PRINTED: 06/07/2024

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES |   |   |          |   |   |                               | FORM APPROVED<br>OMB NO. 0938-039 |  |
|--|---|---|----------|---|---|-------------------------------|-----------------------------------|--|
|  | NT OF DEFICIENCIES OF CORRECTION                          | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155693   |          | JILDING   | ONSTRUCTION   | (X3) DATE<br>COMPI<br>05/22   |                                   |  |
|  | PROVIDER OR SUPPLIER                                      |   | <u> </u> | 2011 C  | ADDRESS, CITY, STATE, ZIP COD<br>HAPA STREET<br>MBUS, IN 47203  | •                             |                                   |  |
|  | R OAKS HEALTH CAMPUS                                      |   |          |   | T   |                               | Γ                                 |  |
| (X4) ID<br>PREFIX  |   | STATEMENT OF DEFICIENCIE  |          | ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B |   |                               |                                   |  |
| TAG  | · ·   | ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION   |          | TAG   | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | ATE                           | DATE                              |  |
| E 0000   | REGUENTON OF  |   |          | 1110  |   |                               | 2.112                             |  |
| Bldg   | 1 .   | paredness Survey was<br>adiana Department of Health in<br>CFR 483.73.   | E 00     | 000   |   |                               |                                   |  |
|  | Survey Date: 05/22  | 2/24  |          |   |   |                               |                                   |  |
|  | Facility Number: 0<br>Provider Number:<br>AIM Number: 200 | 155693  |          |   |   |                               |                                   |  |
|  | Oaks Health Camp<br>with Emergency Pr                     | Preparedness survey, Silver us was found in compliance reparedness Requirements for local Participating Providers CFR 483.73. |          |   |   |                               |                                   |  |
|  | The facility has 80 the survey, the cens                  | certified beds. At the time of sus was 56.  |          |   |   |                               |                                   |  |
|  | Quality Review con  | mpleted on 05/23/24   |          |   |   |                               |                                   |  |
| K 0000   |   |   |          |   |   |                               |                                   |  |
| Bldg. 01   | Licensure Survey w  | 002955  | K 0      | 000   | The submission of this plan or correction does not indicate a admission by Silver Oaks Heat Campus that the findings and allegations contained herein a accurate, true representation the quality of care provided, at the living environment provided the residents by Silver Oaks | n<br>alth<br>are<br>of<br>and |                                   |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Campus was found not in compliance with

