PRINTED: 05/23/2023

DEPARTMENT	Γ OF HEALTH AND HU	UMAN SERVICES				FO	RM APPROVED
	R MEDICARE & MEDI						IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155693	A. BU B. WI	JILDING		COMPI 04/27	
		133093	D. WI			04/27	72023
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD		
SILVER	OAKS HEALTH CA	AMPUS			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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
E 0000							
Bldg		1 0	F 0.	200			
	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in		E 00	000	Preparation or execution of th	IS	
	accordance with 4	-			plan of correction does not	mant	
	accordance with 4.	2 CFR 483.73.			constitute admission or agree of provider of the truth of the f		
	Survey Date: 04/2	27/23			alleged or conclusions set for		
		23			the Statement of Deficiencies		
	Facility Number:	002955			Plan of Correction is prepared		
	Provider Number:				executed solely because it is		
	AIM Number: 20	0346570			required by the position of Fed	deral	
					and State Law. The Plan of		
	At this Emergency	Preparedness survey, Silver			Correction is submitted to res	oond	
	Oaks Health Camp	ous was found in compliance			to the allegations of		
	with Emergency P	reparedness Requirements for			noncompliance cited during th	е	
		licaid Participating Providers			Life Safety Inspection comple	ted	
	and Suppliers, 42	CFR 483.73.			on April 27, 2023.		
					Please accept this Plan of		
		certified beds. At the time of			Correction as the provider's		
	the survey, the cer	isus was 50.			credible allegation of compliar		
	O1' D'	1-4-1			as of May 19, 2023. The provi		
	Quality Review Co	ompleted on 05/04/23			respectfully requests desk rev with paper compliance to be	iew	
					considered in establishing tha	t the	
					provider is in substantial	t ti ie	
					compliance.		
K 0000							
Bldg. 01							
		e Recertification and State	K 0	000	Preparation or execution of th	is	
	Licensure Survey	was conducted by the Indiana			plan of correction does not		

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

Department of Health in accordance with 42 CFR

483.90(a).

Survey Date: 04/27/23

Facility Number: 002955

Provider Number: 155693

TITLE

constitute admission or agreement

of provider of the truth of the facts alleged or conclusions set forth on

the Statement of Deficiencies. The Plan of Correction is prepared and

required by the position of Federal

executed solely because it is

(X6) DATE

Pamela Cole **Executive Director** 05/19/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ZIDM21 Facility ID: 002955 If continuation sheet Page 1 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	COMI	E SURVEY PLETED 7/2023
	PROVIDER OR SUPPLIEF		2011 C	ADDRESS, CITY, STATE, ZIF CHAPA STREET MBUS, IN 47203	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	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 Occupation of Type V (11 sprinklered except patio outside the Li 0101. The facility smoke detection in to the corridor and The facility has a conference of 50 at the time of All areas where the access were sprinklered services were sprinklered except that the time of the patio and all services were sprinklered except that the time of the patio and all services were sprinklered except that the time of the patio and all services were sprinklered except that the time of the patio and all services were sprinklered except that the patio and all services were sprinklered except that the patio and all services were sprinklered except that the patio and all services were sprinklered except that the patio and all services were sprinklered except that the pation and all services were sprinklered except that the pation and all services were sprinklered except that the pation and all services were sprinklered except that the pation and th	Code survey, Silver Oaks a found not in compliance with articipation in 42 CFR Subpart 483.90(a), are and the 2012 edition of the ction Association (NFPA) 101 Building 0101 and Building I with Chapter 19, Existing ancies. Building 0202 were determined 1) construction and fully he 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. Tesidents have customary ered except the exterior canopy areas providing facility		and State Law. The R Correction is submitte to the allegations of noncompliance cited Life Safety Inspection on April 27, 2023. Please accept this Pl Correction as the pro- credible allegation of as of May 19, 2023. respectfully requests with paper compliance considered in establi- provider is in substar compliance.	during the n completed lan of ovider's compliance The provider desk review be to be shing that the	
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric O National Fire Alari	-				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

