	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155773		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 07/11/2024	
	PROVIDER OR SUPPLIE EE AT SOLARBROI		1701 M	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)	ATE	(X5) COMPLETION DATE
F 0000 Bldg. 00	Home Complaint I IN00435664, IN00 This visit included Residential Complaint IN0043 the allegations are Complaint IN0043 related to the allegations are Complaint IN0043 the allegations are Complaint IN0043 related to the allegations are Complaint IN0043 related to the allegations are cite	the Investigation of aint IN00436509, IN00436054. 7051 - No deficiencies related to cited. 7789 - Federal/State deficiencies ations are cited at F677. 5664- No deficiencies related to cited. 8377- Federal/State deficiencies ations are cited at F677. 6509-No deficiencies related to d. 6054-No deficiencies related to d. 8, 9, 10, 11, 2024.	F 0000	The plan of correction is to se as Solarbron's credible allegatof compliance. Submission of this plan of correction does not constitute admission by Solarbron or its management company that the allegations contained in the streport is a true and accurate portrayal of the provision of nucare and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Solarbron respectfully requesive desk review for this citation.	an ne urvey ursing	

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

TITLE

(X6) DATE

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 disclodays 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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) /) DATE SURVEY COMPLETED				
ANDILAN	OI COMMECTION	155773	B. WING			07/11/2024	
	ROVIDER OR SUPPLIER		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	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA	\G	DEFICIENCY)		DATE
F 0677 SS=E Bldg. 00	Quality review com 483.24(a)(2) ADL Care Provide §483.24(a)(2) A re carry out activities necessary service nutrition, grooming hygiene; Based on interview failed to provide AI care to 4 of 4 reside Bathing was not pro L, Resident N, Resi Findings include: 1. On 7/8/24 at 9:22 sometimes bathing in not done. 7/9/24 at 10:19 a.m. not get a shower yes schedules are support On 7/11/24 at 6:13 awas reviewed. Diag limited to, hemiples cerebral infarction a	ect State Findings cited in 0 IAC 16.2-3.1. spleted on July 18, 2024. ed for Dependent Residents esident who is unable to of daily living receives the set to maintain good g, and personal and oral and record review, the facility DL's (activities of daily living) ent's reviewed for bathing. Evident P, Resident C, Resident dent P, Resident Q) Eva.m., Resident L indicated is hard to get, sometimes it is entered and sterday, new shower ested to start today. Eva.m., Resident L's clinical record moses included, but were not gia and hemiparesis following affecting left non-dominant sysical debility, unspecified	F 0677		F 677 ADL Care Provided for Dependent Residents I. The corrective actions to be accomplished for those residents found to have been affected by the practice. The identities of residents L, N and Q were kept confidential. II. The facility will identify other residents that may potentially be affected by the practice. Other residents have been observed and reviewed to ens provision of bathing per plan ocare. III. The facility will put into	oe I, P, ure	08/12/2024

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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. B	UILDING	00	COMPL	ETED
		155773	B. W	'ING	07/11/2024		2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			CDOWELL RD		
TERRAC	E AT SOLARBRON	N THE			VILLE, IN 47712		
(X4) ID	CLIMMADY	STATEMENT OF DEFICIENCIE	1	ID		1	(Y5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
ino		Minimum date Set) assessment	+	1710	place the following systemat	ic	DATE
		cated cognition intact, shower/			changes to ensure that the		
	bathe self- partial/m				practice does not recur.		
	outile self-purtius if	iodorate assistance.			practice does not recui.		
	Care plans included	l, but were not limited to: CNA			Licensed nurses, QMA's, and		
	-	sident has specific needs			CNA's are being educated		
	_	: Approach : Resident prefers a			regarding provision bathing pe	er	
		esday/Friday day shift, start			plan of care.		
	date 9/19/23, edited						
					IV. The facility will monitor th	пе	
	A facility grievance	form dated 6/25/24 was			corrective action by		
		ded, but was not limited to:			implementing the following		
	Nature of concern: " Showers not getting Done.				measures.		
	They had care conference a few weeks ago. Have						
	already changed Shower days several times"				The DON, or designee, will re-	view	
	Concern received fr				bathing documentation for each	ch	
	_	eview and action taken: "			resident to ensure provision of	f	
	_	evamped shower schedule,			bathing per plan of care daily		
	educated staff."				weeks, then weekly for 8 weel		
					then monthly for 9 months for		
		edules were reviewed and			total of 12 months of monitorir	ng.	
		L's shower days were Tuesday					
	and Friday day shift	t.			The results of these reviews w		
	D:4411 BOG G	Daint Of Canal his			discussed at the monthly facili	-	
	· ·	Point Of Care) history was			Quality Assurance Committee		
		g for May, June, July, 2024 and			meeting monthly for 3 months		
	included the follow	ing:			then quarterly thereafter once		
	POC May 2024:				compliance is at 100%.	(iows	
	5/2- shower				Frequency and duration of rev will be increased as needed, i		
	5/4- PBB (partial be	ed bath)				'	
	5/13- shower	ouui)			compliance is below 100%.		
	5/16- shower						
	5/22- shower				V. Plan of Correction		
	5/24- PBB				completion date.		
	5/30- shower				completion date.		
	2.30 SH5W01				Date of Compliance : 8/12/24		
	Shower sheets were	reviewed and indicated a			The Administrator will be		
		ed that was not documented in			responsible for ensuring the fa	acility	
	the POC for bathing				is in compliance by date of		
		-					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
TERRAC	E AT SOLARBRON	N THE		MCDOWELL RD SVILLE, IN 47712	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	DBE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	5/6			compliance listed.	
	type of bathing was shower days: 5/1 5/3 5/5 5/7 5/8 5/9 5/10 5/11 5/12 5/13 5/15 5/17 5/18 5/19 5/20 5/21 5/23 5/25 5/26 5/27 5/28 5/29 June 2024 POC: 6/6- shower 6/10- shower 6/26- shower 6/30- PBB	were not recorded that any provided in the POC for non-		compliance listed.	
		ereviewed and indicated a ed that was not documented in			
	the POC for bathing				
	6/3	<u>.</u>			
	6/6				
	6/13				

