

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
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NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 05/30/12</p> <p>Facility Number: 000447 Provider Number: 155551 AIM Number: 100289950</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rolling Meadows Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and 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.</p> <p>This one story facility was determined to be of Type III (211)</p>	K0000		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the Oak Lane resident rooms, corridors and areas open to the corridors. The facility has a capacity of 115 and had a census of 102 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/05/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the doors to 4 of 4 shower rooms used for storage of soiled linen, therefore creating a hazardous area, would self close and latch into the frame. This deficient practice could affect any residents near the Maple Lane, Willow Lane and Birch Lane shower rooms.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Supervisor on 05/30/12 from 12:02 p.m. to 12:25 p.m., soiled linen barrels were stored in the Maple Lane, Willow Lane and both Birch Lane shower rooms. The shower rooms</p>	K0029	<p>K 029: CORRECTIVE ACTIONS: - No residents were negatively affected by the practice. The closure units on 4 of 4 shower rooms have been properly installed.</p> <p>IDENTIFICATION OF AND CORRECTIVE ACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE ALLEGED PRACTICE: - No residents were identified as having the potential to be affected. All shower room doors have been inspected with no noted concerns.</p> <p>MEASURES TAKEN TO AND SYSTEMATIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR: - All doors that need a closure unit have been audited and will have a closure unit installed. All doors in the facility</p>	06/29/2012
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	<p>lacked self closing devices although they did latch into the door frame. Based on an interview with the Maintenance Supervisor at the time of observations, soiled linens are stored in these barrels until they are taken by the laundry staff to the laundry room.</p> <p>3.1-19(b)</p>		<p>will be documented on monthly on our TELS system by our maintenance staff or designee.</p> <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:</p> <ul style="list-style-type: none"> - Maintenance supervisor or designee report of monitoring will be forwarded to the Administrator for the monthly QA review, response and compliance. Plan will be adjusted accordingly. <p>CORRECTIONS COMPLETED:</p> <ul style="list-style-type: none"> - Corrections completed June 29, 2012 		

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K0053 SS=E	<p>NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7)</p> <p>Based on record review and interview, the facility failed to ensure 3 of 43 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2.1 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms</p>	K0053	<p>K 053: CORRECTIVE ACTIONS: - No residents were negatively affected by the practice. A smoke sensitivity test has been completed and an accurate report has been generated. IDENTIFICATION OF AND CORRECTIVE ACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE ALLEGED PRACTICE: - All residents were identified as having the potential to be affected. A facility wide smoke sensitivity test was completed by SafeCare with no noted concerns. MEASURES TAKEN TO AND SYSTEMATIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR: - All smoke detectors have been tested during the smoke sensitivity test. All smoke detectors fall within the normal range. Bi-yearly tests of the smoke sensitivity test will have on going monitoring and scheduling</p>	06/29/2012			

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	<p>shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect any number occupants near the E Dining S, the Oak Lane Nurses' station and outside side resident room 109.</p> <p>Findings include:</p>		<p>through TELS.</p> <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:</p> <ul style="list-style-type: none"> - Maintenance supervisor or designee report of monitoring will be forwarded to the Administrator for the monthly QA review, response and compliance. Plan will be adjusted accordingly. <p>CORRECTIONS COMPLETED:</p> <ul style="list-style-type: none"> - Corrections completed June 29, 2012 	
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	<p>Based on record review on 05/30/12 at 10:50 a.m. with the Administrator and the Maintenance Supervisor, the SafeCare smoke detector record titled "Sensitivity Test and Inspection Report" indicated the sensitivity test for the smoke detectors in the E Dining S was 3.71, at the Oak Lane nurses' station it was 3.80 and outside resident room 109 it was 3.74. The sensitivity range for each was 1.50-3.66. These smoke detectors failed the sensitivity test but received a "pass" on the report. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p>				

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K0062 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure cubicle curtains installed in 1 of 2 Willow Lane shower room privacy curtains was in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Because of the lack of cubicle curtain and sprinkler location coordination which may obstruct the sprinkler spray onto the fire or may shield the heat from the sprinkler, this deficient practice could affect any resident in the Willow Lane shower room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 05/30/12 at 12:04 p.m., one of two privacy curtains in Willow Lane shower room lacked 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inch below the sprinkler</p>	K0062	<p>K 062 CORRECTIVE ACTIONS - No residents were affected by the practice. 1 of 2 shower curtains in the Willow Lane shower room has been changed. 2. 1 of 1 sprinkler head has been added in the Maple Lane shower room. IDENTIFICATION OF AND CORRECTIVE ACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE ALLEGED PRACTICE: - Any resident in the Willow Lane shower room has the potential to be affected. All shower rooms have been audited for appropriate shower curtains with proper mesh. 2. Any resident using the Maple Lane shower room has the potential to be affected. All shower rooms have been inspected for obstructions to spray patterns. No additional concerns at this time. MEASURES TAKEN TO AND SYSTEMATIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR: - Any shower curtains with less than 1/2 inch diagonal mesh have been discarded. Appropriate shower curtains will be ordered. 2. Any shower room that needs</p>	06/29/2012

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	<p>deflector. This was acknowledged by the Administrator and the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 Maple Lane shower room sprinkler heads was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect any resident in the Maple Lane shower room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 05/30/12 at 11:55 a.m., the spray pattern of the sprinkler head in</p>		<p>additional sprinkler heads will be added and anyremodeling will be monitored for compliance in the area of adding sprinklerheads that may be obstructed. HOW THE CORRECTIVE ACTIONS WILLBE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENTPRACTICE DOES NOT REOCCUR: - Maintenance supervisor or designee report ofmonitoring will be forwarded to the Administrator for the monthly QA review,response and compliance. Plan will be adjusted accordingly. CORRECTIONS COMPLETED: - Corrections completed June 29, 2012</p>		