Page 2 of 20

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155693	B. WI	NG		04/27/	/2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			HAPA STREET		
SILVER	OAKS HEALTH CA	MPUS			MBUS, IN 47203		
	T		1		T		<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCE		DATE
	and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72						
			17.0	2.45			05/12/2022
		review and interview, the sure all smoke detector fire	K 0	343	1. Corrective Action for t		05/12/2023
	_	ting devices were inspected			1. Corrective Action for the resident(s) affected by the	ne	
	-	lance with the schedules for			alleged deficient practice:		
		ng frequencies in NFPA 72.			alleged delicient practice.		
	_	es a fire alarm system to be			This deficient practice had the	<u> </u>	
	_	d maintained in accordance			potential to affect 50 residents		
	· · · · · · · · · · · · · · · · · · ·	ional Electrical Code and NFPA			staff and visitors at the time of		
	· · · · · · · · · · · · · · · · · · ·	larm and Signaling Code.			survey.		
	NFPA 72, 2010 Edition, Table 14.4.5 at 15(h) states						
	smoke detectors shall be functionally tested						
	annually. This defi-	cient practice could affect all					
	residents, staff, and visitors.				2. Corrective Actions tak	en	
					for those resident(s) having	the	
	Findings include:			potential to be affected by the		е	
					alleged deficient practice:		
		the fire alarm system					
	_	or's "Alarm System Inspection			No resident's, staff or visitors		
		entation dated 06/17/22 with			were identified or reported any		
		at Operations (DPO) and the			findings suggestive of having		
	_	nent Support during record		affected by the deficient practice.		ce.	
		m. to 12:15 p.m. on 04/27/23,					
	_	ctors were not identified as					
	_	The 27 manual pull stations in			2 Compositive Actions include	!	
	•	e only initiating devices ag functionally tested on			3. Corrective Actions includ	•	
		of the fire alarm system			Measures/Systemic changes		
		or's "Fire Alarm Inspection -			put in place to assure the	••	
	_	n System Inspection"			alleged deficient practice do not re occur:	62	
		ed 09/08/22 indicated there are			Hot re occur.		
		e detectors in the facility. The					
		' section of the 09/08/22					
		ntation has an itemized listing			The Executive Director and/o	r	
	by location of the 1	_			designee provided re-education		
	_	but the listing is in error as			the Director of Plant Operation		
		ations in the 300 Hall are			Fire Alarm System - Testing a		
		vice Listing" of the report.			Maintenance A fire alarm syst		
	_	ations in the 100 Hall, 200 Hall			is tested and maintained in		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet Page 3 of 20

PRINTED: 05/23/2023

	Γ OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693	l í	UILDING	onstruction <u>01</u>	(X3) DATE COMPI 04/27	SURVEY LETED
	PROVIDER OR SUPPLIER			2011 C	ADDRESS, CITY, STATE, ZIP COD CHAPA STREET MBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR and 600 Hall are no Hall smoke detector interview at the tim and the Facilities M additional fire alarn the most recent twe available for review portion of the facilit Hall and 600 Hall.	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION It listed and the listing of 300 rs was incomplete. Based on e of record review, the DPO lanagement Support stated in inspection documentation for live month period was not or and stated the health care ty is the 100 Hall, 200 Hall, 300 The DPO and the Facilities out confirmed by telephone		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and N 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintena and testing are readily availab 9.6.1.3, 9.6.1.5, NFPA 70, NF 72	FPA nce ile.	(X5) COMPLETION DATE
	interview with the f contractor at the tim itemized listing of a the contractor on 09 applicable to this fa	ire alarm system inspection ne of record review that the all smoke detectors tested by 0/08/22 was in error and not cility.			The Director of Plant Operation immediately called contractor Koorsen to update the paperwate to show correct device address locations.	ork/	
	facility failed to ensity was maintained in a 9.6.1.3 requires a fit tested, and maintain 70, National Electri National Fire Alarm Section 14.4.5 require accordance with Frequencies. Section 14.4.5.3.2 section 14.4.5.3 section 14.4.5.3 section 14.4.5 sect	review and interview, the sure 1 of 1 fire alarm systems accordance with 9.6.1.3. LSC re alarm system to be installed, and in accordance with NFPA cal Code and NFPA 72, an Code. NFPA 72, 2010 Edition, ires testing shall be performed Table 14.4.5 Testing on 14.4.5.3.1 states sensitivity thin 1 year after installation. states sensitivity shall be nate year thereafter unless 1 by compliance with 14.4.5.3.3. soke detectors or smoke alarms			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 the contractor paperwork for smoke detector sensitivity testing documentatis shows the correct device addr locations. The Director of Plar Operations and/or Designee w perform the observation audits three times a week, for three	ons ion ress nt vill	

