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.

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 **April 24, 2024** until **April 24, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **322020**

ISSUING OFFICER

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 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: APRIL 24, 2024

[redacted]
Faith Friendship Ministries Inc
[redacted]

RE: Faith Friendship Villa of Mountville
128 West Main Street
Mountville, Pennsylvania 17554
License #: 32202

Dear Ms. Morris:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 14, 2024, February 15, 2024, and April 16, 2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-Term Living

Enclosure
<Licensing Inspection Summaries>

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

April 23, 2024

[redacted]
FAITH FRIENDSHIP MINISTRIES INC
[redacted]

RE: FAITH FRIENDSHIP VILLA OF MOUNTVILLE
128 WEST MAIN STREET
MOUNTVILLE, PA, 17554
LICENSE/COC#: 32202

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/14/2024, 02/15/2024 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: *FAITH FRIENDSHIP VILLA OF MOUNTVILLE* **License #**: *32202* **License Expiration**: *04/17/2024*

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]

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**: *63* **Waking Staff**: *47*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *02/15/2024*

Inspection Dates and Department Representative

02/14/2024 - On-Site: [redacted]

02/15/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *63*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *51* **Are 60 Years of Age or Older**: *40*

Diagnosed with Mental Illness: *49* **Diagnosed with Intellectual Disability**: *16*

Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

02/14/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/04/2024*

Inspections / Reviews *(continued)*

03/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/11/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/19/2024*

03/22/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/11/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/17/2024*

04/23/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/11/2024*

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

Resident #1 is prescribed Humalog Mix 75/25 Vial Inject 50 Units subcutaneously every morning with breakfast (Diabetes Mellitis)
On 12/4/23, Resident #1 was administered the Humalog 50 Units at 5:00 PM. The home did not report this incident to the Department until 12/6/24.

On 02/06/24, Resident #2 reported an allegation of verbal abuse by Resident #3 to the home. However, the home did not report the allegation of abuse to the to the Department until 02/08/24.

Repeated Violation- 2/15/23, et al.

Plan of Correction ***Directed [redacted] - 03/21/2024)***

02/06/24 2600.16c - FFV will continue to make sure that staff who are aware of an incident must report the said incident in a timely manner. Managers, Administrator and ED are all a part of the investigative team concerning reportable incidents. The Administrator or the ED will report the incident within 24 hours to the department. Care Managers were reminded by the Administrator via email on 2/28/24 of this requirement and the proper procedures to follow. Clarification of FFV's policy and procedures was attached to the email in a word document. In addition a copy of the DHS 2600 policy & procedures were attached to the email. Copy attached.

(Directed)

- *On 2/28/24, the administrator emailed the Care managers regarding the 2600.16c regulatory requirements.*
- *Starting 02/28/24 the administrator will ensure Reportable Incidents are reported to the department within 24 hours per regulatory requirements.*
- *The administrator will ensure all staff is educated by 03/29/24 regarding the 2600.16c regulatory requirements.*
- *Starting 03/29/24, the administrator will audit Incident Reports monthly for 3 months.*
- *The administrator will develop a audit checklist by 03/29/24 to document the results of the audits.*
- *Starting 03/29/24, the administrator will ensure audit checklists and training documentation such as sign-in sheets are kept in the home.*

Directed Completion Date: *03/29/2024*

Implemented [redacted] - 04/16/2024)

42b - Abuse

2. Requirements

42b - Abuse *(continued)*

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

On 2/6/24, Resident #2 reported to staff that Resident #3 has been verbally abusing Resident #2 for a long period of time. Resident #2 stated Resident #3 calls Resident #2 by a vulgar name, and stares at Resident #2 in an intimidating manner. Resident #3 admitted to Staff Member A that these incidents have taken place.

Repeated Violation-2/15/23, et al.

Plan of Correction ***Directed ([redacted] - 03/21/2024)***

Resident #3 was issued a written house rule violation concerning this mistreatment and verbal abuse of Resident #2 on 2/7/24 by the Administrator and Care Manager of residents #2 and #3. All residents have been reminded by the LPN on 2/27/24 to report any case of verbal abuse to staff immediately; including the Executive Director, Administrator or Resident Council. Professional de-escalation training for all staff will be held by a Mental Health America in May or June 2024. The Administrator or the Executive Director will implement any new measures gleaned from the training immediately following the training. In addition, the ED will continue to discuss behavior issues with residents during her weekly session with them. Staff continue to redirect residents, intervene when necessary and report behavior issues or suspected abuse to the ED and Administrator. These are ongoing practices by staff and administration and are not subject to any particular time frame but are ongoing.

