PRINTED: 12/07/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES  OMB NO. 0938-039								
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155773	B. WING 10/31/2023					
		1		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					ICDOWELL RD			
TERRACE AT SOLARBRON THE				SVILLE, IN 47712				
TEINIO	1			LV/IIV	T T T T T T T T T T T T T T T T T T T			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0000								
B. 1 . 00								
Bldg. 00	Total Control	D						
		Recertification and State	F 00	)00	1			
	1	nd Investigation of Complaints			Solarbron Terrace			
		419853, and IN00420287. This			Annual SNF & Residential Care			
		te Residential Licensure			Relicensure Survey			
	Survey.				October 23-27, 30-31 2023			
	C1-:4 INIO0410	0670 No 4-5-1-1-1-1-4-44-			ONE Black of Commention			
	the allegations are			SNF - Plan of Correction				
	the allegations are t	cited.		- The plan of correction se		20		
	Complaint INO0416	t IN00/10853 No deficiencies related to			Solarbron Terrace's credible	15		
	Complaint IN00419853 - No deficiencies related to							
	the allegations are cited.				allegation of compliance. Submission of this plan of			
	Complaint IN00426	0287 - Federal/State deficiencies			correction does not constitute	on		
	-	ations are cited at F580.			admission by Solarbron Terrac			
	related to the allega	ations are cited at 1 500.			its management company that			
	Survey dates: Octo	ber 23, 24, 25, 26, 27, 30 & 31,			allegations contained in the su			
	2023	,,,,,,			report is a true and accurate	. voy		
					portrayal of the provision of nu	rsing		
	Facility number: 01	10930			care and other services in this	-		
	Provider number: 1			facility. Nor does this provisi				
	AIM number: 2012	274710			constitute an agreement or			
					admission of the survey			
	Census Bed Type:				allegations.			
	SNF/NF: 81							
	Residential: 30				F-Tag 554: Resident Self-Adn	nin		
	Total: 111				Meds-Clinically Appropriate			
					The corrective actions to	be		
	Census Payor Type	::			accomplished for those resider	nts		
	Medicare: 11				found to have been affected by	y the		
	Medicaid: 48				practice. Currently, residents h	ıave		
	Other: 22				had no ill effects from this alleg	ged		
	Total: 81				deficient practice. Resident 69			
					self- administration assessmer	nt is		
		reflect State Findings cited in			completed.			
	accordance with 41	0 IAC 16.2-3.1.			The facility will identify otl			
	1		1		residents that may potentially l	oe		

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

affected by this practice. Current

TITLE

(X6) DATE

McElwee Mark 11/23/2023

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/31/2023				
	ROVIDER OR SUPPLIER E AT SOLARBRON		STREET ADDRESS, CITY, STATE, ZIP COD  1701 MCDOWELL RD  EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
		pleted on November 6, 2023.		residents have the potential to affected by this alleged deficie practice. Current residents that wish to self-administer medications have been audite ensure self -administration assessments are completed.  The facility will put into pit the following systematic change to ensure that the practice does not recur. Licensed nurses an IDT will be re-educated on self-administration policy.  The facility will monitor the corrective action by implement the following measure. Director Nursing or designee will audit random residents 3 x weekly a weeks, then weekly x 4 weeks then monthly x 4 months to ensure self-administration assessment are completed on those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those who wish to self-administration assessment are completed or those will addit the provide the monthly Quantity of the self-administration assessment are completed or those self-admi	ent at d to lace ges es d lee ting or of 5 k 4 k s lits. ed. lee be es be ents y the es to			

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Facility ID: 010930

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155773	B. WING 10/31/2023			/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
TENNAC		V 111L		LVANO	······································		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					the facility and Resident M's		
					family has been notified.		
					The facility will identify ot	her	
					residents that may potentially	be	
					affected by this practice.		
					Residents residing at Solarbro		
					have the potential to be affect		
					by this alleged deficient practi		
					Residents with changes have		
					audited to ensure notification	was	
					made to families and the		
					physician.		
					The facility will put into pl		
					the following systematic chang	-	
					to ensure that the practice doe		
					not recur. Licensed nurses wil		
					re-educated on making notification		
					to families and the physicians		
					residents when resident condi	tions	
					change.		
					The facility will monitor th		
					corrective action by implemen	-	
					the following measure. Directo		
					Nursing or designee will audit		
					residents with changes to ens		
					notification is made to families	anu	
					the physician at least 5 x per	. v 1	
					weeks then bi weekly v 4	y X <del>4</del>	
			1		weeks, then bi-weekly x 4 months, then monthly x 3 mor	the	
			1		to ensure notification to familie		
					and the physician is made. Th		
					results of these audits will be	C	
					presented to the monthly Qua	lity	
					Assurance/Performance	iity	
					Improvement Committee. The		
			1		facility will achieve 100%		
					compliance threshold prior to		
					adjusting the frequency of auc	lite	
					Plan to be updated as indicate		
	I		1		I i iaii io be upualeu as iliulcale	·u.	I

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#### CENTERS FOR MEDICARE & MEDICAID SERVICES

		A. BUILDING						
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE			STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				F-Tag 641: Accuracy of Assessments  The corrective actions to accomplished for those reside found to have been affected by practice. Currently, residents had no ill effects from this alle deficient practice. The MDS for Resident 50 was corrected on day the coding error was identified.  The facility will identify of residents that may potentially affected by this practice. Currer residents have the potential to affected by this alleged practice. Dialysis residents who reside Solarbron Terrace have been audited to ensure MDS coding correct. The MDS of residents have been audited to ensure comprehensive assessments coded and completed accurate The facility will put into ple the following systematic change to ensure that the practice does not recur. MDS staff will be re-educated on proper coding resident assessments.  The facility will monitor the corrective action by implement the following measure. Director Nursing or designee will audit random residents 3 x weekly a weeks, then weekly x 4 weeks.	nts y the nave ged or the her be ent be ent be ee, at g is are eely, acce ges es of ne ting or of 5 c 4			

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DEPARTMENT CENTERS FOI	FORM APPROVED OMB NO. 0938-039					
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	ETED
		155773	B. WING		10/31/	2023
	PROVIDER OR SUPPLIE		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712		
TERRAC	E AT SOLARBRO	IN THE	EVAINS	5 VILLE, IN 477 12		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				then monthly x 4 months to		
				ensure resident assessment a		
				completed accurately. The res		
				of these audits will be present	ted	
				to the monthly Quality		
				Assurance/Performance		
				Improvement Committee. The	;	
				facility will achieve 100%		
				compliance threshold prior to	-1:4 -	
				adjusting the frequency of aud		
				Plan to be updated as indicate	ea.	
				F-Tag 689: Free of Accident		
				Hazards/Supervision/Device	S	
				The corrective actions to	be	
				accomplished for those reside		
				found to have been affected b	-	
				practice. Resident M's fracture	e is	
				healing, and her current fall		
				interventions have been revie		
				The facility will identify of		
				residents that may potentially	be	
				affected by this practice.		
				Residents residing at Solarbro		
				have the potential to be affect		
				by this alleged deficient practi		
				Current residents fall interven		
				have been audited to ensure		
				interventions are implemented	and	
				appropriate.		
				The facility will put into p		
	I		ı	the following systematic chan	ges	

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to ensure that the practice does not recur. Nursing staff will be re-educated on our fall policy, sit

The facility will monitor the corrective action by implementing the following measure. The

to stand lift policy, and implementing interventions.

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	PLAN OF CORRECTION  Tement of Deficiencies (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (155773		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  10/31/2023			
	ROVIDER OR SUPPLIER E AT SOLARBRON		STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION DATE			
				Director of Nursing or design audit fall interventions at least per week for 4 weeks, then x 4 weeks, then bi-weekly amonths, then monthly x 6 m to ensure fall interventions implemented.  The results of these audits presented to the monthly Q Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior adjusting the frequency of a Plan to be updated as indicting the frequency of a Plan to be updated as indicting the frequency of a Plan to be updated as indicting the frequency of a Plan to be updated as indicting the frequency of a Plan to be updated as indicting the frequency of a Plan to be updated as indicting the frequency of a Plan to be updated as indicting the corrective actions accomplished for those restound to have been affected practice. Residents M's UT resolved and suffered no ill from this alleged deficient practice.  The facility will identify residents that may potential affected by this practice. Residents residing at Solar Terrace have the potential affected by this alleged deficient practice. Residents residing Solarbron Terrace with a dispersion of the facility will put into the following systematic characteristics. It is a proportion to ensure that the practice of the facility will put into the following systematic characteristics. Licensed nurses been re-educated on appropriate treatment is proportional treatment in the following systematic characteristics.	ast 5 x weekly 4 anonths are will be ruality The to audits. rated.  r to be idents d by the I has effects  other lly be bron to be icient g at x of UTI re povided. p place anges does have			

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						PKIN	IED:	12/0//2023
	Γ OF HEALTH AND HU							PROVED
CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 09	938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		Y
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED	
		155773	B. WIN	IG		10/31/	2023	
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE			STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		1	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMF	PLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	Di	ATE
					treatment of UTIs.  The facility will monitor the corrective action by implement the following measure.  DON/Designee will review 3 random residents per week for	ting		

F-Tag 695: Respiratory Care

Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated.

(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

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

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
		155773	B. WING 10/31/202			/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			CDOWELL RD		
TERRAC	E AT SOLARBRON	J THE			VILLE, IN 47712		
ILINIAO	L AT GOLANDION	V 111L		LVAINS	VILLE, IIN 71112		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					bottles.		
					The facility will put into pl		
					the following systematic chang		
			1		to ensure that the practice doe		
			1		not recur. Licensed nurses/QN		
					will be re-educated on respirat	iory	
					care policy.		
					The facility will monitor th		
					corrective action by implemen the following measure. Director	-	
					Nursing or designee will audit		
					residents with oxygen tubing a		
					humidification bottles at least		
					per week for 4 weeks, then we		
					x 4 weeks, then bi-weekly x 4	Citiy	
					months, then monthly x 3 mon	iths	
					to ensure fall interventions are		
					implemented. The results of the		
			1		audits will be presented to the		
			1		monthly Quality		
					Assurance/Performance		
					Improvement Committee. The		
					facility will achieve 100%		
					compliance threshold prior to		
			adjusting the frequency of audits			lits.	
					Plan to be updated as indicate	ed.	
			1		F-Tag 732: Posted Staffing		
					Information		
					The corrective actions to		
					accomplished for those reside		
					found to have been affected b	-	
					practice. Currently, residents h		
					had no ill effects from this alle	yea	
					deficient practice.	hor	
					The facility will identify ot		
					residents that may potentially affected by this practice. Curre		
					residents have the potential to		
					affected by this alleged deficie		
	I		1		I andoted by this alleged delible	, 1 I L	I

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	IT OF DEFICIENCIES OF CORRECTION				nstruction 00	(X3) DATE SURVEY COMPLETED 10/31/2023	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
TERRAC	E AT SOLARBRON	I THE			CDOWELL RD VILLE, IN 47712		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION		AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
					practice. Daily staffing informa has been updated and posted The facility will put into pl		
					the following systematic change		
					to ensure that the practice doe not recur. The current schedul		
					will be educated on ensuring of		
					staffing information to be upda	ited	
					and posted daily at the main entrance and the nursing units		
					The facility will monitor th		
					corrective action by implemen		
					the following measure. Directo		
					Nursing or designee will audit	•	
					staffing information posting 3 x		
					weekly x 4 weeks, then weekly 4 weeks, then monthly x 4 mo		
					to ensure daily staffing informa		
					is accurate and posted daily.		
					results of these audits will be		
					presented to the monthly Qual	ity	
					Assurance/Performance Improvement Committee. The		
					facility will achieve 100%		
					compliance threshold prior to		
					adjusting the frequency of aud	its.	
					Plan to be updated as indicate	d.	
					F-Tag 761: Labeling of Drugs	;	
					and Biologicals		
					The corrective actions to		
					accomplished for those reside		
					found to have been affected by	y tne	
					practice. The three medication		
					administration refrigerators loc	hated	

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155773	B. WING		10/31/2023	
NAME OF P	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COD		
			1701 M	ICDOWELL RD		
TERRAC	E AT SOLARBRON	N THE	EVANS	SVILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				on the West, North, and South	n	
				Units observed with blank		
				temperature logs during the si	·	
				were corrected the day the iss	sue	
				was identified.		
				The facility will identify of		
				residents that may potentially	pe	
				affected by this practice.		
				Residents residing at Solarbro have the potential to be affect		
				by this alleged deficient practi		
				The temperature logs inside the		
				medication administration		
				refrigerators on the nursing ur	nits	
				have been audited to ensure		
				temperatures are being logger	d.	
				The facility will put into pl		
				the following systematic change		
				to ensure that the practice doe		
				not recur. Licensed nurses an		
				QMAs will be re-educated on		
				recording temperatures on the	,	
				temperature log inside of the		
				medication administration		
				refrigerators.		
				The facility will monitor th		
				corrective action by implemen	•	
				the following measure. Directo		
				Nursing or designee will audit		
				medication administration		
				refrigerator temperature logs a		
				least 5 x per week for 4 weeks	5,	
				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 thes		
				audits will be presented to the		
				monthly Quality		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155773	B. WING		10/31/2023	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	BROWDERS BY AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				Improvement Committee. The		
				facility will achieve 100%		
				compliance threshold prior to		
				adjusting the frequency of aud		
				Plan to be updated as indicate	ed.	
				F-Tag 804: Nutritive		
				Value/Appearance,		
				Palatable/Pref/Temperature		
				The corrective actions to	be	
				accomplished for those reside	nts	
				found to have been affected b	y the	
				practice. No residents suffered		
				adverse effects from this alleg	ed	
				deficient practice.		
				The facility will identify of		
				residents that may potentially	be	
				affected by this practice. The		
				DFS/designee will audit food temperatures during mealtime	c to	
				ensure food is served at an	S 10	
				appetizing and appropriate		
				temperature.		
				The facility will put into p	ace	
				the following systematic change		
				to ensure that the practice do		
				not recur. Dietary staff and nu	-	
				staff will be re-educated on fo	bd	
				temperatures and delivering the	ne	
				trays timely to residents.		
				The facility will monitor th		
				corrective action by implemen	ting	
				the following measures The	J:4	
				DFS/designee will monitor/aud		
				hall tray food temperatures, a interview 5 residents weekly for		
				weeks, then biweekly x 8 wee		
				then monthly x 3 months to	NO,	
				ensure food is served at		
Ī	I		I	Silouis lood to convoca at	1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/31/2023	
	ROVIDER OR SUPPLIE		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	temperatures. The results of 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 au Plan to be updated as indicated.  F-Tag 921: Safe/Functional/Sanitary/Coortable Environment What corrective action(see accomplished for those residents found to have been affected by the deficient practice being the from this alleged deficient practice.  How will other residents having the potential to be affected by the same deficient practice be identified and what correct action(s) will be taken? Currect residents residing at Solarbrothave the potential to be affected by this alleged deficient practice does implemented.  What measures will be provided in the deficient practice does into place and what systematic changes will be made to ensith the deficient practice does recur? The administrator or	these e  dits. ted.  omf s) will tice? way s ue vere ent ected e will tive ent on ted tice. s were n has out tic ure
				designee will re-educate	

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i ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155773	B. W	ING		10/31/	2023
NAME OF P	PROVIDER OR SUPPLIER	•	-		ADDRESS, CITY, STATE, ZIP COD	•	
					CDOWELL RD		
IERRAC	E AT SOLARBRON	I IHE		EVANS	VILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	KEGULATUKY OR	LSC IDENTIFYING INFORMATION		TAG	housekeeping and maintenand		DATE
					staff on the cleaning and		
					disinfection of environment		
					surfaces policy and will re-edu	ıcate	
					staff on putting in work orders	for	
					carpeted areas needing to be		
					cleaned.		
					How the corrective action		
					will be monitored to ensure the		
					deficient practice will not recui	Γ,	
					i.e., what quality assurance program will be put into place;	the	
					Administrator/designee will	u IC	
					monitor/audit carpeted areas t	0	
					ensure the areas are clean an		
					odor-free weekly x 4 weeks, th	nen	
					bi-weekly for 8 weeks, then		
					monthly for 3 months to ensur	е	
					the carpeted areas are clean a		
					odor-free. The results of these		
					audits will be presented to the	9	
					monthly Quality Assurance/Performance		
					Improvement Committee. The		
					facility will achieve 100%		
					compliance threshold prior to		
					adjusting the frequency of auc	lits.	
					Plan to be updated as indicate		
					Posidontial Care Blan of		
					Residential Care – Plan of Correction		
					<u> </u>		
					R0246 – Pharmacy (PRN		
					Medications)		
					What corrective action(s)	will	
					be accomplished for those		
					residents found to have been		
					affected by the deficient practi		
					No ill effects were noted from		
			1		alleged deficient practice. The	!	

