accused, suspected and charged as a predator targeting the most vulnerable among us.

While we didn't do anything wrong - there must be more right we can do to protect our residents. This is our commitment.

The 1/9/23 incident was between 3 residents. The resident was relocated to a new facility due to the severity of the incidents and [redacted] psychological deterioration.

1/23/23 was between a resident and resident. The resident has been warned and any further instances will result in immediate discharge.

The incident on 2/17/23 reported on 2/22/23 to CEO was between a resident and employee witnessed by another employee and partially heard by other residents and staff. The employee gave a verbal statement to the CEO/ED. The employee was suspended, pending an investigation. After an internal investigation by FFM and discussions with DHS inspectors who were on site (who also heard the complaint during their open-door interviews) conducted their own investigation and believe that the incident was substantiated. Based on the findings of both investigations, this violation and past performance the employee was terminated.

The 11 residents cited above in this violation were revealed as victims of Staff Member D.

It was felt strongly by FFM's CEO through prayer that God wanted FFM to have individual conversations with every resident to discover if any additional stories of abuse existed. This was not required, suggested or recommended or advised by any agency, actually it was never discussed. However, FFM's CEO and PCHA in partnership w/our legal team felt strongly this was the right course of action to pursue. We believe that this should be a required best practice, put in place for any PCH/AL/NH/LTCC who has suspected sexual abuse. Prevention is the highest priority, but crisis management cannot always be prevented.

There were four questions agreed upon and the residents were all asked the same ones. All or almost all of the interviews with [redacted] residents were performed by two staff. The interviews with [redacted] residents were more informal, as it became clear that [redacted] residents were targeted and that no allegations of abuse by our [redacted] residents existed or were made by them. The original accusations made in August of 2022, were a shock to us all but set this entire discovery process in motion. We are grateful to that resident's [redacted] for hearing [redacted] adult child and to the resident for the courage to share [redacted] story with authorities.

The list of things that FFM is doing and will do in addition to current practices, to prevent ANY instances of abuse like this in the future is extensive. I'll name a few for the sake of this report.

1) Implement a high quality and proven Abuse Prevention System - in process
Formally started as of new organizational insurances policy start date 3/31/23
Informally November 2022.

2) Increase training for staff -in process happened and happening, starting February 2023- present. This will not be completed, but ongoing

42b - Abuse (continued)

3) Increase Residents awareness of their rights through speakers, trainings, in partnership with the YWCA Victim Advocacy program and the DA's Victim Witness Services - happening and will be a routine part of our communication with residents. Services started in December 2022. Expected to continue as part of the culture.

4) The ED will continue to have unscheduled conversations with residents to check in and see if they have any concerns. January 2022-present (some dates, November 22, January, February, March, and April 2023. The ED works at least one evening per week, but typically two. By working this 2nd shift, she is able to spend more time with residents.

5) Establish a Resident council, and develop and implement an anonymous complaint and suggestion box. Activities coordinator is planning a start of May/June 2023.

6) Empower and Encourage Residents: Continue to make announcements often, to all residents informing them of their rights and expectation of professional, appropriate and kind treatment. to also encourage residents to know they are not in danger of losing their housing if they are a whistleblower.

4) In addition to the pre-employment checks, FFM will annually perform Criminal checks on all staff.

5) Teach residents and staff how to spot grooming, abuse, etc. - Currently working with YWCA and DA's office.

Thank you - TTM/HY

Licensee's Proposed Overall Completion Date: *04/18/2023*

Not Implemented [redacted] 10/12/2023)

57b - 1 Hour/Day

8. Requirements

2600.
57.b. Direct care staff persons shall be available to provide at least 1 hour per day of personal care services to each mobile resident.

Description of Violation

On Sunday, 2/5/2023, there were 68 residents located in the home and only 66 hours of direct care were provided.

