

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 000 Bldg. 00	<p>This survey was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaint IN00171398.</p> <p>Complaint IN00171398-Substantiated. Federal/State deficiency related to the allegation is cited at F-250.</p> <p>Survey dates: April 28, 29, 30, May 4, 6, 7, 2015</p> <p>Facility number: 010930 Provider number: 155773 AIM number: N/A</p> <p>Census bed type: SNF: 33 Residential: 31 Total: 64</p> <p>Census payor type: Medicare: 15 Other: 18 Total: 33</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>This plan of correction is to serve as The Terrace at Solarbron's credible allegation of compliance.</p> <p>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.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident was appropriately accompanied during a transfer to another facility, in that, a confused resident was transported to another facility for treatment and was left unattended. (Resident C)</p> <p>Findings include:</p> <p>On 5/04/15 1:34 p.m., Resident C's clinical record was reviewed. Resident C's diagnoses included, but were not limited to, debility, UTI, lung mass, confusion, and disorientation. The resident's admission date was 2/4/15 and the date of death was 4/13/15.</p> <p>On 2/17/15 the Resident C was diagnosed with C-Diff (a bacterial infection in the colon) and pneumonia.</p> <p>The physicians orders included the following medications: Prozac (an antidepressant) 10mg (milligrams) daily Flutivasone (an antiasthmatic) 50 mcg</p>	F 250	<p>F 250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>Resident C returned from the mentioned appointment on 3/30 at 3:45p without s/s of any distress. The staff at the MD office stated that she, although drowsy when her name was called, "asked for the steroid injections", "appeared to know what was going on", and "was pleasant and answered questions appropriately". Resident C experienced an acute change in condition on 04/03/15 that kept her from returning to her Assisted Living Apartment as previously planned.</p> <p>All other residents that would require being accompanied during an appointment have been identified and will have either a staff member or family member accompany them. There have been no other identified concerns or issues noted.</p> <p>The systemic change includes:</p>	06/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>(micrograms) daily Lasix (a diuretic) 80mg every other day Lorazepam (an antianxiety) 0.5mg 1 tablets qid prn Lopressor (an antihypertensive) daily 100mg Ranitidine (an acid reducer) 150 mg daily Aldactone (a diuretic) 50 mg daily</p> <p>Resident C's Admission BIMS (Brief Interviewable Mental Status) on 2/11/15 was 6 (indicating severe impairment) and the BIMS on the 60 day evaluation on 4/3/15 was 4.</p> <p>The resident's functional status included extensive assist for transfer for wheelchair. The resident's hearing, speech, and vision indicated the resident could hear adequately, could make self understood, and was able to understand others.</p> <p>The clinical record contained an order on 2/28/15 to make an appointment with the resident's orthopedic specialist for bilateral pelvic pain.</p> <p>In review of the nursing notes for Resident C, they indicated: On 3/27/15 resident was always pleasant with occasional confusion On 3/22/15 resident has complaining of lots of pain in hips, resident goes to dining room to eat.</p>		<p>Facility staff will, upon receiving notification of appointments, attempt to contact family to inquire of their intentions to accompany resident to the upcoming appointment. This information will be recorded on the daily transportation log. Should a family member not be available to accompany, the nurse will assess the cognitive status of each resident prior to transport for medical services outside of the facility and a determination will be made based on that assessment as to whether the resident will require accompaniment for the duration of the appointment. The nurses' determination will be documented on the Nurse Transportation Approval Form. Arrangements will be made for Solarbron staff accompaniment as needed as determined by the nurse .</p> <p>Education will be provided for licensed nurses, transportation scheduler and transportation staff regarding the systemic change and assessment of the resident's cognitive status and arrangement of accompaniment to appointments outside of the facility.</p> <p>The transportation log and Nurse Approval forms will be reviewed Mon-Friday at the clinical meeting. SSD or designee will complete an audit tool for completion of "Nurse Transportation Approval Form".</p>	

