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	10/07/2024

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 a Recertification and State Licensure Survey. Survey dates: October 1, 2, 3, 4, and 7, 2024 Facility number: 012534 Provider number: 155792 AIM number: 201028420 Census Bed Type: SNF/NF: 116 SNF: 12 Total: 128 Census Payor Type: Medicare: 7 Medicaid: 88 Other: 33 Total:: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 17, 2024.	F 0000	October 24, 2024 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID O26X11 Dear Ms. Buroker: Please find attached my Plan of Correction for the deficiencies cited during this Annual/Recertification Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Karsen Rauch, HFA Administrator Countryside Meadows – Avon, IN.	
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for 4 of 8 residents reviewed for call lights (Resident 25, 50, 52, and 72). Findings include:	F 0558	**Plan of Correction** **F558 – Reasonable Accommodations Needs/Preferences** **What corrective action(s) will be accomplished for those**	10/24/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karsen Rauch	Executive Director, HFA	10/24/2024

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	10/07/2024

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
	1. On 10/4/24 at 11:55 a.m., Resident 25's call light was observed out of reach. Her diagnoses included, but were not limited to, right-sided hemiplegia (loss of strength or paralysis), atrial fibrillation (irregular heartbeat), hypertension (HTN) (high blood pressure), paroxysmal tachycardia (episodes of rapid heart rate), convulsions (sudden, violent, irregular movement of a limb or the body cause by involuntary contraction of the muscles), osteoporosis (OP) (bone disease that causes bones to become weak and more likely to break), and anxiety disorder (excessive and persistent feelings of fear, worry, or dread). A care plan, dated 8/27/15, indicated Resident 25 was at risk for falls due to her medications, atrial fibrillation, osteopenia (OP) (loss of bone density), decreased mobility, incontinence (lack of voluntary control of bladder and/or bowel), right-sided hemiplegia, hypertension, cerebral vascular accident (CVA), seizures (uncontrolled burst of electrical activity in the brain causing changes in behavior, movement and awareness), transient ischemic attack (TIA) (stroke), anxiety, hypoxic (oxygen deficiency) respiratory failure, chronic kidney disease (CKD) (impaired kidney-blood filtration), weakness, right-hand contracture (permanent tightening of the muscles, tendons, and skin), and history of respiratory failure. Interventions included to keep her personal items in reach and keeping her call light in reach. A care plan, dated 5/24/19, indicated Resident 25 was at risk for pathological fracture due to a diagnosis of osteopenia. Interventions included to remind the resident to ask for help, assist with		**residents who found to have been affected by the deficient practice?** The call lights were placed within reach of residents noted when deficiency was reported. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. An in-service was completed and education was provided about the necessity of having call lights within resident reach at all times. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Following education, the Call Light Audit Tool will be kept by ED and will be completed weekly for 4 weeks and bi-weekly for 4 weeks after. The audit tool will be completed for 10 random residents throughout the week. **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?** The ED will be responsible for the completion of the Call Light Audit Tool weekly for 4 weeks and bi-weekly for 4 weeks after.	

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	10/07/2024

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
	transfers, and her call light in reach. 2. On 10/4/24 at 11:57 p.m., Resident 52's call light was observed not in reach. Her diagnoses included, but were not limited to, dementia, cerebral ischemia, encephalopathy (brain disease affect the function of the brain), HTN, paroxysmal atrial fibrillation, history of falls, cervical spondylosis (degeneration of the bones and discs in the neck), lumbar scoliosis (condition that causes an abnormal sideways curve in the lower back), postural lordosis (condition were the spine curves too much forward), anorexia (eating disorder), generalized anxiety disorder (GAD) (excessive, ongoing anxiety and worry), and weakness. A care plan, dated 8/8/24, indicated Resident 52 was at risk for falls due to decreased mobility, cognition, history of falls, medications, and related to cerebral ischemia (blockage in an artery restricts the delivery of oxygen rich blood to the brain, resulting in brain damage), a head injury related to a fall, dementia (loss of cognitive functioning such as thinking, remembering, and reasoning), encephalopathy, HTN, atrial fibrillation, cervical disc degeneration, cervical spondylosis, lumbar scoliosis, and postural lordosis. Interventions included keeping her personal items in reach and keeping her call light in reach. 3. On 10/4/24 at 11:59 a.m., Resident 72's call light was observed out of reach. His diagnoses included, but were not limited to, heart failure, chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM) (blood sugar disorder), cerebral infarction, TIA, angina		The Call Light Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and/or including termination of the employee responsible.	