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	<p>the Maple Lane shower room was obstructed by a wall. Based on an interview with the Maintenance Supervisor at the time of observation, the wall would prevent sprinkler coverage in the tub area of the shower room.</p> <p>3.1-19(b)</p>			
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K0064 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 K-Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This</p>	K0064	<p>K 064</p> <p>CORRECTIVE ACTIONS:</p> <ul style="list-style-type: none"> - No residents have been negatively affected by this practice. 1 of 1 Fire extinguisher in the kitchen has had a K-Class placard added. <p>IDENTIFICATION OF AND CORRECTIVE ACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE ALLEGED PRACTICE:</p> <ul style="list-style-type: none"> - No resident has the potential to be negatively affected due to not having access to the kitchen. All fire extinguishers have been inspected in the kitchen and appropriate identification has been added. <p>MEASURES TAKEN TO AND SYSTEMATIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:</p> <ul style="list-style-type: none"> - All fire extinguishers have been properly serviced and tested. Monthly tests of the fire extinguishers will have on going monitoring, maintenance compliance and scheduling through TELS. <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED AND THE QA SYSTEM IMPLEMENTED TO</p>	06/29/2012

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	<p>deficient practice could affect any residents using the main dining room and all kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Supervisor on 05/30/12 at 1:07 p.m., the kitchen K-Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Supervisor at the time of observation, the kitchen K-Class fire extinguisher lacked a placard identifying its use as a secondary backup to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p>		<p>ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOTREOCCUR:</p> <ul style="list-style-type: none"> - Maintenance supervisor or designee report of monitoring will be forwarded to the Administrator for the monthly QA review, response and compliance. Plan will be adjusted accordingly. <p>CORRECTIONS COMPLETED:</p> <ul style="list-style-type: none"> - Corrections completed June 29, 2012 		

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room.</p> <p>Findings include:</p>	K0130	<p>K 130 CORRECTIVE ACTIONS: - No residents were negatively affected by this practice. A rolling fire door inspection was completed and the appropriate tags have been added.</p> <p>IDENTIFICATION OF AND CORRECTIVE ACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE ALLEGED PRACTICE: - No resident has the potential to be negatively affected due to not having access to the kitchen. The rolling fire hood protection system was tested and found to have no other concerns. MEASURES TAKEN TO AND SYSTEMATIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR: - A yearly inspection tag has been added to the rolling fire hood. Yearly tests of the rolling hood inspection will have ongoing monitoring and scheduling through TELS. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR: - Maintenance supervisor or designee report of monitoring will be forwarded to the Administrator for the monthly QA review, response and compliance.</p>	06/29/2012	

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	<p>Based on observation with the Administrator and the Maintenance Supervisor on 05/30/12 at 12:15 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on the SafeCare inspection tag the last annual inspection was conducted on 05/02/11. Based on interview with the Maintenance Supervisor at the time of observation, no other documentation was available for review.</p> <p>3.1-19(b)</p>		<p>Plan will be adjusted accordingly. CORRECTIONS COMPLETED: - Corrections completed June 29, 2012</p>	

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NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940			
(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) COMPLETION DATE			
K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintaining the minimum exhaust gas temperatures, or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a</p>	K0144	<p>K 144</p> <p>CORRECTIVE ACTIONS:</p> <ul style="list-style-type: none"> - All residents have the potential to be affected by the practices. The weekly generator inspection is currently being completed as scheduled. <p>IDENTIFICATION OF AND CORRECTIVE ACTIONS TAKEN FOR OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE ALLEGED PRACTICE:</p> <ul style="list-style-type: none"> - No other residents were identified as having the potential to be affected. A load bank test has been completed by SafeCare. <p>MEASURES TAKEN TO AND SYSTEMATIC CHANGES MADE TO ENSURE THE ALLEGED DEFICIENT PRACTICE DOES NOT REOCCUR:</p> <ul style="list-style-type: none"> - A load bank test will be completed. The generator will be tested, under load, and monitored on our TELS weekly system. Weekly tests of the generator load bank test will have on going monitoring and scheduling through TELS. <p>HOW THE CORRECTIVE ACTIONS WILL BE MONITORED AND THE QA SYSTEM IMPLEMENTED TO ENSURE THE ALLEGED</p>	06/29/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2012	
NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
	<p>written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on review of the "Weekly Emergency Generator Record" with the Administrator and the Maintenance Supervisor on 05/30/12 at 11:00 a.m., the generator test log showed a monthly load test for the past twelve months, but the log did not indicate if the diesel generator was exercised under operating conditions, maintaining the minimum exhaust gas temperatures, or at not less than thirty percent of the EPS nameplate rating monthly, for a minimum of thirty minutes. Based on an interview with the Maintenance Supervisor at the time of record review, the generator was unable to reach thirty percent of the EPS nameplate rating so the facility</p>		<p>DEFICIENT PRACTICE DOES NOT REOCCUR:</p> <ul style="list-style-type: none"> - Maintenance supervisor or designee report of monitoring will be forwarded to the Administrator for the monthly QA review, response and compliance. Plan will be adjusted accordingly. <p>CORRECTIONS COMPLETED:</p> <ul style="list-style-type: none"> - Corrections completed June 29, 2012 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
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NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940
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	<p>has an annual load bank test. The last load bank test was completed on 05/20/11.</p> <p>3.1-19(b)</p>			