	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey .eted /2023
	PROVIDER OR SUPPLIER			1701 M	ADDRESS, CITY, STATE, ZIP COD CDOWELL RD VILLE, IN 47712		
(X4) ID PREFIX TAG E 0000	(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date: 11/13 Facility Number: 0 Provider Number: 201 At this Emergency Terrace at Solarbro compliance with En Requirements for M Participating Provid 483.73. The facility has 91 the survey, the cens Living section of the census of 33.	3/23 010930 155773	E 00	000	Submission of this plan of correction in no way constitute an admission by The Terrace Solarbron or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or ot services provided in this facilit The Plan of Correction is prepand executed solely because required by Federal and State Law. This statement of deficiencies plan of correction will be revie at the Monthly Quality Assurance/Assessment Committee meeting.	at is a the her cy. ared it is	
E 0041 SS=C Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power sy- emergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.	ILTC Emergency Power tion for Participation: ad standby power systems. implement emergency and stems based on the set forth in paragraph (a) of a the policies and set forth in paragraphs (b)(1) section.					

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

TITLE (X6) DATE

Mark McElwee Administrator 12/08/2023

Any defiency statement 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 X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u></u>	COMPL	
		155773	B. W	ING		11/13/	/2023
NIAME OF T	DROMDER OF CURPLYEE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF				CDOWELL RD		
TERRAC	E AT SOLARBRON	NTHE		EVANS	VILLE, IN 47712		
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	-	and the CAH] must ency and standby power					
		n the emergency plan set					
		(a) of this section.					
		. ,					
	. , , , .	83.73(e)(1), §485.625(e)(1)					
		rator location. The					
	_	e located in accordance with					
	-	rements found in the Health ode (NFPA 99 and Tentative					
		ents TIA 12-2, TIA 12-3, TIA					
		nd TIA 12-6), Life Safety					
		and Tentative Interim					
	Amendments TIA	12-1, TIA 12-2, TIA 12-3,					
		d NFPA 110, when a new					
		r when an existing					
	structure or buildir	ng is renovated.					
	482.15(e)(2), §48;	3.73(e)(2), §485.625(e)(2)					
	, , , , =	rator inspection and testing.					
		H and LTC facility] must					
	implement the em	nergency power system					
		g, and [maintenance]					
	-	nd in the Health Care					
		FPA 110, and Life Safety					
	Code.						
	482.15(e)(3), §48;	3.73(e)(3), §485.625(e)(3)					
		rator fuel. [Hospitals, CAHs					
	and LTC facilities]	that maintain an onsite fuel					
	source to power e	emergency generators must					
		ow it will keep emergency					
		perational during the					
	emergency, unles	s it evacuates.					
	*[For hospitals at	§482.15(h), LTC at					
		CAHs §485.625(g):]					
	- ,-,	corporated by reference in					
	·	oproved for incorporation by					
	reference by the D	Director of the Office of the					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
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TERRAC	E AT SOLARBRON	N IHE	EVAN	ISVILLE, IN 47712			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION			
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		n accordance with 5 U.S.C.					
		the sources listed below					
	the material from the sources listed below. You may inspect a copy at the CMS						
		a copy at the CMS arce Center, 7500 Security					
		ore, MD or at the National					
		ords Administration					
		mation on the availability of					
	l '	ARA, call 202-741-6030, or					
	go to:	, 54 252 7 7 7 6500, 51					
	•	es.gov/federal register/code					
		ations/ibr locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
	1	ederal Register to					
	announce the cha						
		Protection Association, 1					
	Batterymarch Parl						
	Quincy, MA 02169						
	1.617.770.3000.	, ,					
		th Care Facilities Code,					
		ed August 11, 2011.					
		im amendment (TIA) 12-2 to					
	NFPA 99, issued	` ,					
		FPA 99, issued August 9,					
	2012.	-					
	(iv) TIA 12-4 to NF	FPA 99, issued March 7,					
	2013.						
	(v) TIA 12-5 to NF	PA 99, issued August 1,					
	2013.						
	` '	FPA 99, issued March 3,					
	2014.						
	. ,	fe Safety Code, 2012					
	edition, issued Au	<u> </u>					
	` ′	IFPA 101, issued August					
	11, 2011.						
	· '	FPA 101, issued October					
	30, 2012.						
	l ` '	PA 101, issued October					
	22, 2013.						