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	10/07/2024

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
	pectoris (severe pain caused by an inadequate blood supply to the heart), cognitive communication deficit (brain injury that makes it difficult for a person to communicate), and osteoarthritis (OA) (degenerative joint disease that breaks down cartilage in the joint). A care plan, dated 10/9/23, indicated Resident 72 was at risk for falls due to decreased mobility, incontinence, history of falls, medications, visual impairments, and related to a diagnosis of heart failure, COPD, DM, CVA, TIA, angina pectoris, HTN, and chest pain. The goal was to reduce risk factors to prevent significant fall related injury. Interventions included keeping personal items in reach and her call light in reach A care plan, dated 10/13/23, indicated Resident 72 had impaired vision related to verbalizing that with his eyeglasses, he can only read large print. The goal was the resident will not experience negative consequences of vision loss as evidenced by remaining physically safe. Interventions included to be sure that the lenses of his eyeglasses were clean and keeping his call light in reach. 4. On 10/4/24 at 12:00 p.m., Resident 50's call light was observed out of reach. His diagnoses included, but were not limited to, paranoid schizophrenia (chronic mental disorder that affects how people think, feel, and behave), diabetes mellitus, pain in (unspecified) knee, HTN, acute kidney failure (AKF), TIA, and long term (current) use of antithrombotic (to prevent blood clots) / antiplatelets (to stop platelets from sticking together and forming blood clots) and muscle weakness.			

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	10/07/2024

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
	A care plan, dated 6/14/24, indicated Resident 50 was at risk for falls due to decreased mobility, incontinence, history of falls, medications and related to diagnosis of history of methicillin-resistant staphylococcus aureus (MSSA), history of sepsis (life-threatening emergency that occurs when the body's immune system had an extreme response to an infection or injury), DM, bacteremia (blood stream infection), colitis (inflammation of the lining of the colon), HTN, schizophrenia, bilateral knee pain, history of psychoactive (affecting the mind) drug use, history of CVA, and insomnia. The goal was to have fall factors reduced to avoid significant fall related injuries. Interventions included personal items in reach and keeping his call light in reach. A current policy, titled, "IDT Comprehensive Care Plan Policy, dated 8/2023, was provided by the Director of Nursing (DNS) on 10/3/24 at 12:55 a.m. She indicated the facility did not have a call light policy and this policy was used for call lights. A review of the policy indicated, " ...The care plan must 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 well-being ...." 3.1-3(v)(1)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on observation, interview, and record review, the facility failed to ensure the physician was notified of a resident's, (Resident 102) change of condition after a fall when he experienced break through pain and a decline in his ability to perform activities of daily living for 1 of 1 residents	F 0580	**Plan of Correction** **F580 Notify Changes (Injury/Decline/Room, etc.) (update)** **What corrective action(s) will be accomplished for those**	10/24/2024

