

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 03/17/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00192814.</p> <p>Complaint IN00192814- Substantiated. Federal/State deficiencies related to the allegations are cited at F353.</p> <p>Survey dates: March 16 & 17, 2016</p> <p>Facility number: 010930 Provider number: 155773 AIM number: 201274710</p> <p>Census bed type: SNF: 34 SNF/NF: 27 Residential: 30 Total: 91</p> <p>Census payor type: Medicare: 16 Medicaid: 12 Other: 33 Total: 61</p> <p>Sample: 7</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This plan of correction is to serve as The Terrace atSolarbron's credible allegation of compliance. Submission of this plan of correction does not constitute anadmission by The Terrace at Solarbron or its management company that theallegations contained in the survey report are a true and accurate portrayal ofthe provision of nursing care and other services in this facility. Nor does this submission constitute anagreement 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 <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2016
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

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 0353 SS=E Bldg. 00	<p>Quality review completed by #02748 on March 24, 2016.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to ensure call lights were answered in a timely manner for 4 of 7 residents reviewed. (Resident A, Resident B, Resident C, Resident D, Resident E, Resident F, Resident G)</p> <p>Findings include:</p> <p>1. On 3/17/16 at 10:45 a.m., Resident A</p>	F 0353	<p>483.30(a) SUFFICIENT 24 HR NURSING STAFF PER CARE PLANS The resident identifier list was not shared with the facility due to the investigation of Complaint IN00192814. Staff forget at times to reset the pendant alarm after answering the resident's call light, making the reports appear to be a lengthier response time than actual response. All residents have their call lights</p>	04/15/2016

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 03/17/2016	
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>indicated that he sometimes had to wait a long time for the staff to answer his call light.</p> <p>On 3/17/16 at 2:00 p.m., Resident A's device activity report was reviewed. The report included, but was not limited to:</p> <p>On 2/27/16 at 8:22 a.m., the call light was alarmed and answered at 8:39 a.m. (16 minutes)</p> <p>On 2/27/16 at 10:41 a.m., the call light was alarmed and answered at 11:01 a.m. (19 minutes)</p> <p>On 2/27/16 at 3:12 p.m., the call light was alarmed and answered at 3:32 p.m. (19 minutes)</p> <p>On 2/29/16 at 12:41 a.m., the call light was alarmed and answered at 12:56 a.m. (15 minutes)</p> <p>On 3/5/16 at 7:28 p.m., the call light was alarmed and answered at 7:54 p.m. (25 minutes)</p> <p>On 3/7/16 at 7:50 a.m., the call light was alarmed and answered at 8:17 a.m. (27 minutes)</p> <p>On 3/7/16 at 6:17 p.m., the call light alarmed and was answered at 6:48 p.m. (30 minutes)</p> <p>On 3/10/16 at 5:13 p.m., the call light alarmed and was answered at 5:49 p.m. (36 minutes)</p> <p>On 3/11/16 at 5 26 p.m., the call light alarmed and was answered at 6:02 p.m.</p>		<p>answered in a timely manner.</p> <p>The systemic change includes that the pendant system for the call lights will be programmed through the facility's server and provides a text alert to the cell phone of an administrative staff member when the threshold has been reached on maximum time for the call light to be sounding. This staff member will then investigate why the call light has not been responded to by either going to the unit or calling the facility. In addition, the reports for call light response time will be reviewed daily at the clinical meeting (Monday through Friday) and investigated if the call light response time is too long. Education will be provided to nursing and administrative staff regarding the systemic change, including the protocol to follow if a call light has been sounding past the threshold time. In addition, education will be provided to staff regarding how to reset the pendant alarm and the systemic change. The Administrator or designee will monitor the call light response time reports daily (Monday through Friday) at the clinical meeting. Any call light response time that is beyond the facility threshold will be reviewed and further action will be taken as appropriate. In addition, the administrative team member responsible for receive a text alert when the call light is over threshold will submit a report to 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 03/17/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>(36 minute) On 3/11/16 at 9:42 p.m. the call light alarmed and was answered at 10:01 p.m.</p> <p>(19 minutes) On 3/16/16 at 7:10 a.m., the call light alarmed and was answered at 7:31 a.m.</p> <p>(21 minutes) On 3/16/16 at 4:47 p.m., the call light was alarmed and answered at 5:35 p.m.</p> <p>(48 minutes)2. On 3/17/16 2:15 p.m., Resident F indicated she had to wait a long time for her call light to be answered in the evening.</p> <p>3. On 3/17/16 at 2:15 p.m., Resident G indicated he sometimes had to wait more than 20 minutes for his call light to be answered.</p> <p>4. On 3/17/16 at 2:45 p.m., Resident C's Device Activity Report was reviewed. The report included, but was not limited to:</p> <p>On 1/28/16 at 7:25 a.m., the call light was alarmed and answered at 8:13 a.m.</p> <p>(47 minutes) On 1/28/16 at 10:39 a.m., the call light was alarmed and answered at 10:56 a.m.</p> <p>(16 minutes) On 1/29/16 at 12:07 p.m., the call light was alarmed and answered at 12:27 p.m.</p> <p>(19 minutes) On 1/29/16 at 12:552 p.m., the call light</p>		<p>administrator,including their actions in response. This audit will be completed 5 days a week for30 days, then weekly thereafter for a total of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at themonthly facility Quality Assurance Committee meeting monthly for 3 months andthen quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will beincreased as needed, if compliance is below 100%.</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 03/17/2016
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

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>was alarmed and answered at 1:14 p.m. (22 minutes)</p> <p>On 1/30/16 at 9:05 p.m., the call light was alarmed and answered at 9:35 p.m. (29 minutes)</p> <p>On 2/2/16 at 10:43 a.m., the call light was alarmed and answered at 11:11 a.m. (27 minutes)</p> <p>On 2/4/16 at 2:01 p.m., the call light was alarmed and answered at 2:19 p.m. (18 minutes)</p> <p>5. On 3/17/16 at 2:00 p.m., the Resident Council Minutes were reviewed. The minutes included, but were not limited to:</p> <p>On 10/6/15, residents voiced complaints about staffing on weekends.</p> <p>On 1/6/16, residents voiced complaints about waiting a long time for call lights to be answered.</p> <p>On 3/17/16 at 2:30 p.m., the Administrator indicated if a call light was activated, it remained activated until nursing staff disarmed it.</p> <p>On 3/17/16 at 3:35 p.m., the Administrator indicated there was not a policy on call lights.</p> <p>This Federal tag relates to Complaint IN00192814.</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 03/17/2016
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	
	3.1-17(a)				