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>On 3/16/15 resident has been up in dining room from lunch, resident states feels better, in pleasant mood, voices no concerns with staff, shows no psychological distress.</p> <p>On 05/06/15 at 11:34 a.m., and interview with Social Services indicated the receptionist at the front desk took care of arranging all transports of resident to and from facilities.</p> <p>On 05/06/2015 11:40 a.m., an interview with DON (Director of Nursing) indicated if a resident had dementia they are always accompanied by family member, if they are available, if not, a staff member accompanied them and stayed with the resident for the entire visit.</p> <p>On 5/6/15 at 11:45 p.m., a Review of the Transportation Sheet provided by DON, indicated Resident C was transported on Monday March 30, 2015 by driver #1 at 11:15 a.m. to a surgical center for an injection of the hip at 12:00 p.m. and returned back at 3:23 p.m.</p> <p>On 5/6/15 at 1:47 p.m., CI (Confidential Interview) #1 was queried regarding events at the surgical center. CI #1 indicated that her husband was also having a minor surgery that day. The</p>		<p>forms for all transports for 30 days, then 10 transports weekly for 120 days, then 10 transports monthly for an additional 180 days for a total of 12 months on monitoring.</p> <p>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%.</p> <p>Date of compliance: June 5, 2015</p>	

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>following was the account of the observations and what CI #1 over heard while at the surgical center.</p> <p>A female driver from (Name of Facility) had brought the resident into the building and left. The resident was in a wheelchair which had a gaitbelt hanging off of it into waiting room. CI #1 indicated the Resident C obviously had dementia and impairment, because she was trying to stand up by herself and almost fell, the resident was scared and did not know where she was, she did not respond to her name when called to go back to surgery suite.</p> <p>CI #1 could overhear the nurses in the next partitioned room having difficulty communicating with resident. CI #1 indicated she was a CNA and had understanding of residents in nursing home. She stated she called the Nursing Home Facility and talked with an employee who freely gave her the name of resident and other information, about why resident was there, and knew exactly who the CI #1 was talking about, and indicated it was standard practice to take residents and leave them for appointments by themselves.</p> <p>The CI #1 indicated she felt compelled to sit with the resident while her husband was recovering, but a male driver #2 ,came in and said he was sent back to pick her up because she was, "pitching a</p>			

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>fit".</p> <p>On 5/6/15 at 4:45 p.m., during review with Administrator of concerns, she indicated she knew what complaint was about and she is the one who talked to complainant and stated the resident name was Resident C, ADM (Administrator) indicated resident was not cognitively impaired, she ate in dining room, was alert and oriented. ADM indicated Resident C's BIMS score was low because she was sick with C-Diff. ADM indicated resident called her own audiologist to adjust her hearing aides and ADM daily helped resident. ADM indicated the resident was going to be sent back to assisted living but took a turn for the worse and died soon after incident. ADM also indicated after the phone call she sent driver #2 back to get resident and she was already done with procedure and was fine</p> <p>On 5/7/15 at 9:25 a.m., an interview with LPN #1 about residents cognitive abilities, indicated that resident C was not very cognitively aware and had no short term memory.</p> <p>An interview with Facility Consultant 5/7/15 at 9:39 a.m., per her request indicated that Resident C had the ability to call her son on her cell phone, call the</p>			

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>audiologist to adjust her hearing aides. Consultant indicated resident was close to being transferred back to Assisted Living. She also indicated the resident had a fall event on 3/14/15.</p> <p>On 5/7/15 at 10:53 a.m., the Administrator #2 (at the surgical center) indicated the chart would be pulled for Resident C and would call back concerning the residents demeanor when at surgical facility.</p> <p>On 5/7/15 at 1:06 p.m., the Surgical Center Nurse called back regarding caring for Resident C while at surgery center. The Surgical Center Nurse indicated the resident was dropped off by the nursing home alone. The Surgical Center Nurse queried resident if any family was with her, Resident C indicated no she was alone and that's the way her life was. The Surgical Center Nurse stated the resident was very drowsy and was sleeping when she called her name in waiting room. When the resident was taken back to the surgical suite, it was obvious the resident could not assist in taking her clothes off, the resident required 4 people to lift her onto a cart and required 2 people to help her with toileting. The Surgical Center Nurse called the Nursing Home and asked if anyone was going to be accompanying</p>			