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/31/2023
	ROVIDER OR SUPPLIE		1701 M	ADDRESS, CITY, STATE, ZIP COD MCDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5)  D BE OPRIATE  COMPLETION  DATE
				QMA who administered the medication without the authorization of a licensed was re-educated on 11/13. How will other reside having the potential to be by the same deficient practice identified and what corresidents residing at Solar have the potential to be at by this alleged deficient practice.  What measures will linto place and what system changes will be made to eat that the deficient practice recur? Director of Nursing designee will re-educate of proper administration of Proper administration of Proper administration of Program will be monitored to ensure deficient practice will not recommend to the sure of the monitored to ensure program will be put into plow Director of Nursing or designed will be administered properly weekly x 4 weeks bi-weekly for 8 weeks, the monthly for 3 months to e PRN medications are administered properly. The of these audits will be preto the monthly Quality Assurance/Performance Improvement Committee.	d nurse 8/23. ents affected ctice will rective urrent rbron ffected ractice. ad no ill deficient be put matic ensure does not y or QMAs on PRN ction(s) re the recur, re dace; dignee will N ered s, then en nsure e results esented

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  10/31/2023	
	ROVIDER OR SUPPLIE		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				facility will achieve 100% compliance threshold prior to adjusting the frequency of auc Plan to be updated as indicate	dits.	
				R0298 – Pharmacy (Consultate Pharmacist Review)  What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice. No ill effects were noted from alleged deficient practice. Pharmacy reviews for Reside 2,3,5,6,7, and 8 were complet on 11/15/23.  How will other residents having the potential to be affect by the same deficient practice be identified and what correct action(s) will be taken? Currer residents residing at Solarbro have the potential to be affect by this alleged deficient practic Current residents will be audit ensure pharmacy recommendations/reviews are completed. Current residents had no ill effects from this alled deficient practice.  What measures will be pinto place and what systematic changes will be made to ensurth the deficient practice doe recur? Director of Nursing or designee will re-educate Residential Care Manager on ensuring pharmacy reviews or resident records are complete.	ice? this ints ted cted e will ive int in ted ice. ted to e have eged out ic ire s not	

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least every 60 days.

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIE		1701 M	ADDRESS, CITY, STATE, ZIP COD MCDOWELL RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
				How the corrective actions 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 designed audit resident records to ensur pharmacy reviews are completed at least every 60 days weekly weeks, then bi-weekly for 8 weeks, then monthly for 3 mon to ensure pharmacy reviews are completed at least every 60 days to ensure pharmacy reviews are completed at least every 60 days weeks, then monthly for 3 mon to ensure pharmacy reviews are completed at least every 60 days weeks, then monthly for 3 mon to ensure pharmacy reviews are completed at least every 60 days weeks, then monthly for 3 mon to ensure pharmacy reviews are completed at least every 60 days weeks, then monthly for 3 mon to ensure pharmacy reviews are completed at least every 60 days weeks, then monthly for 3 mon to ensure pharmacy reviews are completed at least every 60 days weeks, then monthly for 3 mon to ensure pharmacy reviews are completed at least every 60 days weeks, then bi-weekly for 8 weeks, then monthly for 3 mon to ensure pharmacy reviews are completed at least every 60 days weeks, then bi-weekly for 8 weeks, then bi-weekly for	e will e ed k 4 ths re ys. be ity	
F 0554 SS=D Bldg. 00	§483.10(c)(7) The medications if the defined by §483.2 that this practice is Based on observation review, the facility were self administer assessed for capabil medications for 1 ce	min Meds-Clinically Approperight to self-administer interdisciplinary team, as 21(b)(2)(ii), has determined is clinically appropriate. on, interview, and record failed to ensure residents that ering medications were ality to self administer of 1 residents observed with r room. (Resident 69)	F 0554	F-Tag 554: Resident Self-Adm Meds-Clinically Appropriate  The corrective actions to be accomplished for those resider found to have been affected by practice. Currently, residents he had no ill effects from this alleg deficient practice. Resident 69 self- administration assessment	be hts the ave ged	11/27/2023

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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

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completed.

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The facility will identify other

residents that may potentially be

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155773	B. W	ING		10/31	/2023
				_	_		
NAME OF	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					ICDOWELL RD		
TERRAC	E AT SOLARBRON	NIHE		EVANS	SVILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	\	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIE	DATE
	in the room by hims	self on a bedside commode			affected by this practice. Curr	ent	
		a nebulizer treatment. At that			residents have the potential to		
	_	d the breathing treatment			affected by this alleged deficie		
		o (albuterol with ipratropium			practice. Current residents that		
	bromide) and that the			wish to self-administer			
	· ·	her indicated Resident 69 did			medications have been audite	ed to	
		inistration assessment on file			ensure self -administration		
	for that medication.				assessments are completed.		
	On 10/26/23 at 9:09 A.M., Resident 69's clinical				The facility will put into p	lace	
					the following systematic chan		
		ed. Diagnosis included, but			to ensure that the practice do	_	
	was not limited to, chronic bronchitis.  The most recent admission MDS (Minimum Data				not recur. Licensed nurses an		
					IDT will be re-educated on	. —	
					self-administration policy.		
		ated 9/13/23, indicated no					
		ent, and extensive assistance of					
		nobility, transfers, and			The facility will monitor the	ne	
	toileting.	,			corrective action by implemen		
					the following measure. Directo	_	
	Current physician o	orders included, but were not			Nursing or designee will audit		
	limited to, the follo				random residents 3 x weekly		
		le solution; 0.02 %; amt:			weeks, then weekly x 4 weeks		
		l; inhalation. Special	then monthly x 4 months to				
		vith albuterol Four Times A			ensure self-administration		
	Day, dated 9/20/23.				assessment are completed or	า	
					those who wish to self-admini		
	Physician orders la	cked an order to self administer			The results of these audits wil		
	medication.				presented to the monthly Qua		
					Assurance/Performance	•	
	On 10/26/23 at 10:5	51 A.M., the Director of Nursing			Improvement Committee. The	)	
		esident 69 did not have a self			facility will achieve 100%		
		nedications assessment.			compliance threshold prior to		
					adjusting the frequency of aud	dits.	
	On 3/22/22 at 9:54	A.M., a current non-dated			Plan to be updated as indicate		
		s and self-administration of			,		
	medications policy	was provided, and indicated					
		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

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	ING		10/31/	/2023
NAME OF B	DOLUBED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			1701 M	CDOWELL RD		
TERRAC	E AT SOLARBRON	ITHE		EVANS	VILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY 1		DATE
		of the facility Once stablished, the resident					
		essment A written order for					
	_	of medication is present in the					
	resident's medical record".						
	resident s incurcui i	cora .					
	3.1-11(a)						
F 0580	483.10(g)(14)(i)-(iv	v)(15)					
SS=D		(Injury/Decline/Room, etc.)					
Bldg. 00	§483.10(g)(14) No	otification of Changes.					
	(i) A facility must in	mmediately inform the					
	resident; consult w						
		ify, consistent with his or					
	-	resident representative(s)					
	when there is-						
	, ,	volving the resident which					
		d has the potential for					
	requiring physiciar						
		nange in the resident's					
		or psychosocial status					
		ation in health, mental, or					
	conditions or clinic	is in either life-threatening					
		r treatment significantly					
	, ,	discontinue an existing					
	form of treatment	_					
		to commence a new form					
	of treatment); or						
		ransfer or discharge the					
	, ,	acility as specified in					
	§483.15(c)(1)(ii).	•					
	(ii) When making r	notification under paragraph					
	(g)(14)(i) of this se	ection, the facility must					
	ensure that all per	tinent information specified					
	- ,,,,,	available and provided					
	upon request to th	e physician.					
	, ,	st also promptly notify the					
		esident representative, if					
	any, when there is	; <del>-</del>					

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155773	B. W	ING		10/31	/2023
						<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
TEDD 4.0					ICDOWELL RD		
TERRAC	CE AT SOLARBRON	NIHE		EVANS	SVILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\L	DATE
	(A) A change in ro	oom or roommate					
	assignment as sp	ecified in §483.10(e)(6); or					
		esident rights under Federal					
	, ,	gulations as specified in					
	paragraph (e)(10)	-					
		ust record and periodically					
	1 ' '	ss (mailing and email) and					
	phone number of	, -					
	representative(s).						
	§483.10(g)(15)						
	Admission to a composite distinct part. A facility that is a composite distinct part (as						
		) must disclose in its					
	admission agreen						
	_	uding the various locations					
	_	composite distinct part,					
	-	the policies that apply to					
		tween its different locations					
	under §483.15(c)(						
		and record review, the facility	F 0:	500	F-Tag 580: Notice of Change	00	11/27/2023
		attending physician and the	1 0.	380	The corrective actions to		11/2//2023
	1	r 1 of 5 residents reviewed for			accomplished for those reside		
	-	1 1 of 2 residents reviewed for			found to have been affected b		
		ges. A resident's family was			practice. Notification of change	-	
		ificant weight loss and the			Residents F was discharged f		
		was not notified of increased			_	10111	
	0 1 1	sident M, Resident F)			the facility and Resident M's		
	blood pressure. (Re	sident Wi, Resident I')			family has been notified.	thor	
	Findings in abud-				The facility will identify of		
	Findings include:				residents that may potentially	ье	
	1 During a sanfi 1-	ntial interview on 10/24/23 at			affected by this practice.	<b>.</b> n	
	_				Residents residing at Solarbro		
		indicated Resident M's family			have the potential to be affect		
		ed of a significant weight loss			by this alleged deficient practi		
		not good at communicating			Residents with changes have		
	changes in conditio	n to the family.			audited to ensure notification	was	
					made to families and the		
	On 10/25/23 at 10:1	19 A.M., Resident M's clinical			physician.		

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record was reviewed. Diagnoses included, but

were not limited to, Diabetes Mellitus, dysphagia,

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The facility will put into place