(Directed)

- *On 2/7/24 Resident #3 was issued a written house rule violation by the Administrator and Care Manager.*
- *On 2/27/24 the LPN reminded all residents to report any case of abuse to staff immediately.*
- *The administrator will ensure the professional de-escalation training is completed by Mental Health America for all staff by 4/12/24.*
- *The administrator will submit documentation of the training to the department by 04/15/24.*
- *Starting 03/29/24, the executive director will discuss behaviors with resident during their weekly scheduled sessions and will document the sessions, to include the date of each session.*
- *Starting 03/29/24, the staff will continue to redirect residents, intervene as appropriate and immediately report behavior issues to include suspected abuse to the Executive Director and the administrator.*

Directed Completion Date: *04/15/2024*

Implemented [redacted] - 04/16/2024)

81b - Resident Personal Equipment

3. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 02/15/24, a mobility device was observed installed on Resident #4's bed. The mobility device has an opening greater than 4 ¾ inches which was uncovered and is not securely fastened to the bed frame.

Plan of Correction ***Accept ([redacted] - 03/21/2024)***

On February 19, 2024, maintenance staff installed a new mobility device on Resident #4 bed which meets all DHS

81b - Resident Personal Equipment (continued)

requirements. All mobility devices in the home will be maintained, including kept clean and free of hazards beginning 3/1/24. Monthly maintenance checks began for the devices and were added to the monthly check on their preventative maintenance checklist on 3/1/24. By 3/31/24 the Direct Care Supervisor and the 3rd shift Supervisor will have educated all staff on the use of bedside mobility devices.

Proposed Overall Completion Date: 03/18/2024

Licensee's Proposed Overall Completion Date: *03/18/2024*

Implemented [redacted] - 04/16/2024)

88a - Surfaces

4. 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

On 02/14/23 at 09:55 AM, the refrigerator in the recreation room was soiled with liquid stains.

Plan of Correction ***Directed [redacted] 03/21/2024)***

The housekeeping staff person was made aware on 2/27/24 that it is their responsibility to make sure that all floors, windows, walls, ceilings, doors and other surfaces are kept clean. The housekeeping staff person cleaned the refrigerator on 2/14/24. Refrigerator cleaning in the Rec Room was added to the housekeeper's list of duties by the 1st shift supervisor. The 1st shift supervisor will inspect the refrigerator weekly. The housekeeping staff person will clean the refrigerator on a daily basis.

(Directed)

- *On 2/14/24 the housekeeping staff person cleaned the refrigerator in the recreation room.*
- *On 02/27/24, the housekeeping staff person was made aware of their responsibility to ensure sure all floors, windows, walls, ceilings, doors, and other surfaces are kept clean.*
- *On 02/27/24, the refrigerator cleaning in the recreation room was added to the housekeeper's list of duties by the 1st shift supervisor.*
- *Starting 02/27/24 the 1st shift supervisor will inspect the refrigerator weekly and the the housekeeping staff person will clean the refrigerator daily. The administrator will ensure documentation of cleanings are kept in the home.*

Directed Completion Date: *03/29/2024*

Implemented [redacted] - 04/15/2024)

95 - Furniture and Equipment

5. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

95 - Furniture and Equipment *(continued)*

Description of Violation

On 02/15/24, the faucet on the sink in the shower/bathroom located near room 107 was observed covered with calcium deposits.

Plan of Correction ***Directed [redacted] - 03/21/2024)***

On 2/19/24 the faucet on the sink in the shower/bathroom near room 107 was replaced by the maintenance staff. Maintenance staff will continue to inspect and replace all furniture and equipment to ensure that they that are in good repair, clean and free of hazards. These inspections are part of the weekly walk through conducted by maintenance staff and began in 2023. Any furniture or equipment needing repaired or replaced is to take place as soon as possible of discovery. All staff were reminded again on 3/13/24 to report items in need of repair that they observe to maintenance staff or the administration. The Maintenance Manager is responsible to see that the repair or replacement is completed.