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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	COM	(X3) DATE SURVEY COMPLETED 07/11/2024			
NAME OF P	ROVIDER OR SUPPLIER	.		ADDRESS, CITY, STATE, ZIP COI)			
			1701 MCDOWELL RD					
TERRAC	E AT SOLARBRON	N IHE	EVANS	VILLE, IN 47712				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE PROPRIATE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	6/18	4 4/4						
	a shower was done	ed d/t resident indicated she got						
	6/24							
	0/21							
	The following days	were not recorded that any						
	type of bathing was	provided in the POC for non-						
	shower days:							
	6/1							
	6/2							
	6/4							
	6/5 6/7							
	6/8							
	6/9							
	6/11							
	6/12							
	6/14							
	6/15							
	6/16							
	6/17							
	6/19							
	6/21							
	6/22							
	6/23 6/25							
	6/25 6/27							
	6/28							
	6/29							
	POC July 2024:							
	7/1- shower							
	7/4- shower							
	7/8- PBB							
	7/9- shower							
	The following days	were not recorded that any						
	type of bathing was	provided in the POC for non-						
	shower days:							
	7/2							

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DEPARTMENT	OF HEALTH AND HUN		FORM APPROVED					
ENTERS FOR	MEDICARE & MEDICA	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. Building 00			COMPLETED	
		155773	B. WI	NG		07/11/	2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD				
TO LINE OF T	NO VIDEN ON BOTT EIEN			1701 MCDOWELL RD				
TERRAC	E AT SOLARBRON	I THE		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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	

IERNA	CE AT SOLARDRON THE	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		
	7/3 7/5 7/6 7/7 7/10 No documentation of refusal was in the clinical record except on 6/20/24. 2. On 7/11/24 at 7:25 a.m., Resident N was observed on the locked dementia unit, Resident N was non interviewable. On 7/11/24 at 7:40 a.m., Resident N's clinical record was reviewed. Diagnoses included, but were not limited to, Diabetes Mellitus, dementia. A MDS (Minimum Data Set) assessment, dated 4/24/24 indicated cognition severely impaired, shower/bathe self - supervision or touching assistance.					
	A facility grievance form dated 5/6/24 was reviewed and included, but was not limited to: Nature of concern: "c/o 0 receiving showers" Concern received from: Family. Department Head review: "Nursing/SS to meet w/family 5/21 @10:am."					
	Current shower schedules were reviewed and indicated Resident N's shower days were Wednesday & Saturday day shift.					
	Resident N's POC (Point Of Care) history was reviewed for bathing for May, June, July, 2024 and included the following:					
	POC May 2024: 5/1-shower 5/2- PBB 5/4- shower					

