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	12/07/2018

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 10/11/18 was conducted by the Indiana State Department of Health. Survey Date: 12/07/18 Facility Number: 001128 Provider Number: 001128 AIM Number: NA At this PSR survey, Friends Fellowship Community Inc. 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 sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors, 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 72 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/17/18 - DA	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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K 0130 Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, the facility failed to ensure observed extension cords including powerstrips and non-fused multiplug adapters were not used as a substitute for fixed wiring in 2 of 2 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would affect approximately 20 of 38 residents. Findings include: Based on observation on 12/07/18 at 3:00 pm. with the Maintenance Director, the following was noted: a. Resident room # 44 used a surge protector to power a mini refrigerator. Also, a multiplug was used to power a television. b. Resident room # 28 used a surge protector to power a mini refrigerator. 3.1-19(b) This deficiency was cited on 10/11/18. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0130	The Maintenance Director (MD) will inspect all rooms for the presence of extension cords including powerstrips and non-fused multiplug adapters and will remove all such devices. All appliances will be plugged directly into wall receptacles. The above inspection and remediation by the MD will identify all residents having the potential to be affected by the deficient practice and will correct the same. The DON, all supervisory staff and all nursing personnel will be informed of the policy and instructed to observe for and correct or report any deficient practice. The DON will be responsible for compliance going forward. All staff regularly entering resident rooms will observe for and address violations in the future. Correction will be accomplished by 12/30/18.	12/30/2018
S 0048 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1			

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	Based on interview, the facility failed to ensure its written fire safety plan incorporated all the items outlined in LSC 19.7.2.2 in order to protect 97 of 97 residents. LSC 19.7.1.1 requires every nursing home to have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire and for their evacuation to areas of refuge and for evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available. The provisions of LSC 19.7.1.2 to 19.7.2.3 inclusive shall apply. LSC 19.7.2.1 requires for health care occupancies, the proper protection of residents shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants, confinement of the effects of the fire by closing doors to isolate the fire area, and the execution of those evacuation duties as detailed in the facility's fire safety plan. LSC 19.7.2.2 states a written facility fire safety plan shall provide for: (a) Use of alarms, (b) Transmission of alarm to fire department, (c) Response to alarms, (d) Isolation of fire, (e) Evacuation of immediate area, (f) Evacuation of smoke compartment (g) Preparation of building for evacuation (h) Extinguishment of fire. This deficient practice affects all residents, staff and visitors. Findings include:	S 0048	By December 30, 2018, the Administrative Assistant to the President will amend the facility's written policy to properly address (f) Evacuation of smoke compartment. Written copies of the amended policy will be available to all supervisory personnel and will be available for review. All residents of the facility could potentially be affected by this deficient practice. All supervisors and staff will be instructed of the correction in the policy and will be trained to respond accordingly. The Maintenance Director and the Administrative Assistant will be responsible for instructing supervisory personnel. The Administrative Assistant will assure that all copies of the policy, including those held by supervisory personnel, will be properly amended. Going forward, supervisory personnel will orient and train staff based on the amended policy. The Administrative Assistant will assure, going forward, that all copies of the policy are properly written. All changes will be made to correct this deficient practice by December 30, 2018.	12/30/2018

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	Based on interview on 12/07/18 at 2:30 p.m. with the Maintenance Director (MD) the plan did not address all components of the LSC 19.7.2.2 such as (f) Evacuation of smoke compartment. The plan was not available for review, therefore the correction to the policy could not be verified. This was acknowledged by the MD the Fire Watch Policy was not available for review. 3.1-19(b) This deficiency was cited on 10/11/18. The facility failed to implement a systemic plan of correction to prevent recurrence.			
S 0154 Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on interview, the facility failed to provide a written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.7.6.1 in order to protect 57 of 57 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other	S 0154	The Administrative Assistant to the President, in cooperation with the Maintenance Director, will revise facility policy to ensure that procedures are in place in the event of the automatic sprinkler system being placed out of service for 4 hours or more in a 24-hour period. Policy will assure that the local fire department, insurance carrier, alarm company, administrator and other authorities having jurisdiction will be notified. The plan will also instruct staff to	12/30/2018

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	authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview on 12/07/18 at 2:55 p.m. with the Maintenance Director (MD), the facility had a "Fire Watch Policy" for a sprinkler system failure but did not address all components of LSC Section 9.7.6.1. The plan was not available for review, therefore the correction to the policy could not be verified. 3.1-19(b) This deficiency was cited on 10/11/18. The facility failed to implement a systemic plan of correction to prevent recurrence.		notify the same entities once the sprinkler system has been restored to normal. All residents could potentially be affected by this deficient practice and all will be protected by the corrective action. The Administrative Assistant and the Maintenance Director will work together to assure that all notifications are made. The Administrator will monitor such situations and give oversight to assure compliance. Corrective action will be completed by 12/30/18.	