STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155693	A. BUILDING 01 B. WING	06/16/2023

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/27/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/16/23 Facility Number: 002955 Provider Number: 155693 AIM Number: 200346570 At this PSR 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. 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 46 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/19/23	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Cole	Executive Director	07/10/2023

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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	155693	A. BUILDING 01 B. WING	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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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 and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 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 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	K 0345	**1. Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the potential to affect 46 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 accordance with an approved	07/20/2023

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	155693	A. BUILDING 01 B. WING	06/16/2023

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SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

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	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. Based on review of the fire alarm system inspection contractor's "Inspection & Test Report" documentation dated 05/05/23 with the DPO during record review from 9:10 a.m. to 9:40 a.m. on 06/16/23, smoke detector sensitivity testing documentation was not available for review. The "Sensitivity Alarm Point" column of the 05/05/23 fire alarm system inspection report was left blank. Review of "KFM Work Order" documentation from the fire alarm system		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, and schedule a revisit for sensitivity testing. **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 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: July 20, 2023	

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	contractor dated 05/05/23 stated "Sensitivity done in even years". Based on interview at the time of record review, the DPO stated the facility had the fire alarm system contractor perform a fire alarm system inspection following the 04/27/23 Life Safety Code survey which was supposed to include smoke detector sensitivity testing as well but agreed the 05/05/23 testing documentation did not include smoke detector sensitivity testing. The DPO stated the facility does not have an addressable fire alarm system control panel. This deficiency was cited on 04/27/23. The facility failed to implement a systemic plan of correction to prevent recurrence. These findings were reviewed with the DPO during the exit conference. 3.1-19(b)			
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 with 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 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	K 0761	**K 761 Maintenance, Inspection & Testing- Doors** **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**	10/01/2023

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	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 fully 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. (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		**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 inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2,	

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	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. Based on review of "Quote" documentation dated 05/08/23 with the DPO during record review from 9:10 a.m. to 9:40 a.m. on 06/16/23, a replacement fire door rated at 90-minute fire resistance rating is on order to replace the corridor door to the Main Dining Room and has not yet been installed. Based on interview at the time of record review, the DPO stated the corridor door to the Main		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. The anticipated date of arrival of the door is 09/15/2023. **The facility has submitted a temporary waiver request due to the delay in delivery of the door. Increased fire drills to 2 per month on various shifts through completion of waiver**. **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	

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	Dining Room has not yet been replaced. This deficiency was cited on 04/27/23. The facility failed to implement a systemic plan of correction to prevent recurrence. These findings were reviewed with the DPO during the exit conference. 3.1-19(b)		100% compliance may result in cessation of the monitoring plan based on review. **5.The time frame the campus is alleging compliance.** Date: **October 1, 2023**	
K 0000 Bldg. 02	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/27/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/16/23 Facility Number: 002955 Provider Number: 155693 AIM Number: 200346570 At this PSR 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	K 0000		

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	sprinklered. 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 46 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/19/23			