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	01/21/2025

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 Post Survey Revisit (PSR) to the Life Safety Code State Licensure Survey conducted on 11/26/24 was conducted by the Indiana State Department of Health. Survey Date: 01/21/25 Facility Number: 001128 Provider Number: NA AIM Number: NA At this PSR 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 57 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 conducted on 01/24/25	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	NFPA 101 LIFE SAFETY CODE STANDARD			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
WILLIAM REES	Executive Director	02/21/2025

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.

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	01/21/2025

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
Bldg. 01	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 dated 12/22/87 with the Maintenance Director during record review from 9:45 a.m. to 10:15 a.m. on 01/21/25, 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. In addition, a "draft stop of 1/2 inch gypsum drywall on 3/4 inch furring" was constructed on each side of the 2 hour fire wall in the attic. Per LSC 3.3.65, a draft stop is a continuous membrane used to subdivide a concealed space to resist the passage of smoke and heat. Based on interview at the time of record review, the Maintenance Director stated the openings in the attic wall noted during the 11/26/24 Life Safety Code survey were actually in the draft stop wall protecting the 2-hour fire wall and not in the 2-hour fire wall itself. Based on observations with the Maintenance Director during a tour of the facility from 10:15 a.m. to 11:00 a.m. on 01/21/25, numerous holes including a rectangular shaped access hole was noted in the vertically mounted drywall in the attic in the draft stop wall preceding the 2-hour fire resistance rated 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	K 0012	The wall cited in the original 2567 report dated on 11/26/24 was incorrectly identified as a fire wall. The wall has been correctly identified as a smoke wall. The holes in the drywall have been repaired.	02/04/2025

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	01/21/2025

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
	Maintenance Director agreed the attic wall constructed as a draft stop above the corridor door set by Room 41 was not maintained to subdivide the concealed space to resist the passage of smoke and heat. These findings were reviewed with the Maintenance Director during the exit conference. This deficiency was cited on 11/26/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 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 1 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 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility at 10:49 a.m. on 01/21/25, the corridor door to resident sleeping Room 72 was 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 corridor door 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.**	01/31/2025

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	01/21/2025

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
	This deficiency was cited on 11/26/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 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.) 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 9:45 a.m. to 10:15 a.m. on 01/21/25, visual semi-annual fire alarm system inspection documentation six months after 02/12/24 was not available for review. Based on	K 0052	The Fire Alarm and Life Safety System Inspection was completed by New Era Technology on January 23, 2025.	01/23/2025

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	01/21/2025

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
	interview at the time of record review, the Maintenance Director stated the facility had amended its contract, as of 12/17/24, with the fire alarm system inspection contractor to perform semi-annual fire alarm system visual inspections but they had not performed those inspections by the time of the revisit on 01/21/25 and agreed visual semi-annual visual inspection documentation for the facility's fire alarm system was not available for review. These findings were reviewed with the Maintenance Director during the exit conference. This deficiency was cited on 11/26/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			