the following systematic changes

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155773	B. Wl	ING		10/31	/2023
		l .		STREET	ADDRESS, CITY, STATE, ZIP COD	I	
NAME OF P	ROVIDER OR SUPPLIER	8			CDOWELL RD		
TERRAC	E AT SOLARBRON	J THE			VILLE, IN 47712		
IERRAU	L AT SOLARDRUN	N IIIL		EVAINS	VILLE, IIN 4// IZ		_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	and vascular demen	itia.			to ensure that the practice doe	es	
					not recur. Licensed nurses wil		
	_	arterly (Minimum Data Set)			re-educated on making notification		
	·	9/25/23, indicated Resident M			to families and the physicians		
	had moderate cognitive impairment, had weight				residents when resident condi	tions	
	_	xtensive assistance of 2 staff			change.		
	-	ansfers, toileting, and bathing,			The facility will monitor th		
	and setup assistance	e with supervision for eating.			corrective action by implemen	_	
		1.1.			the following measure. Directo		
		al risk care plan, dated 3/4/23,			Nursing or designee will audit		
		M was at nutritional risk			residents with changes to ens		
related to use of mechanically altered and					notification is made to families	and	
	therapeutic diet due to dysphagia, variable intakes, and significant weight loss.				the physician at least 5 x per		
	intakes, and signific	cant weight loss.			week for 4 weeks, then weekly	/ X 4	
	Tl	: 4:			weeks, then bi-weekly x 4	41	
	first identified on 4	indicated the weight loss was			months, then monthly x 3 mon		
	iirst identified on 4/	(12/23.			to ensure notification to familie		
	On 4/14/22 a Pagis	stered Dietician review			and the physician is made. Th	е	
	_	ght) hx (history): 176#			results of these audits will be	lits /	
		7#(3/28), 184#(1/8), and			presented to the monthly Qual Assurance/Performance	шу	
		gnificant) wt (weight) loss x			Improvement Committee. The		
		overall trending loss x5			facility will achieve 100%		
		body mass index) is 28.5 which			compliance threshold prior to		
	,	t status for ht (height) of 5'6".			adjusting the frequency of aud	lite	
		osis) include dysphagia,			Plan to be updated as indicate		
	, -	I (type 2 diabetes mellitus),			a.r to be apacted as maleate	. u.	
	_	imin) def (deficiency), gout,					
	-	nia), GERD (gastroesophageal					
	reflux disease), HT	,					
	·	er diet is mech (mechanical)					
		gravy start 237mls (milliliters)					
		trol TID (three times a day)					
		extra calories and blood sugar					
		recommend weekly weights x4					
	_	red dietician) available as					
	needed".	,					
	On 5/24/2023 at 2:1	16 P.M. an IDT (Interdisciplinary					
		ed the family was aware of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/31/2023	
	ROVIDER OR SUPPLIEF E AT SOLARBRON		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	notification to the five ight loss prior to On 10/26/23 at 9:36 Support (CCS) 4 in notified of significate significant weight I identified. At that the would be document On 10/31/23 at 9:56 Nursing) indicated notification of the filoss prior to 5/24/23 2. On 10/27/23 at 1 record was reviewed were not limited to occlusion or stenos hypertension.  The most recent add Set) Assessment, da Resident F had most and required setup transfers, and eating A current hypertension indicated Resident required treatment intervention to obsort of elevated blood pressure) > (greater dizziness, flush fact nausea/vomiting).	O A.M., Corporate Clinical dicated family should be ant changes, including oss, the same day it was time, she indicated notifications ted in a progress note.  O A.M., the DON (Director of she was unable to find family for significant weight 3.  1:26 A.M., Resident F's clinical d. Diagnoses included, but a cerebral infarction due to its of small artery and  mission MDS (Minimum Data atted 8/25/23, indicated derate cognitive impairment assistance for bed mobility, g.  sion care plan, dated 8/24/23, F had hypertension that and monitoring with an erve for signs and symptoms ressure (systolic BP (blood of than) 140, diastolic BP >90, e, headache, nosebleed,			
	rnysician orders in	cluded, but weren't limited to,			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155773	B. WING		10/31/2023
			STREET	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF P	ROVIDER OR SUPPLIER	L		ICDOWELL RD	
TERRAC	E AT SOLARBRON	I THE		SVILLE, IN 47712	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	the following:				
		d pressure medication) tablet;			
	- ' - '	amt (amount): 25 mg (1 tablet);			
	· ·	12:00 AM, dated 08/21/2023 to			
	10/16/2023				
	hydralazine tablet: 2	25 mg; amt: 50 mg; oral			
	-	: Check Blood Pressure and			
	-	ic blood pressure) is less than			
		0mg tablet after 25mg are gone.			
	Every 8 hours, date	d 10/16/2023 to 10/19/20			
		25 mg; amt: 50 mg; oral			
	*	: Check Blood Pressure and			
		than 110. May use one 50mg			
		e gone. Report systolic bp			
	>180 Every 8 hours	, dated 10/19/2023			
	A physician's note,	dated 10/16/23, indicated			
		en for report of hypertension			
	this morning with s	ystolic BP > 190. Review of			
	blood pressures not	ed consistently systolic BP is			
	> 160. Will increase	e hydralazine and monitor".			
	A	datad 10/10/22 in ditd			
		dated 10/19/23, indicated en for follow-up regarding her			
		en for follow-up regarding her  ). Her hydralazine was			
		(milligrams) po (by mouth)			
	_	(minigrams) po (by mouth) /16/23. The current supply is			
		The box in the medication			
		mg, take one tab po (by			
	-	rs. The order does say 50 mg,			
		what she is getting routinely.			
		ye been consistently greater			
	•	ith several readings > 190			
	-	e label was clearly marked to			
	•	5 mg tabs are exhausted, she			
		tab every 8 hours. Checked BP			
		(1:15 P.M.), 136/82".			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/31/2023		
	PROVIDER OR SUPPLIEF			1701 M	DDRESS, CITY, STATE, ZIP COD CDOWELL RD VILLE, IN 47712		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	F	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
	REGULATORY OF A progress note, da approximately 12:5 the nurse's station s with his mother. He lid look different; d noted to slightly lov at this time; right ey This writer immedi Vitals: BP 143/24, on room air, Temp (respirations) 16. G able to raise bilaters them up. She stated was blurry compare A&O (alert and orio wanted to eat for lu resident's room app observed resident le wheel chair, Right a the wheel chair; res with slurred speech the room [sic]. Vita 83, O2 90%, Resp verbal order to send (due to) possible sta	ted 10/20/23, indicated "At Opm [sic] resident's son came to tating something was wrong e stated he noticed her right eye rooping. Outer Right eye lid wer then the Left outer eye lid ye lid looked slightly puffy. ately assessed the resident. P (pulse) 84, O2 (oxygen) 95% (temperature) 98.1, Resp rasps were equal bilaterally; al arms above head and hold that her vision in the right eye at to the left eye. She was ented); able to tell me what she nch. I returned to the roximately 5 minutes later and caning to the right side of the arm was hanging down beside ident responded to questions. [Name of provider] arrived ls were repeated: BP 126/65, P 16. [Name of provider] gave 1 to ER (emergency room) d/t roke".  d pressures were obtained 10/20: . 194/82 166/77 . 158/84 1. 166/74 1. 166/77 . 154/72 191/87	F		(EACH CORRECTIVE ACTION SHOULD BE	TE .	
	10/19/23 8:40 A.M 10/19/23 8:17 P.M. 10/19/23 8:32 P.M. 10/20/23 11:09 A.M	191/91 191/91					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155773	B. W	ING		10/31	/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	The MAD (madigat	ion 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.						
		P.M., Corporate Clinical					
		dicated 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						
		ated if call orders for blood					
		pecified, it would be up to the whether to notify the provider.					
	nuise's judgement v	viietilei to notify the provider.					
	On 10/30/23 at 8:44	4 A.M., LPN (Licensed Practical					
		provider notification was					
	1	progress notes. At that time,					
	she indicated that sl	he would notify the provider if					
	a resident's systolic	blood pressure was 160 or					
		all the provider multiple times					
	if the systolic blood	I pressure was in the 190s.					
	On 10/26/23 at 11:0	05 A.M., a "Change in a					
		n or Status" policy, revised					
	October 2010, indic						
	Supervisor/Charge	Nurse will notify the resident's					
	Attending Physician	n or On-Call Physician when					
	there has been a sig	nificant change in the					
		emotional/mental condition					
		ge" of condition is a decline or					
	_	resident's status that will not					
		self without intervention by					
		Supervisor/Charge Nurse will					
	-	responsible party of family					
		gnificant change in the					
	resident's physical,	mental, or psychosocial					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/31/2023
	ROVIDER OR SUPPLIER		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
F 0641 SS=D Bldg. 00	status".  This citation relates 3.1-5(a)(2)  483.20(g) Accuracy of Asses §483.20(g) Accura The assessment is resident's status. Based on interview failed to ensure the Assessment was coresidents reviewed  Finding includes:  On 10/25/23 at 8:53 record was reviewed not limited to, end state of the control o	ssments acy of Assessments. must accurately reflect the and record review, the facility MDS (Minimum Data Set) mpleted accurately for 1 of 1 for dialysis. (Resident 50)  5 A.M., Resident 50's clinical d. Diagnosis included, but was stage renal disease (ESRD).  arterly MDS (Minimum Data ated 7/29/23, indicated cognitive impairment and was sis.  orders included, but were not Center] Pick up time 3:30am s: Early Breakfast Tray Once A Fri, dated 09/13/2023 cian orders included, but were Center] Pick up time 3:30am by tion company] Special	F 0641	F-Tag 641: Accuracy of Assessments  The corrective actions to accomplished for those reside found to have been affected by practice. Currently, residents had no ill effects from this alled efficient practice. The MDS for Resident 50 was corrected on day the coding error was identified.  The facility will identify of residents that may potentially affected by this practice. Curror residents have the potential to affected by this alleged practice. Dialysis residents who reside Solarbron Terrace have been audited to ensure MDS coding correct. The MDS of residents have been audited to ensure comprehensive assessments coded and completed accurate The facility will put into pothe following systematic change to ensure that the practice documents accorded and the practice documents.	11/27/2023  be ents by the have eged or in the ther be ent or be ce. at g is a are rely. lace ges
	_	Breakfast Tray Once A Day on ed 10/24/2022 to 09/13/2023		not recur. MDS staff will be re-educated on proper coding	of

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resident assessments.

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CENTERS FOR	MEDICARE & MEDIC				OM	B NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155773	B. WING		10/31/2023		
		199779	<u> </u>		10/31/	2023	
NAME OF D	DOMED OF CLIPPLIED		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	C	1701 M	ICDOWELL RD			
TERRAC	E AT SOLARBRON	I THE		SVILLE, IN 47712			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	A current hemodial	ysis care plan, dated 6/1/21,		The facility will monitor th	e		
		receives Hemodialysis due to		corrective action by implement			
	ESRD and is at risk	-		the following measure. Director	-		
	ESKD and is at risk	Tor complications.		_			
	D (11.1.1			Nursing or designee will audit			
	<u>-</u>	ment forms were completed		random residents 3 x weekly x			
	on 7/17/23, 7/19/23	, 7/21/23, 7/26/23.		weeks, then weekly x 4 weeks	ί,		
				then monthly x 4 months to			
	[Name of dialysis c	enter] forms were completed on		ensure resident assessment a	re		
	7/17/23, 7/19/23, 7/	/21/23, 7/26/23, 7/28/23.		completed accurately. The res	ults		
				of these audits will be presented	ed		
	On 10/27/23 at 2:06	6 P.M., the MDS Coordinator		to the monthly Quality			
		nt did receive dialysis during		Assurance/Performance			
		l and should have been coded		Improvement Committee. The			
		t time, she indicated the		1 .			
				facility will achieve 100%			
	=	AI (Resident Assessment		compliance threshold prior to			
		Manual as their policy on		adjusting the frequency of aud			
	coding the MDS As	ssessment.		Plan to be updated as indicate	ed.		
	The RAI Manual in	dicated "Code peritoneal or					
	renal dialysis which	occurs at the nursing home or					
	at another facility, r	record treatments of					
	hemofiltration, Slov	w Continuous Ultrafiltration					
		s Arteriovenous Hemofiltration					
		inuous Ambulatory Peritoneal					
	Dialysis (CAPD) in						
		tills item .					
F 0689	483.25(d)(1)(2)						
SS=G							
	Free of Accident	. 15					
Bldg. 00	Hazards/Supervisi						
	§483.25(d) Accide						
	The facility must e						
		e resident environment					
	remains as free of	f accident hazards as is					
	possible; and						
	·						
	\$483.25(d)(2)Fact	h resident receives					
		sion and assistance devices					
	to prevent accider						
			F 0600	F Tax 000, Francis Assistant		11/07/2022	
	Based on observation	on, interview, and record	F 0689	F-Tag 689: Free of Accident		11/27/2023	

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review, the facility failed to ensure a sit to stand

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Hazards/Supervision/Devices

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/31/2023 155773 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1701 MCDOWELL RD TERRACE AT SOLARBRON THE **EVANSVILLE, IN 47712** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE lift was used according to facility policy for 1 of 6 The corrective actions to be residents reviewed for falls. This deficient practice accomplished for those residents led to a fall with a fracture requiring found to have been affected by the hospitalization and surgical repair. (Resident M) practice. Resident M's fracture is healing, and her current fall Finding includes: interventions have been reviewed. The facility will identify other During a confidential interview on 10/24/23 at residents that may potentially be 11:13 A.M., it was indicated that a CNA (Certified affected by this practice. Nurse Aide) dropped Resident M while using a sit Residents residing at Solarbron to stand lift resulting in a broken ankle. have the potential to be affected by this alleged deficient practice. On 10/25/23 at 10:19 A.M., Resident M's clinical Current residents fall interventions record was reviewed. Diagnosis included, but was have been audited to ensure fall not limited to, unspecified fracture of shaft of right interventions are implemented and femur. appropriate. The facility will put into place The most recent quarterly MDS (Minimum Data the following systematic changes Set) Assessment, dated 9/25/23, indicated to ensure that the practice does Resident M had moderate cognitive impairment, not recur. Nursing staff will be had no falls since the prior assessment, and re-educated on our fall policy, sit required assistance of 2 staff for bed mobility, to stand lift policy, and transfers, toileting, and bathing. implementing interventions. The facility will monitor the The quarterly MDS Assessment completed prior corrective action by implementing to the resident's fall, dated 1/17/23, indicated the the following measure. The resident had moderate cognitive impairment, had Director of Nursing or designee will no falls since the prior assessment, and required audit fall interventions at least 5 x extensive assistance of 2 staff for bed mobility, per week for 4 weeks, then weekly transfers, toileting, and bathing. x 4 weeks, then bi-weekly x 4 months, then monthly x 6 months A current falls care plan, dated 3/4/23, indicated to ensure fall interventions are the resident was at risk for falls with injury due to implemented. her impaired mobility, weakness, poor activity The results of these audits will be tolerance, and repair of right femur fracture. presented to the monthly Quality Assurance/Performance A previous falls care plan, dated 1/27/23, indicated Improvement Committee. The the resident was at risk for falling and fall related facility will achieve 100%

incontinence.

