STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00448045. This visit also included a State Residential Licensure Survey. Complaint IN00448045 Federal/State deficiencies related to the allegations are cited at F 921. Survey dates: December 3, 4, 5, 6, 9, & 10, 2024 Facility number: 010930 Provider number: 155773 AIM number: 201274710 Census Bed Type: SNF/NF: 79 Residential: 29 Total: 108 Census Payor Type: Medicare: 3 Medicaid: 49 Other: 27 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 16, 2024.	F 0000	The plan of correction is to serve as Solarbron's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Solarbron or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to ensure a SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Form and Notice of Medicare Non-Coverage (NOMNC) was	F 0582	**F 582 Medicaid/Medicare Coverage/Liability Notice** **I. What corrective actions will**	01/16/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Danielle McClarnon	RN, CS	12/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided following the end of Medicare skilled services for 1 of 1 resident who discharged from Medicare services and continued to reside in the skilled nursing facility. (Resident 33) Findings included: On 12/6/2024 at 10:15 A.M., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed. The form was blank in response to whether Resident 33 received the SNF-ABN form as well as the Notice of Medicare Non-Coverage (NOMNC) Form. The BPN review form provided to the facility indicated Resident 33's Medicare coverage would end on 8/3/2024. Regional Support 7 indicated they did not have the required documents (CMS 10055 AND NOMNC 10123) signed by the resident or representative for beneficiary notification. On 12/10/2024 at 11:05 A.M. the Director of Nursing indicated they do not have a policy in relation to advanced beneficiary notice of non-coverage but follow the instructions form found on the Center for Medicare and Medicaid Services website. 3.1-4(f)(2)		**be accomplished for those residents found to have been affected by the practice?** Resident 33 has had no adverse effects of the alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents who are planned to discharge from Medicare services but continue to reside in the skilled nursing facility are being reviewed to ensure a SNF-ABN for and NOMNC are provided. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Social Services is being educated regarding the process for providing SNF-ABN and NOMNC for residents. **IV. The facility will monitor the corrective action by implementing the following measures.** The Administrator, or designee, will review residents who are discharged from Medicare services and continuing to reside in the skilled nursing facility for provision	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			of the SNF-ABN and NOMNC weekly for 12 weeks, then quarterly ongoing. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits and frequency will be adjusted as needed. **V. Plan of Correction completion date.** January 16th, 2025	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview, and record review, the facility failed to ensure medications were labeled properly for 2 of 2 medication carts observed. (West Hall, East Hall, Resident 16) Findings include: 1. On 12/4/24 at 9:33 A.M., the West Hall medication cart was reviewed. The following medications were observed without a label: Vial of ceftriaxone injection Vial of lidocaine, with an open date of 11/27/24 written on it with black marker Bottle of Bayer aspirin, with an open date of 11/1/24 written on it with black marker At that time, Qualified Medication Aide (QMA) 8 indicated that the ceftriaxone and lidocaine were removed from the Emergency Drug Kit (EDK) and should have had the residents name written on it with black marker. The aspirin was brought in by a family member and should have had the resident's name written on it in black marker.	F 0761	**F 761 Label/Store Drugs and Biologicals** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Identified medications were disposed of properly. **II. The facility will identify other residents that may potentially be affected by the practice.** Other medications were audited and properly labeled and dated. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**	01/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. On 12/4/24 at 10:39 A.M., the East Hall medication cart was reviewed. The following medications were observed without a label: Lantus Solostar insulin pen, with an open date of 11/28/24 written on it in marker Humalog Kwikpen insulin pen, with an open date of 11/23/24 written on it in marker At that time, Licensed Practical Nurse (LPN) 9 indicated the insulin pens belonged to Resident 16 and should be labeled with his name. On 12/9/24 at 10:32 A.M., the Director of Nursing (DON) provided a current undated Medication Labeling policy that indicated "All drugs dispensed for use by the residents in a facility...shall be labeled as follows: ... a. Identification of the pharmacy; b. Resident's name; c. Date of Dispensing; d. Non-proprietary and/or proprietary name of the drug; e. Strength expressed in the metric system whenever possible ... Over the counter medications used for a specific resident must identify that resident and have an appropriate pharmacy label applied". 3.1-25(j) 3.1-25(k) 3.1-25(l)		Licensed nurses and qualified medication aides are being educated on medication labeling and dating. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit all medications in carts for labeling and dating daily for 4 weeks, then weekly for 8 weeks, then quarterly ongoing. Results of these audits will be reviewed in the facility Quality Assurance Meeting which is held monthly and overseen by ED. Results of this audit will be reviewed at the Quality Assurance meeting and frequency and if a threshold of 100% is not achieved, the audits and frequency will be adjusted as needed. **V. Plan of Correction completion date.