STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155551	A. BUILDING **01** B. WING _____	C **07/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS HEALTH CARE CENTER	**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
K 000	INITIAL COMMENTS An Investigation of Complaint Number IN00439547 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Complaint Number IN00439547 was substantiated. No deficiencies related to the allegation were cited. Survey Date: 07/26/24 Facility Number: 000447 Provider Number: 155551 AIM Number: 100289950 At this LSC Complaint survey, Rolling Meadows Health Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with hard wire smoke detection in the resident rooms, corridors and areas open to the corridors. The facility has a capacity of 115 and had a census of 96 at the time of this survey. All areas where residents have customary access were sprinklered. The facility had three detached sheds providing facility services including the maintenance supplies, activity supplies and wheel chairs that were not sprinklered.	K 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155551	A. BUILDING **01** B. WING _____	C **07/26/2024**

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K 000	Continued From page 1 Quality Review completed on 07/31/24	K 000		