STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS FELLOWSHIP COMMUNITY	2030 CHESTER BLVD, RICHMOND, , 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to a Residential Licensure Survey completed on 9/16/25. This visit included the PSR to a State Licensure Survey and Intakes 463737 and 464441. Intake 463737 - Corrected Intake 464441 - Corrected Survey Dates: December 16 and 17, 2025. Facility number: 001128 Residential: 92 Friends Fellowship Community was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Residential Licensure Survey. Quality review completed on December 19, 2025.	R 0000	Preparation and execution of this Plan of Correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed by the provisions of Federal and State law. Facility cordially request paper compliance	

R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.	R 0240	1. Escutcheons were replaced by the Maintenance Director the day of the survey. 2. All residents have the potential to be affected. The Maintenance Director or Designee, will randomly check 5 sprinkler heads, 3 times a week for 6 weeks. Executive Director will monitor for compliance. 4. The Maintenance Director will report findings to the Quality Assurance Committee monthly or as needed for review.	02/17/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURERoger scott Piotrowicz	TITLEExecutive Director	(X6) DATE02/19/2026