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	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace at Solarbron The	1701 McDowell Rd Evansville, IN 47712

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure notification was given to a resident's representative of a worsening pressure ulcer for 1 of 3 resident's reviewed for wounds. (Resident B)Finding includes:On 9/8/25 at 9:41 a.m., Resident B's clinical record was reviewed. Diagnoses included but were not limited to epidural hemorrhage without loss of consciousness, subsequent encounter, pressure ulcer of unspecified site, stage 2, protein-calorie malnutrition, paraplegia, unspecified, essential hypertension, hyperlipidemia, age-related osteoporosis, other fracture of T5-T6 vertebra, anemia, chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity, and unspecified dementia. An admission MDS (Minimum Data Set) assessment dated [DATE] indicated Resident B's cognition was moderately impaired, dependent on bed mobility, and toileting. Resident B was admitted to the facility on [DATE] and discharged on 8/27/25. Care plans were reviewed and included, but were not limited to: Resident is at risk for skin breakdown r/t (related to) impaired mobility, anemia, paraplegia, initiated 7/22/25. Interventions included but were not limited to: assist with bed mobility as indicated, elevate heels as the resident will allow, monitor skin for signs of skin breakdown, pressure reduction cushion in wheelchair, pressure reduction mattress, RD (registered dietician) to evaluate as indicated, turn and reposition (bed mobility), per the resident's individual needs, initiated 7/22/25.The resident had unavoidable skin breakdown with continued expected unavoidable deterioration r/t terminal illness and life sustaining measures have been discouraged, continuous urinary incontinence, peripheral vascular disease, paraplegia, chronic bowel incontinence, initiated 8/4/25. Interventions included but were not limited to: assist with bed mobility as indicated, elevate heels as the resident will allow, monitor skin for signs of skin breakdown, pressure reduction cushion in wheelchair, pressure reduction mattress, turn and reposition (bed mobility) per resident's individual needs, weekly skin assessment, initiated 8/4/25. The resident has a pressure ulcer on the left ankle, initiated 8/11/25.Interventions included but were not limited to: administer treatment as ordered, assist the resident with turning and repositioning, bed mobility, initiated 8/11/25.The resident has a pressure ulcer on the left heel, initiated 8/11/25. Interventions included but were not limited to: administer treatment as ordered, assist the resident with turning and repositioning, bed mobility, initiated 8/11/25. The resident has a pressure ulcer to the coccyx, initiated 8/11/25. Interventions include but are not limited to: administer supplements/vitamins as ordered to promote wound healing, admisniter treatment as ordered, encourage 75-100 % of meal and encourage fluids per pan of care, notify MD if area worsens, increase in pain or shows signs or symptoms of infection, pressure reducing cushion in wheelchair, pressure reducing mattress on bed, provide incontinence care after each incontinent episode, report labs, initiated 8/11/25. Orders for August 2025 were reviewed and included, but were not limited to:Coccyx place foam dressing as a preventative to area. Change every (indicate days) once a day, 6:00 a.m. - 6:00 p.m., start (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date 8/8/25, discontinued 8/25/25, (left ankle, left heel) Apply skin prep as a preventative daily. Remove old treatment prior to applying new, start date 8/8/25, discontinue 8/25/25.Coccyx cleanse area with soap and water, pat dry, apply Santyl to wound bed only, cover with bordered foam dressing daily, once a day 6:00 a.m.- 6:00 p.m. start date 8/25/25, discontinue 8/27/25.left heel, apply skin prep as a preventative daily. Remove old treatment prior to applying new, once daily 6:00 a.m.- 6:00 p.m., start date 8/25/25, discontinue 8/27/25.left outer ankle apply betadine BID (twice a day) and leave open to air once daily 6:00 a.m.- 6:00 p.m, start date 6:00 a.m., discontinue 8/27/25. Wound notes were reviewed and included, but were not limited to:Pressure ulcer - coccyx, date identified 8/4/25 2:10 p.m.Unstageable -deep tissue L (length) 4.5 cm (centimeters) W (width) 1 cm Comments: husband present during assessment, informed of measurements and need to turn and reposition to relieve pressure to restore blood flow, also granddaughter present and asked if she could buy a body pillow to help with positioning. Pressure ulcer - coccyx- date observed 8/11/25 10:51 a.m.Unstageable- deep tissueL- 4.6 cm W 1 cm Wound healing status- decliningPressure ulcer -coccyx - date observed 8/18/25 9:03 a.m.Unstageable- slough and/or escharL- 4.8 cmW 2.6 cmWound healing status- decliningPressure ulcer- date observed 8/25/25 at 11:06 a.m.Unstageable -slough and/or escharL 5 cm W 5 cm Unstageable - slough and/or escharTissue type: necrotic tissue Wound odor- yes Wound healing status- decliningComments: recently noted cognitive decline, decline in mobility, and positive for COVID. Also, a decline in