FORM CMS-2567(02-99) Previous Versions Obsolete

found to have a sensitivity outside the listed and

recalibrated or be replaced. Section 14.6.2.4 states

marked sensitivity range shall be cleaned and

a record of all inspections, testing and

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

months. Findings will be reviewed

Committee in order to determine

during the quarterly QA

the frequency for ongoing

Page 4 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155693		I .	JILDING	01	COMPL 04/27/	ETED	
NAME OF P	ROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP COD HAPA STREET		
SILVER (DAKS HEALTH CAI	MPUS			IBUS, IN 47203		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		be provided that includes all		IAG	monitoring. Findings suggestive		DATE
		ion requested in Figure			100% compliance may result in		
	14.6.2.4. This defic	cient practice could affect all			cessation of the monitoring pla		
	residents, staff and visitors.				based on review.		
	Findings include:						
	Based on review of	the fire alarm system			5.The time frame the campus	S	
	•	or's "Fire Alarm Inspection -			is alleging compliance.		
		n System Inspection"					
		d 09/08/22 with the Director of			Date: May 19, 2023		
		PPO) and the Facilities ort during record review from					
		o.m. on 04/27/23, there are a total					
		tors in the facility. The					
		section of the 09/08/22					
	inspection documen	ntation has an itemized listing					
	by location of the 19	95 smoke detectors sensitivity					
		g is in error as seven different					
		Hall are repeated in the					
		the report. Smoke detector					
		Hall, 200 Hall and 600 Hall are					
		sting of 300 Hall smoke					
		nplete. Based on interview at eview, the DPO and the					
		ent Support stated additional					
		sitivity testing documentation					
		two year period was not					
		and stated the health care					
		ty is the 100 Hall, 200 Hall, 300					
	Hall and 600 Hall.	The DPO and the Facilities					
	Management Suppo	ort confirmed by telephone					
		ire alarm system inspection					
		ne of record review that the					
		all smoke detectors sensitivity					
	-	ctor on 09/08/22 was in error					
	and not applicable to	o this facility.					
	These findings were	e reviewed with the DPO					
	during the exit conf						
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet Page 5 of 20

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693		UILDING	nstruction 01	(X3) DATE COMPL 04/27 /	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 2011 CHAPA STREET COLUMBUS, IN 47203					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE	
	3.1-19(b)							
	facility failed to main accordance with Code as required by 9.6. NFPA 72, Sec otherwise permitted shall be performed schedules in Table by the authority has states that the followinspected semi-annia. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-op This deficient pract staff, and visitors. Findings include: Based on review of Inspection Report with the Director of the Facilities Manareview from 9:15 a. smoke detector sem documentation is in Based on interview the DPO stated he undetector locations in inspection contractor section of "Fire Ala documentation dates"	ble signals ators (e.g. duct detectors, manual eat detectors, smoke detectors, iances pen devices ice could affect all residents, "Fire Alarm System Visual documentation dated 03/09/23 f Plant Operations (DPO) and gement Support during record en. to 12:15 p.m. on 04/27/23, mannual inspection a error and was not complete. at the time of record review, uses the listing of smoke in the fire alarm system or's "Inspection Report" must inspect ion - Annual" and 09/08/22 as his checklist for						
		pection which listed a total of						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet Page 6 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155693		A. BUILDING 01 COMPLETED B. WING 04/27/2023			ETED		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
SILVER (DAKS HEALTH CAN	MPUS			BUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	195 smoke detectors "Inspection Report" inspection documen by location of the 19 listing is in error as the 300 Hall are report the report. Smok Hall, 200 Hall and 6 listing of 300 Hall s incomplete. Based record review, the E Management Suppo detector visual inspersor and stated the facility is the 100 H Hall. The DPO and Support confirmed by the fire alarm system time of record reviews moke detectors test 09/08/22 was in error facility. These findings were during the exit conference of the system o	s in the facility. The section of the 09/08/22 tation has an itemized listing 05 smoke detectors but the seven different locations in eated in the "Device Listing" e detector locations in the 100 000 Hall are not listed and the moke detectors was on interview at the time of 0PO and the Facilities rt stated additional smoke extion documentation for the th period was not available for e health care portion of the all, 200 Hall, 300 Hall and 600 the Facilities Management by telephone interview with in inspection contractor at the w that the itemized listing of all and not applicable to this exercises with the DPO					
K 0351 SS=E Bldg. 01	by construction typ throughout by an a sprinkler system in 13, Standard for th Systems.	Installation nd hospitals where required					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

