STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE AT SOLARBRON THE	1701 MCDOWELL RD EVANSVILLE, IN 47712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F000000	This survey was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 7, 8, 9, 10, 14, 2014 Facility number: 010930 Provider number: 155773 AIM number: N/A Survey Team: Denise Schwandner, RN TC Diana Perry, RN Diane Hancock, RN Barbara Fowler, RN Anna Villain, RN Census bed type: SNF: 31 Residential: 30 Total: 61 Census Payor type: Medicare: 17 Other: 44 Total: 61 Residential Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC	F000000	This plan of correction is to serve as The Terrace at Solarbron's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by The Terrace at Solarbron or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	16.2-3.1. Quality review completed on July 18, 2014 by Jodi Meyer, RN			
F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview, and record review, the facility failed to ensure chemicals were locked up and inaccessible to residents for 1 of 2 resident units, in that the biohazard closet and a storage closet were left unlocked and unattended with chemicals and razors. (East Unit) B. Based on observation and interview, the facility failed to ensure side rails fit the bed tightly for 1 of 28 residents, in that the rail was loose and able to be pulled away from the bed. (Resident #109) Findings include: A1. On 7/7/14 at 9:54 a.m., the biohazard closet was unlocked and unattended. The following items were observed in an unlocked cabinet:	F000323	F323 1. The biohazardous and East Unit Storage rooms noted to be unlocked during survey were closed and locked immediately upon discovery. The bed rail that was noted to be loose was tightened immediately during the survey upon discovery. No residents were harmed related to these citations. 2. No other storage room/biohazardous room doors were found to have been unlocked, and all chemicals are locked up and inaccessible to residents. All side rails fit the bed tightly and no other side rails were found to be loose. 3. The systemic change includes the storage rooms and biohazard rooms are being fitted with automatic locking devices. In addition, Maintenance staff has a checklist to check all side rails quarterly and on an as needed basis. Education will be provided to staff on the new automatic closure and locking devices for storage rooms and biohazard	08/13/2014

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	Stainless Steel Polish, labeled "Danger harmful or fatal if swallowed. Eye Irritant." Germicidal Cleaner and Disinfectant, labeled "Avoid contact with eyes. Keep out of reach of children." A2. On 7/7/14 at 9:55 a.m., the East Unit storage closet was observed to be unlocked and unattended. Items stored in the room included, but were not limited to, razors. A3. Review of the census sheet for the facility, dated 7/7/14, indicated 31 residents resided on the main floor of the facility and would have access to the closets. B. On 7/8/14 at 11:10 a.m., Resident #109's bed was observed. The bed's left hand 1/4 siderail was very loose. The bed was checked again on 7/10/14 at 9:00 a.m. and continued to be very loose. The loose siderail was reported to the Administrator on 7/10/14 at 10:30 a.m. On 7/10/14 at 2:20 p.m., the Administrator indicated the rail had been checked, was noted to be loose and had been tightened up. 3.1-45(a)(1)		rooms as well as the need to keep these doors closed and locked. This education will also include providing Maintenance work orders for any side rails noted to be loose. In addition, Maintenance has been provided education regarding the checklist to check all side rails quarterly and as needed. 4. Maintenance and or designee will complete a QA tool that will include random rounds and checking of side rail fit on 3 beds weekly x 4 weeks then monthly x 11 months to equal 12 months of monitoring. Maintenance and or designee will complete a QA tool that will include checking storage and biohazard rooms for locking daily x 30 days, then weekly x 60 days then monthly x 9 months to total 12 months of monitoring. 5. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview, and record review, the facility failed to ensure medications were monitored in 1 of 3 residents who met the criteria for unnecessary medications, in that a	F000329	F329 1. Resident #46 has had medication and diagnosis review completed per MD. Diagnosis includes dementia and hallucinations. Current nursing	08/13/2014

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	resident did not have an adequate diagnosis or exhibit behaviors for an antipsychotic medication. (Resident #46) Findings include: During an observation on 7/7/14 at 12:15 p.m., Resident #46 was observed eating lunch in the dining room. During an observation on 7/7/14 at 3:17 p.m., Resident #46 was observed sitting on the side of his bed visiting with his son. During the observation, Resident #46 was observed to be tearful. During an observation on 7/9/14 at 10:30 a.m., Resident #46 was observed to be sleeping in a recliner in his room. During an observation on 7/10/14 at 9:45 a.m., Resident #46 was observed to be sleeping in a recliner in his room. The clinical record for Resident #46 was reviewed on 7/8/14 at 3:30 p.m. Resident #46 had diagnosis including, but not limited to, debility, coronary artery disease, metastatic prostate cancer, hypertension, arteriosclerotic cardiovascular disease, anemia, osteoarthritis, and Alzheimer's dementia. A quarterly MDS (Minimum Data Set) assessment, dated 5/4/14, indicated		documentation includes visual hallucinations of "dogs in room ", noted on 7/21/14. Plan of care updated to reflect quantitative monitoring of targeted behavior. Resident has also been referred to psychologist. 2. All other residents currently receiving antipsychotic medications have been identified and reviewed for appropriate diagnosis for use and care plans updated accordingly. 3. The systemic change includes: · All residents receiving new orders for antipsychotic medications and/or new residents admitted with antipsychotic medication orders will be reviewed Monday through Friday at the interdisciplinary clinical meeting for adequate diagnosis or exhibiting behaviors for an antipsychotic medication. · A behavior flow sheet will be initiated for all residents on an antipsychotic medication to document behaviors in regards to the targeted behavior for the antipsychotic medication. This flow sheet will be reviewed by the Director of Nursing or designee and Social Services at the Medication Management Meeting monthly for episodes of behaviors and update the physician as needed. Education will be provided for	

