

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Miller's Merry Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 730 School St Culver, IN 46511	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review, the facility failed to serve food in a sanitary manor in 1 of 1 dining rooms. This deficient practice potentially affected 38 of 38 residents who consumed their meals in the dining room. Findings include: During a continuous observation of the lunch meal service in the dining room, on 2/26/2026 from 12:00 P.M. until 12:31 P.M., Activities Aide (AA) 4 served a meal tray to a resident, readjusted the resident's wheelchair and cut the resident's food before going back to the kitchen to get another tray with two resident meals. The AA 4 had not washed her hands after touching the resident's equipment or before serving four more resident trays. Next, after all the resident meals had been served in the dining room, AA 4 carried resident's empty cups from the dining tables to the drink station and refilled their drink cups. The AA 4 had not performed hand hygiene in-between refilling nine resident drink cups. During a continuous observation of the lunch meal service in the dining room, on 3/2/2026 from 12:00 P.M until 12:36 P.M., RN 2 touched her pony tail before serving a tray with two meals on it to residents. She did not wash her hands after she had touched her hair before she served the meal trays. RN 2, RN 3 and AA 4 moved three residents who already had already been served their meals from one table to another table. After pushing the three resident's wheelchairs to the new table, RN 2, RN 3 and AA 4 did not wash their hands before RN 2 and RN 3 started assisting residents to eat and AA 4 served six more meals without washing her hands. After the all meal trays were served in the dining room, AA 4 began refilling resident drinks by taking the resident's drink cups from their table and refilling the cups at the drink station. AA 4 refilled two resident drinks, but had not washed her hands before or after refilling the cups and returning the cups to the residents. During an interview on 3/2/2026 at 12:36 P.M., the Regional Dietician indicated staff should have washed their hands anytime they touched their own clothing, body or hair and after touching a resident's clothing or equipment. She indicated when staff refilled drinks, the staff should have washed their hands if they had touched the resident's cups while refilling it. During an interview on 3/2/2026 at 2:45 P.M., the Executive Director indicated the facility did not have a policy related specifically to hand washing during dining service, but indicated the facility followed the Hand Hygiene policy. On 3/2/2026 at 3:00 P.M. the ED provided a policy, dated 8/2024, and titled, Hand Hygiene. The ED indicated the policy was the one currently used by the facility. The policy indicated, .Employee's of (facility name) will perform hand hygiene according to the standards of practice and guidance from the Centers of Disease Control 3.1-21(i)(3)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 155589	Facility ID: 155589 If continuation sheet Page 1 of 4

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain infection control protocols for a resident suspected of having a Clostridioides difficile (C. diff) infection and 29 of 29 residents who were in isolation during a Gastrointestinal (GI) outbreak. This had the potential to affect 52 of the 52 residents who resided in the facility. Findings included:1. During an observation of the front lobby on 2/26/2026 at 9:30 A.M., a sign reading, Attention! Stop! If you are not feeling well, please do not enter! We ask that you visit another time. Thank you! was noted to be hanging on the front doors of the facility. During an interview with the Executive Director (ED) on 2/26/2026 at 9:33 A.M., the ED indicated the facility had requested all staff and visitors to wear masks due to a gastrointestinal (GI) virus the facility believed was the Norovirus. The virus had caused nausea, vomiting and diarrhea in some of the residents and staff. Residents who had these symptoms had been placed in isolation and were eating their meals in their rooms. The staff members who had experienced GI symptoms had been instructed to stay home. During an interview with the Infection Preventionist (IP) nurse, on 2/26/2026 at 10:15 A.M., the IP nurse confirmed the facility believed the Norovirus had caused residents and staff to have GI symptoms, but the facility had not formally tested anyone for the presence of the virus. The facility had been treating the outbreak