(Directed)

- *On 2/19/24 the faucet on the sink in the shower/bathroom near room 107 was replaced by the maintenance staff.*
- *Starting 02/19/24, the maintenance staff will conduct weekly walkthroughs and will inspect and replace all furniture and equipment. The maintenance staff will ensure walkthroughs are documented.*
- *Starting 02/19/24, the administrator will ensure furniture or equipment requiring repair or replacement will occur within 10 days of discovery.*
- *On 03/13/24, the administrator informed all staff to report furniture or equipment they observe in need of repair to maintenance staff or the administrator.*

Directed Completion Date: *03/29/2024*

Implemented [redacted] 04/16/2024)

141a 1-10 Medical Evaluation Information

6. 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.

141a 1-10 Medical Evaluation Information *(continued)*

Description of Violation

Resident #5's medical evaluation dated [redacted]/24 does not include the resident's height, weight, pulse rate and temperature in the General Physical Examination section.

Repeated Violation- 11/21/23, 2/15/23, et al.

Plan of Correction ***Directed[redacted] - 03/21/2024)***

On 2/7/24 the Care Manager communicated with the physicians office regarding Resident #5's DME. On 2/15/24 the DME was completed in it's entirety by the resident's Dr. The Care Manager put it into the resident's file on 2/15/24.

If missing information is discovered upon receiving a new annual DME from the Physician, LPN will immediately complete missing information and/or contact Physician's Office within 1 business to obtain required missing information on the DME.
Care Managers began checking DME's for missing information on 2/6/24. Care Managers are and have been using a spreadsheet to check monthly information for incompleteness since 2023. The Administrator also does random audits of the spreadsheet and documents on his checklist.

(Directed)

- *On 2/7/24 the care manager communicated with the physician's office regarding Resident #5's DME. On 2/15/24 the DME was completed in its entirety by the resident's physician. The care manager put the DME into the resident's record on 2/15/24.*
- *Starting 03/29/24, if missing information is discovered upon receiving an annual DME from the Physician, the LPN will immediately complete missing information and/or contact the resident's physician's office within 1 business day to obtain the required information.*
- *Care managers began reviewing all DME's for missing information on 2/6/24. Care Managers will review DME's monthly and will use a spreadsheet to document missing information. Starting 2/6/24 the administrator will continue to conduct random audits of the spreadsheet and will document findings on a checklist.*

Directed Completion Date: *03/29/2024*

Implemented[redacted] - 04/16/2024)

144c1 - Smoking Area Guidelines

7. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 02/15/24, there were approximately 20 cigarette butts observed on the ground in and around the designated smoking area.

144c1 - Smoking Area Guidelines *(continued)*

Plan of Correction ***Directed [redacted] - 03/21/2024)***

On 2/15/24, maintenance staff cleaned up the cigarette butts on the ground around the designated smoking area. A resident has been designated to pick up the cigarette butts on a daily basis. The preventative maintenance check list has been updated to include a weekly check by maintenance staff for cigarette butts in the designated smoking area. A sign has been posted at the designated smoking area for residents to use appropriate cigarette containers provided. An announcement was made by the Maintenance Manger on 2/16/24 in the dining room for all residents pertaining to the issue. Residents were again instructed that they need to throw the cigarette butts in the provided containers in the gazebo. They were told that a sign was posted in the gazebo in reference to proper disposal of the cigarette butts. Residents were also reminded that they could be losing their smoking privileges if they do not comply.

(Directed)

- *On 2/15/24, maintenance staff disposed of the cigarette butts on the ground around the designated smoking area.*
- *On 02/15/24, the preventative maintenance checklist has been updated by the administrator to include a weekly check by maintenance staff for cigarette butts in the designated smoking area. Maintenance Staff will be notified of this change by the administrator by 3/29/24.*
- *On 02/15/24, a sign has been posted at the designated smoking area for residents to use the appropriate cigarette containers provided.*
- *On 02/16/24, the maintenance manager made an announcement to all residents pertaining to smoking in the designated area and ensuring cigarette butts are placed in the receptacle. Residents were also informed of the signage posted in the designated area.*
- *Starting 02/16/24, the maintenance staff will ensure cigarette butts are collected from the ground weekly.*
- *On 02/16/24, the administrator informed residents they may lose their smoking privileges if they do not comply.*

Directed Completion Date: *03/29/2024*

Implemented [redacted] - 04/16/2024)

181c - Self-administration Assessment

8. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #6 is prescribed Lantus Solostar 100 Units Inject 22 Units subcutaneously at Bedtime; Trulicity 4.5 MG/0.5 ML Inject 0.5 Subcutaneously Weekly and Novolog Flexpen Syringe Inject 12 Units Subcutaneously Twice Daily at Breakfast.

