

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2023
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 01/24/2023 |
|---|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123 | |
| (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 |
| F 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00391986, IN00391819, IN00394007, IN00394363, and IN00395065.</p> <p>Complaint IN00391986 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00391819 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00394007 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00394363 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00395065 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 23 and 24, 2023</p> <p>Facility number: 012534 Provider number: 155792 AIM number: 201028420</p> <p>Census Bed Type: SNF: 15 SNF/NF: 112 Total: 127</p> <p>Census Payor Type: Medicare: 13 Medicaid: 82 Other: 32 Total: 127</p> <p>CountrySide Meadows was found to be in</p> | F 000 | | |

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.

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| F 000 | Continued From page 1 compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00391986, IN00391819, IN00394007, IN00394363, and IN00395065. Quality review completed on January 24, 2023. | F 000 | | |