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING COMPLETED			ETED
		155773	B. W	NG		11/13/	2023
	PROVIDER OR SUPPLIER		•	1701 M	ADDRESS, CITY, STATE, ZIP COD CDOWELL RD SVILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	(xi) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S Standby Power Sy including TIAs to 2009. Based on record reversalled to implement inspection, testing, a found in the Health 110, and Life Safety CFR 483.73(e)(2). Based on record reversalled to provide contesting of 1 of 1 Em System in accordant for Emergency and Section 8.4.9, as recompared to the section 8.4.9 states Power Systems shall every three years. A greater than 4 hours terminate the test af 6.4.1.1.6.1 states the electrical system poat Type 10, Class X deficient practice of occupants. Findings include: Based on record reversalled and 1:45 p.m. Supervisor present, provide documentate the emergency generals 36 month periods.	transport to the transp	E 00		I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Observation 1- The community failed to provide complete documentation for the testing of the Emergency generator. The was no documentation that a 4-hour run test every 3 years froccurred. The Maintenance Supervisor has run the general under building load for 4 hours. II. The facility will identify other residents that may potentially be affected by the deficient practice. All staff and residents have the potential to be affected by this deficient practice. III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. A new TELS Task was created ensure the generator run test.	of ere nas ator s.	12/05/2023

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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 11/13/2023	
	ROVIDER OR SUPPLIEF		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	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA* DEFICIENCY)	TE	(X5) COMPLETION DATE
	review. This finding was re	viewed with the Administrator appervisor during the exit			takes place every 3 years. Se attached tasked labeled "Solarbron TELS Generator Retest Task" IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities w inspect all generator paperwor compliance during their annual CQR.	un ill 'k for	
K 0000							
Bldg. 02	Licensure Survey we Department of Head 483.90(a). Survey Date: 11/13 Facility Number: 0 Provider Number: 1 AIM Number: 201 At this Life Safety of Solarbron was foun Requirements for P CFR Subpart 483.9 the 2012 edition of Association (NFPA)	10930 55773	K 0000		Submission of this plan of correction in no way constitute an admission by The Terrace a Solarbron or its management company that the allegations contained in the survey report true and accurate portrayal of provision of nursing care or oth services provided in this facility. The Plan of Correction is prepand executed solely because i required by Federal and State Law. This statement of deficiencies plan of correction will be review at the Monthly Quality Assurance/Assessment Committee meeting.	is a the her y. ared it is	

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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 02	(X3) DATE SURVEY COMPLETED 11/13/2023	
	PROVIDER OR SUPPLIER		1701 M	ADDRESS, CITY, STATE, ZIP COD MCDOWELL RD SVILLE, IN 47712	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE COMPLETION
TAG	This facility consist by a corridor. The conthe first floor of determined to be of was fully sprinklere system with hard w corridors and space hard wired smoke d in all resident room the second floor As due to the lack of a The 2015 addition i building determined construction. The f with hard wired sm spaces open to the cleping rooms. The and had a census of The second floor As capacity of 35 beds time of this survey. All areas where resident and services were sprinklered and serv	dents have customary access d all areas providing facility klered, except a detached sused for the storage of ment.	TAG	DEFICIENCY)	DATE
K 0100 SS=E	Quality Review con				
SS=E Bldg. 02	Section 18.1 and that are not addre K-tags, but are de along with the app	nents - Other RKS section any LSC 19.1 General Requirements ssed by the provided ficient. This information, slicable Life Safety Code or tation, should be included			

