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

December 14, 2022

FAITH FRIENDSHIP MINISTRIES INC
, 128 W MAIN STREET
MOUNTVILLE, PA, 17554

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

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/22/2022, 08/23/2022, 09/12/2022 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *FAITH FRIENDSHIP VILLA OF MOUNTVILLE* **Licen e #**: *32202* **Licen e Expiration**: *02/11/2023*

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

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *FAITH FRIENDSHIP MINISTRIES INC*

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

Phone: **Email**:

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/13/2022*

Inspection Dates and Department Representative

08/22/2022 On Site
08/23/2022 On Site
09/12/2022 Off Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *74* **Residents Served**: *68*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *N/M* **Are 60 Years of Age or Older**: *41*
Diagnosed with Mental Illness: *50* **Diagnosed with Intellectual Disability**: *14*
Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

08/22/2022 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/10/2022*

11/18/2022 - POC Submission

Submitted By: **Date Submitted**: *11/30/2022*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/25/2022*

Inspections / Reviews *(continued)*

11/29/2022 - POC Submission

Submitted By [redacted] **Date Submitted**: *11/30/2022*

Reviewer [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/06/2022*

12/14/2022 - Document Submission

Submitted By: [redacted] **Date Submitted**: *11/30/2022*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

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

Adult Protective Services became aware of an incident of alleged abuse on /22 at approximately PM, involving Resident 1. However, the Act 13 Mandatory Abuse form was not completed and submitted to AAA within 48 hours by the home.

Plan of Correction ***Directed - 11/29/2022)***

August 20- September 1, 2022, the Administrator made available to all managerial staff the procedures for the report of suspected abuse, including the proper filing of the Act 13 Mandatory Abuse form. In addition, all managers were re-trained on the correct reporting procedure, including but not limited to the paperwork for Act 13 Mandatory Abuse form. The Administrator will review all materials of submitted report to also ensure the ACT 13 report was completed immediately.

The ACT 13 paperwork was submitted to AAA on 08/23/2022 @ 12.36pm.
Directed:
Act 13 was submitted by Administrator to AAA on 08/23/2022 @ 12.36pm.

Directed Completion Date: *11/26/2022*

Implemented 12/14/2022)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

Adult Protective Services became aware of an incident of alleged abuse involving Staff Member A and Resident 1 on 22 at approximately PM. However, the home did not develop or implement a plan of supervision or suspend the staff person involved in the alleged incident.

Plan of Correction ***Directed (- 11/29/2022)***

The Administrator and/or on-call Manager will immediately inform the Executive Director of any ncident of alleged abuse. The ED will determine if supervision or suspension is necessary. The Administrator will then prepare and implement a plan of supervision for any staff person suspected in alleged abuse, including but not imited to pairing said staff person with another staff person for the duration of the shift, or sending said staff person home until further notice from the Department. In addition to that procedure, the Administrator, at the request of the ED, contact the Department in writing with the supervisory plan and ask for approval or adjustment of the plan.

Directed:
Administrator-August 20- September 1, 2022, the Administrator made available to all managerial staff the

15b - Supervisor Plan (continued)

procedures for the report of suspected abuse.

Directed Completion Date: *11/26/2022*

Implemented - 12/14/2022)

15d - Resident Abuse-Notification

3. 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

Adult Protective Services became aware of an incident of alleged abuse involving Resident 1 and Staff Member A on 22 at approximately PM. The home did not immediately notify the resident's designated person of a report of suspected abuse involving the resident.

Plan of Correction ***Accept - 11/28/2022)***

On August 20-September 1, 2022, the Administrator made available to all managerial staff the procedures for the report of suspected abuse, including the proper contacting of the resident's designated person. Each resident's designated person is easily found on each Transfer Sheet and is readily available to all Administrator, managers and staff. In addition, all managers were re-trained on the correct reporting procedure, including but not imited to the paperwork for Act 13 Mandatory Abuse form. The Administrator will review all materials of submitted report to also ensure POA was notified immediately.

