STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
			B. W	NG		11/15/2021		
		<u> </u>						
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE			
					HESTER BLVD			
FRIENDS	FELLOWSHIP CO	DMMUNITY		RICHM	OND, IN 47374			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
R 0000		· · · · · · · · · · · · · · · · · · ·						
Bldg. 00								
g.			R 0	000	Plan of correction completed for	or R	ĺ	
	This visit was for a	Residential COVID-19	I K U	300	0407, R 0414 and S 9999 on	01 11		
		Walk Through. This visit			12/3/21.			
		OVID-19 Quality Assurance			12/3/21:			
	Walk Through.	7 TD 17 Quanty Assurance						
	waik imough.							
	Survey date: Nover	mber 15, 2021						
	Survey date: 110 ver	1001 13, 2021						
	Facility number: 00	01128						
	racinty named.	,1120						
	Residential Census	· 9 <u>4</u>						
	residential consus							
	These State Resider	ntial Findings are cited in						
	accordance with 41	•						
	accordance with 11	0 110 10.2 3.						
	Quality review com	npleted on November 22,						
	2021	ipieted on 1 to temper 22,						
	2021							
R 0407	410 IAC 16.2-5-12	2(b)(1-4)						
	Infection Control -							
Bldg. 00		ist establish an infection						
g	. ,	nat includes the following:						
		enables the facility to						
		of known infectious						
	symptoms.							
		tation and in-service						
	, ,	ction prevention and						
		universal precautions.						
	_	n information to residents,						
		limited to, infection						
	transmission and							
		nmunicable disease to						
	public health auth							
	•	on, interview, and record	D O	107	Please accept this plan of		12/02/2021	
			R 0	1 U /		ible	12/03/2021	
		failed to don and doff PPE			correction as the facility's cred	INIC		
		e equipment) appropriately E was contained within trash			allegation of compliance for			
	and ensure used PP	E was contained within trash			Infection Control Survey			
					1			

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

State Form Event ID: HI2311 Facility ID: 001128 If continuation sheet Page 1 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
			B. W	ING		11/15/	/2021
						11/10/	2021
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TOTAL OF I	ROVIDER OR SOLLEE			2030 C	HESTER BLVD		
FRIENDS	S FELLOWSHIP CO	OMMUNITY		RICHM	OND, IN 47374		
	T				·		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	receptacles for 22 of	of 22 residents in the memory			completed on 11/15/21.		
	care unit of the facility.						
	·				Infection Prevention and Conti	rol:	
	Findings include: An entrance conference was conducted with the						
					The facility has established an		
					infection prevention and control		
					-		
	· ·	Nursing) and DMC (Director			program with associated policy		
	_	Communications) on 11/15/21			and procedures to provide a s	ате,	
	at 1:00 p.m. They indicated all of the residents				sanitary and comfortable		
	in the memory care unit of the facility were in				environment and to help preve		
	TBP (transmission based precautions) due to				the development and transmis	sion	
	exposure to Covid positive staff. Staff were to				of communicable diseases and	d	
	don the required PPE prior to entering the unit.				infections.		
	The DON provided a list of 22 Residents in the				Identification of residents with		
	_	of the facility on 11/15/21 at			potential to be affected by		
	I	read at the top "All in TBP d/t			noncompliance of Infection		
	-	esting/contact tracing."			Control policy and procedures		
	[due to] outbreak te	sting/contact tracing.					
	0.1 0.31	a caraca			All residents have the potentia	110	
		y was conducted with the			be affected by the deficient		
		at 1:15 p.m. During the tour,			practice.		
	an observation of the						
		rea located just prior to			410 IAC 16.2-3.1-18		
	entering the memor	y care unit, was made. There			Affected: 16-18-5-1		
	was a trash receptac	cle outside of the double					
	entryway doors into	the memory care unit. The			410 IAC 16.2-5-12 (b) (1-4)		
	receptacle had used	gowns hanging out of the top					
	_	eptacle with the lid resting on			Corrective actions put into place	ce	
		ellow stop sign on the double			due to deficient practices as lis		
	-	the unit. The stop sign			above:		
		coplet precautions requiring			Infection Preventionist providence	led	
		protection, a gown, and gloves.			education on hand hygiene,	icu	
					donning and removing person	ol.	
		d the entryway doors wearing					
	a surgical mask and pushing a rolling bin of trash.				protective equipment, standard		
		he DON he was going into			precautions and handling of so	ollea	
		nit to collect trrash. Porter 2			linen on the following dates to		
		a box of PPE located next to			each department:		
	the trash receptacle	. He applied a gown, then			o Nursing staff- 11/17/21		
	gloves, then an N95	5 mask directly over his			o Dietary, Life Enhancement,		
	surgical mask, then	eye protection glasses and			Environmental Services,		
	l ~				<u>'</u>		