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>the resident due to her need for so much assistance, the Nursing home indicated she would not. Resident C complained of severe pain in both hips and being so tired, she asked for an injection of steroids for both hips and was accommodated for that after talking with doctor. Resident C appeared to know what was going on, was pleasant and answered questions appropriately, but needed extensive assistance with ADL,s.</p> <p>On 5/6/15 at 1:00 p.m., a Policy titled Transportation was received by the DON which indicated the facility will assist with arranging transportation to and from appointments when necessary. # 4 of the policy indicated a member of the nursing or social services department would accompany the resident if medically necessary or ordered by the physician.</p> <p>On 5/7/15 a Policy of Notice of Privacy Practices received by DON on 5/7/15 indicated the resident had the right to give a list of who is to have information, request confidential communication, ask us to limit information which is shared, share information with family, close friends, or others involved in your care per your choice. We are required to by law maintain the privacy and security of your protected health information, We will not use or share your information</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 431 SS=E Bldg. 00	<p>other than as described here unless you tell us we can in writing.</p> <p>This Federal tag relates to Complaint IN00171398.</p> <p>3.1-34(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>			

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were properly labeled with resident name, open dates, expiration dates, or discarded after the death of a resident for one of two carts observed.</p> <p>Findings include:</p> <p>On 4/6/15 at 3:15 p.m. the East medication cart was observed and the following was found:</p> <ol style="list-style-type: none"> 1. A bottle of Megestrol AC Suspension (an appetite stimulant) - 20 cc to be given by mouth, dispensed on 4/7/15, was the medication belonging to a resident that had died on 4/13/15. 2. An open bottle of Milk of Magnesia (a laxative) which had no resident name or open date, the bottle was almost empty. 3. Meclizine (an anti-vertigo) 25 mg with 	F 431	<p>F431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The Megestrol AC Suspension, MOM, Meclizine, and Spiriva noted in the survey have been disposed of properly.</p> <p>All medication/treatment carts have been inspected and currently have no other expired, unlabeled medications or medications for any resident no longer at the facility.</p> <p>The systemic change includes:</p> <ul style="list-style-type: none"> The facility is instituting a "Cart Captain" program with the assistance of the contracted Pharmacy- Designated pharmacy personnel along with the DON or designee have been identified as contact individuals for this program that oversees labeling and storage of drugs and biologicals. The "Cart Captain" reviews the medication and 	06/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>an open date of 3/2014 with no expiration date.</p> <p>4. A Spirvia Inhaler (a bronchodilator) with no resident name or open date.</p> <p>An interview with the RN #2 on 4/6/15 at 3:15 p.m., indicated she was unsure regarding the policy about labeling the expiration dates and residents on the medications.</p> <p>On 5/7/15 at 11:48 p.m., an interview with RN #1 indicated that medications should be labeled with residents name and open and expiration dates.</p> <p>On 5/7/15 at 11:27 p.m., a Policy for Drug Storage was received by DON which indicated discontinued and expired medications should be removed from medication carts, refrigerators and cupboards promptly. Return drugs or destroy according to pharmacy and facility policies.</p> <p>3.1-25(k)(1) 3.1-25(k)(6) 3.1-25(l)(1) 3.1-25(l)(3)</p>		<p>treatment carts at least weekly for expired, unlabeled medications, or medications for any resident no longer at the facility.</p> <p>All discontinued medication orders, and discharged resident orders will be reviewed at the morning meeting and a list will be maintained in this meeting until the medication is removed from the medication or treatment cart.</p> <p>Nurses will receive education on the proper labeling of medications, dating of medications when opened, disposition of expired medications, and medications of residents no longer residing in the facility. Administrative nursing will receive education on the "Cart Captain" program and monitoring during the clinical meeting of medications that need to be removed from the cart.</p> <p>The Staff Development Coordinator will complete a daily audit tool of the carts Monday through Friday for 30 days, then weekly times 120 days then monthly times an additional 180 days for a total of 12 months of monitoring.</p> <p>The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once</p>	

