STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00419670, IN00419853, and IN00420287. This visit included a State Residential Licensure Survey. Complaint IN00419670 - No deficiencies related to the allegations are cited. Complaint IN00419853 - No deficiencies related to the allegations are cited. Complaint IN00420287 - Federal/State deficiencies related to the allegations are cited at F580. Survey dates: October 23, 24, 25, 26, 27, 30 & 31, 2023 Facility number: 010930 Provider number: 155773 AIM number: 201274710 Census Bed Type: SNF/NF: 81 Residential: 30 Total: 111 Census Payor Type: Medicare: 11 Medicaid: 48 Other: 22 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**Solarbron Terrace** **Annual SNF & Residential Care Relicensure Survey** **October 23-27, 30-31 2023** **SNF - Plan of Correction** The plan of correction serves as Solarbron Terrace's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Solarbron Terrace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **F-Tag 554: Resident Self-Admin Meds-Clinically Appropriate** The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. Resident 69 self- administration assessment is completed. The facility will identify other residents that may potentially be affected by this practice. Current	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark McElwee		11/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Quality review completed on November 6, 2023.		residents have the potential to be affected by this alleged deficient practice. Current residents that wish to self-administer medications have been audited to ensure self -administration assessments are completed. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses and IDT will be re-educated on self-administration policy. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit 5 random residents 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months to ensure self-administration assessment are completed on those who wish to self-administer. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 580: Notice of Changes** The corrective actions to be accomplished for those residents found to have been affected by the practice. Notification of changes to Residents F was discharged from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			the facility and Resident M's family has been notified. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Residents with changes have been audited to ensure notification was made to families and the physician. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses will be re-educated on making notification to families and the physicians of residents when resident conditions change. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit residents with changes to ensure notification is made to families and the physician at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure notification to families and the physician is made. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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-Tag 641: Accuracy of Assessments The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. The MDS for Resident 50 was corrected on the day the coding error was identified. The facility will identify other residents that may potentially be affected by this practice. Current residents have the potential to be affected by this alleged practice. Dialysis residents who reside at Solarbron Terrace have been audited to ensure MDS coding is correct. The MDS of residents have been audited to ensure comprehensive assessments are coded and completed accurately. The facility will put into place the following systematic changes to ensure that the practice does not recur. MDS staff will be re-educated on proper coding of resident assessments. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit 5 random residents 3 x weekly x 4 weeks, then weekly x 4 weeks,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			then monthly x 4 months to ensure resident assessment are completed accurately. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 689: Free of Accident Hazards/Supervision/Devices** The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident M's fracture is healing, and her current fall interventions have been reviewed. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents fall interventions have been audited to ensure fall interventions are implemented and appropriate. The facility will put into place the following systematic changes to ensure that the practice does not recur. Nursing staff will be re-educated on our fall policy, sit to stand lift policy, and implementing interventions. The facility will monitor the corrective action by implementing the following measure. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Director of Nursing or designee will audit fall interventions at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 6 months to ensure fall interventions are implemented. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 690: Bowel/Bladder Incontinence** The corrective actions to be accomplished for those residents found to have been affected by the practice. Residents M's UTI has resolved and suffered no ill effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron Terrace have the potential to be affected by this alleged deficient practice. Residents residing at Solarbron Terrace with a dx of UTI have been audited to ensure appropriate treatment is provided. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses have been re-educated on appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			treatment of UTIs. The facility will monitor the corrective action by implementing the following measure. DON/Designee will review 3 random residents per week for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly 3 additional months to ensure appropriate treatment is provided for UTIs. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 695: Respiratory Care** The corrective actions to be accomplished for those residents found to have been affected by the practice. The date of the oxygen tubing and humidification bottles for Residents 13, 22, 31, 44, and 45 were corrected on the day the error was identified. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents with oxygen tubing and humidification bottles have been audited to ensure the proper date is labeled on the oxygen tubing and humidification	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			bottles. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses/QMAs will be re-educated on respiratory care policy. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit residents with oxygen tubing and humidification bottles at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure fall interventions are implemented. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 732: Posted Staffing Information** The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. Current residents have the potential to be affected by this alleged deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			practice. Daily staffing information has been updated and posted. The facility will put into place the following systematic changes to ensure that the practice does not recur. The current scheduler will be educated on ensuring daily staffing information to be updated and posted daily at the main entrance and the nursing units. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit daily staffing information posting 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months to ensure daily staffing information is accurate and posted daily. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 761: Labeling of Drugs and Biologicals** The corrective actions to be accomplished for those residents found to have been affected by the practice. The three medication administration refrigerators located	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			on the West, North, and South Units observed with blank temperature logs during the survey were corrected the day the issue was identified. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. The temperature logs inside the medication administration refrigerators on the nursing units have been audited to ensure temperatures are being logged. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses and QMAs will be re-educated on recording temperatures on the temperature log inside of the medication administration refrigerators. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit medication administration refrigerator temperature logs at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure temperature logs are being completed. The results of these audits will be presented to the monthly Quality Assurance/Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 804: Nutritive Value/Appearance, Palatable/Pref/Temperature** The corrective actions to be accomplished for those residents found to have been affected by the practice. No residents suffered adverse effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. The DFS/designee will audit food temperatures during mealtimes to ensure food is served at an appetizing and appropriate temperature. The facility will put into place the following systematic changes to ensure that the practice does not recur. Dietary staff and nursing staff will be re-educated on food temperatures and delivering the trays timely to residents. The facility will monitor the corrective action by implementing the following measures The DFS/designee will monitor/audit hall tray food temperatures, and interview 5 residents weekly for 4 weeks, then biweekly x 8 weeks, then monthly x 3 months to ensure food is served at appropriate and appetizing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			temperatures. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 921: Safe/Functional/Sanitary/Comfortable Environment** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The hallway on the East Hallway observed smelling musty was addressed on the day the issue was identified. No ill effects were noted from this alleged deficient practice. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Carpeted and hallways areas were inspected, and an action plan has been implemented. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? The administrator or designee will re-educate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			housekeeping and maintenance staff on the cleaning and disinfection of environment surfaces policy and will re-educate staff on putting in work orders for carpeted areas needing to be cleaned. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; the Administrator/designee will monitor/audit carpeted areas to ensure the areas are clean and odor-free weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure the carpeted areas are clean and odor-free. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **Residential Care – Plan of Correction** **R0246 – Pharmacy (PRN Medications)** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No ill effects were noted from this alleged deficient practice. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			QMA who administered the PRN medication without the authorization of a licensed nurse was re-educated on 11/13/23. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents have had no ill effects from this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or designee will re-educate QMAs on proper administration of PRN medications policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Director of Nursing or designee will audit MARs to ensure PRN medications are administered properly weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure PRN medications are administered properly. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **R0298 – Pharmacy (Consultant Pharmacist Review)** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No ill effects were noted from this alleged deficient practice. Pharmacy reviews for Residents 2,3,5,6,7, and 8 were completed on 11/15/23. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents will be audited to ensure pharmacy recommendations/reviews are completed. Current residents have had no ill effects from this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or designee will re-educate Residential Care Manager on ensuring pharmacy reviews of resident records are completed at least every 60 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Director of Nursing or designee will audit resident records to ensure pharmacy reviews are completed at least every 60 days weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure pharmacy reviews are completed at least every 60 days. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 1 of 1 residents observed with medications in their room. (Resident 69) Findings include: On 10/26/23 at 8:43 A.M., LPN (Licensed Practical Nurse) was observed to enter Resident 69's room. Upon entrance, the resident was observed sitting	F 0554	**F-Tag 554: Resident Self-Admin Meds-Clinically Appropriate** The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. Resident 69 self- administration assessment is completed. The facility will identify other residents that may potentially be	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	in the room by himself on a bedside commode self-administering a nebulizer treatment. At that time, LPN indicated the breathing treatment consisted of duoneb (albuterol with ipratropium bromide) and that the resident liked to administer it himself. She further indicated Resident 69 did not have a self administration assessment on file for that medication. On 10/26/23 at 9:09 A.M., Resident 69's clinical record was reviewed. Diagnosis included, but was not limited to, chronic bronchitis. The most recent admission MDS (Minimum Data Set) Assessment, dated 9/13/23, indicated no cognitive impairment, and extensive assistance of two staff with bed mobility, transfers, and toileting. Current physician orders included, but were not limited to, the following: ipratropium bromide solution; 0.02 %; amt: contents of one vial; inhalation. Special Instructions: Mix with albuterol Four Times A Day, dated 9/20/23. Physician orders lacked an order to self administer medication. On 10/26/23 at 10:51 A.M., the Director of Nursing (DON) indicated Resident 69 did not have a self administration of medications assessment. On 3/22/22 at 9:54 A.M., a current non-dated bedside medications and self-administration of medications policy was provided, and indicated "Each resident who desires to self-administer medication will be permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident		affected by this practice. Current residents have the potential to be affected by this alleged deficient practice. Current residents that wish to self-administer medications have been audited to ensure self -administration assessments are completed. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses and IDT will be re-educated on self-administration policy. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit 5 random residents 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months to ensure self-administration assessment are completed on those who wish to self-administer. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and other residents of the facility ... Once cognitive status is established, the resident requires a skills assessment ... A written order for the bedside storage of medication is present in the resident's medical record". 3.1-11(a)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on interview and record review, the facility failed to notify the attending physician and the resident's family for 1 of 5 residents reviewed for hospitalizations and 1 of 2 residents reviewed for notification of changes. A resident's family was not notified of significant weight loss and the attending physician was not notified of increased blood pressure. (Resident M, Resident F) Findings include: 1. During a confidential interview on 10/24/23 at 11:10 A.M., it was indicated Resident M's family had not been notified of a significant weight loss and the facility was not good at communicating changes in condition to the family. On 10/25/23 at 10:19 A.M., Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, Diabetes Mellitus, dysphagia,	F 0580	**F-Tag 580: Notice of Changes** The corrective actions to be accomplished for those residents found to have been affected by the practice. Notification of changes to Residents F was discharged from the facility and Resident M's family has been notified. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Residents with changes have been audited to ensure notification was made to families and the physician. The facility will put into place the following systematic changes	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and vascular dementia. The most recent quarterly (Minimum Data Set) Assessment, dated 9/25/23, indicated Resident M had moderate cognitive impairment, had weight loss, and required extensive assistance of 2 staff for bed mobility, transfers, toileting, and bathing, and setup assistance with supervision for eating. A current nutritional risk care plan, dated 3/4/23, indicated Resident M was at nutritional risk related to use of mechanically altered and therapeutic diet due to dysphagia, variable intakes, and significant weight loss. The progress notes indicated the weight loss was first identified on 4/12/23. On 4/14/23, a Registered Dietician review indicated "Wt (weight) hx (history): 176# (pounds) (4/12), 187#(3/28), 184#(1/8), and 195#(11/9) - sig (significant) wt (weight) loss x (times) 15 days and overall trending loss x5 months. Her BMI (body mass index) is 28.5 which suggests overweight status for ht (height) of 5'6". Pertinent dx (diagnosis) include dysphagia, constipation, T2DM (type 2 diabetes mellitus), depression, vit (vitamin) def (deficiency), gout, HLD (hyperlipidemia), GERD (gastroesophageal reflux disease), HTN (hypertension), hypothyroidism. Her diet is mech (mechanical) soft, ground meats/gravy... start 237mls (milliliters) Boost Glucose Control TID (three times a day) between meals for extra calories and blood sugar management. Also recommend weekly weights x4 weeks. RD (registered dietician) available as needed". On 5/24/2023 at 2:16 P.M. an IDT (Interdisciplinary Team) note indicated the family was aware of the		to ensure that the practice does not recur. Licensed nurses will be re-educated on making notification to families and the physicians of residents when resident conditions change. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit residents with changes to ensure notification is made to families and the physician at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure notification to families and the physician is made. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	weight loss. The clinical record lacked documentation of notification to the family related to significant weight loss prior to 5/24/23. On 10/26/23 at 9:30 A.M., Corporate Clinical Support (CCS) 4 indicated family should be notified of significant changes, including significant weight loss, the same day it was identified. At that time, she indicated notifications would be documented in a progress note. On 10/31/23 at 9:56 A.M., the DON (Director of Nursing) indicated she was unable to find notification of the family for significant weight loss prior to 5/24/23. 2. On 10/27/23 at 11:26 A.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral infarction due to occlusion or stenosis of small artery and hypertension. The most recent admission MDS (Minimum Data Set) Assessment, dated 8/25/23, indicated Resident F had moderate cognitive impairment and required setup assistance for bed mobility, transfers, and eating. A current hypertension care plan, dated 8/24/23, indicated Resident F had hypertension that required treatment and monitoring with an intervention to observe for signs and symptoms of elevated blood pressure (systolic BP (blood pressure) > (greater than) 140, diastolic BP >90, dizziness, flush face, headache, nosebleed, nausea/vomiting). Physician orders included, but weren't limited to,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the following: hydralazine (a blood pressure medication) tablet; 25 mg (milligram); amt (amount): 25 mg (1 tablet); oral Every 8 hours 12:00 AM, dated 08/21/2023 to 10/16/2023 hydralazine tablet; 25 mg; amt: 50 mg; oral Special Instructions: Check Blood Pressure and Hold if SBP (systolic blood pressure) is less than 110. May use one 50mg tablet after 25mg are gone. Every 8 hours, dated 10/16/2023 to 10/19/20 hydralazine tablet; 25 mg; amt: 50 mg; oral Special Instructions: Check Blood Pressure and Hold if SBP is less than 110. May use one 50mg tablet after 25mg are gone. Report systolic bp >180 Every 8 hours, dated 10/19/2023 A physician's note, dated 10/16/23, indicated Resident F was "seen for report of hypertension this morning with systolic BP > 190. Review of blood pressures noted consistently systolic BP is > 160. Will increase hydralazine and monitor". A physician's note, dated 10/19/23, indicated Resident F was "seen for follow-up regarding her HTN (hypertension). Her hydralazine was increased to 50 mg (milligrams) po (by mouth) every 8 hours on 10/16/23. The current supply is 25 mg tabs (tablets). The box in the medication drawer still says 25 mg, take one tab po (by mouth) every 8 hours. The order does say 50 mg, however uncertain what she is getting routinely. Blood pressures have been consistently greater than 160 systolic with several readings > 190 systolic. Ensured the label was clearly marked to take 2 tabs. When 25 mg tabs are exhausted, she will get one 50 mg tab every 8 hours. Checked BP during visit at 1315 (1:15 P.M.), 136/82".