

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2022	
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	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00385967, IN00385740 and for a COVID-19 Focused Infection Control Survey. This visit included a Residential COVID-19 Quality Assurance Walk Through.</p> <p>Complaint IN00385967: Substantiated. No deficiencies related to the allegations were cited. Complaint IN00385740: Substantiated. No deficiencies related to the allegations were cited.</p> <p>Survey date: August 1 & 2, 2022</p> <p>Facility number: 010930 Provider number: 155773 AIM number: 201274710</p> <p>Census bed type: SNF/NF: 82 Residential: 40 Total: 122</p> <p>Census payor type: Medicare: 15 Medicaid: 45 Other: 22 Total: 82</p> <p>The Terrace at Solarbron was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Complaint Investigation of Complaints IN00385967, IN00385740, and the COVID-19 Focused Infection Control Survey.</p>			F 000			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155773	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2022
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	Continued From page 1 Quality review completed on August 11, 2022.	F 000			