State Form Event ID: HI2311 Facility ID: 001128 If continuation sheet Page 2 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
			B. WI	B. WING			2021
						,,	
NAME OF I	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
				2030 CH	HESTER BLVD		
FRIENDS	S FELLOWSHIP CO	DMMUNITY		RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION CHARGON SHOULD BE	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	entered the memory	care unit. He did not			Maintenance and Administrative	/e	
	perform hand hygei	ine prior to applying the PPE.			staff-11/18/21		
	Porter 2 was observ	red to exit the memory care			 Post test for Hand Hygiene a 	nd	
	unit still wearing hi	s gown, gloves, and N95			Standard Precautions distribut	ed	
	mask. Porter 2 remo	oved his N95 mask and			to all department directors to g	jive	
	proceeded to remov	ve the trash from the			to all staff on 11/18/21.		
	overflowing trash receptacle located next to the				 Education regarding infection 	1	
	box of PPE and placed it into his rolling trash				control policy and procedures	and	
	bin. Porter 2 then removed his gown and then his				standard precautions including		
	gloves. CNA 3 approached the entryway doors to				hand hygiene, donning and		
		nit wearing a surgical mask.			removing personal protective		
	CNA 3 retrieved ret	trieved PPE from the box of			equipment, standard precaution	ns	
	PPE. She did not perform hand hygeine and				and handling of soiled linen wi	ll be	
	proceeded to don a gown, then answer her phone				provided to each department		
	-	d place it back into her			monthly by the Infection		
	-	ned hand hygeine, then			Preventionist, or designee. Sta	aff	
		sk over her surgical mask, then			educated will be documented		
		d and gloves and entered the			monthly and returned to the		
	memory care unit.				Infection Preventionist.		
	J						
	An interview was c	onducted with the DON during			410 IAC 16.2-3.1-18		
	the above breezewa	y observation. She indicated			Affected: 16-18-5-1		
	the used gowns sho	uld not be sticking out of the					
		d Porter 2 removed his gown			410 IAC 16.2-5-12 (b) (1-4)		
	and then gloves, wh				, , ,		
		•			System Changes: -Infection		
	The Use Personal P	rotective Equipent (PPE)			Preventionist has completed		
		atients with Confirmed or			infection control rounds in yello	OW	
	_	19 guidelines was provided			transmission-based areas.		
	-	15/21 at 2:30 p.m. It read,			Immediate action was taken for	r	
		on the gear):1. Identify and			the following:		
		PE to don2. Perform hand			o Trash bins were moved from	1	
		sanitzer. 3. Put on isolation			outside resident room to inside		
					resident room at exit to ensure	-	
	gown4. Put on NIOSH-approved N95 filtering a facepiece respirato or hiigheer5. Put on face				staff are removing personal		
		6. Put on gloves7. HCP			protective equipment as close	to	
	0 00	nel] may now enter patient			exit as possible and to ensure		
		ing off the gear):1.			transmission is possible to		
		. Remove gown3. HCP			hallway. This was completed b	nV	
		nt room. 4. Perform hand			end of day 11/15/17.	· y	
	may now exit paties	nt 100m. 4. 1 criomi lianu			Gild Ol day 11/13/17.		

State Form Event ID: HI2311 Facility ID: 001128 If continuation sheet Page 3 of 19

PRINTED: 12/14/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING			COMPLETED 11/15/2021		
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE CHESTER BLVD	
FRIENDS	S FELLOWSHIP CC	MMUNITY		IOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		_		o Standing alcohol-based han sanitizing station was relocated. The Courtyards breezeway are placed directly under keypad at to entering The Courtyards. The was completed on 11/15/21. The courtyards breezeway was removed and placed directly inside the door the Courtyards so staff are removing personal protective equipment immediately prior to exit of The Courtyards. This was completed on 11/17/21. System Changes continued: Hand sanitizer has been placed all personal protective equipments attaions - 11/17/21 of need to inquire regarding was mounted hand sanitizing station to be placed in the Healthcare Center and The Courtyards to increase employee compliance with hand hygiene. Of Purchasing ordered wall mounted hand sanitizing station for the Healthcare Center and Courtyards on 11/19/21. Of Director of Maintenance not of arrival of wall mounting hand sanitizing stations on 11/23/21. Success Evaluation: How the corrective action will be monited to ensure the deficient practice will not recur and what quality assurance measures will be pinto action for the following: 410 IAC 16.2-3.1-18	d in ad prior his sof s of oras ed at ent 7/21 all pons e ons The ified d d i. e ored e ored e