injuries related to weakness, infection, and

compliance threshold prior to

adjusting the frequency of audits.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED  B. WING 10/31/2023				
		155773	B. W	'ING		10/31	/2023
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
					CDOWELL RD		
TERRAC	E AT SOLARBRON	I THE		EVANS'	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	A current behaviore	al care plan, dated 3/4/23,			Plan to be updated as indicate	ea.	
		nt was noncompliant with care					
		ch staff she would allow to					
		want to use sit to stand lift, but					
	needed 2 staff minii	mum for safe transfers.					
	_	ral care plan, dated 1/27/23,					
		nt was noncompliant with care					
		ch staff she would allow to want to use sit to stand lift, but					
	· ·	mum for safe transfers.					
	needed 2 starr minn	main for safe transfers.					
	A Post Fall Assessn	nent indicated Resident M					
	sustained a witnesse	ed fall on 2/28/23 at 5:15 P.M.					
	while being transfer	rred using a sit to stand lift.					
	were not limited to:	ed to the fall included, but					
		I. "Resident was on the sit to					
		came unbearable for staff.					
	_	ent to the floor, obtained the					
		ered pad and lifted resident to					
		ary had occurred during					
	transfers. Resident	stated "This was not bad".					
	Refer for PT (physi	cal therapy) to eval (evaluate)					
	and treat".						
	2/01/2022 0 40 4 3	# HD '1 / / 1 ' 1 'C					
		I. "Resident c/o (complained of)					
		pain scale of 1 to 10) to RLE ity). Resident has bruise to					
	` •	otified [name of provider].					
	-	STAT (immediate) x-ray to					
	bruised area RLE".	, <b>,</b>					
		I. "Said nurse (writer) received					
		be sent to [name of hospital]					
		eport giving [sic] to [name of					
		e of emergency contact] to					
	make aware. Manag	gement notified".					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIEI		1701 N	ADDRESS, CITY, STATE, ZIP COD MCDOWELL RD SVILLE, IN 47712	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	company] transport and in her wheelches on her right leg. Sh with assist of two s Sling was then rem positioned in her be She is now clean ar completed. Mild re moisture contact. S pain pump in her ri [sic] when empty". Resident M underwretrograde intramed was performed.  3/08/2023 8:39 A.N. Note: Resident had was lowered to the unable to bear weighthe sit to stand lift. RLE the next morn resident transferred (treatment). Resident Care plan reviewed Resident care profit for transfers".  A Post Fall Event A indicated the fall of [name of CNA 23] one surface to anoth The assessment indigirl swung me arou was hurting my legassessment showed pain with active/par	M. "Resident arrived via [name of evan. She is on a Hoyer sling air. She has an immbolizer [sic] e was transferred via Hoyer lift taff from her chair to her bed. oved and resident was ed and pericare [sic] performed. In dry. Skin assessment didess on buttocks from he has a [name of company] ght leg set on 8. To disgard went surgery on 3/2/23 where a dullary nailing to the right femur.  M. "IDT (Interdisciplinary Team) incident on 2/28/23 where she floor due to weakness and ght while being transferred in Resident had increased pain to ing, x-rays obtained and to hospital for eval and tx nt returned to facility on 3/4/23. In and updated upon return. It is updated to include Hoyer lift.  Assessment, dated 3/2/23, in 2/28/23 was witnessed by while being transferred from ther using a sit and stand lift. It is a sit and stand lift. It i			
	During an interview	· 011 10/20/25 at 7.50 11.1VI., CCD	1	1	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		A. BUILDING B. WING	onstruction 00	COM	ie survey ipleted 31/2023
		1701 M	CDOWELL RD	COD	
CH DEFICIEN JLATORY OF	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SE	HOULD BE	(X5) COMPLETION DATE
ate Clinical eded to ope e indicated of the event g the sit to a no longer an interview ed a represe y came to a lan in-servent. Following a skills with a fernancial interview of a skills with a skill	Support) 4 indicated two staff rate the sit to stand lift. At that she was unable to confirm including how many staff were stand lift because the staff worked at the facility.  You on 10/27/23 at 1:30 P.M., CCS entative from [name of the facility annually and ice on the sit to stand ing the in-service, staff ralidation. At that time, she dent M's fall, staff were education on the operation of the skills Validation" checklist 1/27/23 at 3:30 P.M. and if members are required for a sheelchair to the toilet and back sing a sit to stand lift by  B. P.M., CNA 11's Job Specific was provided and indicated ed training on operating a lift of the staff of th				
	SUMMARY: CH DEFICIEN SUMMARY: CH DEFICIEN SULATORY OR ate Clinical ded to oper e indicated of the event g the sit to on the sit to one an interview and a repres y came to the sit of the sit to one an interview and a repres y came to the sit of the event of the an in-serv ont. Following and a skills with a state and the sit of the sit of the event of the	DR SUPPLIER  LARBRON THE  SUMMARY STATEMENT OF DEFICIENCIE CH DEFICIENCY MUST BE PRECEDED BY FULL DIATORY OR LSC IDENTIFYING INFORMATION ate Clinical Support) 4 indicated two staff eded to operate the sit to stand lift. At that the indicated she was unable to confirm of the event including how many staff were go the sit to stand lift because the staff In olonger worked at the facility.  In interview on 10/27/23 at 1:30 P.M., CCS and a representative from [name of y] came to the facility annually and In in-service on the sit to stand ant. Following the in-service, staff and askills validation. At that time, she of after Resident M's fall, staff were In additional education on the operation of  sferring a Resident with a fechanical Lift Skills Validation" checklist yided on 10/27/23 at 3:30 P.M. and In "Two staff members are required for a cal lift".  5/23 at 9:22 A.M. during a random ion, CNA 11 was observed transferring a from her wheelchair to the toilet and back heelchair using a sit to stand lift by	DR SUPPLIER  LARBRON THE  SUMMARY STATEMENT OF DEFICIENCIE  HD DEFICIENCY MUST BE PRECEDED BY FULL  LATORY OR LSC IDENTIFYING INFORMATION  atte Clinical Support) 4 indicated two staff  added to operate the sit to stand lift. At that  a indicated she was unable to confirm  f the event including how many staff were  g the sit to stand lift because the staff  an olonger worked at the facility.  In interview on 10/27/23 at 1:30 P.M., CCS  and a representative from [name of  y] came to the facility annually and  at an in-service on the sit to stand  ant. Following the in-service, staff  ad a skills validation. At that time, she  a diditional education on the operation of  sferring a Resident with a  dechanical Lift Skills Validation" checklist  yided on 10/27/23 at 3:30 P.M. and  and "Two staff members are required for a  cal lift".  5/23 at 9:22 A.M. during a random  ion, CNA 11 was observed transferring a  from her wheelchair to the toilet and back  sheelchair using a sit to stand lift by  7/23 at 2:48 P.M., CNA 11's Job Specific  ion report was provided and indicated  had received training on operating a lift  23.  6/23 at 11:05 A.M., a "Transferring a  at with a Stand Up Lift Skills Validations"  undated, was provided and indicated	TISTORY B. WING  STREET ADDRESS, CITY, STATE, ZIP CONTROL TO MCDOWELL RD EVANSVILLE, IN 47712  SUMMARY STATEMENT OF DEFICIENCIE HD DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION the Clinical Support) 4 indicated two staff edded to operate the sit to stand lift. At that is indicated she was unable to confirm for the event including how many staff were go the sit to stand lift because the staff in longer worked at the facility.  In interview on 10/27/23 at 1:30 P.M., CCS ed a representative from [name of y] came to the facility annually and la nin-service, staff ed a skills validation. At that time, she la after Resident M's fall, staff were a additional education on the operation of  sferring a Resident with a fechanical Lift Skills Validation" checklist rided on 10/27/23 at 3:30 P.M. and in "Two staff members are required for a cal lift".  5/23 at 9:22 A.M. during a random ion, CNA 11 was observed transferring a from her wheelchair to the toilet and back heelchair using a sit to stand lift by  7/23 at 2:48 P.M., CNA 11's Job Specific ion report was provided and indicated had received training on operating a lift 23.  6/23 at 11:05 A.M., a "Transferring a twith a Stand Up Lift Skills Validations" indated, was provided and indicated with a stand Up Lift Skills Validations" indated, was provided and indicated the date of the provided and indicated the stand of the provided and indicated had received training on operating a lift 23.	STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712  SUMMARY STATEMENT OF DEFICIENCIE 31 DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION the Clinical Support) 4 indicated two staff shed to operate the sit to stand lift. At that indicated she was unable to confirm if the event including how many staff were get he sit to stand lift because the staff In o longer worked at the facility.  In interview on 10/27/23 at 1:30 P.M., CCS end a representative from [name of y] came to the facility annually and I an in-service on the sit to stand int. Following the in-service, staff ad a skills validation. At that time, she a dafter Resident Wis fall, staff were a duditional education on the operation of sferring a Resident with a techanical Lift Skills Validation" checklist yided on 10/27/23 at 3:30 P.M. and i"Two staff members are required for a cal lift".  5/23 at 9:22 A.M. during a random ion, CNA 11 was observed transferring a from her wheelchair to the toilet and back heelchair using a sit to stand lift by  7/23 at 2:48 P.M., CNA 11's Job Specific ion report was provided and indicated had received training on operating a lift 23.  6/23 at 11:05 A.M., a "Transferring a twith a Stand Up Lift Skills Validations" indated, was provided and indicated indicated, was provided and indicated indicated, was provided and indicated indicated, was provided and indicated

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  10/31/2023	-
	PROVIDER OR SUPPLIEI		1701	r address, city, state, zip cod MCDOWELL RD ISVILLE, IN 47712		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	_
	3.1-45(a)(2)					
F 0690 SS=D Bldg. 00	§483.25(e) (1) The resident who is composed on admissing assistance to main or her clinical contract continence is \$483.25(e)(2) For incontinence, base comprehensive as ensure that- (i) A resident who an indwelling cather unless the resident demonstrates that necessary; (ii) A resident who indwelling cather one is assessed for as soon as possible clinical condition of catheterization is (iii) A resident who receives appropriate to prevent urinary restore continence.  §483.25(e)(3) For incontinence, base comprehensive as	e facility must ensure that ontinent of bladder and on receives services and ntain continence unless his dition is or becomes such not possible to maintain.  a resident with urinary ed on the resident's essessment, the facility must enters the facility without neter is not catheterized nt's clinical condition to catheterization was one enters the facility with an error subsequently receives or removal of the catheter ole unless the resident's demonstrates that				
	bowel receives ap services to restor function as possib	ppropriate treatment and e as much normal bowel	F 0690	F-Tag 690: Bowel/Bladd	er 11/27/2023	
	I Dascu on mich view	and record review, the facility	1 15 11/6/911	i r-iau ozu. Dowei/Diadd(	tı 11/////////	

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]	DEPARTMENT OF HEALTH AND HUMAN SERVICES						
•	CENTERS FOR MEDICARE & MEDICA	AID SERVICES					
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/31/2023 155773 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1701 MCDOWELL RD TERRACE AT SOLARBRON THE **EVANSVILLE, IN 47712** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure appropriate treatment was Incontinence provided to prevent recurring Urinary Tract The corrective actions to be Infections (UTIs) in 1 of 4 residents reviewed for accomplished for those residents UTIs (Resident M). found to have been affected by the practice. Residents M's UTI has Finding includes: resolved and suffered no ill effects from this alleged deficient On 10/25/23 at 10:19 A.M., Resident M's clinical practice. record was reviewed. Diagnoses included, but The facility will identify other were not limited to, urinary tract infection and residents that may potentially be personal history of urinary tract infections. affected by this practice. Residents residing at Solarbron The most recent quarterly MDS (Minimum Data Terrace have the potential to be Set) Assessment, dated 9/25/23, indicated affected by this alleged deficient Resident M had moderate cognitive impairment, practice. Residents residing at was always incontinent of urine and frequently Solarbron Terrace with a dx of UTI incontinent of bowel, and required extensive have been audited to ensure assistance of 2 staff for bed mobility, transfers, appropriate treatment is provided. toileting, and bathing. The facility will put into place the following systematic changes A current UTI care plan, dated 3/4/23, indicated to ensure that the practice does the resident had a history of recurrent abnormal not recur. Licensed nurses have urinalysis/UTI and often required antibiotic been re-educated on appropriate therapy for treatment. treatment of UTIs. The facility will monitor the The clinical record indicated Resident M had 8 corrective action by implementing UTIs since January 2023. the following measure. DON/Designee will review 3 random residents per week for four A progress note, dated 2/20/2023 at 6:52 P.M., (4) weeks, then weekly for four (4) indicated "Received call from [name of provider] weeks, then biweekly for (4) with new orders: UA (urinalysis) micro C+S weeks, then monthly 3 additional (culture and sensitivity) if indicated, cath months to ensure appropriate (catheter) for specimen. Obtain BMP (basic treatment is provided for UTIs. The metabolic panel) in AM (morning) 2/21/23". results of these audits will be presented to the monthly Quality A urine culture lab report, dated 2/26/23, indicated Assurance/Performance the specimen was obtained via in and out cath Improvement Committee. The and "multiple potential uropathogens present in facility will achieve 100% the specimen indicate probable contamination. A compliance threshold prior to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155773	B. Wl	ING		10/31/2023	
	PROVIDER OR SUPPLIER			1701 M	ADDRESS, CITY, STATE, ZIP COD CDOWELL RD VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	V
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	recollect CCMS (cl	ean catch midstream) or in and			adjusting the frequency of aud	its.	
	out catheter specime	en is recommended".			Plan to be updated as indicate	ed.	
	recollection.	lacked documentation of a  7/23, indicated ceftriaxone (an					
	· ·	on) recon (reconstituted) soln					
		injection Special Instructions:					
	· ·	th) lidocaine, adm (administer)					
	• ` / `	ramuscular) x (times) 5 days.					
	Dx (diagnosis): Uri	nary Tract Infection					
	indicated "[name of orders for UA with	ted 3/12/23 at 7:54 P.M., [provider] called with new micro by in and out cath. CBC unt), Renal profile".					
	indicated "Received provider] to d/c (dis Keflex 500mg bid (	ted 3/14/2023 at 10:49 A.M., d orders from [name of scontinue) order for UA. Start twice a day) x 5 days for UTI. vitals q (every) shift and report ition".					
	indicated "Resident possible UTI. The A Criteria. Nsg (Nursi report unusual findi	ted 3/17/23 at 2:58 P.M., is on ATB (antibiotics) for ATB does not meet McGreer ing) to continue to observe and ngs to MD/NP (medical ioner) as indicated".					
	indicated "Received to continue Keflex a when results are fin						
	-	ng results of the culture and sested and not provided.					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. WING 10/31/2023				/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			CDOWELL RD		
TERRAC	E AT SOLARBRON	J THE			VILLE, IN 47712		
121110102711027110110111112			LVAINO	VILLE, IIV 477 12			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		4/23 with a stop date of					
		(an antibiotic medicine)					
		nilligrams); amt (amount): 1					
	-	A Day Dx: Urinary Tract					
	Infection						
	LUDI A						
	UTI 3	4- 1 4/10/22 -4 12:20 D.M					
		ted 4/18/23 at 12:38 P.M., f lab] notified to retrieve Stat					
	(immediate) UA. Re	= = = = = = = = = = = = = = = = = = = =					
	` ′	al malaise. Pale in color. Fluids					
	encouraged. Urine dark yellow and cloudy. Call pendant in place. Care continues".						
	pendant in place.	are continues.					
	A progress note, da	ted 4/18/2023 at 12:51 P.M.,					
		er per [name of provider]:					
		n 1 g (gram) dose at this time".					
	A progress note, da	ted 4/19/23 at 9:15 A.M.,					
		riew: resident received IM					
	Rocephin secondary	y to abnormal lab;					
	Leukocytosis with	WBC (white blood count) -					
	12.1. UA C&S orde	ered and obtained via in/out					
	cath. UA positive, a	awaiting C&S results".					
		dated 4/19/23, indicated "She					
		n 1 gram IM yesterday and are					
	_	sults. Just received report					
		bacteria, likely contaminated.					
		and S on 4/5/23. Given her					
	-	d and her change in mental					
	status. Will treat".						
		. 1 . 14/10/22 : 1: . 1					
		report, dated 4/18/23, indicated					
	-	ained via in and out cath and					
	•	morphotypes present,					
	indicating a contam	imated specimen".					
	An order dated 4/1	8/23, ceftriaxone recon soln; 1					
	<sup>2</sup> 111 01001, uaicu 4/1	or 25, certificatione recoil soin, 1					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED 10/31/2023	
		155773	B. W	ING		10/31/	2023
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
TERRAC	E AT SOLARBRON	J THE			CDOWELL RD VILLE, IN 47712		
	1		1	<u> </u>	··, III III		(N/C)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		injection Once Dx: other					
	general symptoms a	and signs					
	4/24/23, cefuroximo medication) tablet;	0/23 with a stop date of e axetil (an antibiotic 500 mg; amt: 500 mg; oral Jrinary Tract Infection					
	UTI 4	ted 5/1/23, indicated					
		ia, urgency, w/ (with)					
		ations/altered mental status					
		collection via in and out cath.					
	_	and cloudy in appearance. ied to retrieve UA as ordered".					
	[ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [ [	ica to retrieve OA as oraclea.					
		ted 5/02/2023 at 11:08 P.M.,					
		one IM x 1 dose administered					
	today per evening s culture remains pen	hift nurse as ordered. Urine					
	culture remains pen	dding at tins time.					
	A progress note, da	ted 5/03/2023 at 12:59 P.M.,					
		der received new order for					
		Rocephin 1gm x4 q 24hr					
	(nours) beginning 5 contact] contacted".	3/3 to 5/6. [name of emergency					
		ted 5/08/2023 at 12:06 P.M.,					
		continues w/hallucinations					
		ephin injections completed as Resident states she is not sure					
		urinary symptoms. [name of					
	provider] notified, 1	medication review requested.					
	Care continues".						
	A urine culture lab	report, dated 5/1/23, indicated					
		btained via in and out cath					
		erial morphotypes present,					
	indicating a contam	inated specimen".					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 10/31/2023				
		155773	B. W	ING		10/31/	2023
	PROVIDER OR SUPPLIER			1701 M	NDDRESS, CITY, STATE, ZIP COD CDOWELL RD VILLE, IN 47712		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	An order, dated 5/2	/23, ceftriaxone recon soln; 1					
	gram; amt: IM; inje chronic kidney dise	ection Once Dx: anemia in ase					
	An order, dated 5/3	/23 with a stop date of 5/6/23,					
		oln; 1 gram; amt: IM; injection					
		sonal history of urinary tract					
	infections						
	On 5/10/23 Resider	nt M was placed on					
	prophylactic antibio	-					
	An order, dated 5/11/23 with a stop date of						
	5/15/23, indicated Macrobid (an antibiotic						
	medication) (nitroft	urantoin monohyd/m-cryst)					
	capsule; 100 mg; ar	nt: 100 mg; oral Twice A Day					
		6/23 with a stop date of					
		Macrobid (nitrofurantoin					
	monohyd/m-cryst) oral Once	capsule; 100 mg; amt: 100 mg;					
	UTI 5						
		ted 6/2/23 at 1:19 P.M.,					
	_	staff reports resident					
		ehaviors/hallucinations. y taking a prophylactic					
		y taking a prophylactic current UTI; Macrobid 100mg					
		hrough 6/15. This writer					
	•	provider] to review her meds					
	_	fects that could be causing					
	these behaviors. Av						
		ted 6/07/2023 at 6:17 P.M.,					
		lture and sensitivity reviewed					
		cate a contaminated specimen.					
	No new orders."						
		report, dated 6/7/23, indicated btained via CCMS and					

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	PROVIDER OR SUPPLIER		1701 M	ADDRESS, CITY, STATE, ZIP COI CDOWELL RD SVILLE, IN 47712	D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG		a LSC IDENTIFYING INFORMATION morphotypes present, inated specimen".	TAG	DETELLACT		DATE
	indicated "[name of r/t (related to) c/o b monitor".	ted 6/26/23 at 2:06 P.M., [Provider] gave orders for UA urning while urinating. Will				
	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".					
	the specimen was o	report, dated 6/26/23, indicated btained via in and out cath rial morphotypes present, inated specimen".				
	cefdinir (an antibiot	9/23 with a stop date of 7/3/23, tic medication) capsule; 300 aral Twice A Day Dx: Urinary				
	indicated "Call out with c/o painful urin New orders receive	ted 8/16/23 at 2:47 P.M., to triage concerning resident nation and foul smelling urine. d for UA with C&S if indicated C and renal profile. Orders ter".				
	"Despite using in an	dated 8/18/23, indicated and out cath for specimens, successful at getting a sample				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	ING		10/31/	2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R.			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		cteria that sensitivity can be					
	_	s show multiple bacteria. She					
	does report dysuria, "burns bad" when she urinates. She does not have redness that would						
		n urine on the skin. Will go					
	ahead and treat short term antibiotics".						
	A urine culture lab report, dated 8/16/23, indicated						
		btained via in and out cath					
	_	rial morphotypes present,					
	indicating a contam						
	An order, dated 8/1	9/23 with a stop date of					
	8/23/23, ceftin table	et; 500 mg; amt: 500 mg; oral					
	Twice A Day Dx: U	Jrinary tract infection					
	TITLO						
	UTI 8	1-4-10/15/22 :1:4-1					
		dated 9/15/23, indicated ten for follow-up regarding					
		er report of burning with					
		she "trembled" when urinating					
	_	lers were given for good					
	_	in and out cath for UA, C and					
		ns) monitoring. Review of her					
	, ,	ted these orders were given by					
		the facility, but do not see					
	•	ted in EMR (electronic medical					
	-	out. She continues to say she					
	burns/has pain when	never she urinates, or has a					
	-	She has not had a fever, chills,					
	increased confusion	, suprapubic tenderness. Her					
	urine does have a st	rong odor, but this is not new.					
		e has a UTI. He last several					
	-	itive, but grew multiple					
		ought to be contaminated					
		l out cath specimens. Will try					
		ridium, and continue to					
		f active infection. She is mildly					
		r labia, urethra. Her confusion					
	is baseline".						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155773	B. WI	NG		10/31/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	NOVEMBER N. AN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	9/17/23, Pyridium (complete provided and included in surveilla and standardized de used to help recognition).	P.M., Corporate Clinical dicated the provider must give re and sensitivity recheck to vas contaminated. At that time, cility's Infection Preventionist remployee who was filling in who was not in the facility and starting employment on indicated antibiotic use was hly basis and as needed.  P.M., the Administrator y used McGreer criteria to see; however, the provider verride the recommendation. Icated antibiotic use was ility's morning meeting, but or provide any the discussion regarding office use.  P.M., an "Infection Prevention m" policy, dated 6/6/19, was ted "Culture reports, antibiotic usage reviews are ance activities. Medical criteria finitions of infections are ize and manage infections. evaluated, and practitioners					

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155773	B. W	ING		10/31/	/2023
TERRAC	PROVIDER OR SUPPLIEI	N THE	<u>'</u>	1701 M EVANS	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712		aro.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
F 0695 SS=E Bldg. 00	Suctioning § 483.25(i) Respit tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such oprofessional stand comprehensive pother esidents' goad 483.65 of this sub Based on observative, the facility received the necess services in accordans standards of practic for respiratory care physician oxygenat tubing and humidiff Resident 22, Resided 45)  Findings include:  1. On 10/25/23 at 1 observed lying in becannula (nc) at 2 lpoxygen tubing was humidification bottom of 10/27/23 at 9:00 observed sitting upoxygen on at 2 lpm oxygen on at 2 lpm	e and tracheal suctioning, care, consistent with dards of practice, the erson-centered care plan, als and preferences, and opart.  on, interview and record failed to ensure residents ary respiratory care and nee with the professional se for 5 of 6 residents reviewed. The facility failed to follow ion orders and date oxygen fication bottles. (Resident 13, ent 31, Resident 44, Resident  0:15 A.M., Resident 13 was ed with oxygen on per nasal m (liters per minute). The dated 9/11/23. The le was not dated.  0 A.M., Resident 13 was in bed eating breakfast with per nc. The oxygen tubing was there was no date on the	F 00	595	F-Tag 695: Respiratory Care  The corrective actions to accomplished for those reside found to have been affected by practice. The date of the oxyge tubing and humidification bottle for Residents 13, 22, 31, 44, a 45 were corrected on the day the error was identified.  The facility will identify other residents that may potentially affected by this practice. Residents residing at Solarbro have the potential to be affected by this alleged deficient practice. Current residents with oxygen tubing and humidification bottle have been audited to ensure the proper date is labeled on the oxygen tubing and humidification bottles.  The facility will put into plate following systematic change to ensure that the practice does not recur. Licensed nurses/QN	nts y the en es nd the her be n ed ce. es he ion acce ges	11/27/2023

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On 10/30/23 at 10:28 A.M., Resident 13 was

observed wearing oxygen at 2 lpm per nc. The

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care policy.

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will be re-educated on respiratory

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	ING		10/31/	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
TEDDAG	NE AT OOL ABBBOA	1 TUE			CDOWELL RD		
TERRAC	E AT SOLARBRON	NIHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	oxygen tubing was				The facility will monitor th	e	
	humidification bottle was dated 10/30/23.				corrective action by implemen		
	namaneation soule was dated 10/30/25.				the following measure. Directo	•	
	On 10/26/23 at 12:50 P.M., Resident 13's clinical				Nursing or designee will audit	. 0.	
		ved. Resident 13 was admitted			residents with oxygen tubing a	nd	
		es included, but were not			humidification bottles at least		
	_	chronic systolic (congestive)			per week for 4 weeks, then we		
		- · · · · · · · · · · · · · · · · · · ·			x 4 weeks, then bi-weekly x 4	, only	
	heart failure and Alzheimer's disease.				months, then monthly x 3 mon	the	
	The most recent significant change in condition				to ensure fall interventions are		
		ata Set) Assessment, dated			implemented. The results of th		
	,	Resident 13 was unable to			audits will be presented to the	1636	
	· ·	Interview for Mental Status,			monthly Quality		
	_	assistance of two for bed			Assurance/Performance		
	_	er, extensive assistance of one					
		t use, and total dependence for			Improvement Committee. The		
	_	use, and total dependence for			facility will achieve 100%		
	bathing.				compliance threshold prior to	:4 -	
		1 2 1 1 1 1			adjusting the frequency of aud		
		orders included, but were not			Plan to be updated as indicate	ea.	
	limited to, the follo	-					
	dated 9/5/2023	o continue to treat resident,					
	Oxygen per nasal ca	annula 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 b	pottle and nebulizer tubing					
	A current care plan	for oxygen therapy, initiated					
	10/23/23, included,	but was not limited to the					
	following intervent	ion: Administer oxygen as					
	ordered. Start Date						
	2. On 10/25/23 at 1	0:19 A.M., Resident 22 was					
	observed sitting on	the side of the bed eating					
		on at 2 lpm per nc. The					
		le was dated 10/23, the oxygen					
	tubing was not date						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/31/2023
	ROVIDER OR SUPPLIER E AT SOLARBRON THE	1701 [	CADDRESS, CITY, STATE, ZIP COD MCDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	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 oxyge 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. Twick A Day Upon Rising 6:00 A.M 6:00 P.M., Befo 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.	th  th  ce  ce  re  e  ge		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155773	B. WING		10/31/2023	
			CTDE	ET ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	2		ET ADDRESS, CITY, STATE, ZIP COD MCDOWELL RD		
TEDDAG		LTUE		NSVILLE, IN 47712		
TERRAC	E AT SOLARBRON	NIHE	EVA	NSVILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ON (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		OBE COMPLETION	i
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	On 10/31/23 at 11:5	55 A.M., Resident 22's TAR				
	(Treatment Adminis	stration 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 10/8/2	3, 10/15/23, left blank on				
	10/22/23 and initial					
	3. On 10/25/23 at 1	0:59 A.M., Resident 45 was				
	observed lying in be	ed, hob (head of bed) elevated,				
	oxygen on at 2 lpm	per nc. There was no date on				
	humidification bottl	le or oxygen tubing.				
	On 10/27/23 at 9:18	3 A.M., Resident 45 was				
	observed lying in be	ed watching TV, call light in				
	bed. Oxygen on at 2	2 lpm per nc with no date on				
	tubing or humidific					
	On 10/26/23 at 11:0	07 A.M., Resident 45's clinical				
	records were review	ved. Resident 45 was admitted				
	on 7/19/21. Diagno	oses included, but were not				
	limited to, hemipleg	gia and hemiparesis following				
	cerebral infarction,	affected left non-dominant				
	side, psychotic diso	order with delusions due to				
	known physiologica	al condition, major depressive				
	disorder, recurrent,	severe with psychotic				
	symptoms, generali	zed anxiety disorder, and type				
	2 diabetes mellitus	without complications.				
	The most recent qua	arterly MDS Assessment,				
	dated 8/23/23, indic	cated Resident 45 had severe				
	cognitive impairme	nt, required extensive				
	assistance of two fo	or bed mobility,				
	extensive assistance	e of one for eating, total				
		for toilet use and total				
	-	for bathing, oxygen was not				
	marked.					
i l	1		1	į.	I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED 10/31/2023	
		155773	B. W	ING		10/31/	2023
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
TEDDAG		LTUE			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		EVANS	VILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION orders included, but were not		TAG	DEFICIENC!		DATE
	limited to, the follo						
	·	t 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						
		ft 07:00 A.M 3:00 P.M., 3:00					
	P.M 11:00 P.M., 3/29/2023	11:00 P.M 7:00 A.M., dated					
		tygen tubing, humidifier bottle					
	_	s: Change weekly and PRN					
	Once A Day on Sunday 11:00 P.M 7:00 A.M.,						
	dated 3/24/2023						
	_	for oxygen therapy, initiated					
		l, but was not limited to the					
	_	ion: Administer oxygen as					
	_	compliance. See MAR sistration Record) for current					
	liters and route. Sta	· · · · · · · · · · · · · · · · · · ·					
		11:25 A.M., Resident 31's					
		tubing was observed undated					
	and lacked an initia	led label.					
	0.40/05/22						
		6 A.M., Resident 31's nebulizer					
		ved undated and lacked an					
	initialed label.						
	On 10/27/23 at 11:0	05 A.M., Resident 31's nebulizer					
		ved undated and lacked an					
	initialed label.						
		A.M., Resident 33's clinical					
		d. Diagnoses included, but					
	·	Chronic Obstructive (COPD) and chronic					
	respiratory failure v						
	105piratory rantite v	ты пуроли.					
	The current quarter	ly MDS Assessment, dated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	NG		10/31	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
TEINIVAC		V 111E		LVANO	VILLE, IIV 477 12		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Resident 33 was cognitively					
		xtensive assist with the aid of					
	2 for mobility, trans	sferring, and dressing.					
		orders included, but were not					
	limited to:						
		(Liters per minute) to keep O2					
		than) 90% on room air as					
	needed, dated 6/26/23.						
		rol 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:						
		for impaired gas exchange and					
		erapy. Interventions included,					
		d to, administer O2 as ordered,					
	dated 10/23/23.						
	_	tial for respiratory distress					
		nterventions included, but were					
		inister medications per MD					
	(Medical Doctor) o	rder dated 6/02/23.					
		1: 4					
	_	ed interventions to change O2					
	or nebulizer tubing.	•					
	The MAD (Medical	tion Administration Decord					
		tion Administration Record)					
	October 2023 lacke	nt Administration Record) for					
	October 2023 lacke	a documentation.					
	5 On 10/24/23 at 1	10:39 A.M., Resident 44's					
		r tubing was observed undated					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	ING		10/31/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			CDOWELL RD		
TERRAC	E AT SOLARBRON	J THE			VILLE, IN 47712		
TENIXAC	L AT SOLARDINON	N 111L		LVANO	VILLE, IN 477 12		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ne portable oxygen tank was					
	on at 2 liters and no	ot connected to the resident					
	and was not labeled	l with a date or initials. The					
	_	treatment lacked a label of					
	_	initials. There was no red					
	warning "Oxygen in Use" sign on the door.						
		7 P.M., Resident 44's					
		tubing was observed undated					
		here was no oxygen in use					
	warning sign on the	e door.					
		42 A.M., Resident 44's portable					
	_	served not dated or initialed.					
	_	oxygen collar's tubing that was					
		2 tank was also not labeled or					
	initialed.						
	0 10/05/02 + 0.15	7DM D 11 (44) 11 1 1					
		7 P.M., Resident 44's clinical					
		d. Diagnoses included, but					
		pneumonia, acute and chronic					
	respiratory with hyp	poxia, and tracheostomy.					
	The assument assertan	ly MDS Assessment, dated					
	*	hat the resident was					
	·	Resident 44 was independent in					
		d supervision with bathing and					
	toileting.	-					
	tonethig.						
	Current physician o	orders included, but were not					
	limited to:	riders included, but were not					
		xygen tubing, humidifier bottle					
	_	g: change weekly and PRN					
		ay, dated on 9/18/23.					
	once a day on Sund	ay, dated oil 7/10/23.					
	Change track collar	: change weekly and PRN (as					
	_	on Wednesday, dated on					
	9/18/23.	on wednesday, dated on					
	7,10,23.						
	Check overgen tent	and replace as indicated: 4					
	Check oxygen tank	and replace as indicated: 4					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  10/31/2023	
	PROVIDER OR SUPPLIER		1701 M	ADDRESS, CITY, STATE, ZIP COD CDOWELL RD SVILLE, IN 47712	
	SUMMARY:  (EACH DEFICIEN  REGULATORY OR  liters per minute wi  9/19/23.  Current care plans i  to:  Resident is a risk for  complications/infect  tracheostomy place: cancer. Intervention: limited to providing oxygen therapy as of  During an interview (Registered Nurse) and humidification Sunday nights. Som humidification than changed more often humidification bottle everyone knows where  During an interview ADON (Assistant Extended the tubing for the or changed weekly and  A current, undated the Corporate Clinic indicated "the purp for safe oxygen adn Procedure2. place	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Il last 5 days when full, dated Included but were not limited In respiratory Itions/failure secondary to ment due to prior laryngeal Is included, but were not Inebulizer treatments and Indered, dated 7/1/23. In on 10/27/23 at 9:05 A.M., RN Indicated tubing for oxygen bottles were changed on Ite residents used more others, so those bottles got In oxygen tubing and Ite should be dated so Ite on 10/26/23 at 8:52 A.M., the Interctor of Nursing) indicated Ite on the price of the sygen and nebulizers were	1701 M	CDOWELL RD	E COMPLETION
	A current, undated Validations List" w P.M., by the Corpor	Oxygen Administration Skills as provided on 10/27/23 at 1:32 rate Clinical Records Nurse. tted staff was to " date and			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í				X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00  B. WING			COMPLETED 10/31/2023	
		155773	B. WIN			10/31/	2023	
	PROVIDER OR SUPPLIER CE AT SOLARBRON			1701 M	.DDRESS, CITY, STATE, ZIP COD CDOWELL RD VILLE, IN 47712			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	3.1-47(a)(4) 3.1-47(a)(6)							
F 0732 SS=C Bldg. 00	§483.35(g)(1) Dat must post the follobasis: (i) Facility name. (ii) The current da (iii) The total number worked by the follobic licensed and unlice responsible for research (A) Registered number (B) Licensed practive vocational nurses law). (C) Certified nurses (iv) Resident censes (iv) Resident cense	Staffing Information. a requirements. The facility owing information on a daily  te. ber and the actual hours owing categories of ensed nursing staff directly sident care per shift: rses. tical nurses or licensed (as defined under State  e aides. sus.  sting requirements. st post the nurse staffing baragraph (g)(1) of this basis at the beginning of costed as follows: dable format. It place readily accessible to tors.  solic access to posted nurse of facility must, upon oral or ake nurse staffing data ablic for review at a cost not immunity standard.						
	requirements. The	e facility must maintain the						

