STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 01 B. WING	11/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code State Licensure Survey was conducted by the Indiana Department of Health. Survey Date: 11/26/24 Facility Number: 001128 Provider Number: NA AIM Number: NA At this Life Safety Code survey, Friends Fellowship Community was found not in compliance with Requirements of the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open to the corridors and hard wired smoke detectors in the 24 Courtyard Hall resident rooms and battery operated smoke detectors in the 35 Health Center Hall resident rooms. The facility has a capacity of 92 and had a census of 46 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 12/04/24	K 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 solely because it is required by the provisions of federal and state law. Facility cordially requests paper compliance.	
K 0012 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Rees	Interim Executive Director	12/26/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Based on record review, observation and interview; the facility failed to ensure the construction type for the facility was maintained. This deficient practice could affect over 20 residents, staff and visitors in the Healthcare Center area of the facility. Findings include: Based on review of facility blueprint documentation with the Maintenance Director during record review from 10:05 a.m. to 1:00 p.m. on 11/26/24, the construction type for the Healthcare Center is Type V(111). Review of the blueprint information also indicated a "2-hour fire wall to remain" at the corridor door set by Room 41 in the Healthcare Center. Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 2:55 p.m. on 11/26/24, the corridor door set outside Room 41 in the Healthcare Center was equipped with 90-minute fire resistance rating labels affixed to the hinge side of each door and was also equipped with self-closing devices and latching hardware to latch each door into the door frame. Numerous holes including a rectangular shaped access hole was noted in the vertically mounted drywall in the attic in the 2-hour fire resistance rated wall above the corridor door set by Room 41. Drywall was only mounted on one side of the studs in the attic wall above the corridor door set by Room 41. The attic was accessed using an attic access door in the corridor outside Room 41. Based on interview at the time of the observations, the Maintenance Director agreed the attic wall above the corridor door set by Room 41 was not maintained as a 2-hour fire wall. These findings were reviewed with the Maintenance Director during the exit conference.	K 0012	Friends Fellowship Community will be submitting to IDoH a Life Safety Code Waiver Request, a Temporary Waiver Request, to bring the fire wall in the Healthcare Center attic up to code, a 2 hour fire wall rating. 12/26/24 - The Life Safety Code Waiver Request is attached.	03/20/2025

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	3.1-19(b)			
K 0018 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Based on observation and interview, the facility failed to ensure corridor doors to 2 of over 40 resident sleeping rooms did not have an impediment to closing and latching into the door frame. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 2:55 p.m. on 11/26/24, the corridor door to resident sleeping Room 33 was propped in the fully open position with a chair. In addition, the corridor door to resident sleeping Room 72 was also propped in the fully open position with a trash can. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned two corridor doors each had an impediment to closing and latching into the door frame. These findings were reviewed with the Maintenance Director during the exit conference.	K 0018	The Maintenance Director will complete an In-service for all Nursing personnel instructing the personnel that resident corridor doors are not to be propped open with any physical device. The Maintenance Director / Designee will conduct daily rounds to ensure 100% compliance. The Daily Rounding Form will be used to record the rounding results. Any infractions will be reported to the DON / Designee immediately. The Maintenance Director will submit a monthly report of his findings to the monthly QAPI Committee meeting. This is an ongoing process.	12/26/2024
	3.1-19(b)			
K 0029 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Based on observation and interview, the facility failed to ensure 1 of 7 hazardous areas such as soiled linen rooms were separated from other spaces by smoke resistant partitions and doors.	K 0029	The corridor door identified in the survey has been repaired and is closing properly. The Maintenance Director / Designee	12/06/2024

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	This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 20. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 2:55 p.m. on 11/26/24, the corridor door to the soiled linen room by the Janitor's Closet by resident sleeping Room 20 failed to fully self-close and latch into the door frame when tested to close multiple times. The soiled linen room contained a 100-gallon and a 96-gallon cart for soiled linen and numerous red bag waste containers. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to the aforementioned soiled linen room failed to separate this hazardous area from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		will test the door closure 3 times per week for 4 weeks and submit the findings to the QAPI Committee meeting.	
K 0038 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 1. Based on observation and interview, the facility failed to ensure the means of egress through 2 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care	K 0038	Door codes have been posted for the two exit doors identified in the report as not having door codes. The door codes allow the exit doors to be opened in the Healthcare Center. This deficiency has been completed on 12/6/24. DON / Designee will conduct an In-Service for all Nursing personnel	12/26/2024

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	occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 2:55 p.m. on 11/26/24, the exit door to the outside of the facility by Room 17 and by Room 34 in the Healthcare Center were each marked as a facility exit with an exit sign. Each exit door was magnetically locked and could be opened by entering a code at a keypad at the exit door but the code to release each exit door to open was not posted at the keypad. Based on interview at the time of the observations, the Maintenance Director stated residents who have a clinical diagnosis requiring specialized security measures reside in the Courtyards portion of the facility and agreed the code to release the aforementioned two exit doors in the Healthcare Center to open was not posted at the keypad by the exit door. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress for 1 of 6 exits was free of all obstructions which could interfere with their full instant use. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility using the exit door by resident sleeping Room 17.		regarding the proper storage of resident care equipment to ensure that corridors are free from all obstructions. The DON / Designee will conduct an audit 3 times per week for 4 weeks and 2 times per week for 4 weeks to observe that the corridors are free from all obstructions. The findings will be reported to the monthly QAPI Committee meeting. This deficiency will be corrected by 12/26/24.	