Resident 1's Designated Person was contacted by The Administrator on , 2022 at approximately

Licensee's Proposed Overall Completion Date: *11/26/2022*

Implemented (12/14/2022)

42b - Abuse

4. 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

On 22, the Department was notified of allegations of abuse by Staff Member B toward Resident 2. These allegations were reported by the resident Multiple interviews were conducted with the resident by Adult Protective Services and Representatives of the Department. Resident 2 has remained clear, consistent and credible regarding the details of these incidents.

Plan of Correction ***Accept - 11/28/2022)***

- Details of FFM's Response to 42B Violation

42b - Abuse (continued)

Upon notice of allegation on [redacted], 2022, Faith Friendship Ministries, (FFM) Executive Director immediately suspended the employee (Staff Member B) accused of abuse in person and in writing. The employee was directed to have no contact with any of the homes residents and to not come on FFM property. [redacted]

We understand that as the organization that served as both employer and landlord/caregiver, in this situation we carry a degree of responsibility for what occurs in our Villa, with our staff and residents. We take that responsibility and our commitment expressed through our work very seriously. We have endeavored to be an organization that the community can trust and rely on. In our 20-year history FFM has never faced a terrible situation like this. We would never condone or tolerate any abuses of Resident Rights and take this allegation very seriously.

While we do not know all the facts and feel strongly that we should not judge a matter before its time and before the facts are made known, we as an organization are still deeply grieved by this accusation and the possibility that one of our beloved residents may have been harmed is devastating to us. We have done and will do everything we can to cooperate with all authorities and get to the truth so that healing and restoration can occur, while we continue to care for, protect and love our 70 residents.

From the outset, our leadership has cooperated with authorities of law enforcement, Department of Human Services and Adult Protective Services, to ensure access to and sharing of all necessary information. The Executive Director started an internal investigation and while it was severely restricted due to confidentiality and limited access to involved parties, due diligence was performed.

The Executive Director also gave regular written updates and statements to DHS to ensure full cooperation and transparency. We also sought counsel from DHS as to what and when information on the allegation should be shared with our FFM residents, their families, our supporters and community. We were advised to only share this information with individuals in the organization that need to know as to not impede the investigation. ED secured and consulted with legal representation, informed the Board of Directors and FFM managers were kept abreast of the ongoing issue developments as needed and appropriate.
During the period of late August through 9/30/22, FFM did not have access to any details on the accusations from any law or regulatory authority. Since the DHS (BHSL/OLTL) was in an active investigation, FFM made the decision to keep the matter confidential until such a time that either charges were filed or proof from DHS substantiated a claim of abuse. It was and is our intent to be as transparent as the law and regulations allow. [redacted]

Once Faith Friendship Ministries was cited for a 42b violation 09/30/22, the alleged abuser; Staff Member B's employment was formally terminated. Since there was/is an ongoing police investigation and a violation from DHS, Staff Member B was no longer eligible for employment with the home, per our personnel policies and as an at will employer.

Resident #2 was on visit with [redacted] family, and was not staying at the home, at the time of the allegation and

42b - Abuse (continued)

citation, the ED kept in contact with the POA-Mom, to ensure meds, finances and appointment needs were met. The POA was unsure from August-early October 2022, if ███ would ask the Resident to return to residency at FFM, so case management continued while a decision was being considered.

The ED made several contacts with the West Hempfield Police Department to help understand the legal process as to not interfere and try to get permission to talk directly to the Resident #2 for the FFM Internal Investigation. ED was told ███ could talk to anyone as long as ███ let law enforcement interview the alleged victim first. When the ED reached out to POA-Mom, she said law enforcement told her not to share the details of the case with FFM and that the Resident #2 should not and would not give FFM a statement. The ED discontinued attempts to interview the alleged victim believing that DHS would share the statement/information with FFM when appropriate to do so.

███/22 at FFM's request, FFM's ED, ███, Board President, ███ and PCHA, ███ had a conversation with staff of DHS to discuss the allegations of abuse; specifically, three questions:

1) requesting the contents/information gathered in their investigation that substantiated the abuse – No specific information was provided on details of investigation.