Repeated Violation - 3/8/22, et al

57b - 1 Hour/Day *(continued)*

Plan of Correction ***Accept [redacted] - 04/24/2023)***

Upon discovery that FFM were not meeting the required number of personal care hours for residents as specified in regulations 57b and 57d. Executive Director and acting PCHA immediately reviewed care hours on 2/23/23. On 2/24/23 Administration worked to ensure that there would be enough direct care hours to maintain compliance with regulations 57b and 57d. To ensure direct care hours will be maintained in the future, Direct Care Supervisor will review next week's direct care staff schedule prior to being posted. If in the event there will be a call off or unforeseen reason why direct care staff cannot come to fulfill needed hours, other direct care certified staff will be contacted to see if they will cover shifts. If no additional direct care staff can cover that shift, Administration plans to take action to reduce and eliminate gaps. It's no secret to PCH's, AL's and NH's across the Commonwealth and arguably the entire Health System Nationwide, that staffing shortages has been the biggest challenge since COVID hit in 2020. FFM already requires managers and administration to function in Direct Care roles, etc, but sometimes even that is not enough. Administration also plans to utilize the following steps to incentivize staff taking more shifts as well as foster employee retention.

1) Increased pay
2) Added extra shift incentives in addition to overtime which is already required.
3) Added bonuses for referrals
4) Trained additional staff that typically would not but are eligible to provide direct care, when needed. This created access to several qualified staff to step in when needed.
5) Allowing family members of current employees, where appropriate, to obtain employment with FFM for direct care
6) Added an LPN who performs Direct Care work.
7) Increase the number of staff on each shift (hired more employees)
8) Added a PRN Direct Care worker
10) Requiring Care Managers who typically function in a Case Management function to assist with PC when short staffed.
11)Allowing split shifts.
12) FFM will send an email (through ALPHA) to all LC/YB based SSI PCH's making known are need for PRN Direct Care. We would be willing to provide additional hours for their staff when they cannot.

Any technical assistance the state can provide to help us, where we haven't already taken action, we would be open and grateful to consider such support.
Thank you, [redacted]

Licensee's Proposed Overall Completion Date: *04/19/2023*

Not Implemented [redacted] - 10/12/2023)

57d - Waking Hours

9. Requirements

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On Sunday, 2/5/2023, there were 68 residents located in the home. The required number of waking hours of care was

57d - Waking Hours (continued)

51 hours, however only 50.5 hours were provided.

Repeated Violation - 3/8/22, et al

Plan of Correction ***Accept ([redacted] - 04/24/2023)***

Upon discovery that FFM were not meeting the required number of personal care hours for residents as specified in regulations 57b and 57d. Executive Director and acting PCHA immediately reviewed care hours on 2/23/23. On 2/24/23 Administration worked to ensure that there would be enough direct care hours to maintain compliance with regulations 57b and 57d. To ensure direct care hours will be maintained in the future, Direct Care Supervisor will review next week's direct care staff schedule prior to being posted. If in the event there will be a call off or unforeseen reason why direct care staff cannot come to fulfill needed hours, other direct care certified staff will be contacted to see if they will cover shifts. If no additional direct care staff can cover that shift, Administration plans to take action to reduce and eliminate gaps. It's no secret to PCH's, AL's and NH's across the Commonwealth and arguably the entire Health System Nationwide, that staffing shortages has been the biggest challenge since COVID hit in 2020. FFM already requires managers and administration to function in Direct Care roles, etc, but sometimes even that is not enough. Administration also plans to utilize the following steps to incentivize staff taking more shifts as well as foster employee retention.

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3) Added bonuses for referrals

4) Trained additional staff that typically would not but are eligible to provide direct care, when needed. This created access to several qualified staff to step in when needed.

5) Allowing family members of current employees, where appropriate, to obtain employment with FFM for direct care

6) Added an LPN who performs Direct Care work.

7) Increase the number of staff on each shift (hired more employees)

8) Added a PRN Direct Care worker

10) Requiring Care Managers who typically function in a Case Management function to assist with PC when short staffed.

11)Allowing split shifts.

12) FFM will send an email (through ALPHA) to all LC/YB based SSI PCH's making known are need for PRN Direct Care. We would be willing to provide additional hours for their staff when they cannot.

Thank you [redacted]

Licensee's Proposed Overall Completion Date: *04/19/2023*

Not Implemented [redacted] - 10/12/2023)

88a - Surfaces

11. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

The interior of the covered front porch ceiling is exposed due to a missing plank.

