Indiana Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01</b> |  | (X3) DATE SURVEY<br>COMPLETED |  |  |  |  |
|--|--|--|---|--|-------------------------------|--|--|--|--|
|  |  | 001128   | B. WING   |  | 06/13/2025                    |  |  |  |  |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE |  |  |   |  |                               |  |  |  |  |
| FRIENDS FELLOWSHIP COMMUNITY 2030 CHESTER BLVD RICHMOND, IN 47374  |  |  |   |  |                               |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG                               | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETE                   |  |  |  |  |
| K 000  | INITIAL COMMENTS   |  | K 000   |  |                               |  |  |  |  |
|  | A Preoccupancy Survey for State Licensure survey was conducted by the Indiana Department of Health.  |  |   |  |                               |  |  |  |  |
|  | 24 NCC beds from ro from 2 beds per room   | urvey is for the relocation of oms 10-28 and 40-44 (going to 1 bed per room) to rom 0 beds to 2 beds per |   |  |                               |  |  |  |  |
|  | Survey Date: 06/13/25  |  |   |  |                               |  |  |  |  |
|  | Facility Number: 001128 Provider Number: NA AIM Number: NA   |  |   |  |                               |  |  |  |  |
|  | Community was foun<br>Requirements of the<br>Fire Protection Associates  | 2000 edition of the National<br>iation (NFPA) 101, Life<br>Chapter 19, Existing Health                   |   |  |                               |  |  |  |  |
|  | determined to be of T fully sprinkled. The fa system with smoke dincluding the baseme open to the corridors detectors in the 24 Co and battery operated Health Center Hall re- |  |   |  |                               |  |  |  |  |
|  |  | ents have customary access<br>I areas providing facility<br>ed.  |   |  |                               |  |  |  |  |

Indiana Department of Health

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

TITLE (X6) DATE

PRINTED: 06/17/2025 FORM APPROVED

Indiana Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                          | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 |   | (X3) DATE SURVEY<br>COMPLETED |  |  |  |  |  |  |
|---|--|--|--|---|-------------------------------|--|--|--|--|--|--|
|   |  | 001128   | B. WING                                    |   | 06/13/2025                    |  |  |  |  |  |  |
| NAME OF P   | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE |  |  |   |                               |  |  |  |  |  |  |
| FRIENDS FELLOWSHIP COMMUNITY  2030 CHESTER BLVD  RICHMOND, IN 47374 |  |  |  |   |                               |  |  |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG                              | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE |                               |  |  |  |  |  |  |
| K 000   | Continued From page 1  |  | K 000                                      |   |                               |  |  |  |  |  |  |
|   | Quality Review completed on 06/16/25                               |  |  |   |                               |  |  |  |  |  |  |
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