STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155551		A. BUILDING COMPI		(X3) DATE SURVEY COMPLETED 03/27/2023	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
ROLLING	MEADOWS HEAL	TH CARE CENTER		NTAINE, IN 46940	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
E 0000					
Bldg E 0039 SS=F Bldg	conducted by the In accordance with 42 Survey Date: 03/27 Facility Number: 00 Provider Number: 100 At this Emergency Meadows Health Cacompliance with Errace Requirements for Matter Participating Provides 183.73. The facility census of 92 at the 190 Quality Review cordinary (2), 440 441.184(d)(2), 440 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 485 486.360(d)(2), 848 8460.84(d)(2), 848 8483.475(d)(2), 848 8485.625(d)(2), 848 (2), \$491.12(d)(2) *[For ASCs at §41	7/23 00447 .55551 289950 Preparedness survey, Rolling are Center was found not in mergency Preparedness fedicare and Medicaid ders and Suppliers, 42 CFR Thas a capacity of 115 and had a time of this survey. mpleted on 03/27/23 6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), 102(d)(2), 485.625(d)(2), 727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 484.102(d)(2), §485.68(d)(2), 485.727(d)(2), §485.920(d)	E 0000		
	CMHCs at §485.9	20, RHCs/FQHCs at RD Facilities at §494.62]:			
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	GNATURE	TITLE	(X6) DATE

Peyton Byrd Adminstrator 04/07/2023

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 disclodays 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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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	1		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL B. WING			COMPLETED 03/27/2023	
		155551	B. WING			03/2//	2023
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD		
BOLLING	Z MEVDOWS HEVI	TH CARE CENTER			NNAKER ST TAINE, IN 46940		
	IMEADOWS HEAD	III OANE CENTER			I AINE, IN 40340		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION acility] must conduct		TAG	DEFICIENCE!		DATE
		he emergency plan					
		ility] must do all of the					
	following:	,,					
		full-scale exercise that is					
	community-based every 2 years; or (A) When a community-based exercise is						
	' '						
		nduct a facility-based e every 2 years; or					
		ility] experiences an actual					
	, ,	ade emergency that requires					
		mergency plan, the [facility]					
	is exempt from en	gaging in its next required					
	-	or individual, facility-based					
		e following the onset of the					
	actual event.						
	` '	ditional exercise at least					
		posite the year the full-scale cise under paragraph (d)(2)					
		s conducted, that may					
		limited to the following:					
		scale exercise that is					
	community-based	or individual, facility-based					
	functional exercise						
	(B) A mock disast						
		ercise or workshop that is					
		and includes a group					
	discussion using a	a narrated, emergency scenario, and a					
	set of problem sta	•					
	•	pared questions designed					
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					
	*[[440 440/4\.1					
	*[For Hospices at	418.113(d):] spices that provide care in					

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Event ID:

8SMV21 Facility ID: 000447

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155551	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/27/2023	
	PROVIDER OR SUPPLIER	TH CARE CENTER	604 RE	ADDRESS, CITY, STATE, ZIP CO INNAKER ST NTAINE, IN 46940	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETI	ION
	conduct exercises plan at least annuithe following: (i) Participate in a community based (A) When a commaccessible, condubased functional et (B) If the hospice man-made emerging of the emergency exempt from engascale community-facility-based functional exercise of the emer (ii) Conduct an advears, opposite the functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exiled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an erical control of the care directly. The exercises to test to per year. The hose (i) Participate in a that is community	nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or ency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Idditional exercise every 2 to e year the full-scale or e under paragraph (d)(2)(i) tonducted, that may limited to the following: escale exercise that is for a facility based to recise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. Spices that provide inpatient to hospice must conduct the emergency plan twice spice must do the following: an annual full-scale exercise				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE COMPL	
		155551	B. W	ING		03/27	/2023
	PROVIDER OR SUPPLIER	TH CARE CENTER		604 RE	ADDRESS, CITY, STATE, ZIP COD NNAKER ST ITAINE, IN 46940	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accessible, condu	ct an annual individual					
	facility-based fund						
	1 ' '	experiences a natural or					
		ency that requires activation					
		plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.						
	` '	dditional annual exercise					
	· ·	but is not limited to the					
	following:						
		scale exercise that is					
	1	or a facility based					
	functional exercise						
	(B) A mock disas						
		ercise or workshop led by a					
	using a narrated,	udes a group discussion					
	_	rio, and a set of problem					
	1	ed messages, or prepared					
	questions designe						
	emergency plan.	a to onalienge an					
		ospice's response to and					
	1 ' '	ntation of all drills, tabletop					
		nergency events and revise					
		ergency plan, as needed.					
	<u>'</u>						
	*[For PRFTs at §4	l41.184(d), Hospitals at					
	§482.15(d), CAHs	at §485.625(d):]					
	(2) Testing. The [F	PRTF, Hospital, CAH] must					
	conduct exercises	to test the emergency					
	plan twice per yea	ar. The [PRTF, Hospital,					
	CAH] must do the						
	(i) Participate in a	an annual full-scale exercise					
	that is community	-based; or					
	l ` '	nunity-based exercise is not					
	accessible, condu	ct an annual individual,					
	facility-based fund	tional exercise: or					İ