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	Resident #46 did not have any psychotic behaviors. The quarterly BIMS (Basic Interview for Mental Status) assessment, dated 5/14/14, indicated Resident #46 was a 10/15, which indicated moderate cognitive impairment. Resident #46's medications included, but was not limited to Seroquel (an antipsychotic medication) 25 mg (milligram) 1 (one) tablet orally daily at bedtime, Cymbalta (an antidepressant) 20 mg 1 capsule orally daily, Namenda (medication used for the treatment of Alzheimer's dementia) 14 mg tablet 1 orally daily, and Ativan (an antianxiety medication) 0.5 mg 1 tablet orally 3 (three) times a day, and every 6 (six) hours as needed. During an interview on 7/9/14 at 1:59 p.m., RN #1 indicated Resident #46 was started on Seroquel on 4/14/14 as he was often tearful and repeatedly asking questions regarding his location. RN #1 indicated Resident #46 was unable to see and would become anxious when he would go to the dining room. During an interview on 7/9/14 at 2:30 p.m., SSD #1 (Social Service Designee) indicated Resident #46 had periods of confusion, tearfulness, and anxiousness. SSD #1 indicated Resident #46 did not		nurses and Social Services in regards to the systemic change and the federal guidelines and specific conditions that warrant appropriate use of antipsychotic medications. 4. DON or designee will complete daily (Monday-Friday) at the morning clinical meeting a QA tool to monitor for the presence of appropriate diagnosis and/or identification of targeted behavior supporting the use of anti-psychotic medication documented in the medical record. In addition, the DON or designee will review the behavior flow sheets daily during rounds, Monday through Friday. QA will be completed Daily M-F for 90 days, weekly for 90 days then monthly for a total of 12 months of monitoring. 5. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	"really have psychosis" or had a "psychotic episode" in the past but had times where he would repeatedly question his location. SSD #1 indicated Resident #46 had recently had the Ativan increased. The SSD indicated the Seroquel had not really helped with his behaviors and she would contact the resident's physician regarding the Seroquel.. During an interview on 7/10/14 at 9:25 a.m., SSD #1 indicated she had faxed Resident #46's physician to have the resident's medications reviewed and to inform the resident's physician regarding the Seroquel. A policy titled, "Psychotropic Drug Use, obtained from the visiting Director of Nursing on 7/14/14 at 3:43 p.m., indicated only residents that have medical conditions and diagnoses consistent with Federal Standards will receive psychopharmacological drugs. The policy further indicated "antipsychotic drugs should not be used when the only indications are one or more of the following: anxiety, agitated behaviors which do not represent a danger to self or others, indifference to surroundings, or impaired memory..." 3.1-48(a)(4)			

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact			

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	for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to provide adequate glove change and hand sanitization in 1 of 7 residents observed for personal care. (Resident #15) Findings include: During an observation on 7/10/14 at 10:30 a.m., CNA #1 was observed to give Resident #15 a partial bath. CNA #1 applied gloves and assisted Resident #15 from the bed to a wheelchair using a gait belt. CNA #1 then assisted Resident #15 onto the commode and removed the gait belt and placed it on the resident's walker. CNA #1 removed Resident #15's wet brief and discarded it. CNA #1 removed the resident's gown. CNA #1 obtained a clean, wet washcloth and removed the excess water using the side of the sink. CNA #1 laid a clean towel over the resident's upper thighs. CNA #1 washed and rinsed under Resident #15's bilateral axilla and breasts. CNA #1 placed the dirty washcloth into the sink with the clean washcloths and obtained the towel	F000441	F441 1. Resident # 15 experienced no known negative effects and staff are providing adequate glove change and hand sanitization. 2. The facility is providing adequate glove change and hand sanitization for all residents. 3. The systemic change includes that nursing staff will complete a competency check on adequate glove change and hand sanitation. This competency check will also be completed upon hire and every 6 months thereafter. In addition, nursing staff will complete a competency check on providing a bed bath with emphasis on keeping clean versus dirty wash clothes in a separate area. This competency check will be completed upon hire and annually thereafter. Education will be provided to nursing staff regarding adequate glove change and hand sanitization	08/13/2014