There is a hole in the ceiling of the fire escape stairwell that exposes shingles. The plywood boards surrounding the hole are covered in splotches of mold.

88a - Surfaces (continued)

Repeated Violation - 3/8/22, et al

Plan of Correction ***Directed [redacted] - 04/24/2023)***

After becoming aware of the violation, the FFM Property Maintenance Manager (PMM) called Elmer's Roofing to find out what happened that caused this. [redacted] learned that the previous PMM granted the contractor permission to work over the top of the previous shingle and board when installing a new roof. FFM Administration was not aware and did not approve. The PMM has patched this issue with the new board and plans to ask the roofing company to return, to redo this area. During our inspection, we also discovered several boards that need to be replaced. The PMM is working on a plan to replace it. We expect completion in Summer 2023.
Thank you [redacted]

Directed-
"FFM administration will also provide a memo and/or inform all staff by 05/01/2023 to immediately report any issues with the building observed or suspected to Administration and/or Maintenance. To further ensure compliance, this area of concern will also be added to the Maintenance walkthrough logs that will begin in May of 2023. Walkthrough sheets will be maintained and reviewed at scheduled quality assurance meetings quarterly starting May of 2023."

Directed Completion Date: *05/01/2023*

Not Implemented ([redacted] - 09/21/2023)

89b - Hot Water Temperature

12. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

Water temperatures in the following locations exceeded 120 degrees:
146.9 degrees Fahrenheit- Bedroom 207's bathroom.
125.8 degrees Fahrenheit- Bedroom 202's bathroom.
123.7 degrees Fahrenheit- 1st floor bathroom beside laundry room.

Plan of Correction ***Accept [redacted]/24/2023)***

The gauges on the hot water heaters were turned down by the Property Maintenance Manager (PMM) on March 13, 2023, when we learned of the temps being too high and not meeting code requirements. The temperature of these and other faucets are within acceptable range. If this happens again FFM will ask a plumber to install a mixing valve. Monthly tests of water temps have been added to the monthly maintenance schedules, and the revision to the checklist was made on March 16, 2023. The monthly inspections will be performed by the PMM and reviewed by PCHA/ED on a quarterly basis starting May 1, 2023.-See attached checklist Thank you [redacted]

Licensee's Proposed Overall Completion Date: *04/19/2023*

89b - Hot Water Temperature *(continued)*

Not Implemented [redacted] ***- 09/21/2023)***

103f - Refrigerator/Freezer Temps

13. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The temperature in the freezer pantry labeled "F" measured 10 degrees Fahrenheit.

The temperature in the freezer pantry labeled "D" measured 7.5 degrees Fahrenheit.

The refrigerator labeled "Turkey Hill" in the first-floor pantry did not have a thermometer in it.

The freezer section of the resident refrigerator in the main recreational room does not have a thermometer.

Plan of Correction ***Accept*** [redacted] ***04/24/2023)***

While reviewing this violation with the Kitchen Manager(KM), [redacted] *indicated that the freezers cited were opened by kitchen staff immediately preceding the temperature test. Several tests have been conducted by the Kitchen Manager since and passed, unless it was during a period of loading new food or taking out food, for more than 10 seconds. Minor adjustments to the settings have been made by the Kitchen Manager. Turkey Hill fridge and resident fridge/freezer also had a thermometer placed by the KM on 2/16/22. The KM checks are performed daily/ and the logs will be reviewed on a Monthly basis by the Administrator starting May 2023*

See attached - Thank you [redacted]

Licensee's Proposed Overall Completion Date: *04/17/2023*

Implemented [redacted] ***- 09/21/2023)***

105g - Lint Removal and Duct Cleaning

14. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

There was a layer of lint present in the lint trap of 2nd floor dryer, specifically the dryer on the left side. This dryer was not in use at time of observation and no clothing was present in the dryer.