CENTERS FOR MEDICARE & MEDICAID SERVICES		_		OMB NO. 0938-039		
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		
PREFIX TAG	posted daily nurse minimum of 18 mm State law, whiche Based on observation review, the facility staffing sheets contour daily for 7 of 7 days (10/23/23, 10/24/23). The sheet included, following information (Registered Nurse), CNA (Certical QMA (Qualified M Total number of RN each shift Total hours of RN, shift The sheet did not specifically more and shift the sheet did not specifically more daily of the sheet daily of the sheet did not specifically daily of the sheet	e staffing data for a conths, or as required by ver is greater. on, interview, and record failed to ensure posted nurse ained the correct information is reviewed during the survey. 8,10/25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10/25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10, 25/23,10/26/23, 10/27/23, 10/25/25/23, 10/25/25/23, 10/25/25/25/25/25/25/25/25/25/25/25/25/25/	F 0732	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ther be rent ation d. blace ges es aller daily ated s. he niting	
	Daily Staffing Shee 10/25/23, 10/26/23, The sheets included	3 A.M., the Scheduler provided ats dated 10/23/23, 10/24/23. 10/27/23,10/30/23 and 10/31/23. I, but were not limited to, the ion: Shift hours for RN, LPN,		Nursing or designee will audit staffing information posting 3 weekly x 4 weeks, then week 4 weeks, then monthly x 4 mo	t daily x ly x onths	
	CNA, and QMA. Total number of RN each shift.	N, LPN, CNA, and QMA for LPN, CNA, and QMA for each		to ensure daily staffing inform is accurate and posted daily. results of these audits will be presented to the monthly Qua Assurance/Performance Improvement Committee. The	The	

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The sheets did not specify which actual hours

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facility will achieve 100%

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/31/2023		
	ROVIDER OR SUPPLIER E AT SOLARBRON			1701 M	ADDRESS, CITY, STATE, ZIP COD CDOWELL RD VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	-	ch discipline during the name that the total hours were not or of staff.			compliance threshold prior to adjusting the frequency of aud Plan to be updated as indicate		
	Scheduler indicated separation between	or on 10/31/23 at 9:16 A.M., the I she never made a distinct the hours worked by the staff at a variable of 8 and 12 hour					
	Nursing) provided a dated 2/6/2019. The staffing information	24 A.M., the DON (Director of a current "Staffing Policy" e policy indicated "direct care a is posted each day pursuant for Medicare and Medicaid) articipation".					
F 0761 SS=E Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accepted						
	§483.45(h)(1) In a Federal laws, the and biologicals in under proper temp	ge of Drugs and Biologicals accordance with State and facility must store all drugs locked compartments perature controls, and rized personnel to have s.					
	separately locked compartments for	e facility must provide , permanently affixed storage of controlled drugs II of the Comprehensive					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/31/2023 155773 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1701 MCDOWELL RD TERRACE AT SOLARBRON THE **EVANSVILLE, IN 47712** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) 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 F 0761 F-Tag 761: Labeling of Drugs 11/27/2023 review, the facility failed to ensure proper storage and Biologicals of medications for 3 of 3 medication storage rooms The corrective actions to be observed. Refrigerator temperature logs were not accomplished for those residents completely filled out in the medication rooms. found to have been affected by the (South Hall, North Hall, West Hall) practice. The three medication Findings include: administration refrigerators located on the West, North, and South 1. On 10/30/23 at 12:10 P.M., the West Hall Units observed with blank medication room was observed. The refrigerator temperature logs during the survey temperature log for October 2023 lacked were corrected the day the issue temperatures on the following dates: was identified. 10/2/23 The facility will identify other 10/7/23 residents that may potentially be 10/8/23 affected by this practice. 10/14/23 Residents residing at Solarbron 10/15/23 have the potential to be affected 10/24/23 by this alleged deficient practice. 10/25/23 The temperature logs inside the 10/26/23 medication administration 10/27/23 refrigerators on the nursing units 10/28/23 have been audited to ensure 10/29/23 temperatures are being logged. At that time, LPN (Licensed Practical Nurse) 9 The facility will put into place indicated night shift was responsible for filling out the following systematic changes the temperature logs, and they should be filled out to ensure that the practice does daily. not recur. Licensed nurses and QMAs will be re-educated on 2. On 10/30/23 at 12:24 P.M., the North Hall recording temperatures on the medication room was observed. The refrigerator temperature log inside of the

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10/26/23

temperature log for October 2023 lacked

temperatures on the following dates:

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refrigerators.

medication administration

The facility will monitor the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1701 MCDOWELL RD  EVANSVILLE, IN 47712			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION
TAG	10/27/23 10/28/23 10/29/23 At that time, RN (R night shift was resp temperature logs, at to agency staff work 3. On 10/30/23 at 1 medication room w temperature log for temperatures on the 10/27/23 10/28/23 10/29/23 At that time, RN 7 is the temperature log for temperature log for temperatures on the 10/27/23 10/28/23 10/29/23 At that time, RN 7 is the temperature log for temperature log for temperature log suited a current in that indicated "Medifacility in a manner guidelines, such as Medications must be temperatures Ref	2:30 P.M., the South Hall as observed. The refrigerator October 2023 lacked following dates:	TAG	corrective action by implementhe following measure. Director Nursing or designee will audit medication administration refrigerator temperature logs a 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 the 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 auc Plan to be updated as indicated.	ting or of  at s,	DATE
F 0804 SS=E Bldg. 00	Temp §483.60(d) Food a Each resident reco provides-	eives and the facility od prepared by methods that				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	ING		10/31/	2023
				CTREET	ADDRESS CITY STATE ZIR SOD		
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
TEDDAG	NE AT OOL ADDDO.	u Tue			ICDOWELL RD		
TERRAC	E AT SOLARBRON	NIHE		EVANS	SVILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	§483.60(d)(2) Foo	od and drink that is					
	palatable, attractive, and at a safe and						
	appetizing temperature.  Based on observation, record review, and						
			F 0	804			11/27/2023
	interview, the facili	ity failed to ensure that food			F-Tag 804: Nutritive		
	was served at palata	able temperatures for 1 of 1			Value/Appearance,		
	trays tested for tem	perature.			Palatable/Pref/Temperature		
					The corrective actions to	be	
	Finding includes:				accomplished for those reside	ents	
					found to have been affected b		
	On 10/30/23 at 12:3	30 P.M., a test tray was			practice. No residents suffered	•	
	obtained.				adverse effects from this alleg		
	The following temperatures were indicated:				deficient practice.		
	Fish -101.6 degrees Fahrenheit (F)				The facility will identify of	her	
	Beets -111 degrees				residents that may potentially		
	Fruit cocktail - 65.7				affected by this practice. The		
		-			DFS/designee will audit food		
	On 10/24/23 at 11:0	09 A.M., Resident M indicated			temperatures during mealtime	s to	
		varm from hallway trays.			ensure food is served at an		
					appetizing and appropriate		
	During an interview	v on 10/31/23 at 10:06 A.M., the			temperature.		
	Dietary Manager in	ndicated when food leaves the			The facility will put into p	lace	
	holding table to be	put on a tray to go out to the			the following systematic chan	ges	
	residents the temper	rature was 135 for meats,			to ensure that the practice do	es	
	cooked vegetables	at 135, and fruit cocktail 41 or			not recur. Dietary staff and nu		
	lower.				staff will be re-educated on fo	od	
					temperatures and delivering tl	ne	
	During an interview	v on 10/31/23 at 10:35 A.M., the			trays timely to residents.		
	Dietary Manager in	ndicated food was expected to			The facility will monitor th	ne	
	be palatable when i	t arrived to the residents.			corrective action by implemen		
					the following measures The	-	
	On 10/31/23 at 10:3	35 A.M., the Dietary Manager			DFS/designee will monitor/au	dit	
	provided a current l	Food Preparation and Safety			hall tray food temperatures, a		
	policy, dated 2020,	which indicated "Trays are			interview 5 residents weekly for	or 4	
	delivered promptly	to ensure that food is served			weeks, then biweekly x 8 wee	ks,	
	at a preferable temp	perature and to preserve the			then monthly x 3 months to		
	quality of the food.	Tray delivery time is planned			ensure food is served at		
	- '	nt use of the staff's time to			appropriate and appetizing		
	allow quick and acc	curate delivery of meals to the			temperatures. The results of t	hese	
	_	or bedside. This is done to			audits will be presented to the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY  COMPLETED  10/31/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	ensure acceptable to resident's satisfaction kitchen at 135 degree will be at 41 degree 3.1-21(a)(2)	emperatures and increase on Hot foods will leave the ees F or above and cold foods		monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audi Plan to be updated as indicated	its.
F 0921 SS=D Bldg. 00	SS=D 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  F 0921			11/27/2023	
	sanitary environment public for 1 of 4 half	failed to provide a safe and nt for residents, staff, and lls observations on 3 locations East Hall (East Hallway).		F-Tag 921: Safe/Functional/Sanitary/Comortable Environment What corrective action(s) be accomplished for those residents found to have been	will
	observed smelling r	·		affected by the deficient practic The hallway on the East Hallway observed smelling musty was addressed on the day the issue	e e
	On 10/26/23 at 11:2 observed smelling r	25 A.M., the East Hallway was musty.		was identified. No ill effects we noted from this alleged deficier practice.	
	On 10/30/23 at 12:0 observed smelling r	00 P.M., the East Hallway was musty.		How will other residents having the potential to be affect by the same deficient practice	
	Maintenance Super ways were cleaned schedule had been l because the 36 inch was in the shop. Th behind spot cleaner	v on 10/31/23 at 10:19 A.M., the visor indicated the carpet hall on a daily schedule. The nard to keep the past 2 weeks walk behind carpet cleaner e staff used a 12 inch drag during that time. The walk er used a heavy traffic cleaner		be identified and what corrective action(s) will be taken? Curren residents residing at Solarbron have the potential to be affected by this alleged deficient practic Carpeted and hallways areas winspected, and an action plan been implemented.	ve t ed ce. were

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solution and sprayed the carpets with the cleaner.

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What measures will be put

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	ING _		10/31/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
12111010	E 711 GOLF (INDITION	V IIIE		LV/III	, IN 77712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ot cleaner only used hot water			into place and what systemati		
	to clean.				changes will be made to ensu		
					that the deficient practice does	s not	
		45 A.M., the DON (Director of			recur? The administrator or		
		a current undated policy			designee will re-educate		
		service". This policy indicated			housekeeping and maintenan	ce	
		should be done at least once			staff on the cleaning and		
	-	in heavy traffic, or in odor			disinfection of environment		
	conditions".				surfaces policy and will re-edu		
					staff on putting in work orders	for	
	3.1-19(f)				carpeted areas needing to be		
					cleaned.		
					How the corrective action	າ(s)	
					will be monitored to ensure the	Э	
					deficient practice will not recui	ī,	
					i.e., what quality assurance		
					program will be put into place;	the	
					Administrator/designee will		
					monitor/audit carpeted areas t	.о	
					ensure the areas are clean an	d	
					odor-free weekly x 4 weeks, th	nen	
					bi-weekly for 8 weeks, then		
					monthly for 3 months to ensur	е	
					the carpeted areas are clean a	and	
					odor-free. The results of these	<del>)</del>	
					audits will be presented to the	<del>)</del>	
					monthly Quality		
					Assurance/Performance		
					Improvement Committee. The		
					facility will achieve 100%		
					compliance threshold prior to		
					adjusting the frequency of aud	lits.	
					Plan to be updated as indicate		
R 0000							
Bldg. 00							
		State Residential Licensure	R 0	000			
	Survey. This visit is	ncluded a Recertification and			Solarbron Terrace		
	State Licensure Sur	vev	1		Annual SNF & Residential Ca	aro	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  10/31/2023	
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD		
TERRAC	E AT SOLARBRON	N THE		MCDOWELL RD SVILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	·	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
	Survey dates: Octo	ber 23, 24, 25, 26, 27, 30 & 31,		Relicensure Survey October 23-27, 30-31 2023		
	2023	10020		SNF - Plan of Correction		
	Facility number: 01	10930		- The plan of correction serves	as	
	Residential Census	: 30		Solarbron Terrace's credible		
	These State Reside	ntial Findings are cited in		allegation of compliance. Submission of this plan of		
	accordance with 41	0 IAC 16.2-5.		correction does not constitute		
				admission by Solarbron Terra its management company that		
				allegations contained in the su	ırvey	
				report is a true and accurate portrayal of the provision of nu	ırsing	
				care and other services in this		
				facility. Nor does this provision constitute an agreement or	ו	
				admission of the survey		
				allegations.		
				F-Tag 554: Resident Self-Adı	min	
				Meds-Clinically Appropriate The corrective actions to	he	
				accomplished for those reside		
				found to have been affected b		
				practice. Currently, residents I had no ill effects from this alle		
				deficient practice. Resident 69	-	
				self- administration assessme	nt is	
				completed.  The facility will identify of	her	
				residents that may potentially		
				affected by this practice. Curre	ent	
				residents have the potential to		
				affected by this alleged deficient practice. Current residents that		
				wish to self-administer		
				medications have been audite	ed to	
			1	ensure self -administration		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		155773	B. WI	NG		10/31/	/2023
				_			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					CDOWELL RD		
TERRAC	E AT SOLARBRO	NIHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
					assessments are completed.		
					The facility will put into pl	ace	
					the following systematic chang		
					to ensure that the practice doe	es	
					not recur. Licensed nurses an	d	
					IDT will be re-educated on		
					self-administration policy.		
					The facility will monitor th		
					corrective action by implemen	•	
					the following measure. Directo	or of	
					Nursing or designee will audit		
					random residents 3 x weekly x	( 4	
					weeks, then weekly x 4 weeks	5,	
					then monthly x 4 months to		
					ensure self-administration		
					assessment are completed on		
					those who wish to self-adminis		
					The results of these audits will		
					presented to the monthly Qua	lity	
					Assurance/Performance		
					Improvement Committee. The		
					facility will achieve 100%		
					compliance threshold prior to		
					adjusting the frequency of aud		
					Plan to be updated as indicate	ed.	
					5 To 2 500: Notice of Ob	_	
					F-Tag 580: Notice of Change The corrective actions to		
					accomplished for those reside		
					found to have been affected b	-	
					practice. Notification of change		
					Residents F was discharged fi	OIII	
					the facility and Resident M's		
					family has been notified.	hor	
					The facility will identify ot		
					residents that may potentially	be	
					affected by this practice.	_	
l	I		1		Residents residing at Solarbro	n	I