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 2:55 p.m. on 11/26/24, a stand up Hoyer lift and a Hoyer lift were stored in the corridor outside resident sleeping Room 17 near the exit door to the outside of the facility. The Hoyer lift extended 30 inches into the eight foot wide corridor. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress was not free of all obstructions which could interfere with their full instant use. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
K 0050 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Based on record review and interview, the facility failed to ensure fire drill documentation included staff participation and the staff response to fire drills conducted on all shifts for 4 of 4 quarters in the most recent twelve month period. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Director during record review from 10:05 a.m. to 1:00 p.m. on 11/26/24, documentation for fire drills performed on each shift for 4 of 4 quarters in the most recent twelve month period did not include the staff response to the fire drill and did not include the staff who participated in the fire drill.	K 0050	The Maintenance Director will review with the DON and Nursing Leadership the fire drill documentation policy. The Maintenance Director will review the fire drill documentation reports on an ongoing basis. The Maintenance Director will report the findings to the monthly QAPI Committee.	12/26/2024

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	The "Fire Drill Report" documentation listed each campus department on the report documentation but was left blank for "Nursing Department" response on all fire drills conducted within the most recent twelve month period. The aforementioned documentation also did not include "Nursing Department" staff who participated in the fire drill. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day, the fire drill report documentation is supposed to list each department's response on the campus to fire drills but agreed the aforementioned fire drill documentation did not include the Nursing Department's response to fire drills and which Nursing Department staff participated in each drill within the most recent twelve month period. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0051 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 1 of 6 smoke compartments were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 1999 Edition, Section 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by Room 24.	K 0051	The smoke detector identified in the corridor outside of the oxygen storage and transfilling room has been relocated according to the NFPA 72, 1999 Edition, Section 2-3.5.1 to allow for the proper operation of the smoke detector.	12/03/2024

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 2:55 p.m. on 11/26/24, the ceiling mounted smoke detector located in the corridor outside the oxygen storage and transfilling room by Room 24 was installed 18 inches from an air supply vent. Based on interview at the time of the observations, the Maintenance Director stated the smoke detector has been installed at that location for quite some time but agreed the smoke detector was installed where airflow would prevent operation of the detector. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)			
K 0052 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.1 and 9.6. NFPA 72, 1999 Edition, Section 7-3.1 states that unless otherwise permitted, visual inspections shall be performed in accordance with the schedules in Table 7-3.1, or more often if required by the authority having jurisdiction. Table 7-3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)	K 0052	A contract with New Era technology has been executed on 12/19/24 to provide visual semi-annual fire alarm inspection documentation. 12/26/24 - The Maintenance personnel will monitor the fire alarm inspection process when conducting the monthly fire drills. If there are any deficiencies identified during the fire drill, the deficiencies will be documented on the fire drill form and reported to the Maintenance Director. The Maintenance Director will be	12/19/2024

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	d. Notification appliances e. Interfaced equipment This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm & Life Safety System Inspection Certificate" documentation dated 02/12/24 with the Maintenance Director during record review from 10:05 a.m. to 1:00 p.m. on 11/26/24, visual semi-annual fire alarm system inspection documentation six months after 02/12/24 was not available for review. Based on interview at the time of record review, the Maintenance Director agreed visual semi-annual inspection documentation for the facility's fire alarm system six months after 02/12/24 was not available for review. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		responsible for monitoring the entire process and making sure that the appropriate corrections are completed.	
K 0064 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Based on observation and interview, the facility failed to ensure 1 of 84 portable fire extinguishers were maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition, Chapter 4-4.3 states portable fire extinguishers which require 12 year hydrostatic testing were emptied and subjected to the applicable maintenance procedures every six years. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 19.	K 0064	The fire extinguisher in question has been replaced with a new properly certified fire extinguisher. 12/26/24 - The systemic change in in the monitoring process will occur when Koorsen Security completes their annual exchange of fire extinguishers at the facility. The Maintenance Director will record the location of all fire	12/06/2024

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 2:55 p.m. on 11/26/24, the wall mounted portable fire extinguisher installed in the corridor outside the Clean Linen Room by Room 19 had an affixed collar indicating the most recent 6-year maintenance was performed in August 2018. The fire extinguisher maintenance contractor also affixed a sticker on the back of the fire extinguisher indicating the most recent 6-year maintenance was performed August 2016. The fire extinguisher maintenance contractor also affixed a hanging tag to the portable fire extinguisher indicating the most recent annual maintenance was performed in August 2024. Based on interview at the time of the observations, the Maintenance Director agreed it could not be ensured the most recent 6-year maintenance was performed within the most recent six year period. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		extinguishers and will verify that all the fire extinguishers are in compliance with the stated regulations. The Maintenance Director will in-service the Maintenance staff as to the potential deficiencies that could occur. The Maintenance Director will maintain the employee in-service records.	
K 0144 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Based on observation and interview, the facility failed to ensure 1 of 1 remote manual stops for the emergency generator for the facility was labeled in accordance with NFPA 99. NFPA 99, Standard for Health Care Facilities, 1999 Edition, Section 3-4.4.1.1 states emergency generators and standby power system, where required for compliance with this code, shall be installed,	K 0144	The remote manual stop station for the Emergency Generator has been properly labeled 12/26/24 - The Maintenance Department performs weekly testing on the emergency generator. The Maintenance	12/06/2024

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	tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, Section 3-5.5.6 states all installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. Section A.3-5.5.6 states the manual shutdown should be properly identified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:00 p.m. to 2:55 p.m. on 11/26/24, the remote stop for the diesel fired emergency generator for the facility located outside the building on the southeast side of the property was not labeled. Based on interview at the time of the observations, the Maintenance Director agreed the remote manual stop station was not labeled. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		Department will continue to monitor stop and record on the weekly generator log if any deficiencies are identified including the checking of the remote stop label being visible. The Maintenance Director will be responsible for ensuring the remote stop label is visible and in its proper location.	