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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155693 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/10/2026 |
| NAME OF PROVIDER OR SUPPLIER Silver Oaks Health Campus | | STREET ADDRESS, CITY, STATE, ZIP CODE 2011 Chapa Street Columbus, IN 47203 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow appropriate medication administration guidelines for 1 of 3 residents reviewed for significant medication errors. (Resident D) Findings include: During an interview, on 02/09/2026 at 11:08 A.M., a family member indicated they were visiting Resident D on January 10, 2026, when a staff member came into the resident's room to test the resident's blood related to insulin use. The resident was not diabetic and had never been on insulin. The test was intended for a resident in a nearby room. The family member stopped the staff member from testing the resident's blood. The family member indicated seven days later they were notified the resident had received the wrong resident's medications. During an interview, on 02/09/2026 at 1:04 P.M., Qualified Medication Aide (QMA) 2 indicated on the night of 01/17/2026, she was administering medications from the 200 Hall medication cart for the first time. Resident D and Resident E resided in rooms near one another. She had two cups of pills, one with two medications, and one with three medications. After administering medications to Resident D, she went back to the medication cart and realized she had administered the wrong medications. She had given Resident D Resident E's medications. She informed the Director of Nursing and the Administrator right away. They contacted the Nurse Practitioner and monitored the resident for 24 hours. The resident had no negative reactions. They monitored the resident's blood sugar. The other medication was a seizure medication, and the resident showed no signs of an adverse reaction to the seizure medication. They were Resident E's 9:00 P.M. medications. During an interview, on 02/10/2026 at 10:31 A.M., the Director of Nursing (DON) indicated on January 17, 2026, QMA 2 said she was distracted by another resident talking to her while at the medication cart and she accidentally gave the wrong medication to a resident. The clinical record for Resident D was reviewed on 02/09/2026 at 9:16 A.M. An admission Minimum Data Set (MDS), dated [DATE], indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, osteoporosis (reduced bone mass), and dementia (a decline in mental abilities). The January 2026 Electronic Medication Administration Record (EMAR) for Resident D indicated the resident was to receive the following medications during the 9:00 P.M. medication pass: -Atorvastatin (a cholesterol medication) 20 milligrams (mg), at bedtime, with a start date of 01/04/2026, and a discontinued date of 01/20/2026, -Donepezil (a dementia medication) 5 mg, at bedtime, with a start date of 01/03/2026, and a discontinued date of 01/20/2026, and -Zetia (a cholesterol medication) 10 mg, at bedtime, with a start date of 01/04/2026, and a discontinued date of 01/20/2026. The January 2026 EMAR for Resident E indicated the resident was to receive the following medications during the 9:00 P.M. medication pass: -Kepra (a seizure medication) 500 mg, twice a day, with a start date of 12/29/2025, and a discontinued date of 01/20/2026, once between 6:00 A.M. and 10:00 A.M., and once between 6:00 P.M. and 10:00 P.M., and -Metformin (a diabetic medication) 1000 mg, twice a day, with a start date of 12/29/2025, and a discontinued date of 01/20/2026, once between 6:00 A.M. and 10:00 A.M., and once between 6:00 P.M. and 10:00 P.M. The</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: Facility ID: 155693 | If continuation sheet Page 1 of 2 |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>current MEDICATION ADMINISTRATION-GENERAL GUIDELINES policy, with a revised date of 11/2018, was provided by the DON on 02/10/2026 at 10:57 A.M. The policy indicated, .FIVE RIGHTS.Right resident, right drug, right dose, right route [sic] and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. The past noncompliance was corrected prior to the start of the survey after the facility implemented a systemic plan that included the following actions: on 01/23/26, after the facility assessed the residents, provided education to all staff related to medication administration, and an ongoing monitoring audit was put in place for staff administering medications. This citation relates to intake 2728012. 3.1-48(c)(2)</p> | | |