STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/07/2026

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 an investigation of State Intake 3049893. Intake 3049893- State deficiencies related to the allegations are cited at 9999. Unrelated deficiencies cited. Survey Dates: July 6 & 7, 2026 Facility number: 001128 Census bed type: NCC: 60 Residential: 76 Total: 136 Census Payor type: Other: 136 Total: 136 This deficiency reflects State Findings cited in accordance	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	

	with 410 IAC (Indiana Administrative Code) 16.2-3.1. Quality review completed 7/9/26.			
R 9999	FINAL OBSERVATIONS 410 IAC 16.2-3.1-45 Accidents Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1 Sec. 45. (a) The facility must ensure the following: (1) The resident's environment remains as free of accident hazards as is reasonably possible. (2) Each resident receives adequate supervision and assistive devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision for a wandering resident, resulting in elopement for 1 of 3 residents reviewed for elopement. (Resident B) Findings include:	R 9999	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 **Elopement:** **Immediate Actions:** Melissa Harrison, RN, Director of Nursing came to unit on 6/20/26 at 1:48pm to complete investigation and in-person interviews with all nursing staff involved. Melissa provided immediate review of elopement policy to all staff. Melissa also provided immediate education on intervention to prevent any further elopement risks.Amanda Foreman, RN updated resident care plan. Melissa Harrison, RN, DON reviewed Sharon Howell’s care plan and updated on 6/20/26. All nursing staff working on 6/20/26 in The Courtyards were in-serviced on new interventions	07/10/2026

	The clinical record for Resident B was reviewed on 7/6/26 at 2:00 p.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety, and convulsions (condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body). The Annual Minimum Data Set (MDS) assessment, dated 4/6/26, indicated Resident B was severely cognitively impaired, had verbal and physical behaviors toward others, behaviors not directed toward others such as pacing, and wandered daily. A facility reported incident, dated 6/20/26, indicated on 6/20/26 at 11:20 a.m. Resident B was ambulating around secured memory care unit 1 and secured memory care unit 2 (the units are attached by a courtyard and door). Resident B had been let outside into the conjoining locked courtyard from memory care unit 2. She then entered the far south courtyard door into memory care unit 1. Resident B then ambulated in a straight direction through memory care unit 1 and out the emergency/fire door on the far north side of memory care unit 1. The door alarmed and opened after 15 seconds, then continued alarming. Resident B		added to resident's care plan on 6/20/26. Nursing staff and Life Enhancement staff working on 6/20/26 educated on proper communication when need to leave the common area arises. All staff provided training and re-education on Elopement Policy. Staff re-educated that staff member (nursing, Life Enhancement, Dietary) must be present in the open common area at all times. If a need arises that staff must move from the area, communication must be made with another staff to ensure the common area has 24-hour supervision. Melissa Harrison, RN, DON provided written update of expectation for 24-hour coverage of common area and elopement policy to all employees assigned to work in The Courtyards. This was provided on 6/20/26 via email or text message to all staff not at work on the date of incident.Staff provided acknowledgement of re-education and receipt of re-education to Melissa Harrison, RN, DON by 6/22/26. **Identification of Other Areas at Risk:** The fire door on The Courtyards Level Two is identical space that places residents at risk for elopement.	

	exited the door and ambulated to the parking lot in front of the building where she was found by a visitor and returned to the building. During an observation and interview with the Director of Nursing (DON) on 7/6/26 at 1:20 p.m., indicated during the day they leave the doors unlocked to the outside courtyard between memory care unit 1 and memory care unit 2. The DON indicated Resident B was on memory care unit 2 and walked through the outside courtyard into memory care unit 1 and went out the back emergency door. The facility did not have cameras. Observation of the outside of the back door where Resident 2 had exited was a parking lot and pond that sat approximately 100 ft (feet) away. The DON indicated when the incident happened, the emergency doors were set to alarm and unlock immediately (within 15 seconds without holding it in), and the problem was there were no staff to hear the alarm initially. One staff member was giving a bath, one was in a room helping with the bathroom door shut, there was a staff member floating between the two units, one staff member was in the restroom, and two had taken lunch. None of the staff communicated with the others about being off of the		**Identification of Other Residents at Risk for Elopement:** All resident residing in The Courtyards are at risk for elopement. The DON or designee will assess all other residents residing in the Healthcare Center (SNF) and Assisted Living/Residential areas with like conditions, put appropriate interventions into place and document the interventions on the plan of care. Melissa Harrison, RN updated the Elopement Binders with all residents at risk for elopement. This includes the resident name, height, weight, picture and face sheet information. The binders are kept in The Courtyards, The Healthcare Center and the Main Office. **System Changes/Staff Education:** All nursing staff members that work in The Courtyards were provided with re-education of Elopement Policy and safety interventions. Training was provided on 6/20/26 either in-person or via digital education per Melissa Harrison, RN, DON. All staff provided acknowledgement of re-education by 6/22/26. Re-education of elopement and	