Page 7 of 20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/27/2023
	PROVIDER OR SUPPLIER OAKS HEALTH CA		2011 0	ADDRESS, CITY, STATE, ZIP COD CHAPA STREET MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	substituted for spr areas where state sprinklers. In hospitals, sprint clothes closets of where the area of 6 square feet and the closet footprin Standard for Insta Systems. 19.3.5.1, 19.3.5.2, 19.3.5.5, 19.4.2, 1 Based on observation failed to ensure a consystem was provide canopies. NFPA 13 of Sprinkler System states sprinkler System states sprinklers share roofs, canopies, por or similar projection width. Section 8.15 permitted to be omit porte-cocheres, bald projections are consuncombustible, limiter retardant-treated workstandard for Fire Refire-Retardant Coat This deficient practice residents, staff and Living Room pation. Findings include: Based on observation Operations (DPO) of 12:30 p.m. to 2:05 progrations (DPO) of 12:30 p.m. to 2:05 prograti	res are permitted to be inkler protection in specific or local regulations prohibit where are not required in patient sleeping rooms the closet does not exceed sprinkler coverage covers that as required by NFPA 13, llation of Sprinkler sprinkler and interview, the facility omplete automatic sprinkler d for 1 of over 2 exterior sprinkler decoderes, balconies, decks, as exceeding 4 ft. (1.2 m) in 1.7.2 states sprinklers shall be tend where the canopies, roofs, conies, decks, or similar structed with materials that are noted-combustible, or fire food as defined in NFPA 703, the exterior that the sprinklers in the vicinity of the sprinklers in the vicinity of the one of 04/27/23, the exterior the building covering the the ving Room lounge near the sprinklers are not required to the protection of the sprinklers are not of the facility from the building covering the ving Room lounge near the sprinklers are not required to be sprinklers.	K 0351	1. Corrective Action for resident(s) affected by the alleged deficient practice: This deficient practice had the potential to affect over 10 residents, staff and visitors at time of the survey. 2. Corrective Actions ta for those resident(s) having potential to be affected by the alleged deficient practice: No residents, staff or visitors identified or reported any find suggestive of having been affected by the deficient practice. 3. Corrective Actions included the survey of the survey of the deficient practice. 3. Corrective Actions included the survey of the survey of the survey of the deficient practice def	e t the ken the he swere lings fected ding s

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

Page 8 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155693		A. BUILDING B. WING	01	COMPLETED 04/27/2023	
	PROVIDER OR SUPPLIER		2011 C	ADDRESS, CITY, STATE, ZIP COD HAPA STREET MBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility was not springly eight feet from the better the time of the observation of the observation of the canopy is constructed because the roof line canopy, the attic about other exterior canopy sprinklered, this can feet from the building canopy attached to the pation outside the Living front entrance of the facility was not springly attached to the facility was not springly the canopy attached to the facility was not springly the canopy attached to the facility was not springly the canopy attached to the facility was not springly the canopy attached to the canopy	reviewed with the DPO		The Executive Director and/ordesignee provided re-education the Director of Plant Operation Sprinkler System - Installation 2012 EXISTING Nursing home and hospitals where required construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I acconstruction, alternative protes measures are permitted to be substituted for sprinkler protection in specific areas where state of local regulations prohibit sprinklers. In hospitals, sprink are not required in clothes closed for patient sleeping rooms whethe area of the closet does not exceed 6 square feet and sprict coverage covers the closet footprint as required by NFPA Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.9.7.1.1(1) The Director of Plant Operation immediately called to schedul contractor Pride Fire to install new complete automatic sprinkled systems on the living ropatio area. Pride Fire completionstallation on 05/05/2023.	on to ns on les, by ed f and II ction or lers sets ere t nkler -13, 7, ons e two kler om