appetite. Pressure ulcer left ankle date identified 8/6/25 at 6:00 amUnstageable -deep tissue L 1 cm W 1 cm Comments: husband present during assessment and informed of measurements and need for repositioning and pressure relief. Pressure ulcer left heel date identified 8/6/25 at 6:00 a.m.Unstageable - deep tissueL 4 cmW 2.2 cmComments: husband present during assessment and informed of measurements and need for repositioning and pressure relief. A wound note dated 8/25/25 at 9:18 a.m. for the left ankle unstageable deep tissue wound indicated a scab was formed over are. Podus boots on bilateral feet, air mattress in place. TX (treatment) changed to betadine BID to the area and leave open to air. Physician and spouse notified.The clinical record contained no information that Resident B's POA's (power of attorney) representatives were notified of the resident's decline in the coccyx wound, nor were they informed of the development of the wounds to the left ankle or heel. The clinical record indicated that Resident B's POAs were her grandson and granddaughter, and the first contact for financial and health. Resident B's husband's contact information was not listed on the face sheet. On 9/9/25 at 9:17 a.m., the Administrator indicated Resident B's POA was not notified of the decline of the coccyx wound; on 8/25/25, the physician and spouse were notified. On 9/10/25 at 12:38 p.m., the Administrator indicated the facility did not have a policy related to notifying a resident's representative of a change in a resident's condition. This citation relates to Intake 2606700.3.1-5(a)(2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to ensure that Activities of Daily Living (ADLs) were provided daily to residents. Bathing/showers were not documented as done. (Resident B, Resident C)Finding includes: On 9/8/25 at 9:41 a.m., the clinical record was reviewed, for resident B, diagnoses included but were not limited to, epidural hemorrhage without loss of consciousness, subsequent encounter, pressure ulcer of unspecified site, stage 2, protein-calorie malnutrition, paraplegia, unspecified, essential hypertension, hyperlipidemia, age-related osteoporosis, other fracture of T5-T6 vertebra, anemia, chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity, and unspecified dementia. Resident B's clinical record included, but was not limited to, an admission MDS (Minimum Data Set) assessment, dated 7/24/25, indicated Resident B's shower/bathing dependent (the ability to bathe self, including washing, rinsing, and drying self). Resident B was admitted to the facility on [DATE] and discharged on 8/27/25. Care plans were reviewed and included, but were not limited to: ADL's functional status/rehabilitation potential, resident is unable to independently perform late loss ADL's r/t generalized weakness and debility, impaired gait and mobility, A-Fib, recurrent DVT (deep vein thrombosis), osteoporosis, dementia, anemia, thoracic spinal epidural hematoma, paraplegia, chronic T5 FX (fracture), andb requires assistance/encouragement for bed mobility, transfers, toileting and eating, start date 7/22/5. Interventions included but were not limited to: assist/encourage resident in proper transfer/bed mobility, toileting/hygiene, and eating, start date 7/22/5Point of care history for bathing was reviewed for July and August 2025 and included the following:July 7/29- PBB (partial bed bath) 7/24- shower 7/23- PBB7/23- shower August 8/25 - PBB8/20 - PBB8/19 - PBB8/18 - PBB8/17 - PBB8/16 - PBB8/14 - PBB8/13 - PBB8/11 - CBB (complete bed bath)8/8 - PBB8/7 -PBB8/6 - PBB8/5 - PBB8/2 - PBBNo documentation of refusal was observed in the clinical record. On 9/9/25 at 2:19 p.m., Resident C's clinical record was reviewed. An admission MDS (Minimum Data Set) assessment dated [DATE] indicated Resident C's cognition was severely impaired, shower/bathe dependent (the ability to bathe self, including washing, rinsing, and drying self). Resident C was admitted to the facility on [DATE].Care plans were reviewed and included, but were not limited to:Category: CNA Assignment Sheet: Resident has specific needs related to theircare, start date 7/17/25. Interventions included but were not limited to: Resident prefers a shower/bath on Tuesday and Friday and the day shift, start date 8/1/25. Point of care history for bathing was reviewed for July, August, and September 2025 and included the following:July7/29 - PBB7/22 - PBB7/21 - CBB7/20 - CBB August8/29 - PBB8/28 - PBB8/26 - CBB8/25 - PBB8/22 - CBB8/20 - PBB 8/19 - PBB8/17 - PBB8/16 - PBB8/14 - PBB 8/13 - PBB8/11 - CBB8/8 - PBB8/7 - PBB8/6 - PBB8/5 - PBB8/2 - PBB8/1 - CBBSeptember 9/8 - PBB9/3 - PBB9/2 - showerOn 9/10/25 at 11:24 a.m., CNA 2 indicated there is a shower sheet where bathing and resident refusals are documented. If a resident refuses, you have to ask them three different times and let the nurse know. Daily bathing is also supposed to be documented on the computer, including the type receivedOn 9/10/25 at 12:24 p.m., the Administrator provided the current policy on ADLs with a revised date of March 2018. The policy included but was not limited to: 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) .This citation relates to Intake 2606700.3.1-38(a)(1)