	floor. Memory care unit 1 and memory care unit 2 alarms were not combined, so memory care unit 2 could not hear the alarms. Now the door was set to alarm immediately and has a hold time of 15 seconds before it will unlock. The DON indicated Resident B ended up in the front parking lot and a visitor had returned her to the building. During an interview with Certified Nurse Aide (CNA) 2 on 7/6/26 at 1:30 p.m.., indicated the on call nurse had already left for the day and she was the only CNA on memory care unit 1 on 6/20/26. CNA 2 indicated she informed the Staff Assistant that she had a resident that she still had to get out of bed and bathed for the day, so she was in that resident's room with the restroom door and outside door closed. CNA 2 indicated she had to stepped outside of the restroom and when she did, she heard the exit door alarming. She then ran back to the alarming door, looked outside, and did not see anyone outside. CNA 2 then did a headcount for all residents on memory care unit 1, all residents were accounted for, so she informed Qualified Medical Assistant (QMA) 6 who was on memory care unit 2 that all resident's were accounted for and QMA 6 indicated she had let Resident B out into the locked outside		safety interventions reviewed with Life Enhancement staff members who work in The Courtyards on 6/25/26 at 12:00pm. Re-education of elopement and safety interventions reviewed with Dietary staff members who work in The Courtyards on 6/25/26 at 11:00am. Re-education of elopement and safety interventions reviewed with Environmental Service staff members who work in The Courtyards on 6/26/26 at 10:00am. Maintenance Department provided fire door inspection report of The Courtyards fire doors. No concerns noted. Maintenance Director ordered Emergency Exit Only sign on 6/23/26 to be placed on the fire exit doors of The Courtyards Level 1 and Level 2. Upon receipt, these will be placed at eye level on both fire doors in The Courtyards Level 1 and 2. Maintenance Director changed the nuisance switching on the crash bars on both fire doors of The Courtyards Level 1 and 2 on 6/23/26. The setting was changed from immediate to 3 seconds to allow the staff a few more seconds to hear the alarm and act accordingly.The volume was checked and was appropriate for staff to hear. Maintenance Director has reached out to 2 vendors to see	

courtyard earlier and to look there. CNA 2 indicated Resident B was not in the outside courtyard and once all residents but Resident B were accounted for on memory care unit 2, QMA 6 notified the healthcare nurse and maintenance. CNA 2 indicated a few minutes had passed and the resident was brought back in by a visitor. CNA 2 indicated Resident B continues to exit seek and required continual re-direction.

A facility conducted interview with QMA 6, dated 6/20/26 at 1:45 p.m., indicated she was on memory care unit 2 assisting with cleaning up and dining room tables after lunch and could not hear the door alarms. CNA 2 had called QMA 6 to notify her of the door alarm, and that everyone was accounted for on Courtyard 1. QMA 6 then did a census count and found that Resident B was missing. QMA 6 immediately called the healthcare nurse to notify them.

During an interview with CNA 7 on 7/6/26 at 2:30 p.m., indicated he had been assigned to float between memory care unit 1 and memory care unit 2, and was in the central bathing area with the door closed providing a whirlpool to a resident. CNA 7 indicated he did not hear the door alarming.

A facility conducted interview

if the annunciator panels on The Courtyard Level 1 and Level 2 can be connected so that when a door is opened on either level of care both levels of care can hear the alarm.

Ongoing Monitoring:

Melissa Harrison, RN, DON or designee will be conducting Elopement Drills on every shift once weekly x 4 weeks. The results of the drills will be reviewed during the monthly Quality Assurance meeting to be held August 12, 2026.

Maintenance Director to complete daily check of fire alarm doors in The Courtyards to ensure doors and alarm on doors are functioning appropriately.
Maintenance Director will provide a review of the daily fire door inspections at the August 12, 2026 Quality Assurance Meeting.

