

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

July 1, 2026

[REDACTED], CEO
FAITH FRIENDSHIP MINISTRIES INC
[REDACTED]
[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 05/05/2026, 05/06/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: FAITH FRIENDSHIP VILLA OF MOUNTVILLE **License #:** 32202 **License Expiration:** 04/24/2027
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:** Department of Labor and Industry
Type: C-2 LP **Date:** 09/10/2015 **Issued By:** Department of Labor and Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 58 **Waking Staff:** 44

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 05/06/2026

Inspection Dates and Department Representative

05/05/2026 - On-Site: [REDACTED]
05/06/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
License Capacity: 74 **Residents Served:** 58
Secured Dementia Care Unit
In Home: No **Area:** **Capacity:** **Residents Served:**
Hospice
Current Residents: 0
Number of Residents Who:
Receive Supplemental Security Income: 42 **Are 60 Years of Age or Older:** 33
Diagnosed with Mental Illness: 47 **Diagnosed with Intellectual Disability:** 12
Have Mobility Need: 0 **Have Physical Disability:** 2

Inspections / Reviews

05/05/2026 Full
Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 05/29/2026

06/02/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/01/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 06/09/2026

06/12/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/01/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 07/01/2026

07/01/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/01/2026

Reviewer: [REDACTED]

Follow Up Type: Not Required

65f - Training Topics

1. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

Description of Violation

Staff Member A and Staff Member B did not have training in infection control for calendar training year January 2025 through December 2025.

Plan of Correction

Accept (█ - 06/12/2026)

Administrators had the inaccurate understanding that 65.f could include other credited topics as substitutes toward their annual training year calendar. Staff member A and Staff member B completed the training in infection control by the Administrator on May 8, 2026.

Administrators have and will verify that all staff receive and complete all required trainings annually.

Administrators will review all staff trainings every 6 months to maintain compliance.

The review is also a part of the Administrator's checklist.

An initial audit of all other staff training records was completed on 6/4/26 by the Administrator. Two additional staff were found to be out of compliance and will complete makeup training from the Administrator by 6/30/26. An audit will be completed by the Administrator in another 6 months and every six months afterwards.

Licensee's Proposed Overall Completion Date: 06/30/2026

Implemented (█ - 07/01/2026)

65g - Annual Training Content

2. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- 5. Falls and accident prevention.

Description of Violation

Staff Member A did not have training in falls and accident prevention for calendar training year January 2025 through December 2025.

Plan of Correction

Accept (█ - 06/12/2026)

Administrators had the understanding that 65.f could include other credited topics as substitutes toward their annual training year calendar. Staff member A completed the training on falls and accident prevention by the Administrator on 5/8/2026.

Administrators will verify that all staff receive and complete all required trainings annually. Administrators will review all staff trainings every 6 months to maintain compliance. The review is part of the Administrator's checklist.

An initial audit of all other staff training records was completed on 6/4/26 by the Administrator. Two additional staff were found to be out of compliance and will complete makeup trainings from the Administrator by 6/30/26.. An audit will be completed by the Administrator in another 6 months and every six months afterwards.

65g - Annual Training Content (continued)

Licensee's Proposed Overall Completion Date: 06/30/2026

Implemented () - 07/01/2026

87 - Lighting

3. Requirements

2600.

87. Lighting - The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

On 5/5/26 the exterior emergency exit on the east side of the home did not have adequate illumination.

Plan of Correction

Accept () - 06/12/2026

A new motion detector light fixture was added to the exterior emergency exit on 5/5/2026 by the Maintenance Manager.

To maintain compliance with adequate illumination the Maintenance Manager will check all hallways, interior steps, outside doorways, ramps, fire escapes, evacuation routes and outside walkways, etc. as part of his monthly preventative maintenance checks and daily walk throughs.

On a monthly basis, the Administrator will review the Maintenance Manager's monthly checklist to ensure compliance.

An initial audit of all other rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes was completed on 6/8/26. The monthly preventative maintenance checks were completed on 6/10/26 by Maintenance Manager. The monthly Administrator review of the Manager's checklist will begin on 6/15/26.

Licensee's Proposed Overall Completion Date: 06/15/2026

Implemented () - 07/01/2026

91 - Telephone Numbers

4. Requirements

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There were no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident room #112b.