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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 02 B. WING 11/13/2023 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 Based on observation and interview, the facility K 0100 I. The corrective actions to be 12/05/2023 failed to replace battery operated smoke alarms accomplished for those installed in 67 of 67 resident sleeping rooms in the residents found to have been two story portion of the facility in accordance affected by the deficient with NFPA 72. NFPA 72, 2010 Edition, Section practice. 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single-Observation 1 – The Community and multiple-station smoke alarms shall be failed to ensure that 67 battery replaced when they fail to respond to operability powered smoke detectors located tests but shall not remain in service longer than 10 with the community have been years from the date of manufacture. This deficient replaced in the last 10 years. The practice could affect 65 residents, staff and Maintenance Supervisor has visitors. purchased new 10 year Batteryoperated Photoelectric Ionization Findings include: Sensor Smoke Detectors and installed. Based on observations on 11/13/23 between 9:30 a.m. and 1:45 p.m. while performing record review, II. The facility will identify the Maintenance Supervisor brought in several other residents that may resident room battery operated smoke alarms. All potentially be affected by the of the resident room battery operated smoke deficient practice. alarms from the two story portion of the facility had manufactured dates of 03/17/1998 or All Employees and Residents 03/09/2000. Based on interview at the time of could be affected by this deficient observation of the smoke alarms, the Maintenance practice. Supervisor confirmed the smoke alarms had manufactured dates of 03/17/1998 or 03/09/2000 and agreed they were past due for replacement. III. The facility will put into place the following systematic This finding was reviewed with the Administrator changes to ensure that the and Maintenance Supervisor during the exit deficient practice does not conference. recur. 3.1-19(b) The Maintenance Supervisor has been re trained by CarDon corporate to review each inspection while the technician is onsite to ensure that they are documenting the inspection correctly.

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

PRINTED: 12/12/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773			A. BUILDING B. WING	02	COMPLETED 11/13/2023
	ROVIDER OR SUPPLIER E AT SOLARBRON		1701 M	ADDRESS, CITY, STATE, ZIP COD ICDOWELL RD SVILLE, 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
				IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities w track the future replacement d during their annual Corporate Quality Review.	
K 0531 SS=E Bldg. 02	Elevators are insponse specified in ASME Elevators and Esc Service is operated record. Existing elevators A17.3, Safety Cod and Escalators. All a travel distance of below the level that emergency person purposes, conform Requirements of A (Includes firefighter recall and smoke of firefighter's service key operation, made detectors, and elevated to the conforming of the	with Firefighter's Service ASME/ANSI A17.3. r's service Phase I key detector automatic recall, Phase II emergency in-car chine room smoke vator lobby smoke	K 0531	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient	

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Event ID:

97Z321

Facility ID: 010930

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NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE O(4) ID PRETEX TAG PRETEX TAG 19.4.6, Elevator Testing. LSC 9-4.6.2 states that all elevators with fire fiberts' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME ATT.IJCSA B44, Safety Code for Elevators and Escalations. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 11/13/23 between 9:30 a.m. and 1:45 p.m., with the Maintenance Supervisor at the time of record review, the Maintenance Supervisor and the documentation available. Based on observations on 11/13/23 between 1:45 p.m. and 4:45 p.m. during a tour of the facility with the Maintenance Supervisor and the documentation available. Based on observations on 11/13/23 between 1:45 p.m. and 1:45 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor and the documentation available. Based on observations on 11/13/23 between 1:45 p.m. and 1:45 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor and the documentation available. Based on observations on 11/13/23 between 1:45 p.m. and 1:45 p.m. and 1:45 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor and the documentation available. Based on observations on 11/13/23 between 1:45 p.m. and 1:	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X.			(X3) DATE	X3) DATE SURVEY	
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TERRACE AT SOLARBRON THE TERRACE AT SOLARBRON THE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG 9.4.6. Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with by 4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASMF. A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect all residents, staff and visitors in the facility. Based on record review on 11/13/23 between 9:30 a.m. and 1.45 p.m. with the Maintenance Supervisor present, there was documentation available for the monthly firefighter recall test for the elevator, however, it only included the months of January, April, May, and Jane of 2023. Based on interview at the time of record review, the Maintenance Supervisor said the documentation available, Based on observations on 11/13/23 between 1.45 p.m. and 4.45 p.m. during a tour of the facility with the Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator and Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator and Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator and Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator and Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator and Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator and Maintenance Supervisor at the time of observation. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. A monthly TELS Task has been added to the system to ensure the elevator recall test takes place monthly. See attached TELS Task Labeled "Solatoron Elevator Recall Test" III. The facility will monitor the correct			155773	B. W	ING		11/13/	/2023	
TERRACE AT SOLARBRON THE TOAH D SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 9.4.6. Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with Age ton the premises as required by ASMF. A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect all residents, staff and visitors in the facility. Based on record review on 11/13/23 between 9:30 a.m. and 1.45 p.m. with the Maintenance Supervisor state the elevator how a time of record review, the Maintenance Supervisor said the documentation available for the testing of the firefighter recall test for the elevator was testing on the firefighter recall for the elevator was equipped with a firefighter recall for the elevator on the firefighter recall for the elevator on the firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was equipped with a firefighter recall for the elevator was excluded to the substantial that may potentially be affected by the deficient practice. III. The facility will just into place the following systematic changes to ensure that the deficient practice does not recur. A monthly TELS Task has been added to the system to ensure the elevator recall test takes pla					STREET A	ADDRESS CITY STATE 7IP COD			
TERRACE AT SOLARBRON THE IXANDU SUMMARY STATEMENT OF DEFICIENCE GEACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighers' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review on 11/13/23 between 9:30 a.m. and 1.45 p.m. with the Maintenance Supervisor resent, there was documentation available for the monthly firefighter recall test for the elevator, however, it only included the months of January, April, May, and June of 2023. Based on interview at the time of record review, the Maintenance Supervisor said the documentation provided for the resting of the firefighter recall for the elevator was the only documentation available. Based on observations on 11/13/23 between 1.45 p.m. and 4.45 p.m. during a tour of the facility with the Maintenance Supervisor, the elevator was the only documentation available, asserting at the firefighter recall for the elevator was the only documentation available, asserting at the firefighter recall for the elevator was the only documentation available, asserting to the firefighter recall tey operation at the main floor level. This was confirmed by the Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b) The facility will monitor the elevator recall test takes place monthly. See attached TELS and the deficient practice does not recur. A monthly TELS Task has been added to the system to ensure the elevator recall test takes place monthly. See attached TELS and the deficient practice does not recur.	NAME OF P	PROVIDER OR SUPPLIEF	₹						
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Task Labeled "Solarbron Elevator Recall Test" IV The facility will monitor the corrective action by implementing the following			upervisor during the exit			•)		
3.1-19(b) Recall Test" IV The facility will monitor the corrective action by implementing the following		conference.				_			
IV The facility will monitor the corrective action by implementing the following		2.1.10%					ator		
the corrective action by implementing the following		3.1-19(b)				Kecali Lest"			
the corrective action by implementing the following						IV The facility will monitor			
implementing the following						<u> </u>			
						-			
						measures.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	02	COMPL	ETED
		155773	B. WI	NG		11/13	/2023
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
TEDD 4.0	E 4 E 001 4 D D D 04	LTUE			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE		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	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0712 SS=F Bldg. 02	NFPA 101 Fire Drills Fire Drills				CarDon Corporate Facilities we inspect all elevator paperwork during the annual CQR to ensuall parts of the testing take pla	ure	
	alarm signal and seconditions. Fire drand unexpected ticonditions, at least The staff is familia aware that drills aroutine. Where draware that describe alarms. 19.7.1.4 through 1 Based on record revisited to ensure 12 complete document fire alarm signal to department during the 19.7.1.4 requires fire occupancies shall in fire alarm signal and conditions. This deresidents. Findings include:	ay be used instead of	K 0'	712	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Observation 1- The Communit failed to ensure that the fire dr paperwork included the verific that transmission has taken pl with the monitoring company. Maintenance Supervisor has be educated on the need to verify transmission and has updated fire drill paperwork to include a	n ty rill ation ace The peen /	12/05/2023
		pervisor present, all 12 fire			for that verification.		
		ned during the past 12 month					
	period were not pro	vided with documentation for					