Resident Abuse:

Immediate Action:
On 6/25/26 at 3:00pm, Ella Claypoole, CNA and Tiffany Cooper, CNA reported to Melissa Harrison, RN/DON and Jeremy Studt, RN/ADON, the events of 6/2/26. Scott Piotrowicz, Administrator immediately notified at 3:15pm on 6/26/26 by Jeremy Studt, RN/ADON.

	with CNA 8 on 6/20/26 at 2:00 p.m. indicated she was in the restroom at the initial time the emergency door was alarming, and upon exiting was updated by QMA 6 of Resident B missing and she notified maintenance to do a complete search of the outside grounds. During an interview with Registered Nurse (RN) 15 on 7/7/26 at 12:15 p.m., indicated she was notified about Resident B missing after QMA 6 notified her after the fact and she had to fill out an incident report about it. RN 15 indicated QMA 6 had told her she was struggling that day and she could not keep an eye on both sides. QMA 6 also indicated 2 staff members were at lunch during the time Resident B got out of the door. RN 15 indicated she instructed QMA 6 to communicate those needs to nursing staff, because she had a CNA and a Staff Assistant who she could have sent over to help. During an interview with the Director of Maintenance on 7/7/26 at 8:56 a.m., indicated emergency exit doors were set to alarm immediately once the egress bar was held down and would automatically open within 15 seconds. Now when the egress bar would be held down, it would alarm, but was set for 3 seconds hold time before the		Melissa Harrison, RN/DON and Jeremy Studt, RN/ADON immediately initiated an investigation. Aailyah McBride, C.N.A. was terminated from employment at Friends Fellowship Community immediately after investigation was completed on 6/25/26 at 3:45pm. The Staff members (Tiffany Cooper, CNA and Ella Claypoole, CNA) that reported the incident were educated and counseled immediately of the Abuse and Neglect Policy. Initial reporting was reviewed and education provided regarding immediate reporting to Administrator or designee. **Identification of Other Residents at Risk:** All residents have the potential to be affected. All staff members required to complete the Resident Abuse training on Healthcare Academy. Notification sent on 6/26/26 at 10:55am to all staff via One Call. Melissa Harrison, RN/DON had all nursing staff members complete verbal abuse and physical abuse pre and post test on 7/9/26. Tests graded and must pass with 80% passing rate. Should the 80% proficiency not be achieved the Social Service Director, Director of Nursing or Designee will provide	

door would open 15 seconds later. This was put into place to give staff a little bit longer to react. The Maintenance Director indicated the egress bar annunciated itself, and also behind the annunciator panel behind the nurse's desk. The problem was the annunciators between memory care unit 1 and memory care unit 2 were not combined, so you could not hear what is going on on the other side. A 3 second nuisance time was now in place.

During an observation on 7/6/26 at 12:11 p.m., Resident B was confused, ambulating around memory care 2, aimlessly standing at doors, and required re-direction from staff on several attempts.

A plan of care, dated 4/6/26, indicated Resident B was an elopement risk/wanderer related to disorientation to place, aimless wandering, and impaired safety awareness. The interventions included, but were not limited to, maintain continuous supervision of resident and ensure the unit was never left unattended by staff at any time.

An "Elopement/Wandering" policy was provided by the DON on 7/6/26 at 12:00 p.m. It indicated " ...Policy: Friends Fellowship Community wants to ensure that that residents who

individualized training on areas of concern.

Ongoing Monitoring:
Human Resources is tracking all completed inservice training for employees.
Every employee will be required to pass the Resident Abuse competency test following Resident Abuse training during orientation, annual in-service training and monthly in-services with a score of 80% or higher. Should the 80% proficiency not be achieved the Social Service Director, Director of Nursing or Designee will provide individualized training on areas of concern.
All new hired employees will be educated on Resident Abuse Policy and Procedure during the orientation process.The Social Services Director, Director of Nursing and Human Resources Manager will be responsible for maintaining continuous documentation of employee training on abuse prohibition. Documentation will be kept within the individual employee personnel file.
The Director of Nursing will provide monthly in-service training to all nursing staff from July 2026 thru April 2027 on the following abuse topics:
July 8,2026 -Verbal Abuse and Steps on proper reporting suspicions of abuse
August 19, 2026- Sexual Abuse