At this Life Safety Code survey, Silver Oaks

AIM Number: 200346570

TITLE (X6) DATE

Health Campus. The facility recognizes its obligation to provide

legally and medically necessary

care and services to its residents

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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|                            | NT OF DEFICIENCIES OF CORRECTION  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693  | (X2) MULTIPLE C A. BUILDING B. WING | onstruction<br><u>01</u>  | (X3) DATE S  COMPLE  05/22/2                               | ETED                       |
|----------------------------|---|--|-------------------------------------|---|--|----------------------------|
|                            | PROVIDER OR SUPPLIER  |  | 2011 0                              | ADDRESS, CITY, STATE, ZIP C<br>CHAPA STREET<br>MBUS, IN 47203   | OD   |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OR   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | RECTION<br>HOULD BE<br>PPROPRIATE                          | (X5)<br>COMPLETION<br>DATE |
|                            | Life Safety from Fir National Fire Protect and 410 IAC 16.2. 0202 were surveyed Health Care Occupation by Health Care Occupation of Type V (11 sprinklered. The fawith smoke detection open to the corridor rooms. The facility census of 56 at the tax All areas where the access were sprinkle for the patio and all services were sprinkles. | the and the 2012 edition of the extion Association (NFPA) 101 Building 0101 and Building I with Chapter 19, Existing ancies. Building 0202 were determined 1) construction and fully cility has a fire alarm system on in the corridor, in all areas and in all resident sleeping has a capacity of 80 and had a time of this survey.  residents have customary ered except the exterior canopy areas providing facility |                                     | in an economic and eff manner. The facility he maintains it is in substate compliance with all state federal requirements gomanagement of this fact thus submitted as a mastatute only. | ereby<br>antial<br>te and<br>overning the<br>cility. It is |                            |
| K 0372<br>SS=E<br>Bldg. 01 | Barrie Subdivision of Bui Barrier Construction 2012 EXISTING Smoke barriers shall be patrium wall. Smoke in duct penetration systems where and is installed for smoth to the smoke barrian 19.3.7.3, 8.6.7.1(1  | rall be constructed to a cance rating per 8.5. Smoke ermitted to terminate at an e dampers are not required as in fully ducted HVAC approved sprinkler system oke compartments adjacent er.  ) hanical smoke control   |                                     |   |  |                            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155693 |  | X2) MULTIPLE CONSTRUCTION   X3) DATE SURVEY     A. BUILDING   01   COMPLETED     B. WING   05/22/2024  |              |   |  |
|--|--|--|--------------|---|--|
|  | PROVIDER OR SUPPLIEF   |  | 2011 C       | ADDRESS, CITY, STATE, ZIP COD<br>CHAPA STREET<br>MBUS, IN 47203   |  |
| (X4) ID<br>PREFIX  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL   | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | (X5) COMPLETION  |
| TAG  | Based on record review; the facilitative wills were presistance rating of Section 19.3.7.5 reconstructed in account and shall have a mirating. This deficie residents, staff and Main Dining Room.  Findings include:  Based on review of documentation with Operations (DPO) a Support during reconstructed in account and in Dining Room. 2-hour fire resistance observations with the DPO) and the Facing during a tour of the p.m. on 05/22/24, a rectangular shaped wall of the attic abcords observed from the akitchen. Based on observations, the Fastated a contractor requipment installed which was likely the and agreed the aforesmoke barrier wall | facility blueprint In the Director of Plant In the Director of Plant In the Facilities Management In the Facilities Management In the Facilities Management In the Facilities Management In the Plant Operation of the Interest of a minimum Interest of Plant Operation of Plant Operation of Plant Operation of Plant Operation of The Director of Plant Operation of The Director of Plant Operation of The Interest of Plant Operation of The Interest of the Interest of The Interest of Plant Operation of Plant Operation of The Interest of Plant Operation of The Interest of Plant Operation | 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 take for those resident(s) having the potential to be affected by the alleged deficient practice:  No residents, staff or visitors with identified or reported any findire suggestive of having been affee 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 | ne 06/03/2024  the he h |
|  |  | e reviewed with the DPO and  |              | the Director of Plant Operation Subdivision of Building Spaces  | s on   |

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the Facilities Management Support during the exit

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Smoke Barrier Construction 2012

