STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155693	A. BUILDING 01 B. WING	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

(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 Recertification and State Licensure Survey completed on 07/22/19 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/18/19 Facility Number: 002955 Provider Number: 155693 AIM Number: 200346570 At this PSR survey, Silver Oaks Health Campus was found in substantial 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 and 410 IAC 16.2. Building 0101 and Building 0202 were surveyed with Chapter 19, Existing Health Care Occupancies. Building 0101 and Building 0202 were determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 56 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review on 09/18/19	K 0000	September 29, 2019 Submission of this Plan of Correction does not indicate an admission by SilverOaks Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of SilverOaks Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. We respectfully request paper review for this plan of correction. If you need any information or paperwork, please do not hesitate to contact us at (812) 373-0787. Sincerely,	

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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			Pamela Cole, Executive Director	
K 0363 SS=B Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window			

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	assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation, record review and interview; the facility failed to ensure 1 of over 40 corridor doors and 1 of 2 kitchen doors would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the Main Dining Room. Findings include: Based on observation with the Plant Operations Director at 10:45 a.m. on 09/18/19, a 1.25 inch gap was noted between the door and the door stop when fully closed and latched for the corridor door to the Main Dining Room from the service corridor. Based on interview at the time of the observation, the Plant Operations Director indicated a door was ordered for replacement along with another door to the kitchen from the dining room that was found in similar condition and delivery had been expected by 09/10/19 but it was discovered during the ordering process, the doors needed to be specially measured and reordered which extended the delivery date to a currently unknown date. Based on review, the facility presented documentation indicating the doors were originally ordered on 07/30/19 and the facility is working with this contractor to install the doors when they arrive. 3.1-19(b)	K 0363	K 363 Corridor – Doors **1.Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the potential to affect over 20 residents, staff and visitors at the time of the survey. **2.Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No resident's, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **1.Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:** The Executive Director and/or designee provided re-education to the Director of Plan Operations Doors on protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded	10/18/2019

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			core wood or other material capable of resisting fire for at least 20 minutes. On 7/23/2019 The Director of Plant Operations ordered a new door to be installed to the main dining room from the service corridor. Installation will take place as soon as the door arrives at facility which upon order was told could be 4-6 weeks. After the intial order was placed they had to send a representative out to facility to measure for the door and gave an update arrival date of 10/14/2019 for the door to arrive at the facility. **1.Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly door inspection audit that includes monitoring the door in the main dining room from the service corridor for any gaps that could prevent the corridor door from resisting the passage of smoke. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance	

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			may result in cessation of the monitoring plan based on review.	