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	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Oaks Health Campus	2011 Chapa Street Columbus, IN 47203

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure call light accessibility for a resident with a history of frequent falls for 1 of 17 residents reviewed for accommodation of needs. (Resident 61)Findings include:On 05/08/2026 at 2:20 P.M., during an observation, the resident was seated in his recliner with his eyes closed. The recliner control was next to him, but the call light was on the floor behind the wheelchair, approximately six feet away.On 05/08/2026 at 2:52 P.M., during another observation, the resident remained seated in the recliner with his eyes closed, and the call light continued to be located on the floor behind the wheelchair, six feet away. On 05/08/2026 at 2:54 P.M., during an observation and interview, RN 5 observed the call light on the floor behind the wheelchair and stated it should be positioned within the resident's reach. She acknowledged she had recently been in the room to obtain the resident's vital signs but had not noticed the call light was not accessible.On 05/11/2026 at 9:09 A.M., an observation showed the resident seated in his recliner with the call light hanging from the nightstand, approximately four feet away.On 05/11/2026 at 9:34 A.M., during an observation and interview, the Director of Nursing (DON) observed the call light on the nightstand and confirmed it should have been placed close enough for the resident to reach. A clinical record review, completed on 05/08/2026 at 10:30 A.M., revealed an Annual Minimum Data Set (MDS) assessment, dated 04/10/2026, indicating the resident was moderately cognitively impaired. Diagnoses included, but were not limited to, heart failure(a chronic, serious condition where the heart muscle cannot pump enough blood to meet the body's needs for oxygen, often causing fluid to build up in the lungs and legs), and the resident had experienced two or more falls without injury since the previous assessment. The resident required staff assistance for transfers between the chair and bed.An Interdisciplinary Team (IDT) note, dated 05/07/2026 at 10:05 A.M., indicated the resident had been observed on the floor by his recliner on 05/07/2026. The resident had an abrasion to his left forehead. The root cause of the fall was determined to be the resident climbed over the arm of his recliner. The facility's current policy, Guidelines for Answering Call Lights, with a reviewed date of 12/10/2025, provided by the DON on 05/11/2026, states, .The purpose of this policy is to respond to the resident's requests and needs . Ensure the call light is plugged in securely to the outlet and in reach of the resident .410 IAC (Indiana Administrative Code) 16.2-3.1-3(v)(1)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to notify the physician of residents' change in condition for 2 of 17 residents reviewed for notification of change. (Residents 76 and 5)Findings include:1.The clinical record for Resident 76 was reviewed on 05/08/2026 at 1:18 P.M. An admission Minimum Data Set (MDS) assessment, dated 04/27/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, femur fracture and heart failure (a chronic, serious condition where the heart muscle cannot pump enough blood to meet the body's needs for oxygen, often causing fluid to build up in the lungs and legs). A current open-ended physician's order, with a start date of 04/22/2026, indicated the resident was to be weighed daily for congestive heart failure. The resident had the following weight gain with no indication the physician was notified: - On 05/05/2026 the resident weighed 305.7 pounds and on 05/06/2026 the resident weighed 310 pounds. A 4.3-pound weight gain in 24 hours, and -On 05/08/2026 the resident weighed 316.4 pounds and on 05/10/2026 the resident weighed 328.6 pounds. A 12.2-pound weight gain in 48 hours. During an interview, on 05/12/2026 at 10:28 A.M., Licensed Practical Nurse (LPN) 3 indicated when a resident was ordered to have daily weights, the resident's weight would be obtained in the morning and put into the clinical record. The Electronic Medication Administration Record (EMAR) would prompt the user if the physician was notified. The staff would notify the physician by sending them a message. During an interview, on 05/12/2026 at 10:41 A.M., the Director of Nursing (DON) indicated if a resident was to be weighed daily, the resident's weight would be documented in the EMAR or under the vitals report. Resident 76 didn't have a specific order to notify the physician of weight gain but, as a nurse, she would have notified the physician of the resident's weight gain. 2. The clinical record for Resident 5 was reviewed on 05/07/2026 at 3:04 P.M. A Quarterly MDS assessment, dated 03/18/2026, indicated the resident was moderately cognitively impaired. The resident's diagnosis included, but was not limited to, heart failure (a chronic and serious condition in which the heart muscle cannot pump sufficient blood to meet the body's oxygen needs, often resulting in fluid accumulation in the lungs and lower extremities). A current open-ended physician's order, initiated on 11/03/2023, indicated the resident was to be weighed daily for management of congestive heart failure. The order further required nursing staff to notify the provider of a three-pound weight gain within one day or a five pound weight gain within seven days. Record review revealed the following weight gain for Resident 5 with no indication the physician was notified: On 05/03/2026, the resident weighed 241.3 pounds and on 05/04/2026, the resident weighed 251.4 pounds, reflecting a 10.1 pound weight gain in 24 hours. During an interview, on 05/12/2026 at 11:41 A.M., RN 2 stated the resident was weighed each (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning using the mechanical scale when the resident was assisted out of bed. The resident should have been