STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155773	A. BUILDING -- B. WING	12/17/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/17/24 Facility Number: 010930 Provider Number: 155773 AIM Number: 201274710 At this Emergency Preparedness survey, The Terrace at Solarbron was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 91 certified beds. At the time of the survey, the census was 78. The Assisted Living section of the facility has 35 beds with a census of 31. Quality Review completed on 12/23/24	E 0000	January 7, 2025 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: M5TZ21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on December 17, 2024. This letter is to inform you that the plan of correction attached is to serve as The Terrace at Solarbron credible allegation of compliance. We allege substantial compliance on January 10,2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 812-985-0055 Sincerely,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin Crowe	HFA	01/08/2025

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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			Robin Crowe Administrator The Terrace at Solarbron Submission of this plan of correction in no way constitutes an admission by The Terrace at 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 or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/17/24	K 0000	January 7, 2025 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health	

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	Facility Number: 010930 Provider Number: 155773 AIM Number: 201274710 At this Life Safety Code survey, The Terrace at Solarbron was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility consisted of two buildings connected by a corridor. The original building was located on the first floor of a two story building determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus hard wired smoke detectors with battery back up in all resident rooms. The entire facility, including the second floor Assisted Living was surveyed due to the lack of a 2 hour fire-rated separation. The 2015 addition is a one story, fully sprinklered building determined to be of Type V (111) construction. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 91 and had a census of 78 at the time of this survey. The second floor Assisted Living section has a capacity of 35 beds and had a census of 31 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached maintenance garage used for the storage of maintenance equipment.		2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: M5TZ21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on December 17, 2024. This letter is to inform you that the plan of correction attached is to serve as The Terrace at Solarbron credible allegation of compliance. We allege substantial compliance on January 10,2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 812-985-0055 Sincerely, Robin Crowe Administrator The Terrace at Solarbron Submission of this plan of	

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	Quality Review completed on 12/23/24		correction in no way constitutes an admission by The Terrace at 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 or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices	K 0345	**K345** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1 – Facility failed to ensure that the fire system inspection report dated 12/21/2023 was available for review during their life safety audit. This was the one 6 months prior then the 6/10/2024 inspection. The Maintenance Supervisor has	01/10/2025

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	This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 12/17/24 between 10:45 a.m. and 2:45 p.m. with the Maintenance Supervisor and Maintenance Assistant present, there was documentation provided regarding an annual fire alarm system inspection/test dated 06/10/24 by the facility's fire alarm inspection vendor, however, the facility could not provide information of a semi-annual visual inspection of the facility's fire alarm devices, such as smoke detectors, pull stations, and heat detectors within six months prior to, or after the annual fire alarm system inspection/test. Based on interview at the time of record review, the Maintenance Supervisor confirmed there was no semi-annual visual inspection of the facility's fire alarm system devices, such as smoke detectors, pull stations, and heat detectors available for review. This finding was reviewed with the Administrator, Maintenance Supervisor, and Maintenance Assistant during the exit conference. 3.1-19(b)		contacted Safecare to obtain the correct documentation. See attached copy of the fire system inspection dated 12/21/2024. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All Employees and Residents could 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.** The Maintenance Supervisor has been reeducated by CarDon Corporate to review each inspection and ensure that it is printed and put in the life safety binder for review. **IV The facility will monitor corrective action by implementing the following measures.** The Corporate Facilities Staff will audit these records during their annual Corporate Quality Review. **V. Plan of Correction completion date.**	

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			Plan of Completion date is January 10, 2025.	
K 0355 SS=F Bldg. 02	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 30 of 30 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations on 12/17/24 between 2:45 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Supervisor, all portable fire extinguisher in the facility had affixed maintenance tag documenting the date the most recent annual maintenance was performed as November of 2023. Based on interview at the time of each observation, the Maintenance Assistant acknowledged the aforementioned portable fire extinguishers did not	K 0355	**K 355** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The facility failed to ensure that their annual fire extinguisher inspection was completed for 2023. The surveyor said they were due in November of 2023, and it was actual completed on 12/21/2023 so they were still compliant. See attached fire extinguisher inspection dated 12/21/2023 from Safe care. They were recently inspected on 12/20/2024 from Safe care. See attached fire extinguisher inspection dated 12/20/24. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could be affected by this deficient practice.	01/08/2025

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	have documented annual maintenance within the most recent twelve month period. This finding was reviewed with the Administrator, Maintenance Supervisor, and Maintenance Assistant during the exit conference. 3-1.19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is no follow up needed on this citation as the paperwork was correct and uploaded. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all life safety paperwork during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is January 8, 2024.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of 2 doors between the kitchen and main dining room had no impediment to closing and would close completely and latch automatically. This deficient practice could affect over 30 residents, staff, and visitors. Findings include:	K 0363	**K 363** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	01/08/2025