2) asked questions regarding how to write a plan of correction, when no evidence of FFM negligence is evident or stated. – Ideas shared, terminate the employee, or provide constant supervision, provide more training, possibly increase staffing levels to reduce 1 on 1

3) Discussed concerns of POA-Mom requesting the Resident return to live at the Villa. Conversation was held around discharging Resident #2 for 228h. – DHS, Director Cody, offered to assist POA-Mom to relocate Resident #2 to another PCH. The FFM Board of Directors would meet to discuss concerns and decide on residency status.

During the conversation FFM's representative expressed repeated concerns about the violation substantiation.

While DHS stated clearly that they use different criteria than law enforcement uses to determine whether a regulatory violation occurred, they believe that it is highly likely that ███ abuse occurred as the resident alleged; largely because Resident #2 being interviewed by three agencies was both clear consistent and credible. They also said other available information also assisted in their determination.

FFM shared that while their criteria for substantiation is different than law enforcement, that criteria was not shared with FFM, and has not been given any details or access to the investigation/testimony of the Resident that would lead us to understand the substantiation. FFM has asked several times for access to this information. It has not been provided. This could help immensely if we were given access to the reasons for substantiation and the Resident #2's testimony.

FFM expressed their concern that believability alone, especially when they shared that the accused Staff Member B has never been personally interviewed by anyone at DHS, seemed to lead to a decision of inconclusiveness, not substantiation. We understand that our conclusion may be incorrect, but we do not possess enough information to the contrary.

In contrast, FFM's Internal Investigation, revealed nothing that led to a conclusion of a likelihood of abuse

42b - Abuse (continued)

occurring. However, we want to be clear, that we were unable to interview the Resident #2 (alleged victim) because the POA (Mom) would not permit it, stating law enforcement told her not to. Therefore, based on requirements of a fair, complete, and balanced information gathering, our investigation is inconclusive due to lack of information.

f FFM were forced to conclude based only on available information, there would be nothing pointing to a likelihood of the alleged abuse occurring. Does that mean abuse did not occur? No.

The reality is we do not know, if abuse occurred, yet but have taken every precaution and action step necessary to protect our residents and staff once we were informed of the allegation, as if it could have. We all want the truth.

Frustratingly, we have no clear understanding of how DHS came to their conclusion, other than their stated reason of believability and some other factors.

Every victim should be heard and believed, but determining who the victim is, cannot be lightly discarded and easily assumed. Simply put, we cannot judge a matter before its time and without adequate evidence or information.

While it may be unpopular to say so, it is possible that this is a false allegation. That is possible in almost every scenario of accusation where no witnesses exist. Testimony is a huge part of getting to the truth, but it's part of the whole story. We trust law enforcement and the justice system to determine that. We are not qualified to do so. However, IF this were to be a case of a false allegation, a tenured, beloved and valued former member of our organization and the community could have their life ruined because of this. The reality is nobody is unhurt in this situation. Everyone deserves to be heard and a determination of 42B communicates to GUILTY to the public.

We press this matter not only for ourselves, but because of another more global concern. If a resident accuses an employee of a harm and all that is required is an accusation and believability, to be cited with such an egregious iolation as an organization, doesn't this set a dangerous precedent for the other 1100 PCH's in Pennsylvania to be cited without higher standards for substantiation and put staff in danger of losing their livelihood, reputation, etc. The aftershock can be devastating. Humbly, I wouldn't want the job of a DHS investigator. There are no easy answers.

For the record, DHS, Director [redacted] and [redacted] were very helpful during the conversation and this whole process. When we asked how to write a plan of correction when no apparent negligence was determined to have occurred, training is already provided, and the accused employee is no longer at FFM. We were assisted.

We were also granted an extension to submit our Plan of Correction (POC). Our questions in the early days of this awful situation, were answered expeditiously. We appreciate this as a partnership to serve those who are highly ulnerable and most in need.