** January 16th, 2025	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were performed during 1 of 1 wound care and 2 of 2 random	F 0880	**F 880 |Infection Prevention & Control**	01/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observation for cleaning equipment in between residents. (Resident 33, Resident 11, Resident 16, Resident 13) Findings include: 1. On 12/6/24 at 10:17 A.M., RN (Registered Nurse) 2 and LPN (Licensed Practical Nurse)10 were observed performing wound care on Resident 33. RN 2 and LPN 10 both sanitized hands and donned plastic gowns and gloves. RN 3 cleaned the bedside table with cleaning cloth, opened a plastic trash bag, and set up clean dressing supplies with the same gloves on. RN 3 did not change gloves before she began to open supplies for dressing change. LPN 19 placed a drape on the floor to catch debris from the leg wounds. RN 3 began to remove the old dressings from Resident 33's legs with the same gloves that were used to clean the table with. Both RN 3 and LPN 2 removed gloves, sanitized, and then donned new gloves. LPN 10 removed the dressings from the right lower leg, removed gloves, and did not sanitize hands before new gloves placed. RN 3 applied wound cleanser to legs and both preceded to clean legs with gauze. RN 3 did not change gloves or sanitize before new dressing was applied. LPN 10 did not change gloves when starting to place new dressing and wrapping with ace wraps. After leg wrapping was completed, both RN 3 and LPN 10 doffed gowns, gloves, and then sanitized. On 12/4/24 at 11:07 A.M., Resident 33's clinical record was reviewed. Diagnoses included, were not limited to, non-pressure chronic ulcer of left calf with fat layer exposed, non-pressure chronic ulcer of other part of right lower leg with fat layer exposed, cellulitis of right lower limb, and cellulitis of left lower limb.		**I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Infection Control practices and standards are being performed for wound care and equipment cleaning for residents 33, 11, 16, and 13. **II. The facility will identify other residents that may potentially be affected by the practice.** Staff are following infection control practices and standards for wound care and equipment cleaning for other residents requiring wound care and enhanced barrier precautions. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed nurses are being educated regarding proper infection control practices and standards while performing wound care and equipment cleaning between residents requiring enhanced barrier precautions. **IV. The facility will monitor the corrective action by implementing the following measures.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The recent Quarterly MDS (Minimum Data Set) Assessment indicated Resident 33 was cognitively intact, needed substantial help dressing and hygiene, but was independent with transfer. The resident had 3 venous ulcers on legs. Current Physician Orders included, but were not limited to: Betadine (povidone-iodine) solution; 10 %; amount: apply to buttocks/thigh; topical Special Instructions: apply to blood blisters to buttocks/thigh, Twice A Day Upon Rising 07:00 AM - 11:00 AM and Before Bedtime 06:00 PM - 10:00 PM dated 11/28/2024. The current care plan dated 10/7/24 indicated Resident 33 is at risk for complication related to bilateral lower leg venous ulcers and needed monitoring and treatment. Interventions included, but were not limited to, refer to inpatient rounding wound MD and nurse for monitoring and treatment and provide treatments to BLE (Bilateral Lower Extremities) as ordered. See MAR (Medication Administration Record) for current recommendations. During an interview 12/06/24 at 10:35 A.M., LPN 10 indicated the gloves should have been changed after the table was cleaned and before the supplies were opened. RN 3 indicate it was not done. During an interview on 12/10/24 at 9:10 A.M., the DON (Director of Nursing) indicated the gloves should be changed when going from dirty to clean and sanitized before new gloves applied. On 12/10/24 at 9:05 A.M., the DON provided a		The IP/DON, or designee, will observe 3 employees providing care for residents requiring wound treatments and/or EBP to ensure compliance with infection control practices daily for 4 weeks, then weekly for 8 weeks, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for no less than 6 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** January 16th, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	current policy "Hand Washing/Hand Hygiene" dated 3/24/2016. The policy indicated "... hand hygiene with alcohol-based hand gel is the preferred if hands are not visibly soiled...use of hand gel is to be used in the following situations: before handling clean or soiled dressings, after handling used dressing, after removing gloves..."2. During a continuous observation on 12/6/24 from 7:58 A.M. to 8:19 A.M., LPN 9 was observed wearing a blood pressure monitor around her wrist. She entered Resident 13's room, removed the monitor from her wrist, placed it on Resident 13's wrist, and took the resident's blood pressure. The blood pressure monitor was not sanitized after use. LPN 9 placed the blood pressure monitor into a small bag on the medication cart while preparing medication for Resident 16. 3. At 8:19 A.M., LPN 9 retrieved the blood pressure monitor from the small bag, placed it around her wrist, and entered Resident 16's room. LPN 9 removed the monitor from her wrist, placed it on Resident 16's wrist, and took the resident's blood pressure. The blood pressure monitor was not sanitized prior to use. On 12/9/24 at 8:45 A.M., the DON indicated that blood pressure equipment should be cleaned between residents. On 12/9/24 at 10:32 A.M., the DON provided a current Cleaning and Disinfection of Equipment policy, effective 6/6/2019, that indicated "Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Bloodborne Pathogens Standard". 3.1-18(b)(1) 3.1-18(l)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment during 5 random observations. Odor was present in the facility and a resident wall was soiled with paint chipped out of the wall. (Memory Care Unit, East Hall Nurse Station, Front Lobby, Room 412) Findings include: 1. On 12/6/24 at 7:17 A.M., the Memory Care unit was noted to have an odor consistent with marijuana. 2. On 12/6/24 at 8:36 A.M., the East Hall Nurses Station was noted to have an odor consistent with marijuana. 