as if it were Norovirus and indicated residents who had symptoms of the GI virus had been placed in Contact Isolation but the staff were only required to wear gowns, gloves and a mask when providing direct resident care to these residents. During an observation on 2/26/2025 at 2:30 P.M. in room [ROOM NUMBER], an isolation sign was hanging on the outside of the room. The isolation sign indicated Contact Precautions- Everyone Must: clean their hands, including before entering and when leaving the room. Staff Must Also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. There was no signage indicating any specific instructions regarding washing their hands with soap and water was a requirement for entering or exiting the room. During an interview on 2/26/2026 at 2:35 P.M., RN 5 indicated she was the nurse responsible for the resident in room [ROOM NUMBER]. RN 4 indicated the resident had been placed in isolation due to a possible Clostridioides difficile (C. diff) infection. During an interview on 2/26/2026 at 2:40 P.M., CNA 6 indicated she was the CNA responsible for providing care to the residents in room [ROOM NUMBER]. CNA 6 indicated the resident was in isolation and staff were required to wear a mask, gown and gloves when providing resident care. CNA 6 indicated she did not need to wear the gown or the gloves when she answered the call light or just handed the resident the call light or television remote. CNA 6 indicated soap and water was not required and hand sanitizer gel was what she had been using before entering and after exiting the resident's room. During an interview on 2/26/2026 at 2:40 P.M., the IP nurse indicated room [ROOM NUMBER] was in Contact Isolation. The IP nurse indicated Contact Isolation meant staff had been required to wear gowns, gloves and a mask, and required staff to wash their hands when they entered and exited the room. The IP indicated hand sanitizer was an accepted hand washing technique used to perform hand hygiene for a resident in Contact Isolation related to a potential C. diff infection. The IP nurse indicated she had not been aware that there were different types of Contact Isolation and she did not know that soap and water was a requirement for hand hygiene related to potential C. diff infection prevention. The IP nurse indicated there had been no education related to C. diff and hand hygiene for the staff provided after the resident (in 410) had been placed in Contact Isolation. During an interview on 3/3/2026 at 3:20 P.M., the Director of Nursing (DON) indicated the IP nurse had not been correct when she had stated staff had not been aware that they needed to use soap and water when they entered or exited a</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>room. The DON indicated hand washing with soap and water was the facility's preferred method and all staff had been trained to use only soap and water for all hand hygiene, unless there was no soap or water available. However, she did not provide any documentation of hand hygiene audits or training before the survey exit on 3/4/2026. The DON indicated that all care was direct care and staff should have been wearing gowns, gloves and masks anytime they had entered a resident's room who was in isolation, including when handing a resident a television remote. The DON indicated she had been to Infection Control meetings with her Regional Nurse and had never been told there were times when the only acceptable hand hygiene for Contact Isolation had been the use of soap and water, including for potential C. diff infections. During an interview on 3/4/2026 at 12:30 P.M., the DON indicated CNA 6 was a newer CNA and the facility had not had C.diff in the building in over two years and the CNA likely had not worked with a resident with C. diff and would not know she had been required to wash her hands with soap and water. 2. During a continuous observation of the facility on 2/26/2026 from 10:00 A.M. until 2:30 P.M., the following rooms were identified to be in Contact Isolation related to GI symptoms of nausea, vomiting and diarrhea: 301, 304, 311 and 404. There was a Contact Isolation sign on the resident's door, but there was no specific information posted related to ensuring that staff and visitors washed their hands with soap and water only before entering and exiting the room. During an interview on 3/2/2026 at 9:30 A.M., the IP nurse indicated all residents who currently had nausea, vomiting and diarrhea had been placed in Contact Isolation. The IP nurse indicated all residents who had had nausea, vomiting or diarrhea over the last couple of weeks