State Form Event ID: HI2311 Facility ID: 001128 If continuation sheet Page 4 of 19

PRINTED: 12/14/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUC			ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			
			B. WING		11/15/2021	
N	DOLUBED OF STATE	<u>I</u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	К		CHESTER BLVD		
	S FELLOWSHIP C	OMMUNITY	RICHMOND, IN 47374			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TAG (EACH CORRECTIVE ACTION SHOULD		ATE COMPLETION DATE	
IAG	REGULATORY O.	K ESC IDENTIF LING INFORMATION)	TAG	Affected: 16-18-5-1	DATE	
				410 IAC 16.2-5-12 (b) (1-4)		
				Wall mounted sanitizing state	tions	
				arrived on 11/23/21. Director		
				Maintenance notified of arriva		
				hand sanitizing stations and v		
				installed in The Courtyards or 12/2/21	1	
				Post- test for Hand Hygiene a	and	
				Standard Precautions distribu		
				to Department Directors on		
				11/22/21. Tests will be compl	eted	
				by all staff and returned to		
				Infection Preventionist, or		
				designee. Infection Preventio		
				or designee, will grade all tes 12/4/21.	is by	
				• Expectation will be that all s	taff	
				will pass test with 90%. Those		
				do not pass with minimum of		
				will receive re-education from		
				Infection Preventionist, or		
				designee.		
				Nursing Leadership and the Infection Proventionist or		
				Infection Preventionist, or designee, will provide increas	ed	
				focused efforts on infection		
				control practices with specific		
				focused infection control surv		
				to ensure compliance.		
				Infection control observation	10	
				and surveillance will be increased		
				to daily x 4 weeks (beginning		
				11/17/21-12/15/21) and then		
				weekly thereafter. This will be	•	
				performed to determine if state	f are	
				following appropriate standar		
				transmission- based precaution	ons	

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PRINTED: 12/14/2021 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED 11/15/2021		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 CHESTER BLVD				
FRIENDS	FELLOWSHIP CO	MMUNITY	RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
IAU	REGULATOR I OR	LOC DENTIL TING INTONIVATION)	IAU	during periods of heightened surveillance and during times when a resident is placed in yellow or red zone for COVID-transmission- based precaution. The infection control observation will be reviewed monthly during Quality Assurance meetings. The Infection Preventionist, of designee, will randomly select employees from the following departments: Nursing, Environmental Services, Dietar Maintenance, Life Enhancemental Administrative staff. The Infection Preventionist, of designee, will observe for appropriate implementation of standard and transmission-base precaution, including hand hygiene, respiratory/cough etiquette and appropriate done and removing of personal protective equipment. Observations will be recorded the Infection Control Observation and removing will be recorded on a validation checklist to review findings with the employee and provide the employee with corrective action as needed. The Infection Preventionist provided education to all departments on 11/17/21 and 11/18/21 regarding proper containment of soiled personal protection equipment. All staff departments will be responsible temporals.	ans. ions ig or ary, ent or seed ning on ion ail. d		

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PRINTED: 12/14/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 11/15/2021
			_		11/13/2021
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
FRIFND!	S FELLOWSHIP CO	MMUNITY		HESTER BLVD OND, IN 47374	
				T	(77.5)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				for ensuring soiled personal protection equipment is proper placed in trash receptacle and appropriately covered so noth is exposed. Trash will be empimmediately upon filling. • The Infection Preventionist, designee, and members of Nursing Leadership will compobservation and surveillance during the infection control observations and surveillance schedule. This will be daily x weeks (beginning 11/17/21-12/15/21) and then weekly thereafter. The infection control observations will be reviewed monthly during Qual Assurance meetings.	or lete
R 0414	410 IAC 16.2-5-12 Infection Control -	Deficiency			
Bldg. 00	their hands after e	st require staff to wash ach direct resident contact shing is indicated by onal practice.	D 0444	Diagon acceptable when f	10/20/202
	review, the facility t	•	R 0414	Please accept this plan of correction as the facility's cred allegation of compliance for Infection Control Survey completed on 11/15/21.	
	Findings include:			Infection Prevention and Cont	
	An entrance confere	ence was conducted with the		The facility has established ar infection prevention and contr	

State Form Event ID: HI2311 Facility ID: 001128 If continuation sheet Page 7 of 19