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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		
		155773	B. WING		07/11/2024		
		<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP (COD		
NAME OF P	PROVIDER OR SUPPLIEF	8		MCDOWELL RD			
TERRAC	E AT SOLARBRON	N THE		EVANSVILLE, IN 47712			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	pp ov recens av .vv	(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	RRECTION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	5/6- PBB						
	5/9- PBB						
	5/11-shower						
	5/13- PBB						
	5/14- PBB						
	5/15- shower						
	5/18- shower						
	5/19- PBB						
	5/22- PBB						
	5/23- PBB						
	5/24- PBB						
	5/25- shower						
	5/28- PBB						
	5/29- shower						
	5/30- PBB						
	Shower sheets were	e reviewed and indicated a					
		ed that was not documented in					
	the POC for bathing						
	5/8	5.					
	5/13						
	5/13						
	J. 21						
	The following days	were not recorded that any					
		s provided in the POC for non-					
	shower days:						
	5/3						
	5/5						
	5/6						
	5/7						
	5/20						
	5/26						
	5/27						
	5/31						
	POC June 2024:						
	6/1- shower						
	6/5- shower						
	6/10- PBB						
	6/12- shower						
1	0/ 12- 3HO W CI		- 1	1			

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	OF CORRECTION	IDENTIFICATION NUMBER 155773	A. BUILDING B. WING	00	COMP	E SURVEY PLETED 1/2024
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD CDOWELL RD)	
TERRAC	E AT SOLARBRON	I THE		VILLE, IN 47712		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	6/13- PBB	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE !		DATE
	6/15- shower					
	6/16- PBB					
	6/18- PBB					
	6/19- shower					
	6/20- PBB					
	6/22- shower					
	6/26- shower					
	6/29- shower					
	6/30- PBB					
	Shower sheets were reviewed and indicated a shower was provided that was not documented in					
	the POC for bathing:					
	6/8					
		were not recorded that any provided in the POC for non-				
	6/28					
	0.20					
	POC July 2024:					
	7/3- shower					
	7/9- PBB					
	7/10- shower					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building 00			COMPL	ETED
		155773	B. WI	NG		07/11/2024	
				_			
NAME OF F	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
					CDOWELL RD		
TERRAC	E AT SOLARBRON	NTHE		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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Shower sheets were	e reviewed and indicated a					
		ed that was not documented in					
	the POC for bathing						
	7/6						
	The following days	were not recorded that any					
	type of bathing was provided in the POC for non-shower days: 7/1 7/2						
	7/4						
	7/5						
	7/7						
	7/8						
	//8						
	NI- 1						
		of refusal was observed in the					
	clinical record.						
	3 On 7/0/24 at 10:5	59 a.m., Resident Q indicated					
		not receive showers/bathing.					
	they sometimes do	not receive snowers/batting.					
	On 7/11/24 at 0:40	a.m., Resident Q's clinical record					
		gnoses included, but were not					
		ied abnormalities of gait and					
		C					
		ed physical debility, unspecified					
	-	narterly MDS (Minimum Data					
		red 6/5/24 indicated cognition					
	f .	e self- substantial/maximal					
	assistance.						
	Como mlorro : 1 1 - 1	1 hust recome most limited to CNIA					
	_	l, but were not limited to: CNA					
		esident has specific needs					
		. Approach: Resident prefers					
	snowers Wed/Sat e	vening, start date 6/27/23.					
	A facility orievenes	e form dated 5/3/24 was					
		ded, but was not limited to:					
		"Showers and time of					
	shower" Concern	received from: Family.					1

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	OF CORRECTION	IDENTIFICATION NUMBER 155773	A. BUILDING B. WING	00 00	COMP	LETED 1/2024
	PROVIDER OR SUPPLIER		1701 M	ADDRESS, CITY, STATE, ZIP COI 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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Department Head re "Shower time has enforced"	eview and action taken: been addressed and				
		edules were reviewed and Q's shower days were day evening shift.				
		Point Of Care) history was g for May, June, July, 2024 and ing:				
	POC May 2024: 5/9- PBB 5/12- shower 5/13- PBB					
	5/14- PBB 5/16- PBB 5/17- PBB					
	5/18 -shower 5/20- PBB 5/21- PBB 5/22- PBB					
	5/25- shower 5/27- PBB 5/29- PBB 5/30- PBB					
		reviewed and indicated a d that was not documented in				
	the POC for bathing 5/8 5/6					
	5/11 5/15 5/22- type of bathin 5/29	g not marked				
	The following days	were not recorded that any				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773		JILDING	nstruction <u>00</u>	(X3) DATE COMPL 07/11/	ETED
	PROVIDER OR SUPPLIEI			1701 M	NDDRESS, CITY, STATE, ZIP COD CDOWELL RD VILLE, IN 47712		
(X4) ID PREFIX	(EACH DEFICIEN	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	ATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION S provided in the POC for non-		TAG	DEFICIENCY)		DATE
	shower days:	•					
	5/1 5/2						
	5/3						
	5/4						
	5/5						
	5/7						
	5/10 5/19						
	5/23						
	5/24						
	5/26						
	5/28						
	POC June 2024:						
	6/1- shower						
	6/4- PBB						
	6/6- shower 6/8- shower						
	6/9- PBB						
	6/10- PBB						
	6/11- PBB						
	6/12- PBB						
	6/13- PBB						
	6/14- PBB 6/17- PBB						
	6/19- shower						
	6/28- shower						
	6/29- shower						
		e reviewed and indicated a					
	_	ed that was not documented in					
	the POC for bathing	g:					
	6/12 6/15						
	0/13						
		were not recorded that any					
		s provided in the POC for non-					
	shower days:						