had previously been placed into Contact Isolation. The IP nurse indicated Contact Isolation required the use of gloves, mask and gown while providing resident care. The IP nurse indicated hand sanitizer was an acceptable form of hand hygiene in Contact Isolation rooms where GI symptoms were noted. The IP nurse indicated staff had not been required to wear gowns or gloves in the rooms when they had answered call lights or had helped residents with tasks that had not required direct care even though the residents were in Contact Isolation related to GI symptoms. The IP nurse gave the following example: If the resident only needs their remote handed to them or a refill of their water, as a time when staff would not have been required to wear gloves or gown and staff were able to use hand sanitizer for hand hygiene. The IP nurse indicated at the start of the GI outbreak on 2/23/2026, she had spoken to staff about wearing masks, gowns and gloves, but had not instructed staff that they needed to use soap and water before entering or exiting the resident rooms of those residents who were in Contact Isolation related to GI symptoms because she had not known soap and water was a requirement. The IP nurse had not documented the education nor had any of the employees signed a sheet indicating they had received the education. A review of the facility's infection map for the GI outbreak was completed on 3/3/2026 at 11:00 A.M. The ED indicated the map was only for the GI outbreak the facility had experienced and that the resident rooms highlighted on the map reflected the rooms where residents had had nausea, vomiting and/or diarrhea. The map indicated:-On 2/23/2026 the following rooms had been placed on Contact Isolation: 202, 203, 206, 208, 211, 303, 305, 306, 307, 309, 310, 401, 403, 404, 407, 408, 409, 410 and 411.-On 2/24/2026 the following rooms had been placed in Contact Isolation: 201, 303, 305, 308 and 310.-On 2/25/2026 the following rooms had been placed in Contact Isolation: 301, 304 and 311.-On 2/26/2026 room [ROOM NUMBER] was placed in Contact Isolation. A review of the facility's call-off list for those employees experiencing GI symptoms of nausea, vomiting and/or diarrhea for the dates of 2/25 through 2/26/2026 was completed on 3/4/2026 at 10:00 A.M. The list indicated:-CNA 7 called off work on 2/25 and 2/26/2026 for GI symptoms.-RN 8 called off work on 2/25/2026 for GI symptoms.-LPN 9 called off work on 2/25/2026 for GI symptoms.-Cook 10 called off work on 2/25/2026 for GI</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>symptoms.-Cook 11 called off work on 2/26 and 2/27/2026 for GI symptoms.-Housekeeper 12 called off work on 2/26/2026 for GI symptoms.On 2/26/2026 at 3:00 P.M. the ED provided a policy dated 9/2019, and titled, Infection Control Surveillance Program. The ED indicated the policy was the one currently used by the facility. The policy indicated, .C . II. Education regarding hand hygiene, cough etiquette, standard precautions, isolation protocols, catheter care and peri-care will be provided at orientation, annually and in response to infection control/QI data On 3/2/2026 at 3:00 P.M. the ED provided a policy dated 8/2024, and titled, Hand Hygiene. The ED indicated the policy was the one currently used by the facility. The policy indicated, . Employees of Miller's Health System will perform hand hygiene according to the standards of practice and guidance from the Centers of Disease Control.Hand washing with soap and water during care of residents with suspected or confirmed C. diff . The use of alcohol-based hand sanitizer is preferred in most clinical situations.The article, Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings (2011), dated 2/15/2015, was retrieved on 3/5/2026 from the Centers of Disease Control (CDC) website at https://www.cdc.gov/infectioncontrol/guidelines/cauti/index.html. The guidance included: During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus gastroenteritis.The article, How to prevent the Norovirus, dated 1/13/2025, was retrieved on 3/5/2026 from the Centers of Disease Control (CDC) website at https://www.cdc.gov/norovirus/prevention/index.html. The guidance included: Wash hands well with soap and water; hand sanitizer alone does not work well against norovirus.The article, Preventing C. diff, dated 12/18/2024, was retrieved on 3/5/2026 from the Centers of Disease Control (CDC) website at https://www.cdc.gov/norovirus/prevention/index.html. The guidance included: Washing your hands with soap and water is the best way to prevent the spread of C. diff from person to person.3.1(a)</p>		