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|               | IT OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155693 | A. BU | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | (X3) DATE SURVEY COMPLETED 05/22/2024 |                    |
|---------------|-------------------------------------|---|-------|--|--|---------------------------------------|--------------------|
| NAME OF P     | PROVIDER OR SUPPLIER                |   |       |  | ADDRESS, CITY, STATE, ZIP COD  |                                       |                    |
| SILVER (      | OAKS HEALTH CA                      | MPUS  |       |  | HAPA STREET<br>IBUS, IN 47203  |                                       |                    |
| (X4) ID       |                                     | STATEMENT OF DEFICIENCIE                                      |       | ID   | PROVIDER'S PLAN OF CORRECTION  |                                       | (X5)               |
| PREFIX<br>TAG | `                                   | CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION      |       | PREFIX<br>TAG                                    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | TE                                    | COMPLETION<br>DATE |
|               | conference. 3.1-19(b)               |   |       |  | EXISTING Smoke barriers shat constructed to a 1/2-hour fire resistance rating per 8.5. Smoth barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully duth HVAC systems where an approved sprinkler system is installed for smoke compartment adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)  The Director of Plant Operation 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. | red<br>cted<br>ents                   |                    |
|               |                                     |   |       |  | 4. Corrective Actions that w be monitored to ensure the alleged will not re occur:  The Director of Plant Operation and/or Designee developed a weekly audit that includes monitoring that the closure of fire-resistant wall remains in p to ensure that the west wall of main dining room remains fire stopped. The Director of Plant Operations and/or Designee w perform the observation audits three times a week, for three months. Findings will be reviet during the quarterly QA  | ons the lace the vill s               |                    |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |   |          | SURVEY   |       |            |
|--|---------------------|---|---|----------|--|-------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER                       | A. BUILDING <u>01</u> COMPLETED         |          |  | LETED |            |
|  |                     | 155693                                      | B. WING 05/22/2024                      |          |  |       | /2024      |
|  |                     | l .   |   | STDEET A | ADDRESS, CITY, STATE, ZIP COD  |       |            |
| NAME OF P  | ROVIDER OR SUPPLIER | ₹   |   |          |  |       |            |
| SII VED (  | DAKS HEALTH CA      | MDUS  | 2011 CHAPA STREET<br>COLUMBUS, IN 47203 |          |  |       |            |
| JILVLI (   | JANO HLALIII CA     | IVII 03                                     |   | COLON    | 1005, 111 47 205   |       |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | .TE   | COMPLETION |
| TAG  | REGULATORY OR       | R LSC IDENTIFYING INFORMATION               |   | TAG      | DEFICIENCY)  |       | DATE       |
|  |                     |   |   |          | the frequency for ongoing  |       |            |
|  |                     |   |   |          | monitoring. Findings suggestive  |       |            |
|  |                     |   |   |          | 100% compliance may result i   |       |            |
|  |                     |   |   |          | cessation of the monitoring pla  | an    |            |
|  |                     |   |   |          | based on review.   |       |            |
|  |                     |   |   |          |  |       |            |
|  |                     |   |   |          |  |       |            |
|  |                     |   |   |          |  |       |            |
|  |                     |   |   |          |  |       |            |
|  |                     |   |   |          |  |       |            |
|  |                     |   |   |          | 5.The time frame the campu   | s     |            |
|  |                     |   |   |          | is alleging compliance.  |       |            |
|  |                     |   |   |          |  |       |            |
|  |                     |   |   |          | Date: June 03, 2024  |       |            |
|  |                     |   |   |          |  |       |            |
|  |                     |   |   |          |  |       |            |
| IX 0000  | NEDA 404            |   |   |          |  |       |            |
| K 0920<br>SS=E                                       | NFPA 101            |   |   |          |  |       |            |
|  |                     | ent - Power Cords and                       |   |          |  |       |            |
| Bldg. 01   | Extens              | ant Dawer Canda and                         |   |          |  |       |            |
|  |                     | ent - Power Cords and                       |   |          |  |       |            |
|  | Extension Cords     | nationt care vicinity are only              |   |          |  |       |            |
|  | used for compone    | patient care vicinity are only              |   |          |  |       |            |
|  | •                   | ed electrical equipment                     |   |          |  |       |            |
|  | -                   | les that have been                          |   |          |  |       |            |
|  | , ,                 | alified personnel and meet                  |   |          |  |       |            |
|  |                     | 10.2.3.6. Power strips in                   |   |          |  |       |            |
|  |                     | cinity may not be used for                  |   |          |  |       |            |
|  |                     | , personal electronics),                    |   |          |  |       |            |
|  | , -                 | m care resident rooms that                  |   |          |  |       |            |
|  |                     | E. Power strips for PCREE                   |   |          |  |       |            |
|  |                     | r UL 60601-1. Power strips                  |   |          |  |       |            |
|  |                     | the patient care rooms                      |   |          |  |       |            |
|  |                     | n meet UL 1363. In                          |   |          |  |       |            |
|  | •                   | ooms, power strips meet                     |   |          |  |       |            |
|  | •                   | ls. All power strips are                    |   |          |  |       |            |
|  |                     | precautions. Extension                      |   |          |  |       |            |
|  | _                   | d as a substitute for fixed                 |   |          |  |       |            |
|  |                     | re. Extension cords used                    |   |          |  |       |            |
|  | wining or a structu | IG. EARGIBIOTI GOLUB UBGU                   | 1                                       |          |  |       | I          |

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/22/2024 155693 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2011 CHAPA STREET COLUMBUS, IN 47203 SILVER OAKS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K 0920 06/03/2024 K 920 Electrical Equipmentfailed to ensure 1 of 1 extension cords including **Power Cords and Extension** power strips were not used as a substitute for Cords 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 Corrective Action for the NFPA 70, National Electrical Code, 2011 Edition. resident(s) affected by the NFPA 70, Article 400.8 requires that, unless alleged deficient practice: specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of This deficient practice had the a structure. LSC Section 4.5.7 states any building potential to affect no residents in one room. 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 **Corrective Actions taken** Executive Director's office near the main entrance for those resident(s) having the lobby to the health care portion of the facility. potential to be affected by the alleged deficient practice: Findings include: No resident's, staff or visitors Based on observations with the Director of Plant were identified or reported any Operations (DPO) and the Facilities Management findings suggestive of having been Support during a tour of the facility from 11:40 affected by the deficient practice. 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 3. Corrective Actions including entrance lobby to the health care portion of the Measures/Systemic changes facility. Based on interview at the time of the put in place to assure the observations, the DPO and the Facilities alleged deficient practice does

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aforementioned location.