3. On 12/9/24 at 8:45 A.M., the front lobby was noted to smell like sewer gas. During an anonymous interview, it was indicated that there was a strong odor upon entering the facility During an anonymous interview, it was indicated that there were pervasive odors in the facility especially on the East Hall. On 12/9/24 at 8:45 A.M., the Director of Nursing (DON) indicated staff and residents should not use marijuana while in the facility. She indicated	F 0921	**F 921** **Safe/Functional/Sanitary/Comfortable Environment** **I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** The memory care unit, east hall nurse station, front lobby and room 412 have been observed for odors and/or wall maintenance and addressed as indicated. **II. The facility will identify other residents that may potentially be affected by the practice.** Other units in the facility are being reviewed for odors and/or wall maintenance and will be addressed as indicated. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Staff are being educated regarding	01/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the lobby sometimes smelled like sewer gas due to a backed-up trap, especially when it rained. At 12/9/24 at 10:32 A.M., the DON indicated there was not a specific policy for controlling odors and that housekeeping and maintenance took care of those issues. On 12/9/24 at 10:48 A.M., Housekeeper 5 indicated that if an odor was noticed, it would be treated accordingly with the most appropriate option. At that time, Housekeeper 5 provided an undated Daily Cleaning Inspection Form that indicated "Closet looks and smells clean ... Bathroom smells clean, no odors noted". 4. During an observation on 12/4/24 at 10:44 A.M., dried deep red smears, missing chips of paint, and scuff marks were observed along the walls of room 412. During an interview on 12/9/24 at 10:50 A.M., housekeeper 5 indicated each resident room is inspected each day, is deep cleaned once a week, and staff should clean anything out of the ordinary any time it is observed. A daily cleaning inspection form, dated 12/6/24, indicated a full deep clean was performed on 412. During an observation on 12/10/24 at 8:25 A.M., dried deep red smears, missing chips of paint, and scuff marks were observed along the walls of room 412. On 12/9/24 at 1:11 P.M., the Director of Nursing provided a policy titled Quality of Life Homelike Environment, revised 8/09, indicated "The facility staff and management shall maximize the characteristics of the facility that reflect a personalized, homelike setting. These		addressing odors and/or wall maintenance issues promptly. **IV. The facility will monitor the corrective action by implementing the following measures.** The Administrator, or designee, will round the facility to observe for odors and/or wall maintenance issues daily for 4 weeks, then weekly for 8 weeks, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for no less than 6 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** January 16th, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	characteristics include: Cleanliness and order. The facility staff and management shall minimize the characteristics of the facility that reflect a depersonalized, institutional setting. Theses characteristics include: Institutional odors." This citation relates to Complaint IN00448045. 3.1-19(f)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included Investigation of Nursing Home Complaint IN00448045 Survey dates: December 3, 4, 5, 6, 9, & 10, 2024 Facility number: 010930 Residential Census: 29 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.	R 0000	The plan of correction is to serve as Solarbron's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Solarbron or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. The facility respectfully requests desk review for the following citations	
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to ensure pharmacist medication recommendations were reviewed and notification	R 0299	**R 299 Pharmaceutical Services - Noncompliance**	01/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was sent to the physician in a timely manner for 1 of 1 residents reviewed for unsigned drug regimen reviews. (Resident 9) Finding includes: On 12/10/24 at 11:15 A.M., Resident 9's clinical record was reviewed. Resident 9 was admitted on 8/20/24. Diagnoses included, but were not limited to, atrial fibrillation and heart failure. A hospital history and physical, dated 3/27/23, indicated "metoprolol" as an allergy for Resident 9. Current physician orders included, but were not limited to: metoprolol tartrate tablet 25 mg(milligrams) one tablet by mouth twice a day, start date 11/6/24. A pharmacy drug regimen review, dated 11/6/24, indicated a drug allergy reaction and the licensed pharmacist noted "patient has an order for metoprolol but patient has this listed as an allergy, can patient tolerate metoprolol?" The drug regiment review document was not signed by a physician, and clinical record, including documents and progress notes, did not indicate review of the pharmacy review or notification to the physician about the pharmacy review. During an interview on 12/10/24 at 11:21 A.M., the Director of Nursing indicated pharmacy recommendations are not reviewed until the following month after pharmacy sends them and this pharmacy review was not complete due to there being a new unit manager. On 12/10/24 at 11:21 A.M., a policy related to pharmacy recommendations was requested. The		**I. What corrective actions will be accomplished for those residents found to have been affected by the practice?** Pharmacist medication recommendations for Resident 9 were sent to the physician for review. **II. The facility will identify other residents that may potentially be affected by the practice.** Other pharmacist medication recommendations are being reviewed for timely notification. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nursing management is being educated regarding timely notification to the physician for pharmacy reviews. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will review pharmacist medication recommendations monthly for 3 months, then quarterly ongoing for timely notification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155773	A. BUILDING 00 B. WING	12/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director of Nursing indicated the facility policy was to follow federal regulations.		The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for no less than 6 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** January 16th, 2025	