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
			B. WING 11/15			11/15/	2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹					
EDIENDO					HESTER BLVD		
FRIENDS	S FELLOWSHIP CO	DIMINIUNITY		RICHIVI	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	. =	DATE
	DON (Director of N	Nursing) and DMC (Director			program with associated policy	/	
	of Marketing and C	communications) on 11/15/21			and procedures to provide a sa	afe,	
	at 1:00 p.m. They i	ndicated all of the residents			sanitary and comfortable		
	in the memory care	unit of the facility were in			environment and to help preve	ent	
	TBP (transmission	based precautions) due to			the development and transmis	sion	
	exposure to Covid p	positive staff. Staff were to			of communicable diseases and	d	
	don the required PP	E (personal protective			infections.		
	equipment prior to entering the unit.						
					Identification of residents with		
	The DON provided a list of 22 Residents in the				potential to be affected by		
	memory care unit of the facility on 11/15/21 at				noncompliance of Infection		
	2:30 p.m. The list read at the top "All in TBP d/t				Control policy and procedures	:	
	[due to] outbreak testing/contact tracing."				All residents have the potentia	l to	
					be affected by the deficient		
	A tour of the facility was conducted with the				practice.		
	DON on 11/15/21 a	at 1:15 p.m. During the tour,					
	an observation of th	ne breezeway,			410 IAC 16.2-3.1-18		
	entryway/hallway a	rea located just prior to			Affected: 16-18-5-1		
	entering the memor	y care unit, was made. There					
	was a yellow stop s	ign on the double entryway			410 IAC 16.2-5-12 (b) (1-4)		
	doors into the unit.	The stop sign indicated					
		cautions requiring an N95			Corrective actions put into place	ce	
	mask, eye protectio	n, a gown, and gloves. Porter			due to deficient practices as lis	sted	
	2 approached the er	ntryway doors wearing a			above:		
	surgical mask and p	oushing a rolling bin of trash.			 Infection Preventionist provid 	ed	
	Porter 2 informed th	he DON he was going into			education on hand hygiene,		
	the memory care un	nit to collect trash. Porter 2			donning and removing persona		
	retrieved PPE from	a box of PPE located next to			protective equipment, standard	b	
	an overflowing tras	h receptacle. He applied a			precautions and handling of so	oiled	
	gown, then gloves,	then an N95 mask directly			linen on the following dates to		
	over his surgical ma	ask, then eye protection			each department:		
	_	the memory care unit. He did			o Nursing staff- 11/17/21		
	not perform hand hygiene prior to applying the				o Dietary, Life Enhancement,		
		ached the entryway doors to			Environmental Services,		
	1	nit wearing a surgical mask.			Maintenance and Administrative	/e	
		PE from the box of PPE. She			staff-11/18/21		
		nd hygiene and proceeded to			 Post test for Hand Hygiene a 		
		nswer her phone from her			Standard Precautions distribut		
		back into her pocket, then			to all department directors to g	jive	
	performed hand hygiene, then applied an N95				to all staff on 11/18/21.		