Once the conversation concluded, ED, [redacted] followed up with DHS, Director [redacted] in writing to request:

1) due to lack of information sharing provided to FFM, request a withdraw 42b until/unless law enforcement charges the former accused employee or more information sufficient to justify a 42B is presented. – This was denied

2) if no to question #1, requested removing [redacted] [redacted], so that when it is posted in the home, as required by the regulations, does not

42b - Abuse (continued)

unnecessarily add to the mental anguish residents will experience. The other 70 residents in the home already know there are allegations of an incident between Resident #2 and the accused Employee. They do not need to know the exact detail, especially prior to charges being filed. – This was denied.

3) Grant a final Extension for the POC. – A extension to 11/3/22 was granted

Our Plan of Correction
While we do not believe we should be submitting a POC for this 42B citation, we will, because our commitment to caring for our 70 residents is not worth risking our license and previous 20+ years of good standing and excellent provider of services. We pray that justice will ultimately be served, and everyone can heal.

We know clearly, we aren't perfect and that a heart of humility that is open to continuous improvement is wise. A few things became clear during our investigation.

First is that while training is provided by FFM to all staff at start and throughout their employment, we can do a better job of training for incident reporting for managers. FFM will continue its practice of clearly communicating the prohibition morally, ethically and legally of any type of intimate relationship with residents. Observation, peer reviews and resident surveys as a part of supervision strategies will continue.

Second, we are clearly in the dark ages as it pertains to electronic communications with our residents' families. This isn't a suprise to our relatively new ED, but it is more pressing and deserves a big boost on the priority list. Therefore, we are committed to continuing our work of building distribution lists and platforms that will help us communicate both more effectively and quickly.
This is currently occurring.

Third, while this violation has nothing to do with staffing shortages, we like most other long term care providers, post COVID outbreak, are suffering from a staffing shortage and a steep decline in employee commitments to proper work ethic, of some new applicants. Reliability is at an all-time low regarding new hires. Our plan has been to improve the quality of our services to our residents and to do that we have added an LPN, to improve outcomes for residents, and increased the number of direct care staff to exceed DHS's requirements.
This is ongoing.

A standard part of the hiring process is to share our policies that also inform all new employees of both resident rights and policies [redacted]. These items are covered as a part of new employee orientation conducted by the Administrator, Business Manager and Direct Care supervisor. As required all new staff are subject to a Criminal Background Check. Board leadership and the ED have been in the process of updating all organizational documents to reflect current laws, regulations and expectations.
This is also ongoing.

As part of our efforts to equip staff and [redacted]nsure staff awareness and compliance with Regulations and to ensure protection of residents, mandatory training for all staff was held on November 18, 2022 @9am specializing in Mandated Reporting, of Abuse and Neglect, Reportable Incidents and Resident Rights. The presenters were Melissa Laratonda, LTC Ombudsman as well as the Administrator, Laura Smith, FFV. There was 100% staff participation.

The Administrator, [redacted] has arranged for Local Ombudsmen and Adult Protective Service Presenters,

42b - Abuse (continued)

, LTC Ombudsman and (TBD) to offer an in-service for all residents regarding Recognizing and Reporting Abuse, Neglect and the importance of Resident Rights on December 8, 2022 @ 10am.

DHS, thank you for giving us the opportunity to share our thoughts, concerns and solutions, to hopefully increase protections to promote the well-being and safety of our residents. Finally, if our former employee, harmed our resident, we pray for justice and repentance of the former employee and healing and restoration for our resident. We are hopeful that we can strengthen our relationship with you as we partner to serve some of the most vulnerable residents in our state.

n your service,
- Executive Director

Recommended Updates to POC via - DHS - edits

Staff Member B was suspended on 22 when the allegations of abuse were reported to the administrator of the home. Staff Member B was terminated from employment in late October 2022 when the allegations of abuse were substantiated by the state.

To improve outcomes and increase the number of direct care staff hours above the minimum required by regulation, the Executive Director hired a licensed practical nurse in October of 2022

The administrator held a mandatory in-service on 11/18/22 at 10a.m. for all current staff persons. This in-service was provided by the LTC Ombudsman and a representative of Adult Protective Services and included training on mandatory reporting, abuse and neglect, reportable incidents and resident rights.