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A progress note, dated 10/20/23, indicated "At approximately 12:50pm [sic] resident's son came to the nurse's station stating something was wrong with his mother. He stated he noticed her right eye lid look different; drooping. Outer Right eye lid noted to slightly lower then the Left outer eye lid at this time; right eye lid looked slightly puffy. This writer immediately assessed the resident. Vitals: BP 143/24, P (pulse) 84, O2 (oxygen) 95% on room air, Temp (temperature) 98.1, Resp (respirations) 16. Grasps were equal bilaterally; able to raise bilateral arms above head and hold them up. She stated that her vision in the right eye was blurry compared to the left eye. She was A&O (alert and oriented); able to tell me what she wanted to eat for lunch. I returned to the resident's room approximately 5 minutes later and observed resident leaning to the right side of the wheel chair. Right arm was hanging down beside the wheel chair; resident responded to questions with slurred speech. [Name of provider] arrived the room [sic]. Vitals were repeated: BP 126/65, P 83, O2 90%, Resp 16. [Name of provider] gave verbal order to send to ER (emergency room) d/t (due to) possible stroke". The following blood pressures were obtained between 10/16 and 10/20: 10/16/23 9:40 A.M. 194/82 10/16/23 9:46 P.M. 166/77 10/17/23 8:37 A.M. 158/84 10/17/23 10:25 P.M. 166/74 10/17/23 10:30 P.M. 166/77 10/18/23 7:48 A.M. 154/72 10/18/23 8:08 P.M. 191/87 10/18/23 8:53 P.M. 197/87 10/19/23 8:46 A.M. 187/86 10/19/23 8:17 P.M. 191/91 10/19/23 8:32 P.M. 191/91 10/20/23 11:09 A.M. 146/74			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The MAR (medication administration record) for October indicated Resident F received hydralazine as ordered. The clinical record lacked documentation of notification to the attending physician regarding increased blood pressures. On 10/27/23 at 1:30 P.M., Corporate Clinical Support (CCS) 4 indicated that call orders for blood pressure would be listed with the medication and any notification to the provider would be documented in the progress notes. At that time, she indicated if call orders for blood pressure were not specified, it would be up to the nurse's judgement whether to notify the provider. On 10/30/23 at 8:44 A.M., LPN (Licensed Practical Nurse) 15 indicated provider notification was documented in the progress notes. At that time, she indicated that she would notify the provider if a resident's systolic blood pressure was 160 or above, and would call the provider multiple times if the systolic blood pressure was in the 190s. On 10/26/23 at 11:05 A.M., a "Change in a Resident's Condition or Status" policy, revised October 2010, indicated "The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition ... A "significant change" of condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff ... The Nurse Supervisor/Charge Nurse will notify the resident's responsible party of family when...there is a significant change in the resident's physical, mental, or psychosocial			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	status". This citation relates to Complaint IN00420287. 3.1-5(a)(2)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 1 of 1 residents reviewed for dialysis. (Resident 50) Finding includes: On 10/25/23 at 8:55 A.M., Resident 50's clinical record was reviewed. Diagnosis included, but was not limited to, end stage renal disease (ESRD). The most recent quarterly MDS (Minimum Data Set) Assessment, dated 7/29/23, indicated Resident 50 had no cognitive impairment and was not receiving dialysis. Current physician orders included, but were not limited to: [Name of Dialysis Center] Pick up time 3:30am Special Instructions: Early Breakfast Tray Once A Day on Mon, Wed, Fri, dated 09/13/2023 Discontinued physician orders included, but were not limited to: [Name of Dialysis Center] Pick up time 3:30am by [name of transportation company] Special Instructions: Early Breakfast Tray Once A Day on Mon, Wed, Fri, dated 10/24/2022 to 09/13/2023	F 0641	**F-Tag 641: Accuracy of Assessments** The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. The MDS for Resident 50 was corrected on the day the coding error was identified. The facility will identify other residents that may potentially be affected by this practice. Current residents have the potential to be affected by this alleged practice. Dialysis residents who reside at Solarbron Terrace have been audited to ensure MDS coding is correct. The MDS of residents have been audited to ensure comprehensive assessments are coded and completed accurately. The facility will put into place the following systematic changes to ensure that the practice does not recur. MDS staff will be re-educated on proper coding of resident assessments.	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A current hemodialysis care plan, dated 6/1/21, indicated Resident receives Hemodialysis due to ESRD and is at risk for complications. Post dialysis assessment forms were completed on 7/17/23, 7/19/23, 7/21/23, 7/26/23. [Name of dialysis center] forms were completed on 7/17/23, 7/19/23, 7/21/23, 7/26/23, 7/28/23. On 10/27/23 at 2:06 P.M., the MDS Coordinator indicated the resident did receive dialysis during the reporting period and should have been coded in section O. At that time, she indicated the facility used the RAI (Resident Assessment Instrument) User's Manual as their policy on coding the MDS Assessment. The RAI Manual indicated "Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item".		The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit 5 random residents 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months to ensure resident assessment are completed accurately. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a sit to stand	F 0689	**F-Tag 689: Free of Accident Hazards/Supervision/Devices**	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	lift was used according to facility policy for 1 of 6 residents reviewed for falls. This deficient practice led to a fall with a fracture requiring hospitalization and surgical repair. (Resident M) Finding includes: During a confidential interview on 10/24/23 at 11:13 A.M., it was indicated that a CNA (Certified Nurse Aide) dropped Resident M while using a sit to stand lift resulting in a broken ankle. On 10/25/23 at 10:19 A.M., Resident M's clinical record was reviewed. Diagnosis included, but was not limited to, unspecified fracture of shaft of right femur. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 9/25/23, indicated Resident M had moderate cognitive impairment, had no falls since the prior assessment, and required assistance of 2 staff for bed mobility, transfers, toileting, and bathing. The quarterly MDS Assessment completed prior to the resident's fall, dated 1/17/23, indicated the resident had moderate cognitive impairment, had no falls since the prior assessment, and required extensive assistance of 2 staff for bed mobility, transfers, toileting, and bathing. A current falls care plan, dated 3/4/23, indicated the resident was at risk for falls with injury due to her impaired mobility, weakness, poor activity tolerance, and repair of right femur fracture. A previous falls care plan, dated 1/27/23, indicated the resident was at risk for falling and fall related injuries related to weakness, infection, and incontinence.		The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident M's fracture is healing, and her current fall interventions have been reviewed. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents fall interventions have been audited to ensure fall interventions are implemented and appropriate. The facility will put into place the following systematic changes to ensure that the practice does not recur. Nursing staff will be re-educated on our fall policy, sit to stand lift policy, and implementing interventions. The facility will monitor the corrective action by implementing the following measure. The Director of Nursing or designee will audit fall interventions at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 6 months to ensure fall interventions are implemented. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	A current behavioral care plan, dated 3/4/23, indicated the resident was noncompliant with care - selective as to which staff she would allow to work with; did not want to use sit to stand lift, but needed 2 staff minimum for safe transfers. A previous behavioral care plan, dated 1/27/23, indicated the resident was noncompliant with care - selective as to which staff she would allow to work with; did not want to use sit to stand lift, but needed 2 staff minimum for safe transfers. A Post Fall Assessment indicated Resident M sustained a witnessed fall on 2/28/23 at 5:15 P.M. while being transferred using a sit to stand lift. Progress notes related to the fall included, but were not limited to: 2/28/2023 6:18 P.M. "Resident was on the sit to stand lift, weight became unbearable for staff. Staff lowered Resident to the floor, obtained the Hoyer lift administered pad and lifted resident to her recliner. No injury had occurred during transfers. Resident stated "This was not bad". Refer for PT (physical therapy) to eval (evaluate) and treat". 3/01/2023 9:49 A.M. "Resident c/o (complained of) pain 10/10 (10 on a pain scale of 1 to 10) to RLE (right lower extremity). Resident has bruise to right outer ankle. Notified [name of provider]. Order received for STAT (immediate) x-ray to bruised area RLE". 3/01/2023 3:02 P.M. "Said nurse (writer) received Order for resident to be sent to [name of hospital] to eval and treat. Report giving [sic] to [name of nurse], called [name of emergency contact] to make aware. Management notified".		Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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

3/04/2023 1:00 P.M. "Resident arrived via [name of company] transport van. She is on a Hoyer sling and in her wheelchair. She has an immbolizer [sic] on her right leg. She was transferred via Hoyer lift with assist of two staff from her chair to her bed. Sling was then removed and resident was positioned in her bed and pericare [sic] performed. She is now clean and dry. Skin assessment completed. Mild redness on buttocks from moisture contact. She has a [name of company] pain pump in her right leg set on 8. To disgard [sic] when empty".
Resident M underwent surgery on 3/2/23 where a retrograde intramedullary nailing to the right femur was performed.

3/08/2023 8:39 A.M. "IDT (Interdisciplinary Team) Note: Resident had incident on 2/28/23 where she was lowered to the floor due to weakness and unable to bear weight while being transferred in the sit to stand lift. Resident had increased pain to RLE the next morning, x-rays obtained and resident transferred to hospital for eval and tx (treatment). Resident returned to facility on 3/4/23. Care plan reviewed and updated upon return. Resident care profile updated to include Hoyer lift for transfers".

A Post Fall Event Assessment, dated 3/2/23, indicated the fall on 2/28/23 was witnessed by [name of CNA 23] while being transferred from one surface to another using a sit and stand lift. The assessment indicated the resident said "That girl swung me around and I told her to stop she was hurting my leg was hurting". Physical assessment showed new swelling, redness, and pain with active/passive ROM (range of motion).

