

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001128	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER FRIENDS FELLOWSHIP COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 CHESTER BLVD RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00105781.</p> <p>Complaint IN00105781 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: March 29 & 30, 2012</p> <p>Facility number: 001128 Provider number: 001128 AIM number: N/A</p> <p>Survey team: Angel Tomlinson RN TC Barbara Gray RN</p> <p>Census bed type: Residential: 141 NCC: 62 Total: 203</p> <p>Census payor type: Other: 203 Total: 203</p> <p>Sample: 3</p> <p>Friends Fellowship was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00105781.</p> <p>Quality review completed 4/2/12 by Jennie Bartelt, RN.</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE