

Indiana Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2023
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NAME OF PROVIDER OR SUPPLIER FRIENDS FELLOWSHIP COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2030 CHESTER BLVD RICHMOND, IN 47374
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(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Licensure Survey. This visit included a Residential Licensure Survey.</p> <p>Survey Dates: August 14, & 15, 2023</p> <p>Facility number: 001128 Provider number: N/A AIM number: N/A</p> <p>Census bed type: NCC: 37 Residential: 89 Total: 126</p> <p>Census Payor type: Other: 126 Total: 126</p> <p>Friends Fellowship Community was found to be in compliance with 410 IAC 16.2-3.1 in regard to the State Licensure Survey.</p> <p>Quality review completed on August 18, 2023</p>	S 000		
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey. This visit included a State Licensure Survey.</p> <p>Survey dates: August 14, & 15, 2023</p> <p>Facility number: 001128</p> <p>Residential Census: 89</p> <p>Friends Fellowship Community was found to be in compliance with 410 IAC 16.2-5 in regard to the</p>	R 000		

Indiana Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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R 000	Continued From page 1 State Residential Licensure Survey. Quality review completed on August 18, 2023	R 000		