During an interview on 10/26/23 at 9:30 A.M., CCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(Corporate Clinical Support) 4 indicated two staff were needed to operate the sit to stand lift. At that time, she indicated she was unable to confirm details of the event including how many staff were operating the sit to stand lift because the staff involved no longer worked at the facility. During an interview on 10/27/23 at 1:30 P.M., CCS 4 indicated a representative from [name of company] came to the facility annually and provided an in-service on the sit to stand equipment. Following the in-service, staff completed a skills validation. At that time, she indicated after Resident M's fall, staff were provided additional education on the operation of the lift. A "Transferring a Resident with a Hoyer/Mechanical Lift Skills Validation" checklist was provided on 10/27/23 at 3:30 P.M. and indicated "Two staff members are required for a mechanical lift". On 10/25/23 at 9:22 A.M. during a random observation, CNA 11 was observed transferring a resident from her wheelchair to the toilet and back to her wheelchair using a sit to stand lift by herself. On 10/27/23 at 2:48 P.M., CNA 11's Job Specific Orientation report was provided and indicated CNA 11 had received training on operating a lift on 9/19/23. On 10/26/23 at 11:05 A.M., a "Transferring a Resident with a Stand Up Lift Skills Validations" policy, undated, was provided and indicated "Two staff members are required for a mechanical lift".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility	F 0690	**F-Tag 690: Bowel/Bladder**	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	failed to ensure appropriate treatment was provided to prevent recurring Urinary Tract Infections (UTIs) in 1 of 4 residents reviewed for UTIs (Resident M). Finding includes: On 10/25/23 at 10:19 A.M., Resident M's clinical record was reviewed. Diagnoses included, but were not limited to, urinary tract infection and personal history of urinary tract infections. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 9/25/23, indicated Resident M had moderate cognitive impairment, was always incontinent of urine and frequently incontinent of bowel, and required extensive assistance of 2 staff for bed mobility, transfers, toileting, and bathing. A current UTI care plan, dated 3/4/23, indicated the resident had a history of recurrent abnormal urinalysis/UTI and often required antibiotic therapy for treatment. The clinical record indicated Resident M had 8 UTIs since January 2023. UTI 1 A progress note, dated 2/20/2023 at 6:52 P.M., indicated "Received call from [name of provider] with new orders: UA (urinalysis) micro C+S (culture and sensitivity) if indicated, cath (catheter) for specimen. Obtain BMP (basic metabolic panel) in AM (morning) 2/21/23". A urine culture lab report, dated 2/26/23, indicated the specimen was obtained via in and out cath and "multiple potential uropathogens present in the specimen indicate probable contamination. A		**Incontinence** The corrective actions to be accomplished for those residents found to have been affected by the practice. Residents M's UTI has resolved and suffered no ill effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron Terrace have the potential to be affected by this alleged deficient practice. Residents residing at Solarbron Terrace with a dx of UTI have been audited to ensure appropriate treatment is provided. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses have been re-educated on appropriate treatment of UTIs. The facility will monitor the corrective action by implementing the following measure. DON/Designee will review 3 random residents per week for four (4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly 3 additional months to ensure appropriate treatment is provided for UTIs. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	recollect CCMS (clean catch midstream) or in and out catheter specimen is recommended". The clinical record lacked documentation of a recollection. An order, dated 2/27/23, indicated ceftriaxone (an antibiotic medication) recon (reconstituted) soln (solution); 1 gram; injection Special Instructions: Reconstitute w/ (with) lidocaine, adm (administer) once daily (IM) (intramuscular) x (times) 5 days. Dx (diagnosis): Urinary Tract Infection UTI 2 A progress note, dated 3/12/23 at 7:54 P.M., indicated "[name of provider] called with new orders for UA with micro by in and out cath. CBC (complete blood count), Renal profile". A progress note, dated 3/14/2023 at 10:49 A.M., indicated "Received orders from [name of provider] to d/c (discontinue) order for UA. Start Keflex 500mg bid (twice a day) x 5 days for UTI. Continue checking vitals q (every) shift and report any change of condition". A progress note, dated 3/17/23 at 2:58 P.M., indicated "Resident is on ATB (antibiotics) for possible UTI. The ATB does not meet McGreer Criteria. Nsg (Nursing) to continue to observe and report unusual findings to MD/NP (medical doctor/nurse practitioner) as indicated". A progress note, dated 3/19/23 at 8:34 P.M., indicated "Received orders per [name of provider] to continue Keflex as ordered, will review C+S when results are finished". A lab report showing results of the culture and sensitivity was requested and not provided.		adjusting the frequency of audits. Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	An order, dated 3/14/23 with a stop date of 3/19/23, cephalexin (an antibiotic medicine) capsule; 500 mg (milligrams); amt (amount): 1 capsule; oral Twice A Day Dx: Urinary Tract Infection UTI 3 A progress note, dated 4/18/23 at 12:38 P.M., indicated "[name of lab] notified to retrieve Stat (immediate) UA. Resident states she is experiencing general malaise. Pale in color. Fluids encouraged. Urine dark yellow and cloudy. Call pendant in place. Care continues". A progress note, dated 4/18/2023 at 12:51 P.M., indicated "New order per [name of provider]: administer Rocephin 1 g (gram) dose at this time". A progress note, dated 4/19/23 at 9:15 A.M., indicated "ATB review: resident received IM Rocephin secondary to abnormal lab; Leukocytosis with WBC (white blood count) - 12.1. UA C&S ordered and obtained via in/out cath. UA positive, awaiting C&S results". A physician's note, dated 4/19/23, indicated "She was given Rocephin 1 gram IM yesterday and are awaiting C and S results. Just received report indicating multiple bacteria, likely contaminated. She had a similar C and S on 4/5/23. Given her WBC being elevated and her change in mental status. Will treat". A urine culture lab report, dated 4/18/23, indicated a specimen was obtained via in and out cath and "multiple bacterial morphotypes present, indicating a contaminated specimen". An order, dated 4/18/23, ceftriaxone recon soln; 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	gram; amt: 1 gram; injection Once Dx: other general symptoms and signs An order, dated 4/20/23 with a stop date of 4/24/23, cefuroxime axetil (an antibiotic medication) tablet; 500 mg; amt: 500 mg; oral Twice A Day Dx: Urinary Tract Infection UTI 4 A progress note, dated 5/1/23, indicated "Resident c/o dysuria, urgency, w/ (with) urination. Hallucinations/altered mental status noted at time of UA collection via in and out cath. Urine foul smelling and cloudy in appearance. [Name of lab] notified to retrieve UA as ordered". A progress note, dated 5/02/2023 at 11:08 P.M., indicated "Ceftriaxone IM x 1 dose administered today per evening shift nurse as ordered. Urine culture remains pending at this time". A progress note, dated 5/03/2023 at 12:59 P.M., indicated "New Order received new order for resident to receive Rocephin 1gm x4 q 24hr (hours) beginning 5/3 to 5/6. [name of emergency contact] contacted". A progress note, dated 5/08/2023 at 12:06 P.M., indicated "Resident continues w/hallucinations and confusion. Rocephin injections completed as ordered on 5/6/23. Resident states she is not sure if she is having any urinary symptoms. [name of provider] notified, medication review requested. Care continues". A urine culture lab report, dated 5/1/23, indicated the specimen was obtained via in and out cath and "multiple bacterial morphotypes present, indicating a contaminated specimen".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	An order, dated 5/2/23, ceftriaxone recon soln; 1 gram; amt: IM; injection Once Dx: anemia in chronic kidney disease An order, dated 5/3/23 with a stop date of 5/6/23, ceftriaxone recon soln; 1 gram; amt: IM; injection Once a day Dx: personal history of urinary tract infections On 5/10/23 Resident M was placed on prophylactic antibiotics. An order, dated 5/11/23 with a stop date of 5/15/23, indicated Macrobid (an antibiotic medication) (nitrofurantoin monohyd/m-cryst) capsule; 100 mg; amt: 100 mg; oral Twice A Day An order, dated 5/16/23 with a stop date of 6/15/23, indicated Macrobid (nitrofurantoin monohyd/m-cryst) capsule; 100 mg; amt: 100 mg; oral Once UTI 5 A progress note, dated 6/2/23 at 1:19 P.M., indicated "Nursing staff reports resident continues to have behaviors/hallucinations. Resident is currently taking a prophylactic antibiotic due to recurrent UTI; Macrobid 100mg daily, started 5/16 through 6/15. This writer requested [name of provider] to review her meds for possible side effects that could be causing these behaviors. Awaiting response". A progress note, dated 6/07/2023 at 6:17 P.M., indicated "Urine culture and sensitivity reviewed by NP. Results indicate a contaminated specimen. No new orders." A urine culture lab report, dated 6/7/23, indicated the specimen was obtained via CCMS and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	"multiple bacterial morphotypes present, indicating a contaminated specimen". UTI 6 A progress note, dated 6/26/23 at 2:06 P.M., indicated "[name of provider] gave orders for UA r/t (related to) c/o burning while urinating. Will monitor". A progress note, dated 6/29/23 at 12:53 A.M., indicated "call into [name of provider] R/T urine culture results stating that culture was contaminated. Awaiting orders". A progress note, dated 6/29/2023 10:44 A.M., indicated "[name of provider] call with N.O. (new order) Cefdinir 300 mg 1 cap PO (by mouth) BID x 5 days r/t UTI symptoms". A urine culture lab report, dated 6/26/23, indicated the specimen was obtained via in and out cath and "multiple bacterial morphotypes present, indicating a contaminated specimen". An order, dated 6/29/23 with a stop date of 7/3/23, cefdinir (an antibiotic medication) capsule; 300 mg; amt: 300 mg; oral Twice A Day Dx: Urinary tract infection UTI 7 A progress note, dated 8/16/23 at 2:47 P.M., indicated "Call out to triage concerning resident with c/o painful urination and foul smelling urine. New orders received for UA with C&S if indicated via in/out cath. CBC and renal profile. Orders entered into computer". A physicians note, dated 8/18/23, indicated "Despite using in and out cath for specimens, facility has been unsuccessful at getting a sample			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	that can isolate a bacteria that sensitivity can be conducted. Samples show multiple bacteria. She does report dysuria, "burns bad" when she urinates. She does not have redness that would lead to burning from urine on the skin. Will go ahead and treat short term antibiotics". A urine culture lab report, dated 8/16/23, indicated the specimen was obtained via in and out cath and "multiple bacterial morphotypes present, indicating a contaminated specimen". An order, dated 8/19/23 with a stop date of 8/23/23, ceftin tablet; 500 mg; amt: 500 mg; oral Twice A Day Dx: Urinary tract infection UTI 8 A physicians note, dated 9/15/23, indicated Resident M was "seen for follow-up regarding visit last week for her report of burning with urination, reported she "trembled" when urinating due to the pain. Orders were given for good peri-care routinely, in and out cath for UA, C and S, and VS (vital signs) monitoring. Review of her record, and epic noted these orders were given by triage to a nurse at the facility, but do not see where they were noted in EMR (electronic medical record), or carried out. She continues to say she burns/has pain whenever she urinates, or has a bowel movement. She has not had a fever, chills, increased confusion, suprapubic tenderness. Her urine does have a strong odor, but this is not new. She always says she has a UTI. He last several UAs have been positive, but grew multiple bacteria so were thought to be contaminated despite being in and out cath specimens. Will try a couple days of pyridium, and continue to monitor for signs of active infection. She is mildly reddened around her labia, urethra. Her confusion is baseline".