Management Support agreed a power strip was

being used as a substitute for fixed wiring at the

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not re occur:

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|                          | T OF HEALTH AND HU<br>R MEDICARE & MEDIC |   |  |   |  | IB NO. 0938-039            |  |
|--------------------------|--|---|--|---|--|----------------------------|--|
|                          | NT OF DEFICIENCIES OF CORRECTION         | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693                                   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | onstruction<br>01   | (X3) DATE SURVEY COMPLETED 05/22/2024  |                            |  |
|                          | PROVIDER OR SUPPLIEI                     |   | 2011 C                                     | ADDRESS, CITY, STATE, ZIP COD<br>CHAPA STREET<br>MBUS, IN 47203   |  |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                           | STATEMENT OF DEFICIENCIE<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  | ATE  | (X5)<br>COMPLETION<br>DATE |  |
|                          | These findings wer                       | re reviewed with the DPO and gement Support during the exit                               |  | The Executive Director and/o designee provided re-education the Director of Plant Operation Electrical Equipment - Power Cords and Extension CFR(s) NFPA 101 Power strips in a patient care vicinity are only of for components of movable patient-care-related electrical equipment (PCREE) assembent that have been assembled by qualified personnel and meet conditions of 10.2.3.6. Power strips in the patient care vicin may not be used for non-PCF (e.g., personal electronics), except in long-term care reside rooms that do not use PCRE Power strips for PCREE meet 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside ovicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standard All power strips are used with general precautions. Extension cords are not used as a substant for fixed wiring of a structure. Extension cords used temporare removed immediately upon completion of the purpose for which it was installed and met the conditions of 10.2.4.10.2. (NFPA 99), 10.2.4 (NFPA 99, 400-8 (NFPA 70), 590.3 | on to ons on  : used  les on the ity REE dent E. t UL on titute carily on eets 3.6 |                            |  |

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The Director of Plant Operations immediately unplugged the microwave, refrigerator and printer

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|                          | IT OF DEFICIENCIES<br>OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155693                     | A. BU | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | (X3) DATE SURVEY COMPLETED 05/22/2024 |                            |
|--------------------------|-------------------------------------|---|-------|--|--|---------------------------------------|----------------------------|
| NAME OF P                | PROVIDER OR SUPPLIER                |   |       |  | ADDRESS, CITY, STATE, ZIP COD<br>HAPA STREET   |                                       |                            |
| SILVER (                 | OAKS HEALTH CA                      | MPUS  |       |  | 1BUS, IN 47203   |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                      | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION |       | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | λΤΕ                                   | (X5)<br>COMPLETION<br>DATE |
|                          |                                     |   |       |  | from the power strip in Execut<br>Directors office on the day of<br>inspection 5/22/2024 and had<br>new electric receptacle on Ma<br>28, 2024.   | the<br>a                              |                            |
|                          |                                     |   |       |  | 4. Corrective Actions that w<br>be monitored to ensure the<br>alleged will not re occur:   | ill                                   |                            |
|                          |                                     |   |       |  | The Director of Plant Operation and/or Designee developed a weekly audit that includes monitoring the usage of any patrips in Executive Directors of The Director of Plant Operation and/or Designee will perform observation audits three times week, for three months. Finding will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliant may result in cessation of the monitoring plan based on revieweekly audited to the province of the monitoring plan based on revieweekly audited to the province of the p | ower ffice. ons the s a ngs der       |                            |
|                          |                                     |   |       |  | 5.The time frame the campu is alleging compliance.  Date: June 03, 2024  | s                                     |                            |