Plan of Correction

Accept () - 05/29/2026

On 5/5/2026, after the inspection the Administrator surveyed all resident rooms for emergency numbers and discovered that most rooms were in compliance.

91 - Telephone Numbers (continued)

To prevent possible violations concerning this regulation all resident rooms will be checked and have emergency numbers posted in their room by 5/22/2026. An updated list was posted 5/22/2026. All resident rooms will be checked quarterly going forward as part of the Administrator's checklist.

Licensee's Proposed Overall Completion Date: 05/22/2026

Implemented (█) - 07/01/2026)

121a - Unobstructed Egress

6. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

Resident room #206, occupied by two residents, lacked adequate space for both residents to safely evacuate in the event of an emergency. There are mounds of personal belongings in the room which prevent the bedroom door from fully opening and permit only a 14" pathway at the narrowest point.

Plan of Correction

Accept (█) - 06/12/2026)

On 5/29/2026, the Administrators met with the two residents residing in Room #206 regarding excessive personal belongings that are obstructing safe emergency egress within the room. The accumulation of belongings currently prevents the bedroom door from fully opening and reduces the accessible pathway to approximately 14 inches at its narrowest point. The residents were formally instructed to clear the excessive accumulation and restore safe and adequate egress pathways within the room.

Faith Friendship Ministries has worked with these residents over an extended period to address excessive accumulation and hoarding concerns through repeated staff interventions, encouragement, environmental monitoring, and requests for assistance from the residents' appointed representative. While limited progress has been achieved, the room has remained noncompliant with life safety and emergency egress expectations.

The residents will be provided up to 60 days to substantially clear the room and restore safe access pathways. During this time, staff will continue to provide support, reminders, and monitoring. At the conclusion of the first 30-day period, the Administrators will complete a follow-up inspection of Room #206. If the room remains unsafe or noncompliant, Faith Friendship Ministries will pursue additional corrective actions consistent with resident rights, safety obligations, and other applicable measures to ensure safety for all.

To maintain ongoing compliance, Room #206 will be inspected monthly by the Administrators for safe egress and excessive accumulation concerns. This inspection item will be added to the Administrators' routine environmental and safety compliance checklist.

Monthly inspection of room #206 began on 5/29/26. The start date for the 60-day time period began on 5/28/26. A safe pathway has been implemented with staff assistance. Care Management Staff will inspect the room bi-weekly to ensure the pathway is unobstructed and remains unobstructed.

121a - Unobstructed Egress (continued)

Licensee's Proposed Overall Completion Date: 06/30/2026

Implemented (█) - 07/01/2026

125b - Combustible Restrictions

7. Requirements

2600.
125.b. Combustible materials shall be inaccessible to residents.

Description of Violation

On 5/4/26 at 11:10 AM, a partially full red five-gallon gasoline can was unlocked, unattended, and accessible to residents next to the maintenance shed.

Plan of Correction

Accept (█) - 06/12/2026

On 5/5/2026 the Maintenance Manager removed the five-gallon gasoline can that was setting next to the maintenance shed.

Administrators met with the Maintenance Manager on 5/28/2026 to learn why the five-gallon gasoline can was left unattended. The Maintenance Manager did admitt to a lapse in judgement in leaving the five-gallon gasoline can unattended.

Going forward the five-gallon gasoline will be kept off the premises in a rented pole barn.

The Maintenance Manager's checklist will also include weekly checks for flammable items near the maintenance shed.

All staff will receive education on 2600.25(b) from the Administrator. The start date for weekly checks is 5/5/26 and continuing.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented (█) - 07/01/2026

127a - Portable Space Heaters

8. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 5/5/26 at 10:15 AM, an electric portable space heater was located on the 3rd floor of the home.

Plan of Correction

Accept (█) - 05/29/2026

On 5/21/2026 the Administrator removed the portable space heater which was located on the 3rd floor of the attic.

The Administrator did notified all staff via email on 5/22/2026that no portable space heaters are permitted on the home's property going forward. Administrator removed the portable space heater on 5/22/2026.

As of 5/28/2026 the Maintenance Managers's checklist includes a quarterly check that no space heater is in the building.

Licensee's Proposed Overall Completion Date: 05/28/2026

127a - Portable Space Heaters (continued)

Implemented (█) - 07/01/2026)

132b - Safety Inspection/Fire Drill

9. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's last fire safety inspection and supervised fire drill was conducted on 4/20/26. The previous fire safety inspection and supervised drill was conducted on 1/17/25.