105g - Lint Removal and Duct Cleaning *(continued)*

Plan of Correction ***Accept [redacted] - 04/24/2023)***

This duty has been added to the daily housekeeping checklist and signs are placed on the dryers as of February 24, 2023. Direct Care Staff (DCS) will be trained at the time of hire and twice per year, by the Direct Care Supervisor(s). The Administrator will provide monthly checks and this will be added to the Fire Safety Plan (FSP) - ***Thank you*** [redacted]

Licensee's Proposed Overall Completion Date: *04/17/2023*

Not Implemented [redacted] - 10/12/2023)

107c - Food/Water 3 Day Supply

15. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

There are 9 boxes of emergency water that hold 100 packets of water in each box. Each packet holds 4.225 ounces of water. In total, the facility has 29.71 gallons of water. For the 68 residents in the home, a minimum of 204 gallons are required.

Plan of Correction ***Accept [redacted] - 04/24/2023)***

FFM has ordered the needed food and water supplies to meet this codes requirement. On a monthly basis the kitchen manager will verify and ensure the stock is always adequate and rotated.
Water was ordered 3/16 & 3/23 and delivered 3/22 & 3/29.
Food was ordered 3/3 & 3/9 and delivered 3/9 & 3/14.
-TTM See attached receipts.

Licensee's Proposed Overall Completion Date: *04/18/2023*

Not Implemented [redacted] 10/12/2023)

131a - Fire Extinguisher

16. Requirements

2600.
131.a. There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

Description of Violation

The 3rd floor attic of the personal care home has no fire extinguisher.

Plan of Correction ***Accept [redacted] - 04/24/2023)***

A fire extinguisher was added to the 3rd (attic) level of the home on 3/13/23 by the Property Manager and verified on the same day by the PCHA.

131a - Fire Extinguisher (continued)

It was added to the account FFM has with a provider to inspect and recharge extinguishers annually.

The property manager will verify extinguishers are located where required and serviced regularly. This was added to the maintenance schedule on 3/16/23.

Thank you [redacted] (See attached picture)

Licensee's Proposed Overall Completion Date: *04/19/2023*

Not Implemented [redacted] - 10/12/2023)

132a - Monthly Fire Drill

17. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The personal care home did not conduct a fire drill in December 2022.

Plan of Correction ***Directed [redacted] - 04/24/2023)***

The Administrator discovered that the previous maintenance manager did not conduct a fire drill in the month of December, prior to leaving FFM, therefore FFM was not in compliance with 55.2600.132a or e.

The Administrator will verify that the monthly fire drills and acceptable evacuation times are met. The PMM will plan and conduct the fire drills according to regulations 55.2600.132a,d,e ***Thank you [redacted]***

Directed-
"In the event that the Administrator becomes aware of change in Maintenance management, Administrator will ensure that a fire drill is conducted that month before the Maintenance Manager leaves their position or shortly after new personnel take over that position."

Directed Completion Date: *05/01/2023*

Not Implemented [redacted] - 10/12/2023)

132d - Evacuation

18. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The personal care home does not have a recommended maximum safe evacuation time designated in writing by a fire safety expert within the past year. The drills conducted on the following dates were over 2 ½ minutes:
4/18/22 (3 min 12 sec),
6/29/22 (3 min 16 sec),
7/27/22 (2 min 44 sec),

132d - Evacuation (continued)

8/17/22 (2 min 42 sec),
9/21/22 (2 min 43 sec),
10/19/22 (3 min 4 sec),
11/29/22 (2 min 50 sec),
1/22/23 (2 min 57 sec)

Repeated Violation - 3/8/22, et al

Plan of Correction ***Accept (04/24/2023)***

Update:

FFM Administration has contacted Columbia FD, Clark Fire Protection and NFPA for options to contract with a FSE. Clark Fire Protection and a NICET 3 Certified FSE will be out the third week of May 2023 to inspect the building to determine evacuation times and review past recommendations, to establish a quote for their services. We plan to have a contracted/committed FSE by May 26, 2023. ***Thank you***

For many years, the leadership of FFM sought a Fire Safety expert to assist FFM with determining a reasonable emergency evacuation time for residents and staff. , (now retired) Lancaster Bureau of Fire. Fire Marshal for 17 of his 27 years on the department has performed this important evaluation for FFM. ran the fire safety department and program for Franklin and Marshall College for 11 years. has also provided many trainings at FFM and places like us, in a volunteer capacity. verbally verified that did establish a reasonable evacuation time of 3:30. This has been the time used for over a decade and has been referred to by the Bureau of Human Service Licensing OLTL several times. If the Bureau accepts this time as an established reasonable evacuation time, then FFM has been in compliance with expectations of evacuation but does not have a current letter restating this acceptable time. This is where non compliance has occurred.