State Form Event ID: HI2311 Facility ID: 001128 If continuation sheet Page 8 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED	
			B. WI	NG		11/15/	2021	
			<u> </u>	CED FIRE	ADDRESS CHARLES THE CODE			
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE			
					HESTER BLVD			
FRIENDS	S FELLOWSHIP CO	DMMUNITY		RICHM	OND, IN 47374			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE	
		ical mask, then applied a face			Education regarding infection	1		
	_	nd entered the memory care			control policy and procedures			
	unit.	nd entered the memory care			standard precautions including			
	unit.				hand hygiene, donning and	l		
	A i t	onducted with Porter 2 upon			removing personal protective			
		-				no		
	_	care unit. He indicated he			equipment, standard precautions and handling of soiled linen will be			
		he'd used hand sanitizer prior			_	ıı b e		
	_	, but he had some available,			provided to each department			
	_	of hand sanitizer he retrieved			monthly by the Infection	æ		
	from his rolling tras	SN DIN.			Preventionist, or designee. Sta	111		
	A 17 1 1 1 1 1 1 1 POVI I				educated will be documented			
	An interview was conducted with the DON during				monthly and returned to the			
	the above breezeway observation. She indicated				Infection Preventionist.			
		orter 2 performed hand						
		nning his PPE. The hand			410 IAC 16.2-3.1-18			
		ted in the middle of the			Affected: 16-18-5-1			
		moved closer to the memory						
	care entryway for u	se.			410 IAC 16.2-5-12 (b) (1-4)			
	_	policy was provided by the			System Changes: -Infection			
		at 2:30 p.m. It read, "Observe			Preventionist has completed			
	_	s or appropriate infection			infection control rounds in yello	OW		
		follow the Centers for			transmission-based areas.			
		DC) guidelines for hand			Immediate action was taken fo	r		
	washing."				the following:			
		Protective Equipment (PPE)			o Standing alcohol-based hand			
	_	atients with Confirmed or			sanitizing station was relocated			
	Suspected COVID-	19 CDC guidelines was			The Courtyards breezeway an	d		
	provided by the DC	ON on 11/15/21 at 2:30 p.m.			placed directly under keypad p	rior		
		putting on the gear):1.			to entering The Courtyards. Th	nis		
	Identify and gather	the proper PPE to don2.			was completed on 11/15/21.			
	Perform hand hygie	ene using hand sanitizer. 3.			Hand sanitizer has been place	d at		
	Put on isolation gov	wn4. Put on			all personal protective equipme	ent		
	NIOSH-approved N	N95 filtering a facepiece			stations- 11/17/21			
	respirator or higher	5. Put on face shield or			o Purchasing notified on 11/17	/21		
		gloves7. HCP [Health			of need to inquire regarding wa			
		y now enter patient room.			mounted hand sanitizing statio			
		the gear):1. Remove			to be placed in the Healthcare			
		e gown3. HCP may now			Center and The Courtyards to			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	A. BUILDING <u>00</u>		
			B. WING 11/15/2021			
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R				
FRIENDS	S FELLOWSHIP C	OMMUNITY				
	1			- ,	075	
(X4) ID				PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION	
PREFIX TAG	`	R LSC IDENTIFYING INFORMATION)		2030 CHESTER BLVD RICHMOND, IN 47374 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) increase employee complian with hand hygiene. o Purchasing ordered wall mounted hand sanitizing stat for the Healthcare Center an Courtyards on 11/19/21. o Director of Maintenance no of arrival of wall mounting ha sanitizing stations on 11/23/2 Success Evaluation: How the corrective action will be monito ensure the deficient practic will not recur and what qualit assurance measures will be into action for the following: 410 IAC 16.2-3.1-18	TE COMPLETION DATE	
IAU		4. Perform hand hygiene. 5.	IAG			
	_	d or goggles6. Remove and				
		.7. Perform hand hygiene				
	_	respirator/facemask"		_	ons	
		Toop nate of the contract of t		_		
				o Director of Maintenance not	ified	
				of arrival of wall mounting har	d	
				sanitizing stations on 11/23/27	1.	
				Success Evaluation: How the		
				corrective action will be monit		
				to ensure the deficient practic		
				-	ut	
				Affected: 16-18-5-1		
				410 IAC 16.2-5-12 (b) (1-4)		
				Wall mounted sanitizing stat	ions	
				arrived on 11/23/21. Director		
				Maintenance notified of arriva		
				hand sanitizing stations and w		
				installed in The Courtyards by		
				of week 12/4/21.		
				NOTE: 2nd case of sanitizing		
				stations have been ordered; a		
				set to arrive 12/1/21. These w		
				mounted in the Healthcare Ce		
				upon arrival to facility and after		
				The Courtyards sanitizing wal mounts have been mounted.		
				mounts have been mounted.		
				Post- test for Hand Hygiene a		
				Standard Precautions distribu	ted	
				to Department Directors on		
				11/22/21. Tests will be comple	eted	
				by all staff and returned to		
				Infection Preventionist, or		

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		IDENTIFICATION NUMBER:	A. BUILDING 00 B. WING		COMPLETED 11/15/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
FRIENDS	FELLOWSHIP CO	MMUNITY		HESTER BLVD OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				designee. Infection Prevention or designee, will grade all test 12/4/21. • Expectation will be that all st will pass test with 90%. Those do not pass with minimum of 9 will receive re-education from Infection Preventionist, or designee. • Nursing Leadership and the Infection Preventionist, or designee, will provide increase focused efforts on infection control practices with specific focused infection control surveito ensure compliance. • Infection control observations and surveillance will be increase to daily x 4 weeks (beginning 11/17/21-12/15/21) and then weekly thereafter. This will be performed to determine if staff following appropriate standard transmission- based precautio during periods of heightened surveillance and during times when a resident is placed in yellow or red zone for COVID-transmission- based precaution The infection control observation will be reviewed monthly during Quality Assurance meetings. • The Infection Preventionist, of designee, will randomly select employees from the following departments: Nursing, Environmental Services, Dieta Maintenance, Life Enhancemental Administrative staff. • The Infection Preventionist, of the Infect	aff athat 90% ed eys sused on fare dand ons end ons end ons end on sus end o	

