STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155693	A. BUILDING _____ B. WING _____	R-C 06/17/2024

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

(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
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 05/08/24. This visit included a PSR to the Investigation of Complaints IN00430897, IN00431864, IN00432712, and IN00433027 completed on 05/08/24. Complaint IN00430897 - Corrected. Complaint IN00431864 - Corrected. Complaint IN00432712 - Corrected. Complaint IN00433027 - Corrected. Survey date: June 17, 2024 Facility number: 002955 Provider number: 155693 AIM number: 200346570 Census Bed Type: SNF/NF: 25 SNF: 27 Residential: 29 Total: 81 Census Payor Type: Medicare: 16 Medicaid: 19 Other: 17 Total: 52 Silver Oaks Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey and	{F 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
	155693	A. BUILDING _____ B. WING _____	R-C 06/17/2024

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

(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
{F 000}	Continued From page 1 the PSR to the Investigation of Complaints IN00430897, IN00431864, IN00432712, IN00433027. Quality review completed on June 19, 2024.	{F 000}		