The administrator scheduled an additional in-service for all residents to be held on 12/8/22 at 10 a.m. This in-service will also be provided by the LTC Ombudsman and a representative of Adult Protective Services and will cover recognizing and reporting abuse, neglect and the importance of resident rights.

Beginning 11/18/22, the administrator will continue to train newly-hired staff within 1 day of hire on the home's policies regarding resident rights

The administrator will review incident reports and shift logs on a weekly basis beginning 12/1/22 to identify potential issues with staff-resident interactions and ensure concerns and incidents are reported to the Executive Director and if appropriate the Department and conduct an internal investigation in timely manner.

The administrator as instructed by the ED will interview a sample of both residents and staff on a monthly basis beginning 12/1/22 to identify any problematic behaviors or interactions. If identified, the administrator will notify the Executive Director, submit an incident report, Act 13 , if the allegations of abuse are in nature. If the abuse is not of a sexual nature, but violates regulations, the administrator will either provide constant supervision of the staff while the internal investigation is conducted or suspend them entirely.

42b - Abuse (continued)

42b - Abuse (continued)

Licensee's Proposed Overall Completion Date: *12/08/2022*

Implemented (SK - 12/14/2022)

141a - Medical Evaluation

5. 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.

Description of Violation

Resident 1's most recent Documentation of Medical Evaluation (DME), from a 10/26/2020 evaluation, is missing information in multiple sections including:
- If the DME was the initial, annual or a status change.
- Height and weight.
- Medications (no addendum attached)
- Section 4 (if the resident can safety use or avoid poisonous materials)
- If the Resident can self-administer medications or not.
- Section 8 (body positioning/ movement)
- Section 9 (health status) and (cognitive function)
- Section 10 (Mobility Needs Assessment).

Plan of Correction ***Directed (SK - 11/29/2022)***

Laura Smith- Upon completed of yearly DME's, the document will be immediately checked for completion after the PCP sends it to the facility.

Laura Smith- Beginning January 2023 and on a quarterly basis, the Administrator will verify DME documentation for all residents to ensure proper fulfillment of each category on said document. If/When the Administrator finds a discrepancy or omission, the document will be sent back to the PCP for correction.

Directed:
Resident one's Yearly DME was evaluated on 09/09/2022 and completed on 09/14/2022 by the PCP. The Administrator reviewed the DME which is attached.

Directed Completion Date: *01/02/2023*

Implemented (SK - 12/14/2022)

141b1 - Annual Medical Evaluation

6. Requirements

2600.

141b1 - Annual Medical Evaluation *(continued)*

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

Description of Violation

Resident 1 was last evaluated for a DME on 10/26/2020. Resident 1 has not had an annual DME completed since that time.

Plan of Correction ***Directed (SK - 11/29/2022)***

The new DME for Resident 1 was completed on 09/09/2022.

Laura Smith- Moving forward, beginning on January 2023 and on a quarterly basis, the Administrator will check that all yearly medical evaluations are completed for each resident. The Administrator will also create a checklist for all residents for yearly DME due dates (see example attached).

Directed:
Resident 1's PCP conducted the medical evaluation on 09/09/2022 and was completed on 09/14/2022. The Administrator reviewed the DME to ensure all required information is captured before filing in the Resident's record.

Directed Completion Date: *11/26/2022*

Implemented (SK - 12/14/2022)

225c - Additional Assessment

7. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident 1’s last Resident Assessment-Support Plan (RASP) was completed on 12/29/2020,

Plan of Correction ***Directed (SK - 11/29/2022)***

A new RASP fro Resident 1 was completed on 08/24/2022.

Laura Smith- Moving forward beginning January 2023 and on a quarterly basis. the Administrator will assess all resident RASP documents to ensure that they are completed within the allotted time-frame of the RASP and yearly paperwork requirements.

Directed:
A new RASP for Resident 1 was completed on 08/24/2022 by the Administrator.

Directed Completion Date: *01/02/2023*

Implemented (SK - 12/14/2022)