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

Page 9 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

	VT OF DEFICIENCIES OF CORRECTION	TION IDENTIFICATION NUMBER A. BUILDING 155693 B. WING		ONSTRUCTION (X3) DATE SURVEY 01 COMPLETED 04/27/2023	
	PROVIDER OR SUPPLIEF		2011	FADDRESS, CITY, STATE, ZIP COD CHAPA STREET IMBUS, IN 47203	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				4. Corrective Actions that we be monitored to ensure the alleged will not re occur:	dill
				The Director of Plant Operation and/or Designee developed a weekly audit that includes monitoring that we have two automatic sprinkler head systion the living room patio area. Director of Plant Operations at Designee will perform the observation audits three times week, for three months. Findin will be reviewed during the quarterly QA Committee in or to determine the frequency for ongoing monitoring. Findings suggestive of 100% complian may result in cessation of the monitoring plan based on rev	ems The and/or s a ngs der r
				5.The time frame the campuis alleging compliance. Date: May 19, 2023	ıs
K 0372 SS=E Bldg. 01	Barrie	lding Spaces - Smoke lding Spaces - Smoke			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

Page 10 of 20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/27/2023	
	PROVIDER OR SUPPLIER			2011 CH	DDRESS, CITY, STATE, ZIP COD HAPA STREET IBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	1/2-hour fire resis barriers shall be patrium wall. Smok in duct penetration systems where are is installed for smoke barriers. A. S. A. S	nall be constructed to a tance rating per 8.5. Smoke permitted to terminate at an active dampers are not required in sin fully ducted HVAC in approved sprinkler system toke compartments adjacent iter. 1) Chanical smoke control RKS. Wiew, observation and the failed to ensure 1 of 9 smoke protected to maintain the fire the smoke barrier wall. LSC quires smoke barriers to be redance with LSC Section 8.5 minum ½ hour fire resistive ent practice could affect over 20 visitors in the vicinity of the	K 037	72	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 time of the survey.		05/19/2023
	Findings include: Based on review of documentation with Operations (DPO) a Support during rect 12:15 p.m. on 04/2′ room walls, which Main Dining Room 2-hour fire resistance.				2. Corrective Actions take for those resident(s) having to potential to be affected by the alleged deficient practice: No residents, staff or visitors identified or reported any finding suggestive of having been affected by the deficient practice.	the e were	
	facility from 12:30 open ended conduit cables was noted in above the Main Dir	p.m. to 2:05 p.m. on 04/27/23, an for the passage of data the north wall of the attic ning Room. A second open also noted for the passage of			3. Corrective Actions includ Measures/Systemic changes put in place to assure the alleged deficient practice do not re occur:	-	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet Page 11 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155693		(X2) MULTIPLE O A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/27/2023	
	PROVIDER OR SUPPLIE	R	STREET 2011 (T ADDRESS, CITY, STATE, ZIP COD CHAPA STREET IMBUS, IN 47203	1
	SUMMARY (EACH DEFICIENT REGULATORY OF Electrical wiring in the Main Dining REMOVED TO THE METERS OF	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION the north wall of the attic above com. The observations were to access door in the adjoining Room. Each open ended estopped to maintain the fire The smoke barrier wall. Based time of the observations, the torementioned openings in the above the Main Dining Room ed to maintain the fire The smoke barrier wall.			or ion to ons on es - 2012 hall be sincke ducted ucted ucted ucted tant open vall of ng
				The Director of Plant Operat and/or Designee developed a weekly audit that includes	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

Page 12 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/27/2023	
	PROVIDER OR SUPPLIER		2011 C	ADDRESS, CITY, STATE, ZIP COD HAPA STREET MBUS, IN 47203		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
TAG	REGULATORY	CESC IDENTIFICATION ON WATTON		monitoring that the fire-resistal caulking remains in place to ensure that both open ended conduits in the north wall of the attic above the main dining rocare fire stopped. The Director Plant Operations and/or Design will perform the observation at three times a week, for three months. Findings will be review during the quarterly QA Committee in order to determing the frequency for ongoing monitoring. Findings suggestive 100% compliance may result in cessation of the monitoring plates alleging compliance. 5.The time frame the camputaries alleging compliance. Date: May 19, 2023	e om of gnee udits wed ne ve of in	
K 0761 SS=E Bldg. 01						
	interview; the facili inspection and testi- were completed in a Communicating op- required by 19.1.1.4 corridors and shall be self-closing fire doc	view, observation and ty failed to ensure annual ng of all fire door assemblies accordance of LSC 19.1.1.4.1.1. enings in dividing fire barriers 4.1 shall be permitted only in be protected by approved or assemblies. (See also Section upenings required to have a fire	K 0761	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 time of the survey.	Э	