That said we do not see in the regulations or supporting documents where " a fire safety expert" is defined, so we are asking you to help us find a new FSE for a current evacuation analysis.

We are in conversation with Mountville Fire Department to also determine if their chief may perform this too. So far, has referred us back to you the agency in charge of enforcing and providing technical assistance. Please advise and assist us in becoming compliant with the proper documentation.

Thank you

Licensee's Proposed Overall Completion Date: *05/26/2023*

Not Implemented (- 10/12/2023)

132e - Fire Drill Sleeping Hours

19. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

132e - Fire Drill Sleeping Hours *(continued)*

Description of Violation

The most recent fire drill conducted during sleeping hours was on 6/29/22.

Plan of Correction ***Directed [redacted] - 04/24/2023)***

The Administrator discovered that the previous maintenance manager did not conduct a fire drill during sleeping hours in the month of December, prior to [redacted] leaving FFM.

The Administrator will verify that all required monthly fire drills and acceptable evacuation times are met effective March 2023. A daytime drill will occur in March 2023, and A drill during sleeping hours will occur in the month of April 2023. [redacted] is scheduled to come in May to observe a Fire Drill. The PMM is responsible for all aspects of the drills.

Thanks [redacted]

Directed-
"In the event that the Administrator becomes aware of change in Maintenance management, Administrator will ensure that a fire drill is conducted that month before the Maintenance Manager leaves their position or shortly after new personnel take over that position. This will also include that every 6 months, one of these fire drills will be conducted between the hours of 11:00PM and 7:00AM."

Directed Completion Date: *05/01/2023*

Not Implemented [redacted] - 10/12/2023)

141a 1-10 Medical Evaluation Information

20. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 4 has a Documentation of Medical Evaluation (DME) signed by a physician from 07/22/2022. However, the DME does not include the date that the resident was evaluated or the date in which the form was completed. Furthermore, the DME is also missing the resident's pulse rate and temperature.

Resident 2's DME from 03/25/2022 is missing the resident's temperature.

Repeated Violation - 8/22/22, et al

141a 1-10 Medical Evaluation Information (continued)

Plan of Correction ***Accept [redacted] - 04/24/2023)***

"Starting June 1, 2023, Executive Director has implemented that 2 times per week, CMDs will have 2 hours per week to specifically review and audit Resident paperwork completion to include but not limited to DME's, MAR's Prescreens, Assessments and Support plans (RASP's). At this time CMD office hours will be limited to ensure CMD's have amble time to review. During these reviews, CMD's will immediately notify Admin, ED or LPN based upon need for document to be completed/ corrected. Starting (insert date) Administrator will also conduct random resident file reviews weekly to also identify any document errors. Reevaluation of this strategy's effectiveness will be conducted in 6 months by the ED/CEO and PCHA. Furthermore, internal audits are conducted yearly in the Fall to review all Resident Files for completion. This internal yearly audit is conducted by PCHA. LPN will review the DME's of every resident for completeness and correctness at admission as well as annually starting May 2023."
Residents 2& 4's DME have been corrected where appropriate.
Thank you - TTM/HY

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented [redacted] - 10/12/2023)

141b1 - Annual Medical Evaluation

21. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident 3's most recent DME is dated 09/09/2022; the prior DME is dated 08/04/2021, over 30 days late.

Repeated Violation - 8/22/22, et al

Plan of Correction ***Accept [redacted] - 04/24/2023)***

"Starting June 1, 2023, Executive Director has implemented that 2 times per week, CMDs will have 2 hours per week to specifically review and audit Resident paperwork completion to include but not limited to DME's, MAR's Prescreens, Assessments and Support plans (RASP's). At this time CMD office hours will be limited to ensure CMD's have amble time to review. During these reviews, CMD's will immediately notify Admin, ED or LPN based upon need for document to be completed/ corrected. Starting (insert date) Administrator will also conduct random resident file reviews weekly to also identify any document errors. Reevaluation of this strategy's effectiveness will be conducted in 6 months by the ED/CEO and PCHA. Furthermore, internal audits are conducted yearly in the Fall to review all Resident Files for completion. This internal yearly audit is conducted by PCHA. LPN will review the DME's of every resident for completeness and correctness at admission as well as annually starting May 2023."