Resident #7 is prescribed Humalog MIX 75/25 Vial Inject 50 Units Subcutaneously every Morning with Breakfast; Lantus 100 Units ML Vial Inject 50 Units Subcutaneously Daily in the evening, Ozempic 2 MG/Dose (8 MG 3) Inject 2 MG Subcutaneously every week for diabetes.

181c - Self-administration Assessment (continued)

Residents #6 and #7 routinely self-administer the above medications, however, residents 6# and #7 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner to self-administer medications.

Plan of Correction ***Directed [redacted] - 03/21/2024)***

On 2/16/24 immediate action was taken by a Care Manager who contacted Residents #6 and #7's Dr. Residents #6 and #7 who routinely self-administer medications were assessed by their physician with a copy of the order to self-administer in their file. See attachment. Resident#6 was assessed by the Dr. on 2/17/24 and Resident#7 was assessed by the Dr on 2/21/24. Going forward the LPN and/or Care Managers will review the DME to ensure they have the Dr. order for self-administering medication if they are deemed capable of doing so. The review will occur upon admission as well as monthly DME reviews.

(Directed)

- *On 2/16/24 the care manager contacted Residents #6 and #7's physicians.*
- *Resident #6 was assessed by the physician 2/17/24 and Resident #7 was assessed 2/21/24 and both were authorized by their physicians to self-inject their insulin medication. Documentation of this assessment was placed in both resident's files by the administrator.*
- *Starting 02/21/24, the LPN and/or care managers will review all resident records to include physician's orders authorizing residents to self-administer medication; ensure the DME and the RASP reflect the resident's ability to self-administer medications.*
- *Starting 03/29/24, the administrator will ensure DME's are reviewed upon admission as well as monthly and will document the results. The administrator will also ensure resident's RASPs are reviewed monthly. The administrator will ensure any required corrections are completed within 1 week of discovery.*

Directed Completion Date: *03/29/2024*

Implemented [redacted] - 04/16/2024)

185a - Implement Storage Procedures

9. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #4 is prescribed Valtoco 10 MG Nasal Spray, use as needed for seizures. On 02/15/24, the medication was not available in the home.

Resident #8 is prescribed Albuterol HFA 90 MCG Inhale Two Puffs by mouth for wheezing. On 02/15/24, the medication was not available in the home.

Plan of Correction ***Directed [redacted] - 03/21/2024)***

On 2/15/24 the LPN reached out to Residents #4 & 8's physicians to gain either a new prescription for their required medication or a d/c order for said medication. The LPN had reached out several times prior as well, but was unable to get cooperation from the Drs.

185a - Implement Storage Procedures (continued)

On 2/27/24 we received a new prescription for resident #4 prescribed Valtoco 10MG Nasal Spray and will have this medication stored in the medication office behind locked doors. Trained staff will make sure of its safe storage, access, security, distribution and use of medication for resident.

The Care Manger for resident#8 was able to get the medication discontinued on 3/5/24. Direct care staff who administer medications were retrained by the a Train the Trainer on 3/1/24 on the safe storage , access, security, distribution and use of medications. This is an annual training and it will continue. Audits will continue by the Care Managers and/or the LPN as they do monthly reviews on all resident MARS. They are already do the monthly reviews and this will continue. Audits are documented on a spreadsheet.