reweighed to verify the significant weight change and the physician should have been notified of the 10 pound increase. RN 2 confirmed the EMAR includes a designated section to document provider notification. There was no documentation to indicate the physician was notified on 05/04/2026. The current facility policy titled Physician–Provider Notification Guidelines, with a reviewed date of 12/08/2025, was provided by the Administrator on 05/12/2026 at 11:03 A.M. The policy indicated, .The purpose of this policy is to ensure the resident's physician or practitioner (including NP, PA, or clinical nurse specialist) is aware of all diagnostic testing results or any change in condition in a timely manner to allow evaluation and implementation of appropriate interventions for care. 410 IAC (Indiana Administrative Code) 16.2-3.1-5(a)(3)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and interview, the facility failed to ensure proper infection control practices were followed for the maintenance and positioning of an indwelling urinary catheter drainage bag for 1 of 4 residents reviewed for Urinary Tract Infections. (Resident 5) Findings include:On 05/06/2026 at 12:58 P.M., Resident 5 was observed sitting in her wheelchair in her room. The resident's urinary catheter drainage bag was hanging beneath the wheelchair, with approximately two inches of the bag directly touching the floor. On 05/07/2026 at 10:56 A.M., the resident was observed being transported down the 100 Hall while seated in her wheelchair. Approximately six inches of the urinary drainage bag was dragging directly on the floor during transport. On 05/07/2026 at 11:17 A.M., the resident was observed in a common area attending a Resident Council meeting. Her urinary catheter drainage bag was hanging beneath the wheelchair with an estimated six inches touching the floor. During an observation and interview, on 05/07/2026 at 11:34 A.M., the Activities Director (AD) was transporting the resident in her wheelchair from the common area to the dining room. The resident's urinary catheter drainage bag slipped from its secured position, fell to the floor, and the AD inadvertently stepped on the bag before stopping. The AD then picked up the drainage bag with their bare hands and reattached it beneath the wheelchair. She stated that nursing staff should be notified whenever a drainage bag was observed touching the floor. After the AD repositioned the drainage bag under the resident's wheelchair, the bag continued to hang with approximately two inches of the bag was dragging on the floor as the AD continued the resident's transport. During an interview, on 05/07/2026 at 11:38 A.M., Registered Nurse (RN) 2 indicated a resident's urinary catheter drainage bag should not be touching the floor. The RN repositioned the resident's catheter bag to prevent it from contacting the floor. The resident's clinical record was reviewed on 05/07/2026 at 3:04 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 03/18/2026, indicated Resident 5 as moderately cognitively impaired. The resident's diagnosis included, but was not limited to, obstructive uropathy (a structural or functional blockage of urine flow, leading to urine backflow, potential kidney swelling (hydronephrosis), and kidney damage). The resident required total assistance for toileting hygiene and transfers. The March 2026 Electronic Medication Administration Record (EMAR) documented that the resident was receiving Cipro (an antibiotic used for UTIs) 500 milligrams (mg), one tablet twice daily for seven days beginning 03/30/2026, for treatment of a UTI. The current facility policy titled Patient with a Foley Catheter, with a revision date of 08/05/2022, was provided by the Administrator on 05/11/2026 at 9:57 A.M. The policy indicated: .Do not let catheter tubing to touch floor (prevent infection) . 410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to document residents' meal consumption for 3 of 3 residents reviewed for nutrition. (Residents 4, 76 and 7)Findings include:1. The clinical record for Resident 4 was reviewed on 05/08/2026 at 10:27 A.M. An admission Minimum Data Set (MDS) assessment, dated 03/04/2026, indicated the resident was severely cognitively impaired. The resident's diagnosis included, but was not limited to, malnutrition (a serious condition resulting from an imbalance between the nutrients the body needs and what it consumes). The resident had a gastrostomy tube (a surgically inserted device that delivers nutrition, fluids, and medication directly into the stomach, bypassing the mouth and throat). A Registered Dietician Progress Note, dated 05/08/2026, included a recommendation to discontinue the resident's tube feedings. The resident was to continue with a fortified diet and a nutritional pudding cup supplement three times a day. If the resident's weights and intakes were to decline, they may need to reconsider the tube feedings.The Meal Consumption Record was reviewed and indicated the resident's clinical record lacked documented meal intake values for the following dates and times:- On 04/16/2026 at dinner, - On 04/18/2026 at breakfast and lunch, - On 04/22/2026 at breakfast and lunch,- On 04/27/2026 at lunch, - On 05/02/2026 at breakfast and lunch, - On 05/03/2026 at breakfast and lunch, - On 05/06/2026 at breakfast and lunch, and- On 05/08/2026 at breakfast and lunch.2. The clinical record for Resident 76 was reviewed on 05/08/2026 at 1:18 P.M. An admission MDS assessment, dated 04/27/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, femur fracture and heart failure (a chronic, serious condition where the heart muscle cannot pump enough blood to meet the body's needs for oxygen, often causing fluid to build up in the lungs and legs). The Meal Consumption Record was reviewed for Resident 76 and indicated the resident's clinical record lacked documented meal intake values the following dates and times:- On 04/22/2026 at breakfast and lunch, - On 04/23/2026 at lunch, - 04/25/2026 at breakfast and lunch, - On 04/27/2026 at lunch,- On 04/30/2026 at lunch, and - 05/06/2026 at lunch and dinner. 