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	05/22/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/22/24 Facility Number: 002955 Provider Number: 155693 AIM Number: 200346570 At this Emergency Preparedness survey, Silver Oaks Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 80 certified beds. At the time of the survey, the census was 56. Quality Review completed on 05/23/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/22/24 Facility Number: 002955 Provider Number: 155693 AIM Number: 200346570 At this Life Safety Code survey, Silver Oaks Health Campus was found not in compliance with	K 0000	The submission of this plan of correction does not indicate an admission by Silver Oaks Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents by Silver Oaks Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Cole	Executive Director	06/04/2024

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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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
	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 corridor, 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 except the exterior canopy for the patio and all areas providing facility services were sprinklered. Quality Review completed on 05/23/24		in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			

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	155693	A. BUILDING 01 B. WING	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(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
	Based on record review, observation and interview; the facility failed to ensure 1 of 9 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on review of facility blueprint documentation with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:20 a.m. to 11:40 a.m. on 05/22/24, three of four main dining room walls, which includes the west wall of the Main Dining Room, are constructed of a minimum 2-hour fire resistance rating. Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 11:40 a.m. to 1:30 p.m. on 05/22/24, a three foot by one foot rectangular shaped hole was noted in the west wall of the attic above the Main Dining Room as observed from the attic access in the adjoining kitchen. Based on interview at the time of the observations, the Facilities Management Support stated a contractor recently ran wiring to new equipment installed on the ceiling of the kitchen which was likely the cause of the hole in the wall and agreed the aforementioned opening in the smoke barrier wall above the Main Dining Room was not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the DPO and the Facilities Management Support during the exit	K 0372	**K 372 Subdivision of Building Spaces-Smoke Barrier** **1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the potential to affect over 80 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 residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3. 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 Plant Operations on Subdivision of Building Spaces - Smoke Barrier Construction 2012	06/03/2024

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SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

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	conference. 3.1-19(b)		EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) The Director of Plant Operations enclosed the opening in the firewall by drywalling, mudding, and fire caulking the opening in the west wall of the main dining room on 06/03/2024. **4. 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 audit that includes monitoring that the closure of the fire-resistant wall remains in place to ensure that the west wall of the main dining room remains fire stopped. 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	

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	155693	A. BUILDING 01 B. WING	05/22/2024

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			the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review. **5.The time frame the campus is alleging compliance.** Date: June 03, 2024	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used			

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	temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Executive Director's office near the main entrance lobby to the health care portion of the facility. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 11:40 a.m. to 1:30 p.m. on 05/22/24, a refrigerator, a microwave oven and a computer printer were plugged into a power strip placed on the floor in the Executive Director's office near the main entrance lobby to the health care portion of the facility. Based on interview at the time of the observations, the DPO and the Facilities Management Support agreed a power strip was being used as a substitute for fixed wiring at the aforementioned location.	K 0920	**K 920 Electrical Equipment-Power Cords and Extension Cords** **1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the potential to affect no residents in one room. **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. **3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:**	06/03/2024

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	These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		The Executive Director and/or designee provided re-education to the Director of Plant Operations on Electrical Equipment - Power Cords and Extension CFR(s): NFPA 101 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3 The Director of Plant Operations immediately unplugged the microwave, refrigerator and printer	

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			from the power strip in Executive Directors office on the day of the inspection 5/22/2024 and had a new electric receptacle on May 28, 2024. **4. 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 audit that includes monitoring the usage of any power strips in Executive Directors office. 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 may result in cessation of the monitoring plan based on review. **5.The time frame the campus is alleging compliance.** Date: June 03, 2024	

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SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

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K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/22/24 Facility Number: 002955 Provider Number: 155693 AIM Number: 200346570 At this Life Safety Code survey, Silver Oaks Health Campus was found not 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 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 except the exterior canopy for the patio outside the Living Room lounge in Building 0101. 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 except the exterior canopy for the patio and all areas providing facility services were sprinklered. Quality Review completed on 05/23/24	K 0000	The submission of this plan of correction does not indicate an admission by Silver Oaks Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents by Silver Oaks Health Campus. The facility recognizes its 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 all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	

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K 0324 SS=E Bldg. 02	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure staff had access to a shutoff switch for 1 of 1 cook tops in the Transitional Care Unit Therapy Room. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10)	K 0324	**K 324 Cooking Facilities** **1 Corrective Action for the resident(s) affected by the alleged deficient practice:**This deficient practice had the potential to affect over 80 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 residents, staff or visitors were identified or reported any findings suggestive of having been affected by the	06/03/2024

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	and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect over 5 residents, staff and visitors in the Transitional Care Unit (TCU) Therapy Room. Findings include: Based on observations with the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 11:40 a.m. to 1:30 p.m. on 05/22/24, there was an electric cooktop in the TCU Therapy Room that was separated from the corridor but staff were unable to deactivate the cooktop from electrical power. The cooktop was hardwired to an electrical junction box in a cabinet directly below the cooktop. Based on interview at the time of the observations, the DPO agreed a locked switch, or a switch located in a restricted location, is not provided within the cooking facility that deactivates the cooktop. These findings were reviewed with the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		deficient practice.**3** **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 Plant Operations on Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous area but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 The Director of Plant Operations	

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			installed a shut off switch for the cook top in the Transitional Care Unit Therapy room behind a locked cabinet on May 30, 2024. **4. 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 audit that includes monitoring that the shut off switch for the cook top in the transitional care unit therapy room remains in place behind a locked cabinet. 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 may result in cessation of the monitoring plan based on review. /p> **5.The time frame the campus is alleging compliance.** Date: June 03, 2024	