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Event ID:

8SMV21 Facility ID: 000447

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPI	
		155551	B. W	ING		03/27	/2023
NAME OF P	PROVIDER OR SUPPLIER	·			ADDRESS, CITY, STATE, ZIP COD	-	
DOLLING	S MEVDOING FILM	TH CADE CENTED			NNAKER ST		
	A INICADONA UEAL	TH CARE CENTER		1	ITAINE, IN 46940		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION DATE
TAG		Hospital, CAH] experiences	+	TAG			DATE
		or man-made emergency					
	that requires activation of the emergency plan, the [facility] is exempt from engaging in						
		ull-scale community based					
	1	ty-based functional exercise					
		et of the emergency event.					
	_	an [additional] annual					
	· '	at may include, but is not					
	limited to the follow	-					1
	(A) A second full-	scale exercise that is					
	community-based	or individual, a					
	facility-based fund	tional exercise; or					
	(B) A mo	ck disaster drill; or					
	(C) A tabletop	exercise or workshop that					
	1	or and includes a group					
	discussion, using						
	I	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
	1 ' '	he [facility's] response to					
		umentation of all drills,					
	· ·	s, and emergency events					
	_	cility's] emergency plan, as					
	needed.						
	*[For PACE at §46	60.84(d):1					
		PACE organization must					
	1 ' '	s to test the emergency					
	plan at least annu						
	organization must						
	1 -	an annual full-scale exercise					
	that is community-						
	1	nunity-based exercise is not					1
	accessible, condu	ct an annual individual,					
	facility-based fund	ctional exercise; or					
	(B) If the PACE ex	xperiences an actual natural					
	or man-made eme	ergency that requires					
	activation of the e	mergency plan, the PACE					

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155551	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/27/2023	
	PROVIDER OR SUPPLIEI	TH CARE CENTER	604 RE	ADDRESS, CITY, STATE, ZIP CO NNAKER ST NTAINE, IN 46940	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMP	X5) LETION .TE
	full-scale community-based functional exercises, and enthe PACE's emergency processed, including unthe emergency processed functional exercises of this section is obut is not limited to the community-based based functional exercises of this section is obut is not limited to the community-based based functional exercises of the community-based functional exercises, using clinically-relevant set of problem star messages, or preto challenge an enthe PACE's emergency and enthe pace's emergency processed in the emergency processed in	the year the full-scale or e under paragraph (d)(2)(i) conducted that may include, to the following: escale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. PACE's response to and nation of all drills, tabletop hergency events and revise gency plan, as needed. Les at §483.73(d):]				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155551	 UILDING	NSTRUCTION	COMPL 03/27	LETED
NAME OF I	PROVIDER OR SUPPLIEF	₹		NDDRESS, CITY, STATE, ZIP COD		
ROLLING	MEADOWS HEAL	TH CARE CENTER		ITAINE, IN 46940		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION lle community-based or	TAG	DE ICEE.		DATE
	I	based functional exercise				
	1	et of the emergency event.				
	_	dditional annual exercise				
	1 ' '	but is not limited to the				
	following:					
	(A) A second full-	scale exercise that is				
		or an individual, facility				
	based functional e	·				
	(B) A mock disas					
		ercise or workshop that is				
	led by a facilitator discussion, using	~ .				
	_	emergency scenario, and a				
	set of problem sta	•				
	I	pared questions designed				
	to challenge an er					
	(iii) Analyze the [l	LTC facility] facility's				
	response to and n	naintain documentation of				
		exercises, and emergency				
		e the [LTC facility] facility's				
	emergency plan, a	as needed.				
	*[For ICF/IIDs at §	· · · -				
	` '	CF/IID must conduct				
		he emergency plan at least				
		e ICF/IID must do the				
	following: (i) Participate in a	n annual full-scale exercise				
	that is community					
		nunity-based exercise is not				
		ict an annual individual,				
	facility-based fund	ctional exercise; or.				
		experiences an actual				
		ade emergency that requires				
		mergency plan, the ICF/IID				
		igaging in its next required				
		nity-based or individual, ctional exercise following the				
	onset of the emer					
	Shoot of the offici	901.07 01011.				1