FORM CMS-2567(02-99) Previous Versions Obsolete

protection rating by Table 8.3.4.2 shall be

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet Page 13 of 20

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		UILDING	<u>01</u>	COMPLETED		
		155693	B. W	ING		04/27/2	2023	
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD	-		
			2011 CHAPA STREET					
SILVER	OAKS HEALTH CA	MPUS		COLUN	MBUS, IN 47203			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		red, listed, labeled fire door						
		window assemblies and their						
		ware, including all frames,			2. Corrective Actions tal	-		
	closing devices, and	_			for those resident(s) having			
		requirements of NFPA 80,			potential to be affected by the	ne l		
	Standard for Fire Doors and Other Opening				alleged deficient practice:			
	_	at as otherwise specified in this		No regidente staff er visitara	wore			
		ection 5.2.1 states fire door inspected and tested not less			No residents, staff or visitors identified or reported any find			
		a written record of the				٠ .		
	1				suggestive of having been affective by the deficient practice.	ecieu		
	inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door				by the delicient practice.			
	assemblies shall be visually inspected from both							
	sides to assess the overall condition of door							
	assembly.	veran condition of door			3. Corrective Actions include	lina		
	ussemery.				Measures/Systemic changes	-		
	NFPA 80. Section 5	5.2.4.2 states as a minimum, the			put in place to assure the	'		
	following items sha				alleged deficient practice do	es		
	_	or breaks exist in surfaces of			not re occur:			
	either the door or fr							
		light frames, and glazing beads						
		ely fastened in place, if so						
	equipped.	-			The Executive Director and/o	r		
		, hinges, hardware, and			designee provided re-education	1		
	noncombustible thr	eshold are secured, aligned,			the Director of Plant Operation	1		
	and in working orde	er with no visible signs of			Maintenance, Inspection & Te			
	damage.				- Doors Fire doors assemblies	s are		
	(4) No parts are mis	_			inspected and tested annually	/ in		
		do not exceed clearances			accordance with NFPA 80,			
	listed in 4.8.4 and 6				Standard for Fire Doors and C	Other		
	1 ' '	device is operational; that is,			Opening Protectives. Non-rate	1		
		pletely closes when operated			doors, including corridor doors			
	from the full open p				patient rooms and smoke bar			
	1 1	is installed, the inactive leaf			doors, are routinely inspected			
	closes before the ac				part of the facility maintenance			
		are operates and secures the			program. Individuals performi	ng the		
	door when it is in th	-			door inspections and testing			
		vare items that interfere or			possess knowledge, training of			
		re not installed on the door or			experience that demonstrates	•		
	frame.				ability. Written records of			

ZIDM21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTR		ONSTRUCTION	N (X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155693	B. W	'ING		04/27/	2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L.					
SILVED (DAKS HEALTH CA	MBUS	2011 CHAPA STREET COLUMBUS, IN 47203				
SILVER	JAKS REALTH CA	WIPUS		COLUN	1BUS, IN 47203		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(10) No field modif	ications to the door assembly			inspection and testing are		
	have been performe	ed that void the label.			maintained and are available f	or	
	(11) Gasketing and	edge seals, where required, are			review. 19.7.6, 8.3.3.1 (LSC) 5	5.2,	
	inspected to verify their presence and integrity.				5.2.3 (2010 NFPA 80)		
	-	ice could affect over 20					
		visitors in the vicinity of the			The Director of Plant Operation	ons	
	Main Dining Room				immediately called to get quot	es	
					from Central Indiana Hardwar	e and	
	Findings include:				Kenny's Glass for ordering and	d	
					replacing the corridor door to t	:he	
		"Annual Inspection of			main dining room 05/05/2023.		
	Swinging Fire Door Assemblies" documentation						
	dated 06/27/22 with the Director of Plant						
		and the Facilities Management					
		ord review from 9:15 a.m. to			4. Corrective Actions that w	ill	
	_	7/23, annual fire door inspection			be monitored to ensure the		
		he facility within the most			alleged will not re occur:		
		n period did not identify any					
	-	fire door locations inspected					
	-	lew of blueprint documentation					
		our main dining room walls,			The Director of Plant Operation	ons	
		south wall of the Main Dining			and/or Designee developed a		
		ted of a minimum 2-hour fire			weekly audit that includes		
	_	he south wall of the Main			monitoring that the corridor do		
		north wall of the service			the main dining has a minimur	n of	
	=	ndry Room and the staff break			2 hour fire resistance rating		
		servations with the DPO			remains in place. The Directo		
	-	facility from 12:30 p.m. to 2:05			Plant Operations and/or Desig		
	*	ne corridor door to the Main			will perform the observation a	udits	
	-	the service corridor had a			three times a week, for three		
		tance rating label affixed to the			months. Findings will be review	wed	
		or. Based on interview at the			during the quarterly QA		
		tions, the DPO agreed the			Committee in order to determi	ne	
		Main Dining Room from the			the frequency for ongoing	_	
		s not rated with a minimum			monitoring. Findings suggestiv		
		tance rating for a 2-hour fire			100% compliance may result i		
	resistance rated wal	1.			cessation of the monitoring pla	an	
					based on review.		
		e reviewed with the DPO					
	during the exit conf	erence.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet Page 15 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING B. WING		ONSTRUCTION (X3) DATE SURVEY 01 COMPLETED 04/27/2023		ETED			
NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 2011 CHAPA STREET COLUMBUS, IN 47203				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	3.1-19(b)				5.The time frame the campu is alleging compliance. Date: May 19, 2023	s	
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: 04/27/23 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.		K 0	000	Preparation or execution of this plan of correction does not constitute admission or agreed of provider of the truth of the falleged or conclusions set fort the Statement of Deficiencies. Plan of Correction is prepared executed solely because it is required by the position of Fedand State Law. The Plan of Correction is submitted to respond to the allegations of noncompliance cited during the Life Safety Inspection complet on April 27, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliant as of May 19, 2023. The provider sepectfully requests desk rew with paper compliance to be considered in establishing that provider is in substantial compliance.	ment acts h on The l and deral cond deted ace deted	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet Page 16 of 20