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	An order, dated 9/16/23 with a stop date of 9/17/23, Pyridium (an analgesic medication) (phenazopyridine) tablet; 100 mg; amt: 100 mg; oral Three Times A Day Dx: pain On 10/27/23 at 1:30 P.M., Corporate Clinical Support (CCS) 4 indicated the provider must give an order for a culture and sensitivity recheck to occur if specimen was contaminated. At that time, she indicated the facility's Infection Preventionist (IP) was a corporate employee who was filling in for the previous IP who was not in the facility and a new IP would be starting employment on November 7th. She indicated antibiotic use was reviewed on a monthly basis and as needed. On 10/31/23 at 1:06 P.M., the Administrator indicated the facility used McGreer criteria to monitor antibiotic use; however, the provider sometimes would override the recommendation. At that time, he indicated antibiotic use was discussed in the facility's morning meeting, but was unable to recall or provide any documentation of the discussion regarding Resident M's antibiotic use. On 10/27/23 at 3:30 P.M., an "Infection Prevention and Control Program" policy, dated 6/6/19, was provided and indicated "Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. Antibiotic usage is evaluated, and practitioners are provided feedback on reviews". 3.1-41(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure residents received the necessary respiratory care and services in accordance with the professional standards of practice for 5 of 6 residents reviewed for respiratory care. The facility failed to follow physician oxygenation orders and date oxygen tubing and humidification bottles. (Resident 13, Resident 22, Resident 31, Resident 44, Resident 45) Findings include: 1. On 10/25/23 at 10:15 A.M., Resident 13 was observed lying in bed with oxygen on per nasal cannula (nc) at 2 lpm (liters per minute). The oxygen tubing was dated 9/11/23. The humidification bottle was not dated. On 10/27/23 at 9:00 A.M., Resident 13 was observed sitting up in bed eating breakfast with oxygen on at 2 lpm per nc. The oxygen tubing was dated 9/11/23, and there was no date on the humidification bottle. On 10/30/23 at 10:28 A.M., Resident 13 was observed wearing oxygen at 2 lpm per nc. The	F 0695	**F-Tag 695: Respiratory Care** The corrective actions to be accomplished for those residents found to have been affected by the practice. The date of the oxygen tubing and humidification bottles for Residents 13, 22, 31, 44, and 45 were corrected on the day the error was identified. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents with oxygen tubing and humidification bottles have been audited to ensure the proper date is labeled on the oxygen tubing and humidification bottles. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses/QMAs will be re-educated on respiratory care policy.	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	oxygen tubing was not dated and the humidification bottle was dated 10/30/23. On 10/26/23 at 12:50 P.M., Resident 13's clinical records were reviewed. Resident 13 was admitted on 2/8/23. Diagnoses included, but were not limited to, acute on chronic systolic (congestive) heart failure and Alzheimer's disease. The most recent significant change in condition MDS (Minimum Data Set) Assessment, dated 9/18/23, indicated Resident 13 was unable to complete the Brief Interview for Mental Status, required extensive assistance of two for bed mobility and transfer, extensive assistance of one for eating and toilet use, and total dependence for bathing. Current physician's orders included, but were not limited to, the following: Okay for Hospice to continue to treat resident, dated 9/5/2023 Oxygen per nasal cannula at 2-4 liters continuous for comfort prn (as needed) Twice A Day, days 6:00 A.M. - 6:00 P.M., nights 6:00 P.M. - 6:00 A.M., dated 9/5/2023 Lacked an order to change and date oxygen tubing, humidifier bottle and nebulizer tubing A current care plan for oxygen therapy, initiated 10/23/23, included, but was not limited to the following intervention: Administer oxygen as ordered. Start Date 10/23/2023. 2. On 10/25/23 at 10:19 A.M., Resident 22 was observed sitting on the side of the bed eating breakfast, Oxygen on at 2 lpm per nc. The humidification bottle was dated 10/23, the oxygen tubing was not dated.		The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit residents with oxygen tubing and humidification bottles at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure fall interventions are implemented. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 10/27/23 at 10:40 A.M., Resident 22 was observed sitting on the side of the bed talking on the phone. Oxygen on at 2 lpm per nc. The oxygen tubing was not dated and the humidification bottle was dated 10/23. On 10/25/23 at 2:22 P.M., Resident 22's clinical records were reviewed. Resident 22 was admitted on 6/10/20. Diagnoses included, but were not limited to, acute on chronic respiratory failure with hypercapnia; acute on chronic respiratory failure with hypoxia, emphysema and cor pulmonale. The most recent quarterly MDS Assessment, dated 9/28/23, indicated Resident 22 had intact cognition, required extensive assistance of two for bed mobility and toilet use, total dependence of two for transfers and bathing. Current physician's orders included, but were not limited to, the following: Oxygen per nasal cannula at 1-3 liters to maintain sats (saturations) > (greater than) 88% but < (less than) 93% check pulse oximetry every shift. Twice A Day Upon Rising 6:00 A.M. - 6:00 P.M., Before Bedtime 6:00 P.M. - 6:00 A.M., dated 10/20/23 Change and date oxygen tubing, humidifier bottle and nebulizer tubing. Special Instructions: Change weekly and PRN Once A Day on Sunday 11:00 P.M. - 7:00 A.M., dated 10/20/23 Change/Clean oxygen concentrator filters weekly. Once A Day on Sunday 11:00 P.M. - 7:00 A.M., dated 10/20/23 A current care plan for oxygen therapy, initiated 4/12/23, included, but was not limited to the following intervention: Administer oxygen as ordered. Start date: 4/12/23.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	On 10/31/23 at 11:55 A.M., Resident 22's TAR (Treatment Administration Record) was reviewed for change and date oxygen tubing, humidifier bottle and nebulizer tubing Order Once A Day on Sunday Frequency Change weekly and PRN 10/20/2023 - Open Ended x marked on 10/8/23, 10/15/23, left blank on 10/22/23 and initialed on 10/29/23 3. On 10/25/23 at 10:59 A.M., Resident 45 was observed lying in bed, hob (head of bed) elevated, oxygen on at 2 lpm per nc. There was no date on humidification bottle or oxygen tubing. On 10/27/23 at 9:18 A.M., Resident 45 was observed lying in bed watching TV, call light in bed. Oxygen on at 2 lpm per nc with no date on tubing or humidification bottle. On 10/26/23 at 11:07 A.M., Resident 45's clinical records were reviewed. Resident 45 was admitted on 7/19/21. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction, affected left non-dominant side, psychotic disorder with delusions due to known physiological condition, major depressive disorder, recurrent, severe with psychotic symptoms, generalized anxiety disorder, and type 2 diabetes mellitus without complications. The most recent quarterly MDS Assessment, dated 8/23/23, indicated Resident 45 had severe cognitive impairment, required extensive assistance of two for bed mobility, extensive assistance of one for eating, total dependence of two for toilet use and total dependence of one for bathing, oxygen was not marked.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Current physician's orders included, but were not limited to, the following: May keep oxygen at 2 to 4 liters per nasal cannula to keep pulse oximetry >90%, Every Shift - PRN, dated 7/5/2023 Oxygen per nasal cannula 2 lpm at night and naps Special Instructions: encouraged use while sleeping Every Shift 07:00 A.M. - 3:00 P.M., 3:00 P.M. - 11:00 P.M., 11:00 P.M. - 7:00 A.M., dated 3/29/2023 Change and date oxygen tubing, humidifier bottle Special Instructions: Change weekly and PRN Once A Day on Sunday 11:00 P.M. - 7:00 A.M., dated 3/24/2023 A current care plan for oxygen therapy, initiated 3/23/2023, included, but was not limited to the following intervention: Administer oxygen as ordered, encourage compliance. See MAR (Medication Administration Record) for current liters and route. Start Date: 3/23/2023. 4. On 10/24/23 at 11:25 A.M., Resident 31's nebulizer machine tubing was observed undated and lacked an initialed label. On 10/26/22 at 9:06 A.M., Resident 31's nebulizer machine was observed undated and lacked an initialed label. On 10/27/23 at 11:05 A.M., Resident 31's nebulizer machine was observed undated and lacked an initialed label. On 10/25/23 at 8:20 A.M., Resident 33's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD) and chronic respiratory failure with hypoxia. The current quarterly MDS Assessment, dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	6/2/23, indicated Resident 33 was cognitively intact and needed extensive assist with the aid of 2 for mobility, transferring, and dressing. Current physician orders included, but were not limited to: Oxygen 2-4 L/min (Liters per minute) to keep O2 (oxygen) > (greater than) 90% on room air as needed, dated 6/26/23. Ipratropium-albuterol solution for nebulization 0.5 mg -3 mg (milligrams) (2.5 mg base)/ 3 ml(milliliters) use 1 container for inhalation every 8 hours: 12:00 A.M. 8:00 A.M. and 4:00 P.M., dated 6/13/23. Lacked a current order for changing oxygen and nebulizer tubing. Current care plans, included but were not limited to: Resident is at risk for impaired gas exchange and requires oxygen therapy. Interventions included, but were not limited to, administer O2 as ordered, dated 10/23/23. Resident has potential for respiratory distress related to COPD. Interventions included, but were not limited to, administer medications per MD (Medical Doctor) order dated 6/02/23. The care plans lacked interventions to change O2 or nebulizer tubing. The MAR (Medication Administration Record) and TAR (Treatment Administration Record) for October 2023 lacked documentation. 