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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 CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/11/2024		
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	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE		D BE	(X5) COMPLETION DATE	
	type of bathing was shower days: 7/2 7/5 7/8	were not recorded that any provided in the POC for non-						

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4. On 7/11/24 at 10:00 a.m., Resident P's clinical record was reviewed. Diagnoses include but were not limited to, age-related debility, Multiple Sclerosis. An Admission MDS (Minimum Data Set) assessment dated 5/27/24, indicated

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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	COMI	(X3) DATE SURVEY COMPLETED 07/11/2024		
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE		STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, IN 47712					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DECLE ATORY OF LIGHT DEPOTE ATTORY		ID PREFIX	PROVIDER'S PLAN OF CORRECTION PREFIX (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	cognition intact, she substantial/maxima discharged from the Care plans included assignment sheet re related to their care. shower/bath on (lef shift, start date 5/21 A facility grievance reviewed and included Nature of concern: have a shower before been 2 weeks " Concerned been 2 weeks " Concer	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Ower bathe self- I assistance. Resident P r facility on 6/10/24. I, but were not limited to: CNA sident has specific needs Approach: Resident prefers a t blank), days and (left blank) //24. If form dated 6/10/24 was field, but was not limited to: I [resident name] would like to one she discharges today. It's neern received from: Resident. It's neern received from: Resident. It's or resident as soon as we ern." Point Of Care) history was g for May, June, July, 2024 and		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	(XS) COMPLETION DATE	
	5/23 5/24 5/25						
	5/26 5/27 5/28 5/29						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING			PLETED				
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE			1701 M	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 No shower sheets were observed for May 2024.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE A CATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE			
	POC June 2024: 6/1- CBB 6/4- PBB 6/6- PBB 6/8- PBB 6/9- PBB 6/10- shower The following days type of bathing was shower days: 6/2 6/3 6/5 6/7 On 7/11/24 at 11:50 are documented on computer. On non sprovided, care is waresident asked some arm pits, she does it On 7/11/24 at 12 p.: current policy on A revision date of Mabut was not limited to carry out activitie independently will to maintain good nupersonal and oral hy and services will be are unable to carry of the consent of the rewith the plan of carry with the plan of carry.	were not recorded that any provided in the POC for non- a.m., CNA 2 indicated showers shower sheets, also in the hower days bathing is not ashing face, brushing teeth, if a ething specific, like washing the civities of Daily Living with a rech 2018. The policy included, to:Residents who are unable as of daily living receive the services necessary attrition, grooming, and regiene2. Appropriate care provided for residents who but ADL's independently, with resident and in accordance to including appropriate are with: a. hygiene (bathing,							

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/11/2024		
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 REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION to Complaint IN00437789 and		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
R 0000	3.1-38(b)(2)							
Bldg. 00	This visit was for the Investigation of Residential Complaint IN00436509, IN00436054. This visit included the Investigation of Nursing Home Complaint IN00437051, IN00437789, IN00435664, IN00438377. Complaint IN00436509-No deficiencies related to allegations are cited. Complaint IN00436054-No deficiencies related to allegation are cited. Complaint IN00437051 - No deficiencies related to the allegations are cited. Complaint IN00437789 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00435664- No deficiencies related to the allegations are cited. Complaint IN00438377- Federal/State deficiencies related to the allegations are cited at F677 Survey dates: July 8, 9, 10, 11, 2024. Facility number: 010930 Residential census: 25		R 00	000	The plan of correction is to set as Solarbron's credible allegat of compliance. Submission of this plan of correction does not constitute admission by Solarbron or its management company that the allegations contained in the sureport is a true and accurate portrayal of the provision of nucare and other services in this facility. Nor does this submissic constitute an agreement or admission of the survey allegations. Solarbron respectfully request desk review for this citation.	an e irvey irsing		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155773	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/11/2024	
NAME OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE			STREET ADDRESS, CITY, STATE, ZIP COD 1701 MCDOWELL RD EVANSVILLE, 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 APPROPRI		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Investigation of Con IN00436504 survey	nplaints IN00436509 and					

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