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X:		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155773	B. WI	NG		10/31/	2023
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ICDOWELL RD		
TERRAC	E AT SOLARBROI	N THE			SVILLE, IN 47712		
TEINIAC	L AT SOLARDIO	N IIIE		LVANO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					have the potential to be affect	ed	
					by this alleged deficient practi-	ce.	
					Residents with changes have	been	
					audited to ensure notification	was	
					made to families and the		
					physician.		
					The facility will put into pl	ace	
					the following systematic chang	ges	
					to ensure that the practice doe	es	
					not recur. Licensed nurses wil	l be	
					re-educated on making notification	ation	
					to families and the physicians	of	
					residents when resident condi	tions	
					change.		
					The facility will monitor th	ie	
					corrective action by implemen	ting	
					the following measure. Directo	or of	
					Nursing or designee will audit		
					residents with changes to ens	ure	
					notification is made to families	and	
					the physician at least 5 x per		
					week for 4 weeks, then weekly	y x 4	
					weeks, then bi-weekly x 4		
					months, then monthly x 3 mor	iths	
					to ensure notification to familie	es	
					and the physician is made. Th	e	
					results of these audits will be		
					presented to the monthly Qua	lity	
					Assurance/Performance		
					Improvement Committee. The		
					facility will achieve 100%		
					compliance threshold prior to		
					adjusting the frequency of auc	lits.	
					Plan to be updated as indicate	∌d.	
					F-Tag 641: Accuracy of		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155773	B. W.	ING		10/31	/2023
NAME OF E	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
			1701 MCDOWELL RD				
TERRAC	E AT SOLARBRON	N THE	EVANSVILLE, IN 47712				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					Assessments	h -	
					The corrective actions to		
					accomplished for those reside		
					found to have been affected b	-	
					practice. Currently, residents		
					had no ill effects from this alle deficient practice. The MDS fo	-	
					Resident 50 was corrected on		
					day the coding error was	1 410	
					identified.		
					The facility will identify of	ther	
					residents that may potentially		
					affected by this practice. Curre		
					residents have the potential to		1
					affected by this alleged praction		
					Dialysis residents who reside		
					Solarbron Terrace have been		1
					audited to ensure MDS coding	g is	
					correct. The MDS of residents	3	
					have been audited to ensure		
					comprehensive assessments	are	
					coded and completed accurat	-	
					The facility will put into p		
					the following systematic chan	~	
					to ensure that the practice do	es	1
					not recur. MDS staff will be		
					re-educated on proper coding	of	
					resident assessments.		
					The facility will monitor th		1
					corrective action by implemen	-	
					the following measure. Directo		
					Nursing or designee will audit		
					random residents 3 x weekly x		1
					weeks, then weekly x 4 weeks then monthly x 4 months to	>,	
					ensure resident assessment a	aro.	
					completed accurately. The res		
					of these audits will be present		
					to the monthly Quality	.cu	
			1		Assurance/Performance		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W			10/31/	
		100110			_	10/01/	
NAME OF F	PROVIDER OR SUPPLIER	•			ADDRESS, CITY, STATE, ZIP COD		
TWINE OF T	NO VIDER OR SOLVEILL	•		1701 M	CDOWELL RD		
TERRAC	E AT SOLARBRON	NTHE		EVANSVILLE, IN 47712			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOU		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Improvement Committee. The		
					facility will achieve 100%		
					compliance threshold prior to		
					adjusting the frequency of aud	lits.	
					Plan to be updated as indicate		
					F-Tag 689: Free of Accident		
					Hazards/Supervision/Devices	2	
					The corrective actions to		
					accomplished for those reside		
					found to have been affected b		
					practice. Resident M's fracture	-	
					healing, and her current fall	, 13	
					interventions have been review	Ned	
					The facility will identify ot		
					residents that may potentially		
					affected by this practice.	DC	
					Residents residing at Solarbro	'n	
					have the potential to be affect		
					by this alleged deficient practic		
					Current residents fall intervent		
					have been audited to ensure f		
					interventions are implemented		
					appropriate.	and	
					The facility will put into pl	ace	
					the following systematic chang		
					to ensure that the practice doe	-	
					not recur. Nursing staff will be		
					re-educated on our fall policy,		
					to stand lift policy, and	JIL	
					implementing interventions.		
					The facility will monitor th		
					corrective action by implemen		
					the following measure. The	urig	
					Director of Nursing or designe	o will	
					audit fall interventions at least		
					per week for 4 weeks, then we	ckiy	
					x 4 weeks, then bi-weekly x 4	tho	
					months, then monthly x 6 mon		
			1		to ensure fall interventions are	;	

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I i		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 10/31/2023	
	PROVIDER OR SUPPLIE		1701 N	ADDRESS, CITY, STATE, ZIP COD MCDOWELL RD SVILLE, IN 47712		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  DUGG DEFINITION OF THE PROPERTY AND THE PROPERTY OF T	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTINUE	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	implemented. The results of these audits we presented to the monthly Que Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of au Plan to be updated as indicated.  F-Tag 690: Bowel/Bladder Incontinence  The corrective actions to accomplished for those reside found to have been affected practice. Residents M's UTI I resolved and suffered no ill efform this alleged deficient practice.  The facility will identify or residents that may potentially affected by this practice. Residents residing at Solarbit Terrace have the potential to affected by this alleged deficient practice. Residents residing at Solarbit Terrace have the potential to affected by this alleged deficient practice. Residents residing at Solarbit Terrace have the potential to affected by this alleged deficient practice. Residents residing as Solarbit of the following systematic characteristic treatment is proved the following systematic characteristic to ensure that the practice do not recur. Licensed nurses here educated on approping treatment of UTIs.  The facility will monitor accorrective action by implement the following measure.  DON/Designee will review 3 random residents per week for the monthly Quite and the surface and the s	ality e  dits. ted.  be ents by the has ffects  other be ient at of UTI dided. blace hases es ave riate the inting	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	NG		10/31/2023	
				_			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
			1701 MCDOWELL RD				
TERRAC	E AT SOLARBRON	NIHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					(4) weeks, then weekly for fou	r (4)	
					weeks, then biweekly for (4)	` ,	
					weeks, then monthly 3 additio	nal	
					months to ensure appropriate		
					treatment is provided for UTIs	. The	
					results of these audits will be		
					presented to the monthly Qua	lity	
					Assurance/Performance		
					Improvement Committee. The	•	
					facility will achieve 100%		
					compliance threshold prior to		
					adjusting the frequency of auc	lits.	
					Plan to be updated as indicate	ed.	
					F-Tag 695: Respiratory Care		
					The corrective actions to	be	
					accomplished for those reside	nts	
					found to have been affected b	y the	
					practice. The date of the oxyg	en	
					tubing and humidification bottl	es	
					for Residents 13, 22, 31, 44, a	ınd	
					45 were corrected on the day	the	
					error was identified.		
					The facility will identify ot		
					residents that may potentially	be	
					affected by this practice.		
					Residents residing at Solarbro		
					have the potential to be affect		
					by this alleged deficient practi		
					Current residents with oxygen		
					tubing and humidification bottl		
					have been audited to ensure t	ne	
					proper date is labeled on the		
					oxygen tubing and humidificat	ion	
					bottles.		
					The facility will put into pl		
					the following systematic chang	-	
					to ensure that the practice doe		
					not recur. Licensed nurses/QN		
			l		will be re-educated on respirate	tory	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER 155773			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/31/2023	
	ROVIDER OR SUPPLIE E AT SOLARBROI		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				care policy.  The facility will monitor the corrective action by implement the following measure. Directed Nursing or designee will audit residents with oxygen tubing a humidification bottles at least per week for 4 weeks, then with x 4 weeks, then bi-weekly x 4 months, then monthly x 3 monto ensure fall interventions are implemented. The results of the 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 auditional plants of the process of th	ne nting or of stand 5 x eekly nths e hese es extends of the hese extends of the heave eged there is be entation d. lace ges es es	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155773		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/31/2023	
	ROVIDER OR SUPPLIE E AT SOLARBRO		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, 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 APPROPED BEFICIENCY)  will be educated on ensuring staffing information to be upout and posted daily at the main entrance and the nursing unit. The facility will monitor corrective action by implement the following measure. Direct Nursing or designee will aud staffing information posting 3 weekly x 4 weeks, then weekly x 4 weeks, then monthly x 4 m to ensure daily staffing inform is accurate and posted daily, results of these audits will be presented to the monthly Quebassurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of at Plan to be updated as indicated.	g daily dated  its. the enting ctor of lit daily 3 x kly x nonths mation . The entity the entity is a continuous control of the entity is a control of the entity is a control of the entity in the entity is a control of the entity in the entity is a control of the
				F-Tag 761: Labeling of Drug and Biologicals  The corrective actions to accomplished for those reside found to have been affected practice.  The three medication administration refrigerators for the West, North, and Sou Units observed with blank temperature logs during the were corrected the day the is was identified.  The facility will identify of	to be dents by the ocated oth survey ssue

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155773		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  10/31/2023			
	ROVIDER OR SUPPLIER E AT SOLARBRON	THE	STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION DATE		
				residents that may potential affected by this practice. Residents residing at Solar have the potential to be affeby this alleged deficient prathetemperature logs inside medication administration refrigerators on the nursing have been audited to ensure temperatures are being log. The facility will put into the following systematic choto ensure that the practice on the recur. Licensed nurses QMAs will be re-educated or recording temperatures on temperature log inside of the medication administration refrigerators.  The facility will monito corrective action by implement the following measure. Directly action administration refrigerator temperature log least 5 x per week for 4 we then weekly x 4 weeks, the bi-weekly x 4 months, then monthly x 3 months to ensure temperature logs are being completed. The results of the audits will be presented to monthly Quality  Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior adjusting the frequency of a Plan to be updated as indictions.	bron ected actice. e the units re ged. o place anges does and on the ne r the nenting ector of idit gs at eks, n ure hese the The to audits.		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	NG		10/31/	/2023
					I DDD FOO CHEV OF THE THE COL	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
TEDD 4 0	T AT COL ADDDOS	LTUE			CDOWELL RD		
IERRAC	E AT SOLARBRON	N IHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)		•	DATE	
					F-Tag 804: Nutritive		
					Value/Appearance,		
					Palatable/Pref/Temperature		
					The corrective actions to	be	
					accomplished for those reside		
					found to have been affected b	-	
					practice. No residents suffered		
					adverse effects from this alleg	ed	
					deficient practice.		
					The facility will identify ot		
					residents that may potentially	be	
					affected by this practice. The		
					DFS/designee will audit food		
					temperatures during mealtime	s to	
					ensure food is served at an		
					appetizing and appropriate		
					temperature.		
					The facility will put into pl		
					the following systematic change	-	
					to ensure that the practice doe		
					not recur. Dietary staff and nu staff will be re-educated on for	-	
					temperatures and delivering the trays timely to residents.	ic	
					The facility will monitor th	10	
					corrective action by implemen		
					the following measures The	ıy	
					DFS/designee will monitor/aud	dit	
					hall tray food temperatures, a		
					interview 5 residents weekly for		
					weeks, then biweekly x 8 wee		
					then monthly x 3 months to	-,	
					ensure food is served at		
					appropriate and appetizing		
					temperatures. The results of the	nese	
					audits will be presented to the		
					monthly Quality		
					Assurance/Performance		
					Improvement Committee. The		
					facility will achieve 100%		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/31/2023	
	ROVIDER OR SUPPLIE E AT SOLARBRO		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
				compliance threshold prior to adjusting the frequency of au Plan to be updated as indicat	dits.
				F-Tag 921: Safe/Functional/Sanitary/Coortable Environment What corrective action(see accomplished for those residents found to have been affected by the deficient pract. The hallway on the East Hallwobserved smelling musty was addressed on the day the issue was identified. No ill effects would from this alleged deficient practice.  How will other residents having the potential to be affect by the same deficient practice be identified and what correct action(s) will be taken? Curre residents residing at Solarbro have the potential to be affect by this alleged deficient practice carpeted and hallways areas inspected, and an action plant been implemented.  What measures will be printed into place and what systematic changes will be made to ensuthat the deficient practice does recur? The administrator or designee will re-educate housekeeping and maintenar staff on the cleaning and disinfection of environment surfaces policy and will re-edustaff on putting in work orders.	tice?  way  sue  vere ent  ected e will tive ent on ted ice. swere n has out ic cure es not  nce
				F-Tag 921: Safe/Functional/Sanitary/Coortable Environment What corrective action(see accomplished for those residents found to have been affected by the deficient praction of the hallway on the East Hallwobserved smelling musty was addressed on the day the issue was identified. No ill effects we noted from this alleged deficient practice.  How will other residents having the potential to be affect by the same deficient practice be identified and what correct action(s) will be taken? Currer residents residing at Solarbrochave the potential to be affect by this alleged deficient practice does inspected, and an action plant been implemented.  What measures will be printo place and what systematic changes will be made to ensuthat the deficient practice does recur? The administrator or designee will re-educate housekeeping and maintenar staff on the cleaning and disinfection of environment surfaces policy and will re-educate	way s ue vere ent ected e will tive ent on ted cice. s were n has out cic ure es not once