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PRINTED: 12/14/2021 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING		00	COMPLETED 11/15/2021				
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE CHESTER BLVD				
FRIENDS	FELLOWSHIP CO	MMUNITY		RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
S 0000 Bldg. 00	Assurance Walk Th	01128	S 0000	designee, will observe for appropriate implementation of standard and transmission-bar precaution, including hand hygiene, respiratory/cough etiquette and appropriate doni and removing of personal protective equipment. Observations will be recorded the Infection Control Observat log and recorded as pass or far Failures will be recorded on a validation checklist to review findings with the employee and provide the employee with corrective action as needed. Plan of correction completed for 0407, R 0414 and S 9999 on 12/3/21.	sed ning on tion ail.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDIN	LE CONSTRUCTION		E SURVEY PLETED	
AND TEAN OF CORRECTION IDENTIFICATION NUMBER.		B. WING	4G <u>00</u>		5/2021	
				PEET ADDRESS CITY STATE 7		0,2021
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, Z 30 CHESTER BLVD	AF CODE	
FRIENDS	S FELLOWSHIP CO	MMUNITY		CHMOND, IN 47374		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO 1	ON SHOULD BE THE APPROPRIATE	COMPLETION
TAG		s are cited in accordance with	TAG	G DEFICIENCY	YI	DATE
	410 IAC 16.2-3.1.	s are ened in accordance with				
		pleted on November 22,				
	2021					
S 9999						
Bldg. 00						
	410 IAC 16.2-3.1-18 Infection control program Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1 Sec. 18. (a) The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection(1) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record review, the facility failed to perform hand hygiene and don and doff PPE (personal protective equipment) appropriately; ensure soiled linen was contained during transport; ensure used PPE was contained within trash receptacles; and ensure trash receptacle placement for doffing PPE was inside of residents' rooms who were on TBP (transmission based precautions) for 9 of 15 residents in TBP (Residents B, C, D, E, F, G, H, J, and K) Findings include:		S 9999	Please accept this program allegation of compliant facility has established infection prevention program with associand procedures to program with associant and procedures to program and comfort environment and to the development are of communicable disinfections. Identification of resist potential to be affect noncompliance of licential compositions and procedures to program with associant program and procedures to program with associant program with a program with a program with a program with a p	cility's credible ance for arvey 5/21. In and Control: ablished an and control ciated policy provide a safe, rtable help prevent and transmission is eases and dents with cited by infection procedures: the potential to deficient	12/03/2021
	DON (Director of N of Marketing and Co	ence was conducted with the fursing) and DMC (Director communications) on 11/15/21 adicated 15 residents in the		410 IAC 16.2-3.1-18 Affected: 16-18-5-1 410 IAC 16.2-5-12		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00		COMPLETED	
			B. WING			11/15/	2021
				OTD FET A	ADDRESS CITY STATE ZIR CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
			2030 CHESTER BLVD				
FRIENDS FELLOWSHIP COMMUNITY				RICHMOND, IN 47374			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DPOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	health care center of the facility were in TBP due				Corrective actions put into place	ce	
	to exposure to Covi	d positive staff.			due to deficient practices as lis	sted	
					above:		
	On 11/15/21 at 2:30	p.m., the DON provided a			 Infection Preventionist provid 	ed	
	list of 15 residents i	in the health care center of			education on hand hygiene,		
	the facility who wer	re in TBP. The list included			donning and removing person	al	
	Residents B, C, D,	E, F, G, H, J, and K.			protective equipment, standard		
					precautions and handling of so	oiled	
		y was conducted with the			linen on the following dates to		
		at 1:15 p.m. During the tour,			each department:		
		ne health care center was			o Nursing staff- 11/17/21		
		vellow stop signs indicating			o Dietary, Life Enhancement,		
		cautions on the room doors of			Environmental Services,		
		E, F, G, H, J, and K. There			Maintenance and Administrative	/e	
	were trash receptacles for doffing PPE located				staff-11/18/21		
		. The trash receptacle			Post test for Hand Hygiene a		
		G's and Resident H's room had			Standard Precautions distribut		
		d, sticking out of the top.			to all department directors to g	ive	
	· ·	rsing Assistant) 4 exited			to all staff on 11/18/21.		
		D's room wearing a gown. She			Education regarding infection		
	_	outside of the room and threw			control policy and procedures		
		eptacle located outside of the			standard precautions including	l	
	_	perform hand hygiene after			hand hygiene, donning and		
		as observed to don PPE to			removing personal protective		
		ent's room who was in contact			equipment, standard precaution		
		She was already wearing a accesshield. She donned a			and handling of soiled linen wi provided to each department	ıı D C	
	_	d gloves out of a PPE bin,			monthly by the Infection		
		removed her face shield, then			Preventionist, or designee. Sta	aff	
		r her surgical mask, and			educated will be documented	411	
	* *				monthly and returned to the		
	reapplied her face shield.				Infection Preventionist.		
	An interview was co	onducted with the DON during					
	the above observation. She indicated CNA 4 did				System Changes: -Infection		
		aygiene after doffing her PPE			Preventionist has completed		
	_	ents C's and D's room, and all			infection control rounds in yello	OW	
		ere located outside of the			transmission-based areas.		
	_	e placed inside instead.			Immediate action was taken for	r	
	,	•			the following:		
	During the tour, CN	IA 5 was observed walking			o Trash bins were moved from	l	
		Č					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/15/2021		
	PROVIDER OR SUPPLIER S FELLOWSHIP COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2030 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	down the hallway towards a soiled linen bin. She was carrying white soiled linen, not contained, with her bare hands. When she reached the soiled linen bin, she placed the soiled linen into the bin. She then retrieved a bag and bagged the soiled linen from the bin with her bare hands and placed it back into the bin. The DON asked CNA 5 why she was carrying soiled linen down the hallway. CNA 5 indicated it was because she ran out of bags. The DON informed her she should have left the soiled linen in the room, came back to get a bag, and then returned to the room. CNA 5 agreed. The Hand Washing policy was provided by the DON on 11/15/21 at 2:30 p.m. It read, "Observe standard precautions or appropriate infection control measures. Follow the Centers for Disease Control (CDC) guidelines for hand washing." The Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 CDC guidelines was provided by the DON on 11/15/21 at 2:30 p.m. It read, "Donning (putting on the gear):1. Identify and gather the proper PPE to don2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown4. Put on NIOSH-approved N95 filtering a facepiece respirator or higher5. Put on face shield or goggles6. Put on gloves7. HCP [Health care personnel] may now enter patient room. Doffing (taking off the gear):1. Remove gloves2. Remove gown3. HCP may now exit patient room. 4. Perform hand hygiene 5. Remove face shield or goggles6. Remove and discard respirator7. Perform hand hygiene after removing the respirator/facemask"		outside resident room to inside resident room at exit to ensure staff are removing personal protective equipment as close exit as possible and to ensure transmission is possible to hallway. This was completed lend of day 11/15/17. o Standing alcohol-based han sanitizing station was relocated. The Courtyards breezeway ar placed directly under keypad to entering The Courtyards. The was completed on 11/15/21. o Trash bin in The Courtyards breezeway was removed and placed directly inside the door The Courtyards so staff are removing personal protective equipment immediately prior to exit of The Courtyards. This was completed on 11/17/21. System Changes continued: Hand sanitizer has been placed all personal protective equipment in the been placed all personal protective equipment in the stations-11/17/21 of need to inquire regarding was mounted hand sanitizing station to be placed in the Healthcare Center and The Courtyards to increase employee compliance with hand hygiene. o Purchasing ordered wall mounted hand sanitizing station of the Healthcare Center and Courtyards on 11/19/21. o Director of Maintenance not of arrival of wall mounting hand sanitizing stations on 11/23/21.	to to no by d dd in nd prior his s of o ras ed at tent 7/21 all pns e The ified dd		