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|                          | NT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155693   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  02   | (X3) DATE (<br>COMPL<br>05/22/   | LETED                      |
|--------------------------|--|--|--|---|--|----------------------------|
|                          | PROVIDER OR SUPPLIER   |  | 2011 0                                     | ADDRESS, CITY, STATE, ZIP COD<br>CHAPA STREET<br>MBUS, IN 47203   | )  |                            |
| SILVER                   | OAKS HEALTH CA   | IVIF US  | COLUI                                      | VIDO3, IIN 47203  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY)  | TION<br>LD BE<br>ROPRIATE  | (X5)<br>COMPLETION<br>DATE |
| K 0000                   |  |  |  |   |  |                            |
| Bldg. 02                 | Licensure Survey w Department of Head 483.90(a).  Survey Date: 05/22  Facility Number: 0 Provider Number: 200  At this Life Safety of Health Campus was Requirements for P Medicare/Medicaid Life Safety from Fi National Fire Protect and 410 IAC 16.2. 0202 were surveyed Health Care Occupate Building 0101 and to be of Type V (11 sprinklered except to patio outside the Li 0101. The facility is smoke detection in to the corridor and The facility has a conference of 56 at the time of All areas where the access were sprinkle for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the patio and all services were sprinklered except for the pation and all services were sprinklered except for the pation and all services were sprinklered except for the pation and all services were sprinklered except for the pation and all services were sprinklered except for the pation and all services were sprinklered except for the pation and | 202955 155693 346570  Code survey, Silver Oaks is found not in compliance with articipation in 1, 42 CFR Subpart 483.90(a), are and the 2012 edition of the ection Association (NFPA) 101 Building 0101 and Building if with Chapter 19, Existing ancies.  Building 0202 were determined 1) construction and fully the exterior canopy for the ving Room lounge in Building has a fire alarm system with the corridors, in all areas open in all resident sleeping rooms. Apacity of 80 and had a census this survey.  residents have customary ered except the exterior canopy areas providing facility | K 0000                                     | The submission of this placorrection does not indicate admission by Silver Oaks Campus that the findings allegations contained her accurate, true representative quality of care provide the living environment protection of the living environment protection. The fact recognizes its obligation of legally and medically necessary and services to its refin an economic and efficit manner. The facility here maintains it is in substant compliance with all state federal requirements governagement of this facility thus submitted as a matter statute only. | ate an s Health s and rein are ation of ed, and ovided to aks sility to provide cessary esidents ent eby tial and rerning the aty. It is |                            |

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|                            | T OF HEALTH AND HU<br>R MEDICARE & MEDIC   |  |      |                     |  | FORM APPROVE<br>OMB NO. 0938-039 |                            |  |
|----------------------------|--|--|------|---------------------|--|----------------------------------|----------------------------|--|
|                            | NT OF DEFICIENCIES OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693  | ì    | ILDING              | ONSTRUCTION 02   | COMP                             | SURVEY<br>LETED<br>2/2024  |  |
|                            | PROVIDER OR SUPPLIER   |  |      | 2011 C              | ADDRESS, CITY, STATE, ZIP COD<br>HAPA STREET<br>MBUS, IN 47203   |                                  |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | ]    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)   | ATE                              | (X5)<br>COMPLETION<br>DATE |  |
| K 0324<br>SS=E<br>Bldg. 02 | Ventilation Control Commercial Cook * residential cooki appliances such a toasters) are used cooking in accord 19.3.2.5.2 * cooking facilities smoke compartment patients comply with 18.3.2.5.3, 19.3.2 * cooking facilities with 30 or fewer productions under Cooking facilities with 30 or fewer productions under Cooking facilities NFPA 96 per 9.2. enclosed as haza be open to the cooth 18.3.2.5.1 through through 19.3.2.5.8 Based on observation failed to ensure statistically switch for 1 of 1 cooking equipment for 30 or fewer persprovided that the cooking equipment for 30 or fewer persprovided that the cooking c | nt is protected in NFPA 96, Standard for I and Fire Protection of ing Operations, unless: ng equipment (i.e., small as microwaves, hot plates, I for food warming or limited ance with 18.3.2.5.2, open to the corridor in ents with 30 or fewer ith the conditions under 1.5.3, or 1.5.3, or 1.5.4. In the conditions under 1.5.4. In the conditions under 1.5.5.4. In the | K 03 | 24                  | K 324 Cooking Facilities  1 Corrective Action for resident(s) affected by the alleged deficient practice: The deficient practice had the potto affect over 80 residents, stand visitors at the time of the survey. 2 Corrective Actitaken for those resident(s) having the potential to be affected by the alleged deficient practice: No residentice: | nis<br>ential<br>aff             | 06/03/2024                 |  |

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shall be separated from the corridor by partitions

(3) The requirements of 19.3.2.5.3(1) through (10)

complying with 19.3.6.2 through 19.3.6.5.