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLI	ETED
		155773	B. WING			10/31/2023	
		1		CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	₹					
TEDDAC			1701 MCDOWELL RD EVANSVILLE, IN 47712				
TERRAC	E AT SOLARBRON	N I I I I		EVAINS	3VILLE, IN 477 12		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					cleaned.		
					How the corrective action	n(s)	
					will be monitored to ensure the	е	
					deficient practice will not recui	-,	
					i.e., what quality assurance		
					program will be put into place;	the	
					Administrator/designee will		
					monitor/audit carpeted areas t	о	
					ensure the areas are clean an		
					odor-free weekly x 4 weeks, the	nen	
					bi-weekly for 8 weeks, then		
					monthly for 3 months to ensur		
					the carpeted areas are clean a		
					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 auc		
					Plan to be updated as indicate	ed.	
					Pacidontial Care Blan of		
					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 practi	ce?	
					No ill effects were noted from		
					alleged deficient practice. The		
					QMA who administered the PI		
					medication without the		
					authorization of a licensed nur	se l	
					was re-educated on 11/13/23.		
					How will other residents		
					having the potential to be affe	cted	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  10/31/2023
	ROVIDER OR SUPPLIER		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, IN 47712	
TEINIAC	L AT SOLANDINON	· 111L	LVAINS	3 VILLE, IIN 477 12	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				by the same deficient practice be identified and what correcti action(s) will be taken? Currer residents residing at Solarbron have the potential to be affect by this alleged deficient practic Current residents have had not effects from this alleged deficipractice.  What measures will be printo place and what systematic changes will be made to ensure that the deficient practice does recur? Director of Nursing or designee will re-educate QMA proper administration of PRN medications policy.  How the corrective action 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 audit MARs to ensure PRN medications are administered properly weekly x 4 weeks, the bi-weekly for 8 weeks, then monthly for 3 months to ensure PRN medications are administered properly. The resof these audits will be present to the monthly Quality Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of auc Plan to be updated as indicate R0298 – Pharmacy (Consultations).	will ve int in ed ice. iiiii ent ut ic re is not is on in(s) e f f ie e sults ited itis. ed.

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155773	B. WING 10/31/20			/2023	
NAME OF B	PROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF F	ROVIDER OR SUFFLIE	X.	1701 MCDOWELL RD				
TERRAC	E AT SOLARBRO	N THE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					Pharmacist Review)		
					What corrective action(s	) will	
					be accomplished for those		
					residents found to have been		
					affected by the deficient pract		
					No ill effects were noted from	tnis	
					alleged deficient practice.  Pharmacy reviews for Reside	nte	
					2,3,5,6,7, and 8 were complete		
					2,3,3,0,7, and 6 were completed on 11/15/23.	leu	
					How will other residents		
					having the potential to be affe	cted	
					by the same deficient practice		
					be identified and what correct		
					action(s) will be taken? Curre		
					residents residing at Solarbro		
					have the potential to be affect		
					by this alleged deficient practi		
					Current residents will be audit		
					ensure pharmacy		
					recommendations/reviews are	9	
					completed. Current residents	have	
					had no ill effects from this alle	ged	
					deficient practice.		
					What measures will be p		
					into place and what systemati		
					changes will be made to ensu		
					that the deficient practice doe	s not	
					recur? Director of Nursing or		
					designee will re-educate		
					Residential Care Manager on		
					ensuring pharmacy reviews o		
					resident records are complete	ea at	
					least every 60 days.	-(-)	
					How the corrective action		
					will be monitored to ensure th	-	
					deficient practice will not recu	Γ,	
					i.e., what quality assurance		
					program will be put into place		
			1		Director of Nursing or designe	e Will	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/31/2023				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
R 0246	410 IAC 16.2-5-4(	e)(6)		audit resident records to ensur pharmacy reviews are completed at least every 60 days weekly weeks, then bi-weekly for 8 weeks, then monthly for 3 moto ensure pharmacy reviews a completed at least every 60 d. The results of these audits will presented to the monthly Quanta Assurance/Performance Improvement Committee. The facility will achieve 100% compliance threshold prior to adjusting the frequency of audit Plan to be updated as indicated.	eted x 4  Inths are ays. Il be lity			
Bldg. 00	a qualified medica authorization by a physician. The QN authorization for e PRN medication. A physician not on the authorization to acc	ons may be administered by tion aide (QMA) only upon licensed nurse or MA must receive appropriate ach administration of a All contacts with a nurse or the premises for Iminister PRNs shall be a nursing notes indicating						
	Based on interview failed to ensure as nadministered by a Q (QMA) were author of 6 resident records. Resident 7, Resident Findings include:  1. On 10/31/23 at 9:	and record review, the facility eeded (PRN) medications qualified Medication Aide rized by a licensed nurse for 4 s reviewed. (Resident 4, t 6, Resident 2)	R 0246	R0246 – Pharmacy (PRN Medications)  What corrective action(s) be accomplished for those residents found to have been affected by the deficient pract No ill effects were noted from alleged deficient practice. The QMA who administered the P medication without the authorization of a licensed nu was re-educated on 11/13/23.	ice? this e RN			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155773	B. W	NG		10/31/	/2023
				CTREET	ADDRESS SITY STATE ZIR COD		
NAME OF I	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
TEDDAG		LTUE			CDOWELL RD		
TERRAC	E AT SOLARBRON	NIHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					How will other residents		
	Current physician of	orders included, but were not			having the potential to be affect	cted	
	limited to:				by the same deficient practice	will	
	clonidine HCl (an a	antihypertensive medication)			be identified and what correcti	ve	
	tablet 0.1mg (millig	grams) twice a day PRN, dated			action(s) will be taken? Currer	nt	
	4/14/22.				residents residing at Solarbror	า	
					have the potential to be affect	ed	
	Resident 3's MAR	(Medication Administration			by this alleged deficient praction	ce.	
	Record) from 9/202	23 through 10/2023 included, but			Current residents have had no		
	was not limited to,	the following dates that			effects from this alleged defici-	ent	
	clonidine HCl 0.1m	ng PRN was administered by a			practice.		
	QMA without author	orization from a licensed nurse:			What measures will be p	ut	
	9/23/23 at 12:27 A.	M. (no follow-up documented)			into place and what systemation	2	
	10/19/23 at 8:38 A.	M. (follow-up documented by			changes will be made to ensu	re	
	QMA 33)				that the deficient practice does	s not	
	10/28/23 at 22:54 P	P.M. (no follow-up documented)			recur? Director of Nursing or		
	10/30/23 at 8:15 A.	M. (no follow-up documented)			designee will re-educate QMA	s on	
					proper administration of PRN		
		0:34 A.M., Resident 7's clinical			medications policy.		
		d. Diagnoses included, but			How the corrective action	ı(s)	
	was not limited to,	anxiety and pain.			will be monitored to ensure the	Э	
					deficient practice will not recui	.,	
		orders included, but were not			i.e., what quality assurance		
	limited to:				program will be put into place;		
		an antihistamine used for			Director of Nursing or designe	e will	
		e times a day PRN, dated			audit MARs to ensure PRN		
	8/26/23.				medications are administered		
					properly weekly x 4 weeks, the	en	
	` *	eliever) 50mg every six hours			bi-weekly for 8 weeks, then		
	PRN, dated 8/28/23	3.			monthly for 3 months to ensur	е	
					PRN medications are		
		for 9/2023 included, but was			administered properly. The res		
	not limited to, the f	6			of these audits will be present	ted	
		was administered by a QMA			to the monthly Quality		
		on from a licensed nurse:			Assurance/Performance		
		I. (follow-up documented by			Improvement Committee. The		
	QMA 21)				facility will achieve 100%		
					compliance threshold prior to		
		for 9/2023 included, but was			adjusting the frequency of aud		
	not limited to, the f	ollowing dates that Tramadol			Plan to be updated as indicate	ed.	

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			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	r í	JILDING	instruction 00	(X3) DATE COMPL 10/31/	ETED
		ROVIDER OR SUPPLIER E AT SOLARBRON			1701 M	NDDRESS, CITY, STATE, ZIP COD CDOWELL RD VILLE, IN 47712		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	(X5) COMPLETION DATE
		50mg was administ authorization from a 9/2/23 at 6:19 A.M. QMA 25) 9/3/23 at 5:24 P.M. 9/4/23 at 5:40 A.M. QMA 25) 3. On 10/30/23 at 10 record was reviewed were not limited to femur and pain.  Current physician of limited to: tramadol (a pain medicated to the strength of the strength o	ered by a QMA without a licensed nurse: (follow-up documented by  (no follow-up documented) (follow-up documented by  0:42 A.M., Resident 2's clinical d. Diagnoses included, but pathological fracture of left  reders included, but were not edication) - Schedule IV tablet; t): 1 tablet; oral Special nister Tramadol 50mg 1 po (by 6 hours) PRN for moderate  ion administration record) for d Resident 2 received tramadol ys by a QMA without a licensed nurse: QMA 21 and assessed for MA 25 QMA 33 and assessed for MA 24  2:36 P.M., Resident 6's clinical d. Diagnoses included, but anxiety disorder and pain.  reders included, but were not (a sedative) - Schedule IV t: 0.25mg; oral Twice A Day -					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CO A. BUILDING B. WING	3) DATE SURVEY COMPLETED 10/31/2023				
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE		STREET ADDRESS, CITY, STATE, ZIP COD 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  OF Three Times A Day, PRN, dated 06/20/2022	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	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						
R 0298 Bldg. 00	administered".  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,						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER				COMPLETED	
		155773	B. WING			10/31/2023	
NAME OF	DDOWNED OF GUIDNI 151		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				1701 M	ICDOWELL RD		
TERRACE AT SOLARBRON THE				EVANS	SVILLE, IN 47712		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORR			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE		DATE
		d 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						
		ig regimen of each resident					
	1 ' '	ervices at least once every					
	sixty (60) days.						
		and record review, the facility	R 0298		R0298 – Pharmacy (Consultant Pharmacist Review)		11/27/2023
	failed to ensure pharmacy reviews were completed			-			
	at least every sixty	(60) days for 6 of 6 resident			What corrective action(s	) will	
	records reviewed.	(Resident 3, Resident 7,			be accomplished for those		
	Resident 2, Resident 5, Resident 8, Resident 6)				residents found to have been		
					affected by the deficient pract	ice?	1
	Findings include:				No ill effects were noted from	this	
					alleged deficient practice.		
	1. On 10/31/23 at 9:20 A.M., Resident 3's clinical				Pharmacy reviews for Reside		
	record was reviewed. Diagnosis included, but				2,3,5,6,7, and 8 were complete	ted	
	was not limited to, hypertension.				on 11/15/23.		
	D: 14 21 11 1	1			How will other residents	-41	
		l record included current			having the potential to be affe		
		r medications that were			by the same deficient practice		
		ility's pharmacy and			be identified and what correct		
	administered by facility staff.				action(s) will be taken? Curre residents residing at Solarbro		
	Resident 3's clinical record lacked a pharmacy				have the potential to be affect		
		n review from 10/2022 through			by this alleged deficient practi		
	10/2023.				Current residents will be audited to		
					ensure pharmacy		
	2. On 10/31/23 at 1	10:34 A.M., Resident 7's clinical			recommendations/reviews are	•	
		d. Diagnoses included, but			completed. Current residents	have	
	were not limited to,	_			had no ill effects from this alle		1
					deficient practice.	-	
	Resident 7's clinica	l record included current			What measures will be p	ut	
	physician orders for	r medications that were			into place and what systemat	c	
		ility's pharmacy and			changes will be made to ensu	ire	
	administered by fac	cility staff.			that the deficient practice doe	s not	
					recur? Director of Nursing or		
		l record lacked a pharmacy			designee will re-educate		
	medication regimen	n review from 10/2022 through			Residential Care Manager on		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
		155773			10/31/	/2023	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
TEDDAG	NE AT OOL ABBBOA	LTUE			CDOWELL RD		
TERRAC	E AT SOLARBRON	NIHE		EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	10/2023.				ensuring pharmacy reviews of		
	3. On 10/30/23 at 1	2:36 P.M., Resident 6's clinical			resident records are complete		
	record was reviewe	d. Diagnoses included, but			least every 60 days.		
	were not limited to, anxiety disorder and				How the corrective action		
	pulmonary hypertension.				will be monitored to ensure the		
					deficient practice will not recur,		
	Resident 6's clinical record included current				i.e., what quality assurance		
	physician orders for	r medications that were			program will be put into place;		
		ility's pharmacy and		Director of Nursing or designee will			
	administered by fac	eility staff.			audit resident records to ensu	re	
					pharmacy reviews are comple	ted	
	A pharmacy review	was provided dated 2/22/23.			at least every 60 days weekly	x 4	
					weeks, then bi-weekly for 8		
	Resident 6's clinical record lacked any other			weeks, then monthly for 3 months			
	pharmacy medication regimen review from 10/2022			to ensure pharmacy reviews are			
	through 10/2023.				completed at least every 60 da	ays.	
					The results of these audits will	be	
	4. On 10/30/23 at 10:42 A.M., Resident 2's clinical				presented to the monthly Qual	ity	
		d. Diagnoses included, but			Assurance/Performance		
	were not limited to, pathological fracture of the left		Improvement Committee. The				
	femur and hypertension.				facility will achieve 100%		
					compliance threshold prior to		
	Resident 2's clinical record included current				adjusting the frequency of aud	its.	
		r medications that were			Plan to be updated as indicate	d.	
	* *	ility's pharmacy and					
	administered by fac	cility staff.					
		l record lacked a pharmacy					
		review from 10/2022 through					
	10/2023.						
		2:08 P.M., Resident 5's clinical					
		d. Diagnoses included, but					
		, hypothyroidism and					
	hypertension.						
	D 11 (5)						
	_	l record included current					
		r medications that were					
	supplied by the fact	ility's pharmacy and					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			1	COMPLETED		
		155773	B. W	ING		10/31/	2023	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD CDOWELL RD			
TERRACE AT SOLARBRON THE				EVANSVILLE, IN 47712				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	medication regimen 10/2023.  6. On 10/30/23 at 12 record was reviewed.	1 record lacked a pharmacy review from 10/2022 through 2:36 P.M., Resident 8's clinical d. Diagnoses included, but diabetes mellitus and						
	hypertension.							
		record lacked a pharmacy review from 10/2022 through						
		A.M., the DON (Director of pharmacy reviews should be ner month.						
	current non-dated T indicated "Pharmace therapeutic review of and ancillary service with new order [sic] the orders are correct potential drug mished did not include how be done, however at pharmacy medication	23 A.M., the DON provided a cherapeutic Review policy that ists at [facility] conduct a of each resident's medication es profile upon admission and to ensure that all elements of ct and to safeguard that no aps may occur" The policy often pharmacy reviews must that time, the DON indicated on regimen reviews were pleted every sixty (60) days.						

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