STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155564	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILLER'S MERRY MANOR	**259 W HARRISON ST MOORESVILLE, IN 46158**

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure new admission residents were placed on droplet isolation precautions (measures used to prevent the spread of diseases) upon admission to the facility for 2 of 3 residents reviewed for isolation precautions. (Resident 1 and Resident 2) Findings include: 1. On 6/10/20 at 9:58 a.m., during a tour of the facility with Registered Nurse (RN) 2, Resident 1 was observed from the hallway, in her private room, sitting on her bed and watching television. RN 2 indicated, Resident 1 was confined to her room for 14 days, because she was a new admission to the facility. No notification of isolation signage was observed on Resident 1's door, nor was an isolation cart (supplies of personal protective equipment) observed near Resident 1's room. On 6/10/20 at 12:10 p.m., the Executive Director (ED) indicated, Resident 1 was admitted to the facility on [DATE]. Because she was a new admission, Resident 1 was quarantined to her room for 14 days, but droplet isolation precautions were not in place for the resident, because the resident had not shown any signs or symptoms of a respiratory illness. On 6/10/20 at 12:22 p.m., Licensed Practical Nurse (LPN) 5 delivered a lunch tray to Resident 1 in her room. LPN 5 was wearing a mask, sanitized hands before entering the room, placed the tray on a bedside table, and sanitized hands, when she exited Resident 1's room. No notification of isolation signage was observed on Resident 1's door, nor was an isolation cart observed near Resident 1's room. On 6/10/20 at 3:59 p.m., Resident 1 was observed in her room with the door open, sitting on her bed, and watching television. No notification of isolation signage was observed on Resident 1's door, nor was an isolation cart observed near Resident 1's room. Resident 1's record was reviewed on 6/10/20 at 2:45 p.m. Resident 1 was admitted to the facility, from her home, on 6/8/20. Diagnoses, included but not limited to, acute [MEDICAL CONDITION] and [MEDICAL CONDITION]. physician's orders [REDACTED]. Notify physician of temperature greater than 100.0 degrees and symptomatic. A care plan, dated 6/10/20, indicated, Resident 1 was at risk for decline in psychosocial wellbeing related to changes in daily facility operations, related to COVID-19 threat and could possibly become sick. A goal for the resident was to remain free from distress related to changes in facility operations. Interventions on the care plan, included but were not limited to, daily assessments, including checking of temperature and symptoms, eat meals in room to reduce risk until further notice, and provide education to the resident of the importance of following the restrictions to maintain the safety and wellbeing of the resident. The care plan lacked documentation for interventions related to droplet isolation precautions to be implemented. 2. On 6/10/20 at 10:15 a.m., during a tour of the facility with Registered Nurse (RN) 2, Resident 2 was observed from the hallway, in his private room with the door opened, sitting in his wheelchair, while he watched the television. RN 2 indicated, Resident 2 was confined to his room for 14 days, because he was a new admission to the facility. No notification of isolation signage was observed on Resident 2's door, nor was an isolation cart (supplies of personal protective equipment) observed near Resident 2's room. On 6/10/20 at 12:15 p.m., the Executive Director (ED) indicated, Resident 2 was admitted to the facility on [DATE]. Because he was a new admission, Resident 2 was quarantined to his room for 14 days, but droplet isolation precautions were not in place for the resident, because Resident 2 had not shown any signs or symptoms of a respiratory illness. On 6/10/20 at 4:12 p.m., Resident 2 was observed wearing a face mask and propelling himself in a wheelchair down the hallway. Resident 2's room door was open. No notification of isolation signage was observed on Resident 2's door, nor was an isolation cart observed near Resident 2's room. On 6/11/20 at 9:45 a.m., Resident 2's record was reviewed. [DIAGNOSES REDACTED]. physician's orders [REDACTED]. Notify physician of temperature greater than 100.0 degrees and symptomatic. A care plan, dated 6/9/20, indicated, Resident 2 was at risk for decline in psychosocial wellbeing related to changes in daily facility operations, related to COVID-19 threat and could possibly become sick. A goal for the resident was to remain free from distress related to changes in facility operations. Interventions on the care plan, included but were not limited to, daily assessments, including checking of temperature and symptoms, and eat meals in room to reduce risk until further notice. The care plan lacked documentation for interventions related to droplet isolation precautions to be implemented. The Centers for Disease Control and Prevention (CDC), dated 4/28/20, indicated, for all Long Term Care Facilities to, .Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile (without fever) and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected .All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown 3.1-18(b)(1)

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.