

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

PRINTED: 08/12/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155773</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>08/05/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>TERRACE AT SOLARBRON THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1701 MCDOWELL RD</b> <b>EVANSVILLE, IN 47712</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaints IN00385110 and IN00384394 completed on 7/13/22. This visit included the PSR to the COVID-19 Focused Infection Control Survey completed on 7/13/22.</p> <p>This visit was in conjunction to the Post Survey Revisit (PSR) to the Investigation of Complaints IN00382723 completed on 6/24/22.</p> <p>Complaints: IN00384394-Corrected.</p> <p>IN00385110 - Corrected.</p> <p>Survey date: August 5, 2022</p> <p>Facility number: 010930 Provider number: 155773 AIM number: 201274710</p> <p>Census Bed Type: SNF/NF: 83 Residential: 39 Total: 122</p> <p>Census Payor Type: Medicare: 18 Medicaid: 45 Other: 20 Total: 83</p> <p>The Terrace at Solarbron was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to Investigation of Complaints IN00385110,</p>	{F 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

PRINTED: 08/12/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155773</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>08/05/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>TERRACE AT SOLARBRON THE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1701 MCDOWELL RD</b> <b>EVANSVILLE, IN 47712</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000}	Continued From page 1 IN00384394 and the PSR to the COVID-19 Focused Infection Control Survey.  Quality review completed on August 11, 2022.	{F 000}		