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	Based on observations on 12/17/24 between 2:45 p.m. and 5:00 p.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant, the following was noted: a. The right side door to the kitchen from the dining room was held wide open with a rubber door wedge. The Maintenance Assistant removed the rubber door wedge at the time of observation and spoke with kitchen staff about the use of the door wedge. b. The left side door to the kitchen from the dining room was standing in a semi open position and provided with a self closing device. When tested, the door would not close completely and latch automatically. Based on interview at the time of each observation, the Maintenance Supervisor and Maintenance Assistant acknowledged the use of the rubber door wedge and the other door not closing completely and latching automatically. This finding was reviewed with the Administrator, Maintenance Supervisor, and Maintenance Assistant during the exit conference. 3.1-19(b)		Observation 1- Facility failed to ensure that the right side kitchen door would shut and latch properly. The door was held open by a rubber wedge. The Maintenance Supervisor has removed the wedge and educated the kitchen staff that the door cannot be propped open. Observation 2- Facility failed to ensure that the left side kitchen door would shut and latch into the door frame. The Maintenance Supervisor has readjusted the door so it will shut and latch properly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** The Kitchen staff could 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.** The Administrator has in serviced the kitchen staff that they cannot prop open the kitchen doors and they should remain shut and latched at all times. See attached in-service documentation.	

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			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities will audit all kitchen doors during their site visits to ensure they are not wedged open and will shut and latch. **V. Plan of Correction completion date.** Plan of Completion date is January 8, 2024.	
K 0521 SS=F Bldg. 02	NFPA 101 HVAC Based on record review and interview, the facility failed to ensure documentation for the inspection of 23 of 23 fire dampers in the facility was complete for the inspected and provided necessary maintenance at least every four years (in non-health care occupancies) and six years (in health care occupancies) in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and	K 0521	**K 521** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- Facility failed to ensure that the fire damper paperwork 8/12/24 had the proper documentation to be compliant. The 23 onsite dampers were not broken down by location and that if each on passed inspection. The Maintenance Supervisor has had Baylor Mechanical review the	01/08/2025

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	inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents and all other occupants in the facility. Findings include: Based on record review on 12/17/24 between 10:45 a.m. and 2:45 p.m. with the Maintenance Supervisor and Maintenance Assistant present, there was a fire damper inspection report dated 08/12/24 for 23 fire dampers from the HVAC vendor. The report provided only said "We certify the installation of the HVAC system at Solarbron, 1701 McDowell Road has been completed in compliance with the NFPA code, SMACNA regulations, 23 fire dampers as per IFC fire codes, International and Indiana Mechanical codes and approved design. See attached floor plan." There was no itemized list of the individual fire dampers and their location. Furthermore, there was no information on the report about what was inspected with a pass/fail result for each fire damper. Finally, the attached floor plan was only a floor plan with blue dots with no other information. Based on interview at the time of record review, this was confirmed by the Maintenance Supervisor and Maintenance Assistant.		paperwork and rework to be more descriptive. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could 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.** Vendor notified and will provide complete documentation when they audit dampers. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Director will verify that all dampers are listed on audit. **V. Plan of Correction completion date.** Plan of Completion date is January 8, 2024.	

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	This finding was reviewed with the Administrator, Maintenance Supervisor, and Maintenance Assistant during the exit conference. 3.1-19(b)			
K 0921 SS=F Bldg. 02	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents.	K 0921	**K 921** **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 ensure that the annual PCREE test was completed in the last 12 months. The Maintenance Supervisor has contacted SafeCare to do the electrical testing of patient care equipment. See attached proposal from SafeCare and it will be completed prior to 1/17/2025. Once completed, if the life safety follow up has already occurred, it will be emailed to Life Safety. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents and staff could be affected by this deficient practice.	01/17/2025

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	Findings include: Based on record review on 12/17/24 between 10:45 a.m. and 2:45 p.m. with the Maintenance Supervisor and Maintenance Assistant present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, vital sign monitors, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Supervisor and Maintenance Assistant said the facility was not aware PCREE items had to be tested and documented. Based on observation between 2:45 p.m. to 5:00 p.m. during a tour of the facility with the Maintenance Supervisor and Maintenance Assistant , it was revealed the facility provided PCREE such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, vital sign monitors, and other electrical medical equipment was present in the facility. This finding was reviewed with the Administrator, Maintenance Supervisor, and Maintenance Assistant during the exit conference. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** A new TELS Task has been added to conduct the annual PCREE test in January of each year. See attached TELS task labeled "Solarbron Terrace PCREE Test Task" **IV The facility will monitor corrective action by implementing the following measures.** The Maintenance Supervisor and Corporate Facilities Staff will review the PCREE Documentation during the yearly Corporate Quality Review. **V. Plan of Correction completion date.** The plan of Completion date is January 17, 2025.	