	display wandering behavior and/or are at risk for elopement receive adequate supervision to prevent incidents and receive person-centered care addressing their unique features contributing to exhibiting a wandering or elopement risk ...Definitions: "Elopement" occurs when a resident leaves the premises and/or a safe area without authorization (such as an order for discharge or leave of absence) and/or any necessary supervision to do so ... Policy Explanation and Compliance Guidelines: ...2. The Healthcare Center and The Courtyards are equipped with door locks/alarms to help avoid elopements (Friends Fellowship Community acknowledges that alarms are not a replacement for supervision.) ..." This State deficiency relates to intake 3049893. 410 IAC (Indiana Administrative Code)16.2-3.1-27 Abuse and neglect Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1 Sec. 27. (a) The resident has the right to be free from: (1) mental abuse; (b) The resident has the right to be free from verbal abuse. Based on interview and record review, the facility failed to keep a resident free from mental and verbal abuse as evidenced by roughly assisting a resident		September 23, 2026- Physical Abuse October 21, 2026- Mental/Psychological Abuse November 18, 2026- Involuntary Seclusion December 16, 2026- Neglect (physical, medical, emotional) January 20, 2027-Misappropriation of resident property February 17, 2027- Behavioral symptoms (Combative or aggressive behaviors that pose a threat to resident (s), staff or others in the facility) March 17, 2027- Types and characteristics of potential abusers April 21, 2027- How to recognize the signs of burnout, frustration and stress in self and co-workers.	

back to bed and saying, "die already" for 1 of 3 residents reviewed for abuse. (Resident C)

Finding include:

The clinical record for Resident C was reviewed on 7/7/26 at 8:56 a.m. The diagnoses included, but were not limited to, legal blindness, anxiety, depression, and senile degeneration of the brain.

The Quarterly Minimum Data Set (MDS) assessment, dated 5/20/26, indicated Resident C was severely cognitively impaired, had no physical or verbal behaviors toward others, and did not have behaviors for rejecting care.

A facility reported incident, dated 6/25/26, indicated on 6/2/26, Resident C was transferred to memory care unit 2 from the healthcare center at 1:45 p.m. Between 3:00 p.m.-5:00 p.m. Certified Nurse Aide (CNA) 4 and CNA 14 were attempting to transfer Resident C from wheelchair to bed. It indicated Resident C was experiencing increased anxiety and resistance to care. CNA 13 who was assigned to work memory care unit 1, came over to memory care unit 2 and entered the room to help. CNA 4 and CNA 14 were giving Resident verbal cues , and CNA

13 stepped in stating "I'll just do it". CNA 13 then forcibly grabbed Resident C under bilateral arms without using the gait belt from the wheelchair and placed her in the bed forcefully. Prior to leaving the room CNA 13 stated "she just needs to die already".

During an interview with the Director of Nursing (DON) on 7/6/26 at 1:04 p.m. indicated CNA 14 reported to her that CNA 13 entered Resident C's room when herself and CNA 4 were attempting to get Resident C back to bed. Resident C was anxious and tearful already from having been moved rooms that same day. CNA 13 said," I'll just do it", swooped Resident C up under her arms, was rough with the resident, picked her up, without a gait belt, and forcibly placed her in the bed. CNA 14 indicated CNA 13 then said, "she just needs to die already" before leaving the room.

During an interview with CNA 5 on 7/6/26 at 2:40 p.m., indicated they were not in the room when CNA 4 and CNA 14 were assisting Resident C back to bed. CNA 5 indicated when CNA 4 came out of the room, they stated, "CNA 13 just body slammed Resident C and told her she needed to die already. CNA 5 indicated she spoke with CNA 14 a couple days after the

incident and CNA 14 did report to her that CNA 4 did forcibly pick Resident C up out of the wheelchair, without a gait belt, and put her back in the bed forcibly, and afterward, prior to leaving the room said, "she just needs to die already".

A plan of care, dated 5/29/26, indicated Resident C had behavior problems (anxious, restless, agitated) related to depression and anxiety. The interventions included, but were not limited to, caregivers to provide opportunity for positive interaction, attention and approach and speak in a clam manner.