(Directed)

- *On 2/15/24 the LPN reached out to Residents #4 an #8's physicians to gain either a new prescription for their required medication or a discontinued order.*
- *On 2/27/24 the home received a new prescription for resident #4 who is prescribed Valtoco 10MG Nasal Spray and will have this medication stored in the medication office behind locked doors.*
- *The care manager reached resident #8's physician and the medication was discontinued 3/5/24.*
- *On 03/01/24, direct care staff who administer medications were retrained by the Train the Trainer on the safe storage, access, security, distribution, and use of medications.*
- *Starting 03/29/24, the care managers and/or the LPN will audit resident MARs monthly and document the results on a spreadsheet. The administrator will ensure a request is sent residents physicians to refill or discontinue any medications listed on the MAR but not in the home, within 1 week of discovery.*

Directed Completion Date: *03/29/2024*

Implemented ([redacted] - 04/17/2024)

187d - Follow Prescriber's Orders

10. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is prescribed Humalog MIX 75/25 Vial Inject 50 Units Subcutaneously every morning with breakfast (Diabetes Mellitis).
On 12/4/2023, Staff Member B administered the Humalog 50 Units at 5:00 PM.

Resident #9 is prescribed the following medications:

- *Bupropion HCL SR 200 MG T Wellbutrin Take 1 Tablet by Mouth Twice Daily for Depression*
- *Dicyclomine 20 MG Tablet Bentyl Take 1 Tablet by mouth 3 times daily for IBS.*

On 12/05/2023, the resident's 5:00 PM doses of the medications were not administered to the resident.

Plan of Correction ***Directed ([redacted] - 03/21/2024)***

Continual education of medication trained staff will occur especially as it pertains to prescribers orders and as it pertains to the 5 rights of medication administration.
Right person
RIght medication

187d - Follow Prescriber's Orders (continued)

Right time
Right dose
Right route
Direct care staff member B did receive additional medication training and education on 12/8/2023 by the Train the Trainer staff person and the LPN. In addition, direct care staff member B was removed from medication administration for all residents for the next 3 shifts that she worked.

The LPN does a monthly audit of resident's MARS and documents them on a spreadsheet. The train the trainer and Direct Care Supervisor also audit the MARS when new monthly MARS are obtained.

(Directed)

- *Starting 2/15/24, Direct Care Staff Member B was temporarily removed from medication administration for all residents.*
- *The administrator will ensure staff education covering following prescribers order is completed for staff Member B and all staff administering medications by 03/29/24.*
- *Starting 03/29/24, the LPN will audit resident MARs monthly and document the results on a spreadsheet. The administrator will ensure all mediation inconsistencies and errors are addressed within 1 week of discovery.*

Directed Completion Date: *03/29/2024*

Implemented ([redacted] - 04/17/2024)

254c - Records Storing

11. Requirements

2600.
254.c. Resident records shall be stored in locked containers or a secured, enclosed area used solely for record storage and be accessible at all times to the administrator or the administrator's designee, and upon request, to the Department or representatives of the area agency on aging.

Description of Violation

On 02/14/24 at approximately 10:07 AM, the resident privacy coding form was observed publicly posted with the License Inspection Summary (LIS) dated 11/21/23.

Plan of Correction ***Accept [redacted] - 03/21/2024)***

On 2/14/24 the resident privacy coding form was removed from the publicly posted License Inspection Summary (LIS) by the LPN. The Administrator will make sure that this form will not be posted in the future in any public place and has added the check to the Administrator's checklist as of 2/14/24. The Administrator will make the check on a quarterly basis.

Proposed Overall Completion Date: 03/18/2024

Licensee's Proposed Overall Completion Date: *03/18/2024*

Implemented [redacted] - 04/17/2024)

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

April 23, 2024

[redacted]
FAITH FRIENDSHIP MINISTRIES INC
[redacted]

RE: FAITH FRIENDSHIP VILLA OF MOUNTVILLE
128 WEST MAIN STREET
MOUNTVILLE, PA, 17554
LICENSE/COC#: 32202

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 04/16/2024 of the above facility, no regulatory citations have been identified as a result of this inspection.

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

Sincerely,
[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *FAITH FRIENDSHIP VILLA OF MOUNTVILLE* **License #**: *32202* **License Expiration**: *04/17/2024*

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]

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**: *64* **Waking Staff**: *48*

Inspection Information

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

Reason: *Provisional, Interim* **Exit Conference Date**: *04/16/2024*

Inspection Dates and Department Representative

04/16/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *64*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *50* **Are 60 Years of Age or Older**: *43*

Diagnosed with Mental Illness: *51* **Diagnosed with Intellectual Disability**: *16*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

04/16/2024 - Partial

Lead Inspector: [redacted] [redacted] **Type**: *Not Required*

NO DEFICIENCIES FOUND