PRINTED: 05/23/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>02</u>			COMPLETED	
		155693	B. W	NG		04/27/	/2023	
NAME OF D	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
					HAPA STREET			
SILVER (DAKS HEALTH CAI	MPUS		COLUM	1BUS, IN 47203			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	of 50 at the time of	this survey.						
		residents have customary						
	-	ered except the exterior canopy						
	for the patio and all areas providing facility services were sprinklered.							
	services were sprink	dered.						
	Quality Review con	npleted on 05/04/23						
K 0222	NFPA 101							
SS=E	Egress Doors							
Bldg. 02	Egress Doors							
Ü	•	d means of egress shall not						
		a latch or a lock that						
		f a tool or key from the						
	•	s using one of the following						
	special locking arr	-						
	· ·	OR SECURITY THREAT						
	LOCKING							
	Where special lock	king arrangements for the						
	clinical security ne	eds of the patient are						
	used, only one loc	king device shall be						
	permitted on each	door and provisions shall						
	be made for the ra	pid removal of occupants						
	by: remote control	of locks; keying of all						
	locks or keys carri	ed by staff at all times; or						
	other such reliable	means available to the						
	staff at all times.							
	18.2.2.2.5.1, 18.2.	2.2.6, 19.2.2.2.5.1,						
	19.2.2.2.6							
	SPECIAL NEEDS	LOCKING						
	ARRANGEMENTS	3						
	-	king arrangements for the						
	safety needs of the	e patient are used, all of						
		urity Locking requirements				ļ		
	•	addition, the locks must be				ļ		
		it fail safely so as to				ļ		
	•	of power to the device; the						
		ed by a supervised				ļ		
	automatic sprinkle	r system and the locked						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

Page 17 of 20

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155693	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 04/27/2023
	PROVIDER OR SUPPLIER		2011 C	ADDRESS, CITY, STATE, ZIP COD HAPA STREET MBUS, IN 47203	
OILVLIX	JAKO FILALITI OA		100501	7.000, 114 47 200	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		l by a complete smoke			
	-	(or is constantly monitored			
		ation within the locked			
		the sprinkler and detection			
	-	ged to unlock the doors			
	upon activation.				
	18.2.2.2.5.2, 19.2				
	DELAYED-EGRE				
	ARRANGEMENT				
		lelayed-egress locking in accordance with			
	•	permitted on door			
		g low and ordinary hazard			
		gs protected throughout by			
		ervised automatic fire			
		or an approved, supervised			
	automatic sprinkle				
	18.2.2.2.4, 19.2.2	-			
	ACCESS-CONTR				
	LOCKING ARRAN				
		Egress Door assemblies			
		lance with 7.2.1.6.2 shall			
	be permitted.				
	18.2.2.2.4, 19.2.2	.2.4			
	ELEVATOR LOBE	BY EXIT ACCESS			
	LOCKING ARRAN	NGEMENTS			
	Elevator lobby exi	t access door locking in			
	accordance with 7	2.1.6.3 shall be permitted			
		es in buildings protected			
		approved, supervised			
		ection system and an			
		sed automatic sprinkler			
	system.	0.4			
	18.2.2.2.4, 19.2.2		17.0000		05/10/2022
		on and interview, the facility	K 0222	4 0	05/19/2023
		means of egress through 2 of		1. Corrective Action for t	ine
		all courtyard were readily ents without a clinical		resident(s) affected by the	
				alleged deficient practice:	
		specialized security measures.		This deficient prostice had the	
	Doors within a requ	ired means of egress shall not		This deficient practice had th	e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