Licensee's Proposed Overall Completion Date: *06/01/2023*

Not Implemented [redacted] - 10/12/2023)

185b - Medication Procedures

22. Requirements

2600.
185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

The home's medication procedures do not include a system to account for missing medications, specifically Ativan, a schedule IV controlled substance, prescribed for Resident 3. The home does not count these medications as they are included with the resident's regular medications in the weekly pillow packs.

Plan of Correction ***Directed [redacted] - 04/24/2023)***

Update: Completion of all six steps w/implementation of new process no later than July 28, 2023 Thank you [redacted]

In our 15+ year history of serving as a PCH we have never been cited on the b portion of our 2600.185 policies and procedures. However, FFM has a goal to update our MA system and to be excellent, so this is a unique opportunity to both come into compliance and improve our systems/processes/policies. We are grateful for any opportunity to serve our residents better.

We realize this change has many tendrils attached to it that must be addressed. one step at a time. The E-mar and EHR's, resource allocation, inventory control of schedule 2-4 controlled substances, etc. Therefore, FFM's management team including our newly added LPN, have decided to take the following steps to both become compliant and improve our overall MA system.

1) LPN and MA/TTT to conduct assessment and evaluation of current census and total controlled substances. Identify best way to temporarily comply while exploring options for long term approach to 185b. Report to PCHA/CEO

2) Ad-Hoc Team to have discussions w/other PCH's to determine how they comply and what tools they use. Also request copies of their policies and processed. ***Started March 2023 by PCHA***

3) Ad-Hoc team to evaluate tools (e-mar/EHR's) to determine best approach to comply long term.

4) PCHA/CEO identify and secure resources and LPN, MA/TTT implement

5) Train - e-mar/ehr by provider

6)Evaluate- ad-hoc team lead by PCHA.

Thank you [redacted]

185b - Medication Procedures (continued)

Directed-

"Completion of all six steps w/implementation of new process will be completed no later than June 1st, 2023."

Directed Completion Date: *06/01/2023*

Not Implemented [redacted] - 10/12/2023)

187a - Medication Record

23. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

The following medications did not have a diagnosis or purpose listed on each resident's medication administration record (MAR):

Resident 1:
Propranolol 10 MG tablets
Metformin HCL 500 MG tablets
Lithium Carbonate ER 300 MG tablets

Resident 2:
Oyst Cal + Vit D 500 / 200 MG

Resident 3:
Risperidone 2 MG tablets
Gabapentin 300 MG capsules

Repeated Violation - 3/8/322, et al

Plan of Correction ***Directed [redacted] - 04/24/2023)***

Update: *The LPN will start April 10, 2023 reviewing and verifying all MARS have a diagnosis for each RX. It is our hope any e-mar platform we decide upon will have this functionality built in to warn staff if a diagnosis is missing. PCHA will spot check MAR's effective May 1, 2023* ***Thank you,*** [redacted]

187a - Medication Record (continued)

Directed-
"FFM is currently looking into a new E-MAR platform, there is currently no anticipated date of the new EMAR system. Executive Director, Admin and LPN plan to discuss the desired features within the new E-MAR platform with CEO/board of Directors before a new EMAR program is decided upon. Desired features include a built-in functionality to warn staff if a diagnosis is missing. However, until a new E-MAR system is in place, the LPN will immediately start verifying and auditing all MAR's to Ensure there is a diagnosis for each prescription. Audit by LPN will start 04/10/2023. Even with a new system (EMAR), aspects of 187a could potentially be overlooked and it's the responsibility of staff to also ensure MAR's are completed. FFM also plans to train and reeducate all med techs by 06/01/2023 on the importance of ensuring all subsections of 187a are met when reviewing and administering resident medication. "

Directed Completion Date: *06/01/2023*

Not Implemented [redacted] - 10/12/2023)