

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>010930</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>05/07/2015</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRACE AT SOLARBRON THE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1701 MCDOWELL RD</b><br><b>EVANSVILLE, IN 47712</b> |
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| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| R 000              | <p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey<br/>Residential Census: 31<br/>Sample: 7<br/>The Terrace At Solarbron was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.</p> | R 000         |   |                    |

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| Indiana State Department of Health<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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