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staff or visitors were identified or

having been affected by the

reported any findings suggestive of

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                       | X2) MULTIPLE CONSTRUCTION         |                                 |          | (X3) DATE SURVEY   |      |            |
|--|---------------------------------------|-----------------------------------|---------------------------------|----------|--|------|------------|
| AND PLAN   | OF CORRECTION                         | IDENTIFICATION NUMBER             | A. BUILDING <u>02</u> COMPLETED |          |  | ETED |            |
|  |                                       | 155693                            | B. W                            | ING      | 05/22/2024   |      | 2024       |
|  |                                       |                                   |                                 | STREET A | ADDRESS, CITY, STATE, ZIP COD  |      |            |
| NAME OF P  | PROVIDER OR SUPPLIEF                  | 8                                 |                                 |          | HAPA STREET  |      |            |
| SILVER   | OAKS HEALTH CA                        | MPLIS                             | COLUMBUS, IN 47203              |          |  |      |            |
| OIL VER  | - INO FILALITI OA                     |                                   |                                 | JOLON    |  |      |            |
| (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<br>CROSS-REFERENCED TO THE APPROPRIA | TE   | COMPLETION |
| TAG  | ĭ                                     | LSC IDENTIFYING INFORMATION       | ļ                               | TAG      | DEFICIENCY)  |      | DATE       |
|  | and (13) are met.                     |                                   |                                 |          | deficient practice.3   |      |            |
|  | ` ′                                   | A switch meeting all of the       |                                 |          | Corrective Actions including   |      |            |
|  | following is provide                  |                                   |                                 |          | Measures/Systemic changes  | i    |            |
|  |                                       | , or a switch located in a        |                                 |          | put in place to assure the   |      |            |
|  |                                       | is provided within the cooking    |                                 |          | alleged deficient practice do  | es   |            |
|  | 1                                     | ates the cooktop or range.        |                                 |          | not re occur:  |      |            |
|  | 1 1                                   | ed to deactivate the cooktop      |                                 |          | The Executive Director and/or  |      |            |
|  | _                                     | the kitchen is not under staff    |                                 |          | designee provided re-education   |      |            |
|  | supervision.                          |                                   |                                 |          | the Director of Plant Operation  |      |            |
|  |                                       | ice could affect over 5           |                                 |          | Cooking Facilities CFR(s): NF  |      |            |
|  | · · · · · · · · · · · · · · · · · · · | visitors in the Transitional      |                                 |          | 101 Cooking Facilities Cookir  | ng   |            |
|  | Care Unit (TCU) T                     | herapy Room.                      |                                 |          | equipment is protected in  |      |            |
|  |                                       |                                   |                                 |          | accordance with NFPA 96,   |      |            |
|  | Findings include:                     |                                   |                                 |          | Standard for Ventilation Contr   |      |            |
|  |                                       |                                   |                                 |          | and Fire Protection of Comme   |      |            |
|  |                                       | ons with the Director of Plant    | Cooking Operations, unless: *   |          |  |      |            |
|  |                                       | and the Facilities Management     | residential cooking equipment   |          |  |      |            |
|  |                                       | ur of the facility from 11:40     |                                 |          | (i.e., small appliances such as  |      |            |
|  | _                                     | n 05/22/24, there was an electric |                                 |          | microwaves, hot plates, toaste   | ers) |            |
|  | _                                     | Therapy Room that was             |                                 |          | are used for food warming or   |      |            |
|  |                                       | corridor but staff were unable    |                                 |          | limited cooking in accordance  |      |            |
|  |                                       | oktop from electrical power.      |                                 |          | 18.3.2.5.2, 19.3.2.5.2 * cookin  | -    |            |
|  | _                                     | ardwired to an electrical         |                                 |          | facilities open to the corridor in                                     |      |            |
|  | l -                                   | binet directly below the          |                                 |          | smoke compartments with 30   |      |            |
|  | _                                     | interview at the time of the      |                                 |          | fewer patients comply with the   | ;    |            |
|  |                                       | PO agreed a locked switch, or     |                                 |          | conditions under 18.3.2.5.3,   |      |            |
|  |                                       | a restricted location, is not     |                                 |          | 19.3.2.5.3,or * cooking facilitie                                      |      |            |