3. The clinical record for Resident 7 was reviewed on 05/08/2026 at 2:41 P.M. A Quarterly MDS assessment, dated 04/18/2026, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, heart failure. The Meal Consumption Record was reviewed for Resident 7 and indicated the resident's clinical record lacked documented meal intake values for the following dates and times:- On 04/15/2026 at lunch, - On 04/20/2026 at breakfast and lunch, - On 04/29/2026 at breakfast, lunch, and dinner, - On 04/30/2026 at dinner, - On 05/01/2026 at breakfast and lunch, - On 05/02/2026 at breakfast and lunch, and- On 05/03/2026 at breakfast and lunch. During an interview, on 05/12/2026 at 1:22 P.M., Certified Nurse Aide (CNA) 4 indicated all resident meals should be documented in the clinical record after each meal. If the resident was out of the facility or refused a meal it would also be documented to reflect that in their record. During an interview, on 05/12/2026, the Administrator indicated they did not have a policy for documenting resident meal consumptions. 410 IAC (Indiana Administrative Code) 16.2-3.1-46(a)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to maintain complete and accurate clinical records related to the care and monitoring of a resident with an indwelling urinary catheter and failed to ensure accurate documentation of medication/treatment administration for 2 of 18 sampled residents. (Residents 27 and 6)Findings include:1. On 05/07/2026 at 1:46 P.M., during an interview and observation, Resident 27 indicated she had a suprapubic catheter (a thin, flexible tube surgically inserted through a small incision in the lower abdomen directly into the bladder to drain urine) and pointed to the catheter drainage tubing extending from beneath her shirt. The tubing was connected to a drainage bag hanging beneath her wheelchair. The resident reported she had recently completed antibiotic treatment for a urinary tract infection (UTI). A Quarterly Minimum Data Set (MDS), dated [DATE], indicating the resident was cognitively intact. The resident's diagnoses included, but were not limited to, reduced kidney function and neurogenic bladder (nerve damage causing loss of bladder control). The resident had an indwelling urinary catheter. The resident's current physician's orders included an open-ended order, with a start date of 08/04/2025, to irrigate the suprapubic catheter with 250 mL of normal saline every Monday, Wednesday, and Friday. The clinical record contained no additional physician's orders related to catheter care or monitoring, including orders related to insertion site assessment, catheter change frequency, or cleansing and dressing changes. Review of the Vitals section of the Electronic Health Record (EHR) did indicate the Certified Nurse Aides (CNAs) documented urinary output each shift when emptying the drainage bag; however, no routine documentation existed for nursing assessments or catheter care. During an interview, on 05/11/2026 at 1:59 P.M., Registered Nurse (RN) 2 indicated he was familiar with the resident and confirmed the resident had a suprapubic catheter and experienced UTIs a couple times per year. RN 3 indicated typically, the Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) would contain the physician's orders for catheter management, including catheter change frequency, monitoring the insertion site each shift for signs of infection or complications, and cleansing the insertion site and replacing the drain sponge each shift and It should be documented. During an interview, on 05/12/2026 at 10:50 A.M., the Director of Nursing (DON) indicated residents' indwelling catheter care and monitoring should be documented in the resident's EMAR/ETAR. During an interview, on 05/12/2026 at 2:28 P.M., the Administrator indicated the facility did not have a policy regarding clinical record documentation or requirements for accurate and complete resident records. 2.The clinical record for Resident 6 was reviewed on 05/08/2026 at 9:21 A.M. A Quarterly MDS assessment, dated 04/22/2026, indicated the resident was moderately cognitively impaired. The resident's diagnosis included, but was not limited to, depression (a serious, common medical illness causing persistent sadness, loss of interest, and physical symptoms that interfere with daily life for two weeks or more). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 12/15/2025 through 05/06/2026, indicated the resident was to receive sertraline (an antidepressant medication) 50 milligrams. The staff were to administer 1.5 tablets once a day. A current open-ended physician's order, with a start date of 05/06/2026, indicated the resident was to receive sertraline 25 mg. The staff were to administer 25 mg along with 50 mg to equal 75 mg. The resident's record lacked a specific physician's order for the 50 mg of sertraline. During an observation and interview, on 05/12/2026 at 9:12 A.M., RN 2 indicated if a resident had to take two doses of a medication that were different strengths, he was unsure if it was two different physician orders but believed it should have been. He opened the medication cart and displayed the resident's sertraline package for 05/13/2026. The package contained two different tablets and indicated one was a 25 mg tablet, and one was a 50 mg tablet. During an interview, on 05/12/2026 at 9:19 A.M., the Director of Nursing indicated if a resident had two different doses of sertraline, then there should have been two separate physician orders so the nurse would document they were giving both doses. The resident should have had an order for the 50 mg tablet. The current facility policy titled, Medication Orders, with a revision date of 11/2018, was provided by the Administrator on 05/12/2026 at 9:55 A.M. The policy indicated, .Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. 410 IAC (Indiana Administrative Code) 16.2-3.1-50(a)(1)