STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155693	A. BUILDING -- B. WING	04/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/27/23 Facility Number: 002955 Provider Number: 155693 AIM Number: 200346570 At this Emergency Preparedness survey, Silver Oaks Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 80 certified beds. At the time of the survey, the census was 50. Quality Review completed on 05/04/23	E 0000	Preparation or execution of this plan of correction does not 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 executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegations of noncompliance cited during the Life Safety Inspection completed on April 27, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 19, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/27/23 Facility Number: 002955 Provider Number: 155693	K 0000	Preparation or execution of this plan of correction does not 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 executed solely because it is required by the position of Federal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

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	AIM Number: 200346570 At this Life Safety Code survey, Silver Oaks Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 and 410 IAC 16.2. Building 0101 and Building 0202 were surveyed with Chapter 19, Existing Health Care Occupancies. Building 0101 and Building 0202 were determined to be of Type V (111) construction and fully sprinklered except the exterior canopy for the patio outside the Living Room lounge in Building 0101. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 50 at the time of this survey. All areas where the residents have customary access were sprinklered except the exterior canopy for the patio and all areas providing facility services were sprinklered. Quality Review completed on 05/04/23		and State Law. The Plan of Correction is submitted to respond to the allegations of noncompliance cited during the Life Safety Inspection completed on April 27, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 19, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure all smoke detector fire alarm system initiating devices were inspected and tested in accordance with the schedules for inspection and testing frequencies in NFPA 72. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Table 14.4.5 at 15(h) states smoke detectors shall be functionally tested annually. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Alarm System Inspection - No Panel" documentation dated 06/17/22 with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:15 a.m. to 12:15 p.m. on 04/27/23, facility smoke detectors were not identified as functionally tested. The 27 manual pull stations in the facility were the only initiating devices documented as being functionally tested on 06/17/22. Review of the fire alarm system inspection contractor's "Fire Alarm Inspection - Annual" and "Alarm System Inspection" documentation dated 09/08/22 indicated there are a total of 195 smoke detectors in the facility. The "Inspection Report" section of the 09/08/22 inspection documentation has an itemized listing by location of the 195 smoke detectors functionally tested but the listing is in error as seven different locations in the 300 Hall are repeated in the "Device Listing" of the report. Smoke detector locations in the 100 Hall, 200 Hall	K 0345	**1. Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the potential to affect 50 residents, staff and visitors at the time of the survey. **2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No resident's, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:** The Executive Director and/or designee provided re-education to the Director of Plant Operations on Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	05/12/2023

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	and 600 Hall are not listed and the listing of 300 Hall smoke detectors was incomplete. Based on interview at the time of record review, the DPO and the Facilities Management Support stated additional fire alarm inspection documentation for the most recent twelve month period was not available for review and stated the health care portion of the facility is the 100 Hall, 200 Hall, 300 Hall and 600 Hall. The DPO and the Facilities Management Support confirmed by telephone interview with the fire alarm system inspection contractor at the time of record review that the itemized listing of all smoke detectors tested by the contractor on 09/08/22 was in error and not applicable to this facility. These findings were reviewed with the DPO during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and		accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 The Director of Plant Operations immediately called contractor Koorsen to update the paperwork to show correct device address locations. **4. Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly audit that includes monitoring the contractor paperwork for smoke detector sensitivity testing documentation shows the correct device address locations. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing	

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	maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection - Annual" and "Alarm System Inspection" documentation dated 09/08/22 with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:15 a.m. to 12:15 p.m. on 04/27/23, there are a total of 195 smoke detectors in the facility. The "Inspection Report" section of the 09/08/22 inspection documentation has an itemized listing by location of the 195 smoke detectors sensitivity tested but the listing is in error as seven different locations in the 300 Hall are repeated in the "Device Listing" of the report. Smoke detector locations in the 100 Hall, 200 Hall and 600 Hall are not listed and the listing of 300 Hall smoke detectors was incomplete. Based on interview at the time of record review, the DPO and the Facilities Management Support stated additional smoke detector sensitivity testing documentation for the most recent two year period was not available for review and stated the health care portion of the facility is the 100 Hall, 200 Hall, 300 Hall and 600 Hall. The DPO and the Facilities Management Support confirmed by telephone interview with the fire alarm system inspection contractor at the time of record review that the itemized listing of all smoke detectors sensitivity tested by the contractor on 09/08/22 was in error and not applicable to this facility. These findings were reviewed with the DPO during the exit conference.		monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review. **5.The time frame the campus is alleging compliance.** Date: May 19, 2023	