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The Laundry policy was provided by the DON on 11/15/21 at 2:30 p.m. It read "Place all soiled linens in a clear plastic bag, secure, apply TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O Policy of handling soiled linen updated on 11/21/21 and reviewed with nursing staff during		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SU COMPLET 11/15/20	ΓED	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Laundry policy was provided by the DON on 11/15/21 at 2:30 p.m. It read "Place all soiled linens in a clear plastic bag, secure, apply PREFIX TAG PREFIX PREFIX PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE O Policy of handling soiled linen updated on 11/21/21 and reviewed with nursing staff during				2030 CHESTER BLVD				
11/15/21 at 2:30 p.m. It read "Place all soiled updated on 11/21/21 and linens in a clear plastic bag, secure, apply reviewed with nursing staff during	PREFIX	(EACH DEFICIEN REGULATORY OR	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	ILD BE ROPRIATE	COMPLETION	
		11/15/21 at 2:30 p.i linens in a clear pla colored dot, and pla	m. It read "Place all soiled stic bag, secure, apply		updated on 11/21/21 and	l aff during		
hamper." • Success Evaluation: How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance measures will be put into action for the following: 410 IAC 16.2-3.1-18 Affected: 16.8-5-1 410 IAC 16.2-5-12 (b) (1-4) • Wall mounted sanitizing stations arrived on 11/23/21. Director of Maintenance notified of arrival of hand sanitizing stations and installed in The Courtyards on 12/22/21. NOTE: 2nd case of sanitizing stations have been ordered; and set to arrive 12/1/21. These will be mounted in the Healthcare Center upon arrival to facility and after The Courtyards sanitizing wall mounted. Post- test for Hand Hygiene and Standard Precautions distributed to Department Directors on 11/22/21. Tests will be completed by all staff and returned to Infection Preventionist, or designee. Infection Preventionist, or designee, will grade all tests by 12/4/21. • Expectation will be that all staff will pass test with 90%. Those that		-			Success Evaluation: Ho corrective action will be not ensure the deficient primit of the ensure the deficient primit of the ensure will into action for the following 410 IAC 16.2-3.1-18 affected: 16-18-5-1 410 IAC 16.2-5-12 (b) (1-10 Wall mounted sanitizing arrived on 11/23/21. Direct Maintenance notified of a hand sanitizing stations as installed in The Courtyard 12/2/21. NOTE: 2nd case of sanitistations have been orderest to arrive 12/1/21. The mounted in the Healthcar upon arrival to facility and The Courtyards sanitizing mounts have been mounted been mounted in the Healthcar upon arrival to facility and The Courtyards sanitizing mounts have been mounted in the Healthcar upon arrival to facility and the Courtyards sanitizing mounts have been mounted in the Healthcar upon arrival to facility and the Courtyards sanitizing mounts have been mounted in the Healthcar upon arrival to facility and the Courtyards sanitizing mounts have been mounted in the Healthcar upon arrival to facility and the Courtyards sanitizing mounts have been mounted in the Healthcar upon arrival to facility and the Courtyards sanitizing mounts have been mounted in the Healthcar upon arrival to facility and the Courtyards sanitizing mounts have been mounted in the Healthcar upon arrival to facility and the Courtyards sanitizing mounts have been mounted in the Healthcar upon arrival to facility and the Health	ow the nonitored actice uality be put ng: -4) g stations ctor of arrival of and ds on sizing ed; and see will be re Center d after g wall ted. ene and stributed on ompleted on pentionist, I tests by all staff		