If continuation sheet

Page 18 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
and Plan of Correction identification number 155693		155693	B. WING		04/27/2023		
				CTD FET	ADDRESS STEW STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
OIL VED (MPLIC	2011 CHAPA STREET				
SILVER OAKS HEALTH CAMPUS				COLUN	IBUS, IN 47203		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	FIX FIX FIX FIX FIX FIX FIX FIX		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i.L	DATE
	be equipped with a	latch or lock that requires the			potential to affect 50 residents		
	use of a tool or key	from the egress side unless			staff and visitors at the time of		
	otherwise permitted	_			survey.		
	Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient				,		
	practice could affec	t over 15 residents, staff and					
	_	exit the 600 Hall Dining			2. Corrective Actions tak	en	
	Room outdoor cour				for those resident(s) having t	the	
		•			potential to be affected by th		
	Findings include:				alleged deficient practice:		
	C						
	Based on observation	ons with the Director of Plant			No resident's, staff or visitors		
	Operations (DPO) during a tour of the facility from				were identified or reported any	,	
	12:30 p.m. to 2:05 p.m. on 04/27/23, the 600 Hall				findings suggestive of having i		
	Dining Room has to	vo exit doors which discharge			affected by the deficient practi		
	_	rtyard. Both exit doors were			,		
		exit with an exit sign and each					
		cked but was posted with					
		age. The delayed egress			3. Corrective Actions		
		exit doors was not in			including Measures/Systemic	C	
	-	loor courtyard has two locked			changes put in place to assu		
	-	he courtyard fence which			the alleged deficient practice		
	could be opened by	entering a four digit code into			does not re occur:		
	a keypad at the gate	d exit doors but the code was					
	not posted at the tw	o courtyard exit doors. Based			The Executive Director and/or	r	
		time of the observations, the			designee provided re-education	n to	
	DPO stated the 600	Hall Dining Room exit doors			the Director of Plant Operation	is on	
		code was not posted at the			Doors within a required means		
	courtyard gated exit	s because some residents are			egress shall not be equipped v		
	an elopement risk b	ut stated not all residents in			a latch or lock that requires the		
	the health care porti	on of the facility in the 600			use of a tool or key from the		
		diagnosis to be in a secure			egress side unless otherwise		
		e code was not posted at the			permitted by LSC 19.2.2.2.4.		
		e fence for the courtyard.			Door-locking arrangements sh	all	
		-			be permitted in accordance wi		
	These findings were	e reviewed with the DPO			19.2.2.2.5.2. The Director of F		
	during the exit conf				Operations posted the gate co	de	
	-				at the courtyard gated exit doc		
	3.1-19(b)				the TCS courtyard and applied		
					proper signage on 5/11/2023.		
			1				

PRINTED: 05/23/2023

	OF HEALTH AND HUN						RM APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER 155693				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 04/27/2023	
NAME OF PROVIDER OR SUPPLIER SILVER OAKS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			<u>, </u>	2011 C	ADDRESS, CITY, STATE, ZIP COD HAPA STREET MBUS, IN 47203			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	CROSS-REFERENCED TO THE APPROPRIATE				(X5) COMPLETION DATE	
					4. Corrective Actions that will be monitored to ensure the alleged will not re occur: The Director of Plant Operation and/or Designee developed a weekly door inspection audit the includes monitoring the placer of code postage by the gate of at the courtyard gated exit door the TCS courtyard. The Direct of Plant Operations and/or Designee will perform the 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% compliance may result in cessation of the monitoring plan based on reviewed.	che che che che che che che che		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZIDM21

Facility ID: 002955

Date: May 19, 2023

If continuation sheet

Page 20 of 20