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	3.1-19(b) 3. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Fire Alarm System Visual Inspection Report" documentation dated 03/09/23 with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:15 a.m. to 12:15 p.m. on 04/27/23, smoke detector semiannual inspection documentation is in error and was not complete. Based on interview at the time of record review, the DPO stated he uses the listing of smoke detector locations in the fire alarm system inspection contractor's "Inspection Report" section of "Fire Alarm Inspection - Annual" documentation dated 09/08/22 as his checklist for the semiannual inspection which listed a total of			

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	195 smoke detectors in the facility. The "Inspection Report" section of the 09/08/22 inspection documentation has an itemized listing by location of the 195 smoke detectors but the listing is in error as seven different locations in the 300 Hall are repeated in the "Device Listing" of the report. Smoke detector locations in the 100 Hall, 200 Hall and 600 Hall are not listed and the listing of 300 Hall smoke detectors was incomplete. Based on interview at the time of record review, the DPO and the Facilities Management Support stated additional smoke detector visual inspection documentation for the most recent six month period was not available for review and stated the health care portion of the facility is the 100 Hall, 200 Hall, 300 Hall and 600 Hall. The DPO and the Facilities Management Support confirmed by telephone interview with the fire alarm system inspection contractor at the time of record review that the itemized listing of all smoke detectors tested by the contractor on 09/08/22 was in error and not applicable to this facility. These findings were reviewed with the DPO during the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by 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 and II construction, alternative			

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	protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, 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, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of over 2 exterior canopies. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible, limited-combustible, or fire retardant-treated wood as defined in NFPA 703, Standard for Fire Retardant- Treated Wood and Fire-Retardant Coatings for Building Materials. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Living Room patio. Findings include: Based on observations with the Director of Plant Operations (DPO) during a tour of the facility from 12:30 p.m. to 2:05 p.m. on 04/27/23, the exterior canopy attached to the building covering the patio outside the Living Room lounge near the	K 0351	**1. Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the potential to affect over 10 residents, staff and visitors at the time of the survey. **2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:**	05/19/2023

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	front entrance of the health care portion of the facility was not sprinklered. The canopy extended eight feet from the building. Based on interview at the time of the observations, the DPO stated the canopy is constructed of combustible materials because the roof line extends to the edge of the canopy, the attic above the canopy is wood, the other exterior canopies for the facility are fully sprinklered, this canopy extended more than four feet from the building and agreed the exterior canopy attached to the building covering the patio outside the Living Room lounge near the front entrance of the health care portion of the facility was not sprinklered. These findings were reviewed with the DPO during the exit conference. 3.1-19(b)		The Executive Director and/or designee provided re-education to the Director of Plant Operations on Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by 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 and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, 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, 9.7, 9.7.1.1(1) The Director of Plant Operations immediately called to schedule contractor Pride Fire to install two new complete automatic sprinkler head systems on the living room patio area. Pride Fire completed installation on 05/05/2023.	

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			4. Corrective Actions that will be monitored to ensure the alleged will not re occur: The Director of Plant Operations and/or Designee developed a weekly audit that includes monitoring that we have two automatic sprinkler head systems on the living room patio area. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review. **5.The time frame the campus is alleging compliance.** Date: May 19, 2023	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke			

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	Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on record review, observation and interview; the facility failed to ensure 1 of 9 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on review of facility blueprint documentation with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:15 a.m. to 12:15 p.m. on 04/27/23, three of four main dining room walls, which includes the north wall of the Main Dining Room, are constructed of a minimum 2-hour fire resistance rating. Based on observations with the DPO during a tour of the facility from 12:30 p.m. to 2:05 p.m. on 04/27/23, an open ended conduit for the passage of data cables was noted in the north wall of the attic above the Main Dining Room. A second open ended conduit was also noted for the passage of	K 0372	**1. Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the potential to affect over 20 residents, staff and visitors at the time of the survey. **2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:**	05/19/2023

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	electrical wiring in the north wall of the attic above the Main Dining Room. The observations were noted using the attic access door in the adjoining Restorative Dining Room. Each open ended conduit was not firestopped to maintain the fire resistance rating of the smoke barrier wall. Based on interview at the time of the observations, the DPO agreed the aforementioned openings in the smoke barrier wall above the Main Dining Room were not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the DPO during the exit conference. 3.1-19(b)		The Executive Director and/or designee provided re-education to the Director of Plant Operations on Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) The Director of Plant Operations immediately placed fire resistant caulking to ensure that both open ended conduits in the north wall of the attic above the main dining room were fire stopped on 04/28/2023. **4. Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly audit that includes	