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 05/07/2015
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 441 SS=E Bldg. 00	<p>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.</p> <p>(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.</p> <p>(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</p>		<p>compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.</p> <p>Date of compliance: June 5, 2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to implement infection control practices to help prevent the spread of infections, in that, hands were not washed in between resident contacts or between dirty and clean tasks and medications were handled with bare hands for 4 of 5 residents observed for infection control. (Resident #57, Resident #14, Resident #51, Resident #118)</p> <p>Findings include:</p> <p>1. On 5/6/15 at 9:20 a.m., CNA #1 and CNA #2 were observed to assist Resident #14 to toilet. CNA #1 and CNA #2 applied gloves and assisted the resident to the commode. CNA #1 cleansed Resident #14's perineal area, applied cream to the residents buttocks, and removed the gloves. CNA #1 applied a new pair of gloves. There was not any hand hygiene observed in between glove</p>	F 441	<p>F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>Resident # 14, Resident # 57- both remain in the facility and have had no adverse effect noted . Resident # 118 has discharged from facility.</p> <p>Hand washing and appropriate glove changing is occurring between resident contacts, between clean and dirty tasks and medications are not handled with bare hands. RN # 1 & 3, and C.N.A. #1 & 2 have received education regarding hand washing and appropriate glove changing between resident contacts and clean to dirty tasks. RN #1 has received education regarding touching medication with bare hands.</p> <p>The Systemic Change includes:</p>	06/05/2015

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>changes.</p> <p>2. On 5/6/15 at 11:20 a.m., RN #3 was observed to perform accuchecks (a blood test to assess the blood sugar). RN #3 applied gloves and assessed Resident #57's blood sugar. RN #3 removed the gloves and applied a new pair. RN #3 began to prepare and administer an injection for Resident #57. RN #3 removed the gloves and exited the residents room. RN #3 discarded the trash, applied new gloves, and cleansed the accucheck machine. RN #3 prepared to administer an accucheck for Resident #51. RN #3 applied gloves and assessed the residents blood sugar. RN #3 removed the gloves, discarded the trash, and exited the room. RN #3 then cleansed the accucheck machine.</p>		<p>Nursing staff will complete a skills competency check off upon hire and twice annually regarding hand washing, glove changes while providing care and during medication pass.</p> <p>Nursing Staff will receive education on the facility 2013 Hand washing/Hand hygiene policy, with emphasis on appropriate glove changing between resident contacts and between clean and dirty tasks. In addition, Licensed Nurses will receive education on handling and breaking of oral medications. Current nursing staff will receiving a skills competency check off on hand washing and glove use and licensed nurses and QMAs will complete a competency check off on handling of medications.</p> <p>SCD or designee will observe the administration of 5 oral medications daily, including weekends, for adherence to policy for 30 days, then 10 medications weekly times 120 days, and 10 medications monthly x an additional 180 days for a total of 12 months of monitoring. In addition, the Staff Development Coordinator or designee will monitor for hand washing and glove use, according to facility policy, daily (7 days a week) on random shifts during personal care of two random residents per day. These audits will</p>	

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 05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
R 000 Bldg. 00	This visit was for a State Residential Licensure Survey Residential Census: 31 Sample: 7 The Terrace At Solarbron was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.	R 000	continue for 30 days, then weekly for 30 days, then every other week for a total of 12 months of monitoring. The results of these reviews will be discussed at the 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%. Date of compliance: June 5, 2015 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	

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 05/07/2015
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
			admission of the survey allegations.		