An "Abuse and Neglect" policy was provided by the Director of Nursing (DON) on 7/6/26 at 10:58 a.m. It indicated " ...Policy: Residents have the right to be free from abuse, neglect, exploitation, and misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, freedom from discrimination due to a resident's sexual orientation or gender identity, involuntary seclusion and any physical or chemical restraint that is not required to treat the resident's medical symptoms ...Definitions: 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or

	punishment with resulting physical harm, pain or mental anguish ...6. Mistreatment: Inappropriate treatment or exploitation of a resident ...11. Willful: Means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm ... 410 IAC (Indiana Administrative Code)16.2-3.1-28 Staff treatment of residents Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1 Sec. 28. (a) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. Based on interview and record review, the facility failed to timely report an allegation of abuse to the Indiana Department of Heath (IDOH) for 1 of 3 residents reviewed for			

abuse. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 7/7/26 at 8:56 a.m. The diagnoses included, but were not limited to, legal blindness, anxiety, depression, and senile degeneration of the brain.

The Quarterly Minimum Data Set (MDS) assessment, dated 5/20/26, indicated Resident C was severely cognitively impaired, had no physical or verbal behaviors toward others, and did not have behaviors for rejecting care.

A facility reported incident, dated 6/25/26, indicated on 6/2/26, Resident C was transferred to memory care unit 2 from the healthcare center at 1:45 p.m. Between 3:00 p.m.-5:00 p.m. Certified Nursing Assistant (CNA) 4 and CNA 14 were attempting to transfer Resident C from wheelchair to bed. It indicated Resident C was experiencing increased anxiety and resistance to care. CNA 13 who was assigned to work memory care unit 1, came over to memory care unit 2 and entered the room to help. CNA 4 and CNA 14 were giving Resident verbal cues , and CNA 13 stepped in stating "I'll just do it". CNA 13 then forcibly grabbed Resident C under

bilateral arms without using the gait belt from the wheelchair and placed her in the bed forcefully. Prior to leaving the room CNA 13 stated "she just needs to die already".

During an interview with the Director of Nursing (DON) on 7/6/26 at 1:04 p.m. indicated CNA 14 reported to her that CNA 13 entered Resident C's room when herself and CNA 4 were attempting to get Resident C back to bed. Resident C was anxious and tearful already from having been moved rooms that same day. CNA 13 said," I'll just do it", swooped Resident C up under her arms, was rough with the resident, picked her up, without a gait belt, and forcibly placed her in the bed. CNA 14 indicated CNA 13 then said, "she just needs to die already" before leaving the room. The DON indicated she was not informed about this incident until 6/25/26 at 3:00 p.m. CNA 14 and CNA 5 were who reported to the DON. This indicated the abuse allegation was not reported for 23 days after it occurred.

During an interview with CNA 5 on 7/6/26 at 2:40 p.m., indicated they were not in the room when CNA 4 and CNA 14 were assisting Resident C back to bed. CNA 5 indicated when CNA 4 came out of the room,

they stated, "CNA 13 just body slammed Resident C and told her she needed to die already". CNA 5 indicated she spoke with CNA 14 a couple days after the incident and CNA 14 did report to her that CNA 4 did forcibly pick Resident C up out of the wheelchair, without a gait belt, and put her back in the bed forcibly, and afterward, prior to leaving the room said, "she just needs to die already". CNA 5 indicated she did not know why she did not report the abuse sooner to the DON or Administrator and the longer she thought about it, she knew it needed to be reported. CNA 5 indicated looking back she would have reported it sooner because she knew that it was wrong and knew how she would have felt if that was her family member.

An "Abuse and Neglect" policy was provided by the Director of Nursing (DON) on 7/6/26 at 10:58 a.m. It indicated " ...4. Protect the resident: a. Assess the Involved Resident(s): i. Staff should report all incidents/allegations immediately to the Executive Director/Administrator or designee ...5. Initial Report: a. Timing: i. Executive Director/Administrator. All incidents and allegations of Abuse, Neglect, Exploitation, Mistreatment and

	Misappropriation of resident property and all Injuries of Unknown Source must be reported immediately to the Executive Director/Administrator or designee. The Executive Director/Administrator/designee should be notified by informing him/her in person, calling via telephone, or sending an email or text message ...ii. ISDH: If any form of abuse is alleged (e.g., physical, verbal, etc.) the Executive Director/Administrator or his/her designee will notify ISDH immediately, but not later than 2 hours after the allegation is made or the serious bodily injury identified ..."			

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 SIGNATUREMelissa	TITLEHarrison	(X6) DATE07/15/2026