

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>155299</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/16/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>MILLER'S MERRY MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP <b>5909 LUTE RD PORTAGE, IN 46368</b>	
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 0880  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Provide and implement an infection prevention and control program.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and/or contain COVID-19 related to personal protective equipment (PPE) not worn properly with resident interaction and protective eyewear not in use for random observations for infection control on 1 of 3 Units. (The 300 Unit) Findings include: 1. During a random observation, on 10/16/20 at 9:17 a.m., CNA 1 was standing inside of the doorway of room [ROOM NUMBER]. The door to the room was open and a sign was posted on the door indicating the resident was in contact/droplet precautions. The CNA was wearing an isolation gown, gloves, and an N95 mask. She was not wearing a face shield or goggles. Continued observation at the time, indicated two transport staff members were also in the room. They were wearing surgical masks and gloves. No gowns or protective eyewear were in use. The resident was in bed with her mask positioned below her nose. The Infection Preventionist educated the transport staff at the time about needing an isolation gown and a face shield. Interview with the Infection Preventionist on 10/16/20 at 9:30 a.m., indicated the CNA should have either been wearing a face shield or safety glasses while in the resident's room and the transport staff should have been wearing gowns and eye protection as well since the resident was in contact/droplet precautions. Review of the current facility policy titled, Prevention and Containment of Coronavirus (COVID-19) on 10/16/20 at 12:00 p.m., indicated existing infection control and prevention practices were to be monitored which included: handwashing, applying and removing personal protective equipment (gloves, gowns, masks, and eye shields), appropriate use of isolation and precautions. 2. During a random observation, on 10/16/20 at 9:20 a.m., the Housekeeping Supervisor was standing near her cart in the 300 Unit. She was not wearing protective eyewear. Interview with the Housekeeping Supervisor on 10/16/20 at 10:20 a.m., indicated she should have been wearing her safety glasses due to the fact the facility had an active case of COVID-19. 3.1-18(b)(1)</p>		

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.