Plan of Correction

Accept (█) - 06/12/2026)

During the cited compliance period, the required supervised annual fire drill was not completed within the required timeframe due to communication and scheduling disruptions associated with the merger of local fire companies. Faith Friendship Ministries did not receive its usual scheduling coordination during the transition period, resulting in the annual supervised drill not being conducted prior to the compliance deadline.

The Administrator contacted the Mountville Fire Company on 5/21/2026 to schedule the required supervised annual fire drill for 2027 prior to the April 20 compliance deadline. The Fire Company advised that scheduling for supervised drills and inspections is completed approximately two months prior to the requested date and therefore could not yet formally schedule the drill. Documentation of this communication is attached.

The Administrator and Maintenance Manager will ensure the supervised annual fire drill and related fire safety inspection are scheduled within the Fire Company's allowable scheduling timeframe in advance of future compliance deadlines.

To maintain ongoing compliance, the Administrator will monitor completion and scheduling of required monthly and annual fire drills through the Administrator's routine compliance checklist to ensure all drills are conducted and documented within required timeframes. In addition, the Administrator will complete an audit every 6 months.

Licensee's Proposed Overall Completion Date: 06/11/2026

Implemented (█) - 07/01/2026)

181f - Record of Medication

10. Requirements

2600.

181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 5/5/26, Resident #1's record did not include a current list of medications.

Plan of Correction

Accept (█) - 06/12/2026)

On 5/5/2026 the Care Manager spoke to Resident #1 and communicated with the physician concerning the

181f - Record of Medication (continued)

matter. On 5/11/2026 the resident and Care Manager met with physician. See attachment. On 6/10/26, care manager for resident #1 reach out to the physician to get an update on resident #1 status for self-administration.

Beginning on 6/10/26 Train the Trainers completed the initial check and education was provided to all self-administering residents. Beginning the week of 6/22/26 Care Managers will conduct bi-monthly checks of all resident lock boxes for proper administration of their own medications, mars and residents understanding. The check will include all current lists of prescriptions, CAMs and OTCs. As part of the education to self-administering residents, each resident was provided a copy of their MAR and what is expected to be in their lock box. They were also provided education on what to do if they need to add or subtract any medication.

Administrators will conduct quarterly checks beginning 9/1/26.

On June 10, 2026, Care Manager reached out to

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented (█ - 07/01/2026)

183b - Meds and Syringes Locked**11. Requirements**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 5/5/26 at 10:51 AM, Resident #2's Lisinopril 10 MG tablet was unlocked, unattended and accessible on the radiator in the resident's bedroom.

On 5/5/26 at 10:50 AM, Resident #1's locking medication storage box was unlocked, unattended and accessible on the floor of the resident's bedroom. The box contained Prilosec 40 MG capsules and Escitalopram 20 MG tablets.

Plan of Correction

Accept (█ - 06/12/2026)

On 5/5/2026 the Administrator spoke to Resident #2 about the issue and on 5/5/2026 the Care Manager spoke to Resident #2. █ was asked to keep █ medications in █ lock box until time of administration. Resident #2's care manager spoke to resident as well about the importance of keeping █ medications locked. Going forward we will put Resident #2 on a 30 day trial with close monitoring by the Care Manager on a bi-monthly report.

On 5/5/2026, Resident #1 had lock box unattended and not locked. It was brought to staff's attention by inspectors and when staff opened the box it was discovered that Resident #1 was not taking their medication for about 2 months and had other OTC medication in the box that was not on the MAR. On 5/6/2026, two care managers spoke with resident #1 about their concerns about this and resident #1 agreed to go see primary care physician on 5/11/2026, and also agreed to allow staff to administer █ medications until █ was reassessed by █ physician. On 6/10/26, care manager reach out to physician who is on vacation until 6/23/26, to get status on self-administration.

183b Meds and Syringes Locked (continued)

Beginning on 6/10/26 Train the Trainers completed the initial check and education was provided to all self administering residents. Beginning the week of 6/22/26 Care Managers will conduct bi monthly checks of all resident lock boxes for proper administration of their own medications, mars and residents understanding. The check will include all current lists of prescriptions, CAMs and OTCs. Administrators will conduct quarterly checks beginning 9/1/26.

Licensee's Proposed Overall Completion Date: 06/26/2026

Implemented (█ - 07/01/2026)