5. On 10/24/23 at 10:39 A.M., Resident 44's tracheostomy collar tubing was observed undated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and not initialed. The portable oxygen tank was on at 2 liters and not connected to the resident and was not labeled with a date or initials. The nebulizer breathing treatment lacked a label of date of change with initials. There was no red warning "Oxygen in Use" sign on the door. On 10/25/23 at 1:07 P.M., Resident 44's tracheostomy collar tubing was observed undated and not initialed. There was no oxygen in use warning sign on the door. On 10/27/23 at 10:42 A.M., Resident 44's portable tank tubing was observed not dated or initialed. The tracheostomy oxygen collar's tubing that was connected to the O2 tank was also not labeled or initialed. On 10/25/23 at 2:17 P.M., Resident 44's clinical record was reviewed. Diagnoses included, but were not limited to, pneumonia, acute and chronic respiratory with hypoxia, and tracheostomy. The current quarterly MDS Assessment, dated 10/5/23, indicated that the resident was cognitively intact. Resident 44 was independent in mobility, but needed supervision with bathing and toileting. Current physician orders included, but were not limited to: Change and date oxygen tubing, humidifier bottle and nebulizer tubing: change weekly and PRN once a day on Sunday, dated on 9/18/23. Change trach collar: change weekly and PRN (as needed) once a day on Wednesday, dated on 9/18/23. Check oxygen tank and replace as indicated: 4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	liters per minute will last 5 days when full, dated 9/19/23. Current care plans included but were not limited to: Resident is a risk for respiratory complications/infections/failure secondary to tracheostomy placement due to prior laryngeal cancer. Interventions included, but were not limited to providing nebulizer treatments and oxygen therapy as ordered, dated 7/1/23. During an interview on 10/27/23 at 9:05 A.M., RN (Registered Nurse) 7, indicated tubing for oxygen and humidification bottles were changed on Sunday nights. Some residents used more humidification than others, so those bottles got changed more often. Oxygen tubing and humidification bottles should be dated so everyone knows when they were changed. During an interview on 10/26/23 at 8:52 A.M., the ADON (Assistant Director of Nursing) indicated the tubing for the oxygen and nebulizers were changed weekly and should be labeled. A current, undated "Oxygen Administration" policy was provided on 10/27/23 at 1:30 P.M., by the Corporate Clinical Records Nurse. The policy indicated " the purpose was to provide guidelines for safe oxygen administration...Steps in Procedure...2. place an "Oxygen in Use" sign on the outside of the room entrance door...". A current, undated "Oxygen Administration Skills Validations List" was provided on 10/27/23 at 1:32 P.M., by the Corporate Clinical Records Nurse. The skills list indicated staff was to ".... date and initial tape and attach to tubing...".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3.1-47(a)(4) 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets contained the correct information daily for 7 of 7 days reviewed during the survey. (10/23/23, 10/24/23,10/25/23,10/26/23, 10/27/23, 10/30/23, 10/31/23), Finding includes: On 10/23/23 at 9:00 A.M., the Daily Staffing Sheet was observed on the wall by the receptionist desk dated 10/23/23. The sheet included, but was not limited to, the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse), CNA (Certified Nursing Assistant), and QMA (Qualified Medicine Aide). Total number of RN, LPN, CNA, and QMA for each shift Total hours of RN, LPN, CNA, and QMA for each shift The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. On 10/31/23 at 9:18 A.M., the Scheduler provided Daily Staffing Sheets dated 10/23/23, 10/24/23. 10/25/23, 10/26/23,10/27/23,10/30/23 and 10/31/23. The sheets included, but were not limited to, the following information: Shift hours for RN, LPN, CNA, and QMA. Total number of RN, LPN, CNA, and QMA for each shift. Total hours of RN, LPN, CNA, and QMA for each shift. The sheets did not specify which actual hours	F 0732	**F-Tag 732: Posted Staffing Information** The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. Current residents have the potential to be affected by this alleged deficient practice. Daily staffing information has been updated and posted. The facility will put into place the following systematic changes to ensure that the practice does not recur. The current scheduler will be educated on ensuring daily staffing information to be updated and posted daily at the main entrance and the nursing units. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit daily staffing information posting 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months to ensure daily staffing information is accurate and posted daily. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100%	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. During an interview on 10/31/23 at 9:16 A.M., the Scheduler indicated she never made a distinct separation between the hours worked by the staff because they worked a variable of 8 and 12 hour shifts. On 10/31/23 at 10:24 A.M., the DON (Director of Nursing) provided a current "Staffing Policy" dated 2/6/2019. The policy indicated "direct care staffing information is posted each day pursuant to the CMS (Center for Medicare and Medicaid) Requirements of Participation...".		compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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. Based on observation, interview, and record review, the facility failed to ensure proper storage of medications for 3 of 3 medication storage rooms observed. Refrigerator temperature logs were not completely filled out in the medication rooms. (South Hall, North Hall, West Hall) Findings include: 1. On 10/30/23 at 12:10 P.M., the West Hall medication room was observed. The refrigerator temperature log for October 2023 lacked temperatures on the following dates: 10/2/23 10/7/23 10/8/23 10/14/23 10/15/23 10/24/23 10/25/23 10/26/23 10/27/23 10/28/23 10/29/23 At that time, LPN (Licensed Practical Nurse) 9 indicated night shift was responsible for filling out the temperature logs, and they should be filled out daily. 2. On 10/30/23 at 12:24 P.M., the North Hall medication room was observed. The refrigerator temperature log for October 2023 lacked temperatures on the following dates: 10/26/23	F 0761	**F-Tag 761: Labeling of Drugs and Biologicals** The corrective actions to be accomplished for those residents found to have been affected by the practice. The three medication administration refrigerators located on the West, North, and South Units observed with blank temperature logs during the survey were corrected the day the issue was identified. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. The temperature logs inside the medication administration refrigerators on the nursing units have been audited to ensure temperatures are being logged. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses and QMAs will be re-educated on recording temperatures on the temperature log inside of the medication administration refrigerators. The facility will monitor the	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	10/27/23 10/28/23 10/29/23 At that time, RN (Registered Nurse) 3 indicated night shift was responsible for filling out the temperature logs, and the gaps were probably due to agency staff working on those dates. 3. On 10/30/23 at 12:30 P.M., the South Hall medication room was observed. The refrigerator temperature log for October 2023 lacked temperatures on the following dates: 10/27/23 10/28/23 10/29/23 At that time, RN 7 indicated night shift filled out the temperature logs. On 10/30/23 at 1:03 P.M., the Administrator provided a current non-dated Drug Storage policy that indicated "Medications will be stored at the facility in a manner consistent with manufacturers' guidelines, such as proper temperature ... Medications must be stored under appropriate temperatures ... Refrigeration: 36 [degrees Fahrenheit] - 46 [degrees Fahrenheit] ...". 3.1-25(m)		corrective action by implementing the following measure. Director of Nursing or designee will audit medication administration refrigerator temperature logs at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure temperature logs are being completed. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 trays tested for temperature. Finding includes: On 10/30/23 at 12:30 P.M., a test tray was obtained. The following temperatures were indicated: Fish -101.6 degrees Fahrenheit (F) Beets -111 degrees F Fruit cocktail - 65.7 degrees F On 10/24/23 at 11:09 A.M., Resident M indicated the food was lukewarm from hallway trays. During an interview on 10/31/23 at 10:06 A.M., the Dietary Manager indicated when food leaves the holding table to be put on a tray to go out to the residents the temperature was 135 for meats, cooked vegetables at 135, and fruit cocktail 41 or lower. During an interview on 10/31/23 at 10:35 A.M., the Dietary Manager indicated food was expected to be palatable when it arrived to the residents. On 10/31/23 at 10:35 A.M., the Dietary Manager provided a current Food Preparation and Safety policy, dated 2020, which indicated "Trays are delivered promptly to ensure that food is served at a preferable temperature and to preserve the quality of the food. Tray delivery time is planned for the most efficient use of the staff's time to allow quick and accurate delivery of meals to the dining room table or bedside. This is done to	F 0804	**F-Tag 804: Nutritive Value/Appearance, Palatable/Pref/Temperature** The corrective actions to be accomplished for those residents found to have been affected by the practice. No residents suffered adverse effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. The DFS/designee will audit food temperatures during mealtimes to ensure food is served at an appetizing and appropriate temperature. The facility will put into place the following systematic changes to ensure that the practice does not recur. Dietary staff and nursing staff will be re-educated on food temperatures and delivering the trays timely to residents. The facility will monitor the corrective action by implementing the following measures The DFS/designee will monitor/audit hall tray food temperatures, and interview 5 residents weekly for 4 weeks, then biweekly x 8 weeks, then monthly x 3 months to ensure food is served at appropriate and appetizing temperatures. The results of these audits will be presented to the	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	ensure acceptable temperatures and increase resident's satisfaction ... Hot foods will leave the kitchen at 135 degrees F or above and cold foods will be at 41 degrees F or below...". 3.1-21(a)(2)		monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment for residents, staff, and public for 1 of 4 halls observations on 3 locations observations of the East Hall (East Hallway). Finding includes: On 10/24/23 at 9:00 A.M., the East Hallway was observed smelling musty. On 10/26/23 at 11:25 A.M., the East Hallway was observed smelling musty. On 10/30/23 at 12:00 P.M., the East Hallway was observed smelling musty. During an interview on 10/31/23 at 10:19 A.M., the Maintenance Supervisor indicated the carpet hall ways were cleaned on a daily schedule. The schedule had been hard to keep the past 2 weeks because the 36 inch walk behind carpet cleaner was in the shop. The staff used a 12 inch drag behind spot cleaner during that time. The walk behind carpet cleaner used a heavy traffic cleaner solution and sprayed the carpets with the cleaner.	F 0921	**F-Tag 921: Safe/Functional/Sanitary/Comfortable Environment** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The hallway on the East Hallway observed smelling musty was addressed on the day the issue was identified. No ill effects were noted from this alleged deficient practice. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Carpeted and hallways areas were inspected, and an action plan has been implemented. What measures will be put	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	The drag behind spot cleaner only used hot water to clean. On 10/31/23 at 10:45 A.M., the DON (Director of Nursing) provided a current undated policy "Housekeeping In-service". This policy indicated that "shampooing... should be done at least once a year, more often in heavy traffic, or in odor conditions...". 3.1-19(f)		into place and what systematic changes will be made to ensure that the deficient practice does not recur? The administrator or designee will re-educate housekeeping and maintenance staff on the cleaning and disinfection of environment surfaces policy and will re-educate staff on putting in work orders for carpeted areas needing to be cleaned. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; the Administrator/designee will monitor/audit carpeted areas to ensure the areas are clean and odor-free weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure the carpeted areas are clean and odor-free. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.	R 0000	**Solarbron Terrace** **Annual SNF & Residential Care**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Survey dates: October 23, 24, 25, 26, 27, 30 & 31, 2023 Facility number: 010930 Residential Census: 30 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.		**Relicensure Survey** **October 23-27, 30-31 2023** **SNF - Plan of Correction** The plan of correction serves as Solarbron Terrace's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Solarbron Terrace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. **F-Tag 554: Resident Self-Admin Meds-Clinically Appropriate** The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. Resident 69 self- administration assessment is completed. The facility will identify other residents that may potentially be affected by this practice. Current residents have the potential to be affected by this alleged deficient practice. Current residents that wish to self-administer medications have been audited to ensure self -administration	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			assessments are completed. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses and IDT will be re-educated on self-administration policy. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit 5 random residents 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months to ensure self-administration assessment are completed on those who wish to self-administer. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 580: Notice of Changes** The corrective actions to be accomplished for those residents found to have been affected by the practice. Notification of changes to Residents F was discharged from the facility and Resident M's family has been notified. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			have the potential to be affected by this alleged deficient practice. Residents with changes have been audited to ensure notification was made to families and the physician. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses will be re-educated on making notification to families and the physicians of residents when resident conditions change. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit residents with changes to ensure notification is made to families and the physician at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure notification to families and the physician is made. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 641: Accuracy of**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Assessments The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. The MDS for Resident 50 was corrected on the day the coding error was identified. The facility will identify other residents that may potentially be affected by this practice. Current residents have the potential to be affected by this alleged practice. Dialysis residents who reside at Solarbron Terrace have been audited to ensure MDS coding is correct. The MDS of residents have been audited to ensure comprehensive assessments are coded and completed accurately. The facility will put into place the following systematic changes to ensure that the practice does not recur. MDS staff will be re-educated on proper coding of resident assessments. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit 5 random residents 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months to ensure resident assessment are completed accurately. The results of these audits will be presented to the monthly Quality Assurance/Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 689: Free of Accident Hazards/Supervision/Devices** The corrective actions to be accomplished for those residents found to have been affected by the practice. Resident M's fracture is healing, and her current fall interventions have been reviewed. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents fall interventions have been audited to ensure fall interventions are implemented and appropriate. The facility will put into place the following systematic changes to ensure that the practice does not recur. Nursing staff will be re-educated on our fall policy, sit to stand lift policy, and implementing interventions. The facility will monitor the corrective action by implementing the following measure. The Director of Nursing or designee will audit fall interventions at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 6 months to ensure fall interventions are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			implemented. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 690: Bowel/Bladder Incontinence** The corrective actions to be accomplished for those residents found to have been affected by the practice. Residents M's UTI has resolved and suffered no ill effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron Terrace have the potential to be affected by this alleged deficient practice. Residents residing at Solarbron Terrace with a dx of UTI have been audited to ensure appropriate treatment is provided. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses have been re-educated on appropriate treatment of UTIs. The facility will monitor the corrective action by implementing the following measure. DON/Designee will review 3 random residents per week for four	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			(4) weeks, then weekly for four (4) weeks, then biweekly for (4) weeks, then monthly 3 additional months to ensure appropriate treatment is provided for UTIs. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 695: Respiratory Care** The corrective actions to be accomplished for those residents found to have been affected by the practice. The date of the oxygen tubing and humidification bottles for Residents 13, 22, 31, 44, and 45 were corrected on the day the error was identified. The facility will identify other residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents with oxygen tubing and humidification bottles have been audited to ensure the proper date is labeled on the oxygen tubing and humidification bottles. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses/QMAs will be re-educated on respiratory	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			care policy. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit residents with oxygen tubing and humidification bottles at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure fall interventions are implemented. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 732: Posted Staffing Information** The corrective actions to be accomplished for those residents found to have been affected by the practice. Currently, residents have had no ill effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. Current residents have the potential to be affected by this alleged deficient practice. Daily staffing information has been updated and posted. The facility will put into place the following systematic changes to ensure that the practice does not recur. The current scheduler	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			will be educated on ensuring daily staffing information to be updated and posted daily at the main entrance and the nursing units. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit daily staffing information posting 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 months to ensure daily staffing information is accurate and posted daily. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 761: Labeling of Drugs and Biologicals** The corrective actions to be accomplished for those residents found to have been affected by the practice. The three medication administration refrigerators located on the West, North, and South Units observed with blank temperature logs during the survey were corrected the day the issue was identified. The facility will identify other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			residents that may potentially be affected by this practice. Residents residing at Solarbron have the potential to be affected by this alleged deficient practice. The temperature logs inside the medication administration refrigerators on the nursing units have been audited to ensure temperatures are being logged. The facility will put into place the following systematic changes to ensure that the practice does not recur. Licensed nurses and QMAs will be re-educated on recording temperatures on the temperature log inside of the medication administration refrigerators. The facility will monitor the corrective action by implementing the following measure. Director of Nursing or designee will audit medication administration refrigerator temperature logs at least 5 x per week for 4 weeks, then weekly x 4 weeks, then bi-weekly x 4 months, then monthly x 3 months to ensure temperature logs are being completed. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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-Tag 804: Nutritive Value/Appearance, Palatable/Pref/Temperature The corrective actions to be accomplished for those residents found to have been affected by the practice. No residents suffered adverse effects from this alleged deficient practice. The facility will identify other residents that may potentially be affected by this practice. The DFS/designee will audit food temperatures during mealtimes to ensure food is served at an appetizing and appropriate temperature. The facility will put into place the following systematic changes to ensure that the practice does not recur. Dietary staff and nursing staff will be re-educated on food temperatures and delivering the trays timely to residents. The facility will monitor the corrective action by implementing the following measures The DFS/designee will monitor/audit hall tray food temperatures, and interview 5 residents weekly for 4 weeks, then biweekly x 8 weeks, then monthly x 3 months to ensure food is served at appropriate and appetizing temperatures. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **F-Tag 921: Safe/Functional/Sanitary/Comfortable Environment** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The hallway on the East Hallway observed smelling musty was addressed on the day the issue was identified. No ill effects were noted from this alleged deficient practice. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Carpeted and hallways areas were inspected, and an action plan has been implemented. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? The administrator or designee will re-educate housekeeping and maintenance staff on the cleaning and disinfection of environment surfaces policy and will re-educate staff on putting in work orders for carpeted areas needing to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			cleaned. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; the Administrator/designee will monitor/audit carpeted areas to ensure the areas are clean and odor-free weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure the carpeted areas are clean and odor-free. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **Residential Care – Plan of Correction** **R0246 – Pharmacy (PRN Medications)** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No ill effects were noted from this alleged deficient practice. The QMA who administered the PRN medication without the authorization of a licensed nurse was re-educated on 11/13/23. How will other residents having the potential to be affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents have had no ill effects from this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or designee will re-educate QMAs on proper administration of PRN medications policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Director of Nursing or designee will audit MARs to ensure PRN medications are administered properly weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure PRN medications are administered properly. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated. **R0298 – Pharmacy (Consultant**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Pharmacist Review) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No ill effects were noted from this alleged deficient practice. Pharmacy reviews for Residents 2,3,5,6,7, and 8 were completed on 11/15/23. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents will be audited to ensure pharmacy recommendations/reviews are completed. Current residents have had no ill effects from this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or designee will re-educate Residential Care Manager on ensuring pharmacy reviews of resident records are completed at least every 60 days. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Director of Nursing or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			audit resident records to ensure pharmacy reviews are completed at least every 60 days weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure pharmacy reviews are completed at least every 60 days. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were authorized by a licensed nurse for 4 of 6 resident records reviewed. (Resident 4, Resident 7, Resident 6, Resident 2) Findings include: 1. On 10/31/23 at 9:20 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension.	R 0246	**R0246 – Pharmacy (PRN Medications)** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No ill effects were noted from this alleged deficient practice. The QMA who administered the PRN medication without the authorization of a licensed nurse was re-educated on 11/13/23.	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Current physician orders included, but were not limited to: clonidine HCl (an antihypertensive medication) tablet 0.1mg (milligrams) twice a day PRN, dated 4/14/22. Resident 3's MAR (Medication Administration Record) from 9/2023 through 10/2023 included, but was not limited to, the following dates that clonidine HCl 0.1mg PRN was administered by a QMA without authorization from a licensed nurse: 9/23/23 at 12:27 A.M. (no follow-up documented) 10/19/23 at 8:38 A.M. (follow-up documented by QMA 33) 10/28/23 at 22:54 P.M. (no follow-up documented) 10/30/23 at 8:15 A.M. (no follow-up documented) 2. On 10/31/23 at 10:34 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but was not limited to, anxiety and pain. Current physician orders included, but were not limited to: hydroxyzine HCl (an antihistamine used for anxiety) 25mg three times a day PRN, dated 8/26/23. Tramadol (a pain reliever) 50mg every six hours PRN, dated 8/28/23. Resident 7's MAR for 9/2023 included, but was not limited to, the following dates that hydroxyzine 25mg was administered by a QMA without authorization from a licensed nurse: 9/16/23 at 8:35 P.M. (follow-up documented by QMA 21) Resident 7's MAR for 9/2023 included, but was not limited to, the following dates that Tramadol		How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents have had no ill effects from this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or designee will re-educate QMAs on proper administration of PRN medications policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Director of Nursing or designee will audit MARs to ensure PRN medications are administered properly weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure PRN medications are administered properly. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	50mg was administered by a QMA without authorization from a licensed nurse: 9/2/23 at 6:19 A.M. (follow-up documented by QMA 25) 9/3/23 at 5:24 P.M. (no follow-up documented) 9/4/23 at 5:40 A.M. (follow-up documented by QMA 25) 3. On 10/30/23 at 10:42 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to pathological fracture of left femur and pain. Current physician orders included, but were not limited to: tramadol (a pain medication) - Schedule IV tablet; 50 mg; amt (amount): 1 tablet; oral Special Instructions: Administer Tramadol 50mg 1 po (by mouth) q6h (every 6 hours) PRN for moderate pain, dated 9/21/23 The MAR (medication administration record) for September indicated Resident 2 received tramadol on the following days by a QMA without authorization from a licensed nurse: 9/23/23 - given by QMA 21 and assessed for effectiveness by QMA 25 9/30/23 - given by QMA 33 and assessed for effectiveness by QMA 24 4. On 10/30/23 at 12:36 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder and pain. Current physician orders included, but were not limited to: Xanax (alprazolam) (a sedative) - Schedule IV tablet; 0.25 mg; amt: 0.25mg; oral Twice A Day - PRN, dated 06/22/2023 tramadol - Schedule IV tablet; 50 mg; amt: 50mg;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	oral Three Times A Day - PRN, dated 06/22/2023 The MAR for October indicated Resident 6 received xanax on the following days by a QMA without authorization from a licensed nurse: 10/20/23 - given by QMA 33. The clinical record lacked documentation of who assessed for effectiveness. 10/28/23 - given by QMA 33 and assessed for effectiveness by QMA 21 The MAR for October indicated Resident 6 received tramadol on the following days by a QMA without authorization from a licensed nurse: 10/20/23 - given by QMA 33 and assessed for effectiveness by QMA 22 On 10/30/23 at 1:10 P.M., QMA 17 indicated that a QMA should talk to a nurse before giving any PRN medication and that after it is given, the nurse would complete the assessment of effectiveness. On 10/31/23 at 10:29 A.M., the Director of Nursing (DON) provided a current Medication and Treatment Records policy, revised 5/2012, that indicated "Authorization by a licensed nurse will be obtained for any PRN treatment or medication administered".			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure pharmacy reviews were completed at least every sixty (60) days for 6 of 6 resident records reviewed. (Resident 3, Resident 7, Resident 2, Resident 5, Resident 8, Resident 6) Findings include: 1. On 10/31/23 at 9:20 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but was not limited to, hypertension. Resident 3's clinical record included current physician orders for medications that were supplied by the facility's pharmacy and administered by facility staff. Resident 3's clinical record lacked a pharmacy medication regimen review from 10/2022 through 10/2023. 2. On 10/31/23 at 10:34 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and pain. Resident 7's clinical record included current physician orders for medications that were supplied by the facility's pharmacy and administered by facility staff. Resident 7's clinical record lacked a pharmacy medication regimen review from 10/2022 through	R 0298	**R0298 – Pharmacy (Consultant Pharmacist Review)** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No ill effects were noted from this alleged deficient practice. Pharmacy reviews for Residents 2,3,5,6,7, and 8 were completed on 11/15/23. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Current residents residing at Solarbron have the potential to be affected by this alleged deficient practice. Current residents will be audited to ensure pharmacy recommendations/reviews are completed. Current residents have had no ill effects from this alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Director of Nursing or designee will re-educate Residential Care Manager on	11/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	10/2023. 3. On 10/30/23 at 12:36 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety disorder and pulmonary hypertension. Resident 6's clinical record included current physician orders for medications that were supplied by the facility's pharmacy and administered by facility staff. A pharmacy review was provided dated 2/22/23. Resident 6's clinical record lacked any other pharmacy medication regimen review from 10/2022 through 10/2023. 4. On 10/30/23 at 10:42 A.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, pathological fracture of the left femur and hypertension. Resident 2's clinical record included current physician orders for medications that were supplied by the facility's pharmacy and administered by facility staff. Resident 2's clinical record lacked a pharmacy medication regimen review from 10/2022 through 10/2023. 5. On 10/30/23 at 12:08 P.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, hypothyroidism and hypertension. Resident 5's clinical record included current physician orders for medications that were supplied by the facility's pharmacy and administered by facility staff.		ensuring pharmacy reviews of resident records are completed at least every 60 days. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Director of Nursing or designee will audit resident records to ensure pharmacy reviews are completed at least every 60 days weekly x 4 weeks, then bi-weekly for 8 weeks, then monthly for 3 months to ensure pharmacy reviews are completed at least every 60 days. The results of these audits will be presented to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	10/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Resident 5's clinical record lacked a pharmacy medication regimen review from 10/2022 through 10/2023. 6. On 10/30/23 at 12:36 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus and hypertension. Resident 8's clinical record included current physician orders for medications that were supplied by the facility's pharmacy and administered by facility staff. Resident 8's clinical record lacked a pharmacy medication regimen review from 10/2022 through 10/2023. On 10/31/23 at 9:57 A.M., the DON (Director of Nursing) indicated pharmacy reviews should be completed every other month. On 10/31/23 at 10:23 A.M., the DON provided a current non-dated Therapeutic Review policy that indicated "Pharmacists at [facility] conduct a therapeutic review of each resident's medication and ancillary services profile upon admission and with new order [sic] to ensure that all elements of the orders are correct and to safeguard that no potential drug mishaps may occur" The policy did not include how often pharmacy reviews must be done, however at that time, the DON indicated pharmacy medication regimen reviews were supposed to be completed every sixty (60) days.			