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SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monitoring that the fire-resistant caulking remains in place to ensure that both open ended conduits in the north wall of the attic above the main dining room are fire stopped. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review. **5.The time frame the campus is alleging compliance.** Date: May 19, 2023	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be	K 0761	**1. Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the potential to affect over 20 residents, staff and visitors at the time of the survey.	05/19/2023

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	protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80, Section 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.		**2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:** The Executive Director and/or designee provided re-education to the Director of Plant Operations on Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of	

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	(10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on review of "Annual Inspection of Swinging Fire Door Assemblies" documentation dated 06/27/22 with the Director of Plant Operations (DPO) and the Facilities Management Support during record review from 9:15 a.m. to 12:15 p.m. on 04/27/23, annual fire door inspection documentation for the facility within the most recent twelve month period did not identify any deficiencies for any fire door locations inspected in the facility. Review of blueprint documentation indicated three of four main dining room walls, which includes the south wall of the Main Dining Room, are constructed of a minimum 2-hour fire resistance rating. The south wall of the Main Dining Room is the north wall of the service corridor by the Laundry Room and the staff break room. Based on observations with the DPO during a tour of the facility from 12:30 p.m. to 2:05 p.m. on 04/27/23, the corridor door to the Main Dining Room from the service corridor had a 45-minute fire resistance rating label affixed to the hinge side of the door. Based on interview at the time of the observations, the DPO agreed the corridor door to the Main Dining Room from the service corridor was not rated with a minimum 90-minute fire resistance rating for a 2-hour fire resistance rated wall. These findings were reviewed with the DPO during the exit conference.		inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) The Director of Plant Operations immediately called to get quotes from Central Indiana Hardware and Kenny's Glass for ordering and replacing the corridor door to the main dining room 05/05/2023. **4. Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly audit that includes monitoring that the corridor door to the main dining has a minimum of 2 hour fire resistance rating remains in place. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	

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	3.1-19(b)		**5.The time frame the campus is alleging compliance.** Date: May 19, 2023	
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. The facility has a capacity of 80 and had a census	K 0000	Preparation or execution of this plan of correction does not 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 executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegations of noncompliance cited during the Life Safety Inspection completed on April 27, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of May 19, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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	of 50 at the time of this survey. All areas where the residents have customary access were sprinklered except the exterior canopy for the patio and all areas providing facility services were sprinklered. Quality Review completed on 05/04/23			
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried 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 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked			

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	space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 2 of 2 exits in the 600 Hall courtyard were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not	K 0222	**1. Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the	05/19/2023

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	be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15 residents, staff and visitors if needing to exit the 600 Hall Dining Room outdoor courtyard. Findings include: Based on observations with the Director of Plant Operations (DPO) during a tour of the facility from 12:30 p.m. to 2:05 p.m. on 04/27/23, the 600 Hall Dining Room has two exit doors which discharge into an outdoor courtyard. Both exit doors were marked as a facility exit with an exit sign and each exit door was not locked but was posted with delayed egress signage. The delayed egress functionality for the exit doors was not in operation. The outdoor courtyard has two locked gated exit doors in the courtyard fence which could be opened by entering a four digit code into a keypad at the gated exit doors but the code was not posted at the two courtyard exit doors. Based on interview at the time of the observations, the DPO stated the 600 Hall Dining Room exit doors are not locked, the code was not posted at the courtyard gated exits because some residents are an elopement risk but stated not all residents in the health care portion of the facility in the 600 Hall have a clinical diagnosis to be in a secure wing and agreed the code was not posted at the two exit doors in the fence for the courtyard. These findings were reviewed with the DPO during the exit conference. 3.1-19(b)		potential to affect 50 residents, staff and visitors at the time of the survey. **2. Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No resident's, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3. Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:** The Executive Director and/or designee provided re-education to the Director of Plant Operations on Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. The Director of Plant Operations posted the gate code at the courtyard gated exit door in the TCS courtyard and applied the proper signage on 5/11/2023.	

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			4. Corrective Actions that will be monitored to ensure the alleged will not re occur: The Director of Plant Operations and/or Designee developed a weekly door inspection audit that includes monitoring the placement of code postage by the gate code at the courtyard gated exit door in the TCS courtyard. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review. **5. The time frame the campus is alleging compliance.** Date: May 19, 2023	