

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>155579</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>06/05/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>MILLER'S MERRY MANOR</b>		STREET ADDRESS, CITY, STATE, ZIP <b>7440 N COUNTY ROAD 825 E HOPE, IN 47246</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 0695  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Provide safe and appropriate respiratory care for a resident when needed.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to monitor temperatures related to infection prevention of COVID-19 for 1 of 3 residents reviewed for a Respiratory Care. (Resident B) Findings include: The clinical record for Resident B was reviewed on 06/04/20 at 11:30 A.M. An Admission MDS (Minimum Data Set) assessment, dated 03/28/20, indicated the resident was severely cognitively impaired. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Notify MD of temp greater than 100.0 and symptomatic. Every day shift. The April 2020 MAR (Medication Administration Record) lacked documentation of the resident's temperature for the following dates: 04/09/20, 04/10/20, 04/22/20, 04/27/20, 04/28/20, and 04/30/20 The clinical record lacked any other temperatures for the above dates. During an interview on 06/04/20 at 1:56 P.M., LPN (Licensed Practical Nurse) 2 indicated the residents temperatures were to be documented every shift. The temperatures were then documented in the computer. During an interview on 06/05/20 at 1:48 P.M., the DON (Director of Nursing) indicated that the residents temperatures were to be monitored daily and then this past week they started completing them every shift. The current facility policy titled Respiratory Assessments during COVID that was dated 04/27/20, was provided by the DON on 06/05/20 at 1:48 P.M. The policy indicated .To assess residents for potential COVID-19 infection based upon degree of exposure, symptoms and testing .Complete on residents not displaying symptoms of COVID-19 or suspected of .Consists of assessing, temperature .If normal, document on the Medication record . 3.1-47(6)		

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.