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MUL A. BUIL B. WING	DING	NSTRUCTION 02	(X3) DATE SURVEY COMPLETED 11/13/2023	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE SEY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION The alarm to the monitoring	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) II. The facility will identify		(X5) COMPLETION DATE
	record review, the acknowledged ther fire drill reports to alarm was received. This finding was re-	n interview at the time of Maintenance Supervisor e was no information on the 12 verify that transmission of the by the monitoring company. eviewed with the Administrator upervisor during the exit			other residents that may potentially be affected by th deficient practice. All residents and staff could be affected by this deficient practice.	e	
	and Maintenance Supervisor during the exit conference. 3-1.19(b) 3.1-51(c)				III. The facility will put into place the following systema changes to ensure that the deficient practice does not recur. The Maintenance Supervisor been educated on the need to verify transmission and has updated his fire drill paperwol include a line for that verificat	has o	
					IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities vaudit all fire drill paperwork dutheir annual CQR to ensure it includes verification of transmission.	vill uring	
K 0918 SS=C Bldg. 02	Electrical System System Maintena The generator or source and assoc	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power ciated equipment is capable ce within 10 seconds. If the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	III.TIPI E CC	ONSTRUCTION	(X3) DATE	SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	r í	ULTIPLE CC JILDING	02	COMPI			
AND PLAN	OF CORRECTION	155773	B. W		<u>UZ</u>	11/13			
		100/10	D. W			11/13	12023		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	<u></u>			
					CDOWELL RD				
TERRAC	E AT SOLARBRON	N THE		EVANSVILLE, IN 47712					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	DRRECTION (X:			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTF	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIL.	DATE		
	10-second criterio	n is not met during the							
	monthly test, a pro	ocess shall be provided to							
	annually confirm t	his capability for the life							
	safety and critical	branches. Maintenance							
	and testing of the	generator and transfer							
	switches are perfo	ormed in accordance with							
	NFPA 110.						1		
	Generator sets are	e inspected weekly,							
	exercised under lo	oad 30 minutes 12 times a					1		
		intervals, and exercised							
	once every 36 mo	nths for 4 continuous hours.							
	Scheduled test un	ider load conditions include							
	a complete simula	ated cold start and							
	automatic or man	ual transfer of all EES							
	loads, and are cor	nducted by competent							
		nance and testing of stored							
	energy power sou	rces (Type 3 EES) are in							
	accordance with N	NFPA 111. Main and feeder							
	circuit breakers ar	e inspected annually, and a							
		dically exercising the							
		tablished according to							
		uirements. Written records							
		nd testing are maintained							
		ble. EES electrical panels							
		arked, readily identifiable,							
	•	n normal power circuits.							
		ssibility of damage of the							
		source is a design							
	consideration for r								
		(NFPA 99), NFPA 110,							
	NFPA 111, 700.10			010			10/05/2022		
		view and interview, the facility	K 0	918	l. <u>.</u>		12/05/2023		
	-	mplete documentation for the			I. The corrective actions to	pe			
	-	nergency Power Standby			accomplished for those				
	-	ce with NFPA 110, Standard			residents found to have bee	n			
		Standby Power Systems,			affected by the deficient				
		quired by NFPA 99 Health Care			practice.				
		that all Layel 1 Emangement			Observation 4 The serve	4			
		that all Level 1 Emergency			Observation 1- The communi	ty			
	Power Systems sha	ll be tested at least once within			failed to provide complete				

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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 02 COMPLETED 155773 B. WING 11/13/2023 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 every three years. Where the assigned class is documentation for the testing of greater than 4 hours, it shall be permitted to the Emergency generator. There terminate the test after 4 hours. NFPA 99 Section was no documentation that a 6.4.1.1.6.1 states that Type 1 and Type 2 essential 4-hour run test every 3 years has electrical system power sources shall be classified occurred. The Maintenance at Type 10, Class X, Level 1 generator sets. This Supervisor has run the generator deficient practice could affect all building under building load for 4 hours. occupants. II. The facility will identify Findings include: other residents that may potentially be affected by the Based on record review on 11/13/23 between 9:30 deficient practice. a.m. and 1:45 p.m. with the Maintenance Supervisor present, the facility was unable to All staff and residents have the provide documentation of a four hour load test of potential to be affected by this the emergency generator conducted within the deficient practice. past 36 month period. This was confirmed by the Maintenance Supervisor at the time of record III. The facility will put into review. place the following systematic changes to ensure that the This finding was reviewed with the Administrator deficient practice does not and Maintenance Supervisor during the exit recur. conference. A new TELS Task was created to 3.1-19(b) ensure the generator run test takes place every 3 years. See attached tasked labeled "Solarbron TELS Generator Run Test Task" IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities will inspect all generator paperwork for compliance during their annual CQR.

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

PRINTED: 12/12/2023 FORM APPROVED OMB NO. 0938-039

	OT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/13/2023		
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		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE

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