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Event ID:

8SMV21 Facility ID: 000447

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155551		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF A. BUILDING COMPLETE B. WING 03/27/20				
	PROVIDER OR SUPPLIER	TH CARE CENTER	604 RE	ADDRESS, CITY, STATE, ZIP COD ENNAKER ST NTAINE, IN 46940		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE COMPL	
PREFIX TAG	(ii) Conduct an addithat may include, I following: (A) A second full-scommunity-based facility-based function (B) A mock disaste (C) A tabletop exelled by a facilitator discussion, using clinically-relevant set of problem stamessages, or prepto challenge an er (iii) Analyze the IC maintain documer exercises, and em the ICF/IID's emer *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following:	ditional annual exercise out is not limited to the scale exercise that is or an individual, tional exercise; or er drill; or reise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed orared questions designed energency plan. EF/IID's response to and entation of all drills, tabletop dergency events, and revise gency plan, as needed. 14.102] HHA must conduct the emergency plan at the HHA must do the full-scale exercise that is	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPI	
	(A) When a country is not accessible, individual, facility-levery 2 years; or. (B) If the HHA natural or man-material activation of the elexempt from engate full-scale communifacility based functionset of the emergian Conduct an advice of the years, opposite the	community-based exercise conduct an annual coased functional exercise A experiences an actual ade emergency that requires mergency plan, the HHA is ging in its next required ity-based or individual, tional exercise following the				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155551	l í	ILDING	NSTRUCTION	(X3) DATE (COMPL 03/27/	ETED
	PROVIDER OR SUPPLIER	TH CARE CENTER		604 REI	DDRESS, CITY, STATE, ZIP COD NNAKER ST ITAINE, IN 46940		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	of this section is conclude, but is not (A) A second community-based facility-based function (B) A mock di (C) A tableton is led by a facilitat discussion, using clinically-relevant set of problem state messages, or preper to challenge an er (iii) Analyze the H maintain documer exercises, and enter the HHA's emergent (ii) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergency plan. I actual natural or not required testing exercises, and enter the emergency plan. I actual natural or not required testing exercises, and enter the emergency (ii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Of maintain documer exercises, and enter the emergency (iii) Analyze the Off maintain documer exercises, and enter the emergency (iii) Analyze the Off maintain documer exercises, and enter the emergency (iii) Analyze the Off maintain documer exercises, and enter the emergency (iii) Analyze the Off maintain documer exercises, and enter the emergency (iii) Analyze the Off maintain documer exercises, and enter the emergency (iiii) Analyze the Off maintain documer exercises, and enter the emergency (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	limited to the following: full-scale exercise that is or an individual, ctional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. HA's response to and ntation of all drills, tabletop nergency events, and revise ency plan, as needed. 36.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ats, directed messages, or as designed to challenge an aff the OPO experiences an anan-made emergency plan, the om engaging in its next exercise following the onset					

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Event ID:

8SMV21 Facility ID: 000447

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155551	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/27/2023	
	PROVIDER OR SUPPLIER	TH CARE CENTER		604 RE	ADDRESS, CITY, STATE, ZIP COD NNAKER ST ITAINE, IN 46940		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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)	ιΤΕ	(X5) COMPLETION DATE
	exercises to test the RNHCI must do the (i) Conduct a paper at least annually, a group discussion I narrated, clinically scenario, and a sed directed message designed to challed (ii) Analyze the RN maintain documer exercises, and em the RNHCI's emer Based on record reversal failed to conduct explan at least twice punannounced staff or procedures. The LT following: (i) Participate in an is community-based a. When a community-based a. When a community facility-based functions if the emergency ple from engaging its necommunity-based of the emergency ple from engaging its necommunity-based of the onset of the activation of the conset	e RNHCI must conduct the emergency plan. The emergency plan. The emergency plan. The emergency tabletop exercise is a ed by a facilitator, using a relevant emergency of of problem statements, is, or prepared questions ange an emergency plan. HCI's response to and attation of all tabletop ergency events, and revise gency plan, as needed. iew and interview, the facility ercises to test the emergency er year, including brills using the emergency of facility must do the annual full-scale exercise that the company plan individual, onal exercise. If yexperiences an actual natural ency that requires activation and the LTC facility is exempt ext required full-scale in a remindividual, facility-based exercise for 1 year following all event. It to the following: the exercise that is remindividual, facility-based	EO	039	Plan of Correction 1. What corrective action(s) will be accomplishe for those residents found to have been affected by the deficient practice? No residents experienced adversactions to this deficient practice. How other resident having the potential to be affected by the same deficie practice will be identified an what corrective action(s) will be taken? All residents residing in the facility have the potential of affected by this deficient practice does not practice to ensure that deficient practice does not recur? The Administrator will complete actual event	rerse tice. hts nt d I n o be cice.	03/31/2023

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Event ID:

8SMV21 Facility ID: 000447

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155551		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/27/2023	
	PROVIDER OR SUPPLIER	TH CARE CENTER	604 RE	ADDRESS, CITY, STATE, ZIP COD NNAKER ST NTAINE, IN 46940	
ROLLING (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN) REGULATORY OR c. A tabletop exercise facilitator that incluse a narrated, clinically and a set of problem messages, or prepartically and set of problem messages, or prepartically set of problem messages, or prepar	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION se or workshop that is led by a des a group discussion, using y relevant emergency scenario, n statements, directed ed questions designed to ency plan. 'C facility's response to and ation of all drills, tabletop gency events, and revise the gency plan, as needed in	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) documentation for one of the exercise requirements. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? The maintenance director conducted a live community tornado drill at the facility on 3 at 11:30 pm. The exercises w documented in facility's Emergency Preparedness Ma Any concerns noted will receivimmediate follow-up. Administrator/designee report be presented at monthly QA for review and plan of action will adjusted accordingly. 5. By what date will the systematic changes be completed? 3/31/22	b/31 fill be finual. five will for
	_	or the Administrator of the Operations during the exit			
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State ras conducted by the Indiana th in accordance with 42 CFR	K 0000		

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Event ID:

8SMV21 Facility ID: 000447

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155551	A. BUILDING 01 B. WING			ESURVEY LETED 7/2023
	PROVIDER OR SUPPLIER		604 R	ADDRESS, CITY, STATE, ZIP COD ENNAKER ST		
ROLLING	MEADOWS HEAL	TH CARE CENTER	LA FC	NTAINE, IN 46940		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	Health Care Center Requirements for Pa Medicare/Medicaid Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupa This one story facility Type V (111) const sprinklered. The fa with smoke detection to the corridors and facility has a capaci 92 at the time of thi All areas where the	Code survey, Rolling Meadows was found in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the etion Association (NFPA) 101, LSC), Chapter 19, Existing ancies and 410 IAC 16.2. ity was determined to be of ruction and was fully cility has a fire alarm system on in the corridors, areas open in the resident rooms. The try of 115 and had a census of s survey. residents have customary ered. All areas providing re sprinklered.				

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