|  |                                       | cooking facility that             |                                 |          | smoke compartments with 30   | or   |            |
|  | deactivates the cool                  | ctop.                             |                                 |          | fewer patients comply with   |      |            |
|  |                                       | t distance t                      |                                 |          | conditions under   |      |            |
|  | 1                                     | e reviewed with the DPO and       |                                 |          | 18.3.2.5.4, 19.3.2.5.4. Cooking  | -    |            |
|  | · ·                                   | gement Support during the exit    |                                 |          | facilities protected according t                                       | 0    |            |
|  | conference.                           |                                   |                                 |          | NFPA 96 per 9.2.3 are not  |      |            |
|  | 2.1.10(1.)                            |                                   |                                 |          | required to be enclosed as   |      |            |
|  | 3.1-19(b)                             |                                   |                                 |          | hazardous area but shall not b   |      |            |
|  |                                       |                                   |                                 |          | open to the corridor. 18.3.2.5.  |      |            |
|  |                                       |                                   |                                 |          | 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 Operatio   | ns   |            |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                     | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |                       |  |            |  |
|--|---------------------|---|-----------------------|--|------------|--|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER                       | A. BUILDING <u>02</u> |  | COMPLETED  |  |
|  |                     | 155693                                      | B. WING               |  | 05/22/2024 |  |
|  |                     | 1.00000                                     |                       | -  | 00/11/101  |  |
| NAME OF F  | PROVIDER OR SUPPLIE | ER  |                       | ADDRESS, CITY, STATE, ZIP COD  |            |  |
|  |                     |   |                       | CHAPA STREET   |            |  |
| SILVER   | OAKS HEALTH CA      | AMPUS                                       | COLU                  | MBUS, IN 47203   |            |  |
| (X4) ID  | SUMMARY             | STATEMENT OF DEFICIENCIE                    | ID                    | PROVIDER'S PLAN OF CORRECTION  | (X5)       |  |
| PREFIX   | (EACH DEFICIE       | NCY MUST BE PRECEDED BY FULL                | PREFIX                | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |  |
| TAG  | REGULATORY C        | R LSC IDENTIFYING INFORMATION               | TAG                   | DEFICIENCY)  | DATE       |  |
|  |                     |   |                       | installed a shut off switch for  | the        |  |
|  |                     |   |                       | cook top in the Transitional C   | are        |  |
|  |                     |   |                       | Unit Therapy room behind a   |            |  |
|  |                     |   |                       | locked cabinet on May 30, 20   | 24.        |  |
|  |                     |   |                       | 4. Corrective Actions that v   | will       |  |
|  |                     |   |                       | be monitored to ensure the   |            |  |
|  |                     |   |                       | alleged will not re occur: Th  | e          |  |
|  |                     |   |                       | Director of Plant Operations a   | and/or     |  |
|  |                     |   |                       | Designee developed a weekly  | y          |  |
|  |                     |   |                       | audit that includes monitoring   | that       |  |
|  |                     |   |                       | the shut off switch for the coo  | k top      |  |
|  |                     |   |                       | in the transitional care unit the                                      | erapy      |  |
|  |                     |   |                       | room remains in place behind   | la         |  |
|  |                     |   |                       | locked cabinet. The Director of  | of         |  |
|  |                     |   |                       | Plant Operations and/or Design   | -          |  |
|  |                     |   |                       | will perform the observation a   | udits      |  |
|  |                     |   |                       | three times a week, for three  |            |  |
|  |                     |   |                       | months. Findings will be revie   | ewed       |  |
|  |                     |   |                       | during the quarterly QA  |            |  |
|  |                     |   |                       | Committee in order to determ   | ine        |  |
|  |                     |   |                       | the frequency for ongoing  |            |  |
|  |                     |   |                       | monitoring. Findings suggesti  |            |  |
|  |                     |   |                       | 100% compliance may result   |            |  |
|  |                     |   |                       | cessation of the monitoring pl   | an         |  |
|  |                     |   |                       | based on review.   |            |  |
|  |                     |   |                       |  |            |  |
|  |                     |   |                       | /p> 5.The time frame the   |            |  |
|  |                     |   |                       | campus is alleging   |            |  |
|  |                     |   |                       | compliance.  |            |  |
|  |                     |   |                       | Data: Iuma 00 0004   |            |  |
|  |                     |   |                       | Date: June 03, 2024  |            |  |
|  |                     |   |                       |  |            |  |

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