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	from the resident's legs to dry the resident's bilateral axillas and breasts. CNA #1 placed a clean bra, clean shirt, and clean jacket onto Resident #15. CNA #1 proceeded to remove Resident #15's shoes. CNA #1 applied clean socks,a clean brief, and slacks to Resident #15. CNA #1 assisted Resident #15 to a standing position and obtained a disposable wipe and cleansed the resident's rectal area. CNA #1 then proceeded to wash, rinse, and dry the resident's buttocks and periarea. CNA #1 pulled up Resident #15's slacks and briefs and lowered the resident's shirt and jacket before seating the resident into the wheelchair. CNA #1 washed her hands for 10 seconds and applied clean gloves. CNA #1 finished care and assisted Resident #15 to the table to fill out a menu. CNA #1 indicated the resident needed to have a pad alarm placed in the wheelchair. CNA #2 entered Resident #15's room and applied gloves at 7:55 a.m.. CNA #1 and CNA #2 assisted to stand Resident #15 and placed the pad alarm onto the seat. CNA #2 removed her gloves and left the room. CNA #1 removed her gloves and washed her hands. During an interview on 7/10/14 at 8:05 a.m., CNA #1 indicated gloves should be removed and hands washed before giving		after direct resident contact for which hand washing is indicated by accepted professional practice, as well as keeping clean versus dirty washcloths separate when providing a bed bath. 4. DON or designee will monitor 5 staff/resident care interactions for adequate glove changes and hand sanitization 5 days a week on random days for 60 days, then weekly for 120 days then monthly x 6 months for a total of 12 months of monitoring. The DON or designee will also monitor 2 random bed baths per week for keeping clean versus dirty washcloths separate for 30 days, then 1 resident per week for 30 days, then 1 resident every other week for a total of 12 months of monitoring. A QA tool will be completed by the DON/Designee weekly to review findings of above observations monitoring compliance and determining if any changes in frequency/monitoring are needed. 5. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	

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	care, when going from dirty to clean areas, and at the end of care. CNA #1 further indicated CNA #2 should have washed her hands prior to applying gloves and after assisting with standing the resident before she left the room. A policy titled, "General Instruction for Resident Care," dated 2003 and obtained from the visiting Director of Nursing on 7/14/14 at 3:43 p.m., indicated disposable gloves should be removed and discarded after contact with each resident, fluid item, or surface. The policy further indicated hands should be washed immediately after gloves are removed." 3.1-18(b)(1) 3.1-18(l)			
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe and sanitary environment, in that drywall was missing from wall, walls were marred	F000465	F465 1. Scuff marks in room 122, 126,	08/13/2014

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	and scuffed, a resident door was very scuffed and marred, 5 of 31 rooms observed during stage 1. (Room # 122A, #126A, #130, 132, and #118.) Findings include: On 7/7/2014 between 9:30a.m till 7/8/14 at 2:00 p.m.at the following rooms were observed: 1. Room 122 bed A had scuff marks along wall. 2. Room 126 bed A had scuffed walls. 3. Room 130 the entry door to room very scuffed and marred. 4. Room 132 room had scuff marks on walls. 5. Room 118 had dry wall (four inches by 8 inches) missing off wall between shower and toilet. On 7/8/14 at 3:43 p.m. observation of the same rooms were found to be unchanged. On 7/9/14 at 1:41 p.m. interview with DoN (Director of Nursing) indicated a painter has been hired by the company to begin painting and touching up rooms. New carpet is going to be installed also.		132 have been touched up. Entry door 130 has been repaired. Missing dry wall in 118 has been replaced. 2. All facility rooms have been toured and assessed for additional areas of scuffs, marring, missing dry wall. Any concerns will be addressed and repairs completed. 3. The systemic change includes: · Maintenance has been provided a checklist to review all rooms no less than monthly for areas of scuffs, marring and missing dry wall and schedule repair of any items found. Education will be provided to staff for completion of maintenance work orders should additional scuffed, marred or areas of missing drywall be noted. In addition, education will be provided to Maintenance staff and Administrative staff regarding the systemic change. 4. Maintenance and/or designee will complete QA rounds weekly in all rooms to monitor for scuff, marring and missing dry wall. Any concerns will be addressed. Rounds will occur weekly x 4 weeks then monthly x 11 months for a total of 12 months of monitoring. 5. The results of these reviews	

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	. On 7/9/14 at 2:08 p.m. interview with Head of Maintenance indicated quarterly inspections were done per company policy, in which each room was inspected personally and notes made of what improvements need to be completed, painted. caulked, drywall and ect. is taken care of. 3.1-19(f)		will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
R000000	Terrace At Solarbron was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.	R000000	This plan of correction is to serve as The Terrace at Solarbron's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by The Terrace at Solarbron or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	