STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	500 WALKERTON TR WALKERTON, IN 46574

(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
F000000	This visit was for a Recertification and State Licensure survey. Survey Dates: May 7, 8, 9, 10, 13, 2013 Facility Number: 000431 Provider Number: 155574 AIM Number: 100290380 Survey Team: Shauna Carlson, RN-TC Julie Baumgartner, RN Shelly Vice, RN Census Bed Type: SNF: 11 SNF/NF: 71 Total: 82 Census by Payor Type: Medicare: 10 Medicaid: 46 Other: 26 Total: 82 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on May 20, 2013, by Brenda Meredith, R.N.	F000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	500 WALKERTON TR WALKERTON, IN 46574

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/13/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WALKERTON TR WALKERTON, IN 46574	

(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
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interviews and record reviews the facility failed to provide smoking cessation care for Resident #118. This affected 1 of 1 resident sampled. Finding includes: On 5/8/2013 at 1:15 p.m., a record review of Resident #118's Clinical Medical Record (CMR) indicating the admission to the facility, on 5/6/2013, was for wound management of a Stage 4 pressure ulcer and for smoking cessation. An interview was conducted with LPN #1 indicating that Resident #118 was admitted to, "...help him quit smoking and to take care of his wound..." On 5/9/13 from 11:00 a.m. through 12:00 p.m., a record review was completed of Resident #118's Clinical Medical Record (CMR). The following documents were reviewed: The Physician Orders reviewed,	F000309	It is the policy of Miller's Merry Manor Walkerton to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Resident 118 suffered no ill effects from this finding, nor has he shown negative or withdrawal symptoms or requested any assistance due to side affects from smoking cessation. In addition, Resident 118 has not asked for tobacco products of any kind during his stay. The care plan for resident 118 was updated to reflect the need for a smoking cessation program due to his upcoming surgery. An Inservice entitled,"New Admission Assessment Tool for Residents who Actively Smoke" was held on May 30, 2013 for all RN's and LPN's. To prevent this from occuring again, any new admission that actively smokes will be assessed with a new assessment tool (Attachment A) that will provide questions and guidance regarding smoking	06/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/13/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WALKERTON TR WALKERTON, IN 46574	

(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
	dated for May 2013, did not indicate routine, PRN (as needed) or ancillary orders for managing smoking cessation/ nicotine withdrawal. The Pre-Admission Assessments Home & Hospital Miller's Merry Manor, dated 4/19/2013, completed by the Director of Nursing indicating a Medical Status with handwritten information, "...Primary diagnosis: Stage IV decubiti, Secondary Diagnosis: paraplegic, Significant Medical Hx(history) surgeries: Tobacco abuse, noncompliance...." The Initial Nursing Assessment, dated 5/6/2013, completed by LPN#2 with Resident #118's name did not indicate an assessment of residents smoking status. (name of acute hospital of care) dated 4/3/2013: Wound Healing Center Progress Notes indicated the following, "...Subjective:...He [resident #118] has seen [Dr.'s name] on a couple of occasions and has been offered a flap which would really be the best opportunity for him to heal this wound. However, in order to qualify for the surgery, he needs to stop smoking, which he has been extensively counseled repeatedly on. He has been able to quit for 2 or 3		cessation. If the resident indicates via the questionnaire that they prefer a smoking cessation agent, the physician will be notified and orders for that agent will be obtained. Should a new resident require a cessation program, interventions will be put in place and added to the care plan. The inter-disciplinary team will review the effectiveness of the cessation program weekly through chart reviews and interviews with the resident. The weekly meeting will be held until successful completion of the cessation program. Results and a summary of these weekly meetings will be reviewed with the Quality Assurance committee monthly. If the cessation program is successful for three consecutive months, meetings and interviews will be held monthly and reviewed at the Quality Assurance committee monthly. After six months of cessation success, the reviews of the chart and interviews with the resident will be held at the quarterly care plan and these findings will be reviewed at the Quality Assurrance committee meeting monthly and on an ongoing basis. I am requesting an IDR for this finding because the surgeon who is doing resident 118's upcoming surgery, documented that" his patient is not allowed to have any products that contain nicotine in them for 4 weeks prior to his surgery and 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/13/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WALKERTON TR WALKERTON, IN 46574	

(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
	days at that time, but never for an extended period of time...[Dr.'s name] has encourage him to go into a nursing home to assist him in smoking cessation...Assessment: 1. Stage IV coccyx pressure ulcer. 2. Tobacco abuse. 3. Noncompliance. 4. Paraplegia... he can also use nicotine patches...Objective:...I have essentially presented him with 2 choices, one would be to stop smoking at home for at least a month and then get back with [Dr.'s name] to have surgery or choice #2 to be admitted to a nursing home at this time to assist him in smoking cessation efforts so that he can have the flap procedure...." (name of acute hospital of care) dated 4/17/2013: Wound Healing Center Progress Notes indicated the following, "... Subjective: History of Present Illness: The patient states that he has not quit smoking since our visit 2 weeks ago. He has given a lot of thought to our proposal and is, at this time, willing to enter into into nursing home to prepare for a flap procedure by [Dr.'s name]. He does need to be off cigarettes for a month prior to this surgery being done according to [Dr.'s name] past consultation. The patient is currently still smoking a pack a day...He has a		weeks after surgery"(Attachment B). Jessica House, CMA stated that this means no patches, no fake cigarettes, no gum - it all contains nicotine. Also, after interviewing resident 118, he stated that he wanted to go "cold turkey" and that he tried Wellbutrin at home and it didn't work and patches never worked for him either. He brought candy and pop to the facililty and he has had no ill effects since he arrived with his smoking cessation nor has he requested any tobacco products of any kind.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/13/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WALKERTON TR WALKERTON, IN 46574	

(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
	history of longstanding non compliance...Plan: Today we have initiated the process to assist him in being admitted to a nursing facility for 4-6 weeks prior to surgery and the 2-3 months after surgery that will be required for him to heal...." A copy of a wound clinic office note, dated 4/17/2013, "... History of Present Illness: The patient states that he has not quit smoking...." On 5/13/13 at 11:30 a.m. to 11:50 a.m., an interview was conducted with the Director of Nursing (DON). The DON indicated Resident #118 was admitted from his home. The DON indicated that while the resident was home he couldn ' t stop smoking because the home was not supportive for stopping from smoking. The resident had been admitted to this facility in the year 2008 for the very same issue and had left against medical advice due to his inability to stop smoking. On 5/13/13 the following interviews were conducted: At 12:00 p.m., an interview was conducted with Resident #118 indicating he had not been offered any interventions for stopping			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155574	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/13/2013
NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 500 WALKERTON TR WALKERTON, IN 46574	

(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
	smoking and indicated he would like a patch to help with his addiction to smoking. At 12:15 p.m., an interview was conducted with LPN#1 indicating the resident had not been offered a nicotine patch and that this usually does occur in the first week of a residents admission. On 5/13/13, the following record reviews were completed: At 3:00 p.m., an electronic record review was conducted indicating no progress notes from Social Services, Minimum Data Systems or Nursing Services in regards to smoking cessation for Resident #118. At 4:00 p.m., a record review was conducted of the Policy and Procedure for Resident Tobacco use/ Smoking Policy, dated to expire on May 13, 2013. The policy and procedure does not provide guidance for residents admitted to the facility for smoking cessation. 3.1-37(a)			