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		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 11/15/2021		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 CHESTER BLVD				
FRIENDS FELLOWSHIP COMMUNITY				IOND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				do not pass with minimum of will receive re-education from Infection Preventionist, or designee. Nursing Leadership and the Infection Preventionist, or designee, will provide increas focused efforts on infection control practices with specific focused infection control survito ensure compliance. Infection control observation and surveillance will be increated to daily x 4 weeks (beginning 11/17/21-12/15/21) and then weekly thereafter. This will be performed to determine if staffollowing appropriate standard transmission- based precautic during periods of heightened surveillance and during times when a resident is placed in yellow or red zone for COVID transmission- based precautic The infection control observated will be reviewed monthly during Quality Assurance meetings. The Infection Preventionist, designee, will randomly select employees from the following departments: Nursing, Environmental Services, Dieta Maintenance, Life Enhancemental Administrative staff. The Infection Preventionist, designee, will observe for appropriate implementation of standard and transmission-based precaution, including hand hygiene, respiratory/cough	ed eys s ased on f are d and ons -19 ons. ions ions or t ary, ent or		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 11/15/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
FRIENDS	FELLOWSHIP CO	MMUNITY		HESTER BLVD OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				etiquette and appropriate doni and removing of personal protective equipment. Observations will be recorded the Infection Control Observat log and recorded as pass or far Failures will be recorded on a validation checklist to review findings with the employee and provide the employee with corrective action as needed. • The Infection Preventionist provided education to all departments on 11/17/21 and 11/18/21 regarding proper containment of soiled personal protection equipment. All staff departments will be responsib for ensuring soiled personal protection equipment is proper placed in trash receptacle and appropriately covered so nothing exposed. Trash will be employed in trash receptacle and appropriately covered so nothing exposed. Trash will be employed in the Infection Preventionist, of designee, and members of Nursing Leadership will complobservation and surveillance during the infection control observations and surveillance schedule. This will be daily x 4 weeks (beginning 11/17/21-12/15/21) and then weekly thereafter. The infection control observations will be reviewed monthly during Qual Assurance meetings.	on cion cion cion cion cion cion cion ci

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	ILDING	INSTRUCTION 00	(X3) DATE COMPL 11/15	ETED
NAME OF PROVIDER OR SUPPLIER FRIENDS FELLOWSHIP COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 2030 CHESTER BLVD RICHMOND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERNCED TO THE APPROF		ΛΤΕ	(X5) COMPLETION DATE	
TAG	REGULATORT OR	LSC IDENTIFTING INFORMATION)	-	TAU	DEI ICIERCI /		DATE

State Form Event ID: HI2311 Facility ID: 001128 If continuation sheet Page 19 of 19