STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00410320, IN00410368, and IN00409969. Complaint IN00410320 - No deficiencies related to the allegations are cited. Complaint IN00410368 - No deficiencies related to the allegations are cited. Complaint IN00409969 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: June 16, 17, and 19, 2023 Facility number: 012534 Provider number: 155792 AIM number: 201028420 Census Bed Type: SNF/NF: 124 SNF: 9 Total: 133 Census Payor Type: Medicare: 6 Medicaid: 100 Other: 27 Total: 133 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 22, 2023.	F 0000	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection Report. Countryside Meadows respectfully requests consideration for a desk review of this plan of correction in lieu of post survey revisit.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara	McGlothllin	06/30/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observations and record review, the facility failed to implement the comprehensive, person-centered care plans for a resident who required adaptive equipment to promote independence with eating and skin care prevention for 1 of 3 residents reviewed for quality of care (Resident E). Findings include: During an observation on 6/16/23 at 11:41 a.m., Resident E was lying in bed with the head of the bed up. His heels were not floated and pressing into the mattress. He had a regular cup on his bedside table that was full of warm water. During an observation on 6/16/23 at 12:55 p.m., Resident E was sitting up in the bed. He was being assisted with eating by Certified Nursing Aide (CNA) 7. Resident E had a built-up spoon, a regular spoon, and did not have a 2 handled cup. During an observation on 6/17/23 at 5:35 p.m., Resident E was sitting up in the bed. His heels were pressing into the mattress. His dinner tray was on a cart in the hallway. His chocolate milk, house shake, and water were unopened. He had a 2 handled cup but did not have a built-up spoon on his tray.	F 0656	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • IDT, with therapy included, to review resident's current orders and most appropriate needs for equipment by 6/30/23. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • IDT will review all residents with current orders for pressure reducing boots or adaptive equipment for eating to ensure order is accurate and care plan is in place. • All residents with pressure reducing boots or adaptive equipment for eating have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the	06/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	During an observation on 6/17/23 at 6:05 p.m., Resident E's heel protectors were on the floor next to his bed. During an observation on 6/17/23 at 6:58 p.m., Resident E's heels was sitting up in bed. His heels were pressing into the mattress. During an observation 6/17/23 at 8:05 p.m., Resident E was sitting up in the bed. His heels were pressing into the mattress. His heel protectors were on the floor next to his bed. A record review was completed on 6/19/23 at 10:01 a.m. Resident E had the following diagnoses but not limited to cerebral infarction, atrial fibrillation, COPD (chronic obstructive pulmonary disease), ASHD (atherosclerotic heart disease), essential hypertension, hyperlipidemia, chronic kidney disease, and dementia, Resident E had an order, dated 5/12/23, for a regular diet with special instructions for a weighted built-up curved spoon, a two handled cup, and a standard fork for all meals. Resident E had an order, dated 1/4/23, for heel Medix boots to bilateral lower extremities (BLE) while in bed with special instructions to check placement every shift. Resident E's care plan, dated 9/28/22, indicated Resident E required extensive assistance with Activities of Daily Living (ADLs) including bed mobility, transfers, eating, and toileting related to decreased mobility, cognition, and related to diagnoses of atrial fibrillation, COPD, CVA, dysphagia, esophageal cancer, CAD and history of COVID. The goal of the care plan problem was, dated 8/16/23, and indicated Resident had the		deficient practice does not recur? • DNS or designee will provide education to nurses on or before 6/30/23 regarding placement of pressure reducing boots, documenting placement and documenting refusals. • CSM or designee will provide education to all culinary staff regarding adapative equipment for eating on or before 6/30/23. • DNS or designee will complete an audit for placement of pressure reducing boots daily x 30 days; weekly x 4 weeks and monthly x 2 months. • CSM or designee will complete an audit for placement of adaptive eating equipment during every meal x 30 days; weekly x 4 weeks; monthly x 2 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS or designee will be responsible for completing the “Wound and skin management” QA tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	desire to improve current functional status. An intervention dated 5/12/23 indicated resident was to have weighted, built up and curved spoon, two handled cups, as well as standard fork for all meals. Resident E's care plan, dated 9/28/22, indicated Resident E was at risk for skin breakdown related to decreased mobility, incontinence, friction/shearing, poor intakes at times, refusals of meals at times and diagnoses of atrial fibrillation, CVA, CAD, aortic regurgitation, cerebral artery stenosis, aortic stenosis, angina, hyperlipidemia, chronic kidney disease, elevated troponin, bradycardia, neuropathy, spinal stenosis, history of coronary artery bi-pass graft (CABG), and history of COVID. An intervention, dated 10/21/22, indicated Resident E would wear heel Medix boots to bilateral lower extremities while in bed. During an interview with the Director of Nursing Services (DNS) on 6/19/23 at 2:22 p.m., she indicated Resident E did not have any pressure ulcers to his heels. On 6/19/23 at 1:47 p.m., the DNS provided a policy titled, "IDT Comprehensive Care Plan Policy." It indicated, " ...It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental and psychosocial needs. Purpose: Create an organized resident-centered review on a routine basis to improve communication with resident's goals, total health status, including functional		all shifts until continued compliance is maintained for 2 consecutive quarters. The CSM or designee will be responsible for completing the “tray accuracy” QA tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. BUILDING 00 B. WING	06/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MEADOWS	762 N DAN JONES RD AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	status, nutritional status, rehabilitation, and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, sensory and physical impairments, as well as care and services provided to main or restore health and well-being, improve functional level or relieve symptoms...."			