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	10/07/2024

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
	reviewed for notification of change of condition. Findings include: On 10/1/24 at 11:47 a.m., Resident 102 was observed. He was seated in a specialty wheelchair (WC) and was positioned slouched/slid down in his seat. He had a visitor who sat with him and waited for lunch. On 10/1/24 at 11:51 a.m., an unidentified nursing staff member and the visitor repositioned Resident 102 in his WC. They pulled him to an upright seated position. As they pulled him up, Resident 102 called out nonsensical words and grimaced his face. During an interview on 10/1/24 at 11:55 a.m., Resident 102's visitor identified herself as his sister and indicated she visited him almost every day. She indicated Resident 102 had Down's Syndrome (a genetic condition where a person is born with an extra chromosome which causes developmental and intellectual delays) and Alzheimer's dementia (a degenerative brain disease which affects cognitive function and memory). When asked about his positioning in the WC, his sister indicated, they (she and the facility's Interdisciplinary team [IDT]) had a difficult time finding a good fit wheelchair for his stature, posture, and fluctuating mobility. Resident 102 had always used a rollator walker, but since his last fall, which had resulted in a femur fracture and required surgery, he needed to use a WC because he had not been able to regained his ability to walk and had experienced a stark decline in his overall condition. On 10/3/24 at 9:48 a.m., Resident 102 medical record was reviewed. He was a long-term care		**residents found to have been affected by the deficient practice?** Education was provided to all nurses about the deficient practice cited, as well as, the future necessity of the immediate notification of MD on changes of condition. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. An in-service was completed on the necessity of physician notification upon a resident change in condition. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Following education, a MD Notification Audit Tool will be kept by DNS/Designee and will be completed in morning meeting daily for 4 weeks and weekly for 4 weeks after. The audit tool will be completed for the previous day to ensure the physician/physician rep was notified of any changes of condition and a progress note was placed in the resident's record. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	10/07/2024

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
	resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, Down's Syndrome, slowness and poor responsiveness, and epilepsy (a chronic brain disease that causes seizures, which are episodes of abnormal electrical activity in the brain). A nursing progress note, dated 2/20/24 at 5:58 a.m., indicated Resident 102 was found on floor after an unwitnessed fall and he sustained a laceration to his right brow. The NP and Director of Nursing (DON) were notified. A nursing progress note, dated 2/24/24 at 1:20 p.m., indicated Resident 102 refused the morning meal and was resistant to care. He was gotten up and brought to the dining room for lunch. Resident 102 complained of pain and limped on his right lower extremity when ambulating, so he used a WC instead. The progress note lacked documentation the NP was notified of ongoing pain, and limping. A nursing progress note, dated 2/25/24 at 2:00 p.m., indicated, Resident 102 was "very hostile" and resisted morning care. He was aggressive towards staff and not easily redirected and was educated on "kindness." The progress note lacked documentation the NP was notified of his change of behavior. An OT daily summary note dated 2/27/24 at 3:13 p.m., indicated Resident 102 refused to stand due to knee pain. Resident demonstrated full Functional Outcome Measure (FOM) of the right knee. When the therapist attempted to move Resident 102's leg similarly the resident reported pain and refused to move further. Resident 102 reported he needed to use the bathroom, but when taken to the bathroom he refused to transfer		**assurance program will be put into place?** The DNS/Designee will be responsible for the completion of the MD Notification Audit Tool daily for 4 weeks and weekly for 4 weeks after. The MD Notification Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	10/07/2024

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
	to toilet once in there. The note indicated nursing was notified. The record lacked documentation that nursing notified MD or NP of Resident 102's continuing breakthrough pain and refusal to transfer to the toilet. An OT daily summary note, dated 2/29/24 at 1:54 p.m., indicated, " ...patient performed therapeutic exercises using Omnicycle [the OmniCycle is a motorized therapeutic exercise system that can be used by patients with neurological, orthopedic, cardiac, or other challenges] ... patient's response included 35% activity with multiple rest breaks ... patient refused standing on this date ...." The record lacked documentation the MD was notified that Resident 102 still refused to stand. On 10/4/24 at 12:15 p.m., the DON provided a copy of current facility policy titled, "Resident Change of Condition Policy," revised, 11/2018. The policy indicated, " ...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ... acute medical change a. any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician...." Cross Reference F684. 3.1-5(a)(2)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments			

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	10/07/2024

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
	Based on interview and record review, the facility failed to ensure information reported on the Minimum Date Set (MDS) was accurate for 1 of 2 residents reviewed for MDS accuracy (Resident 61). Findings include: On 10/7/24 at 9:56 a.m., Resident 61's record was reviewed. She was admitted on 9/9/24. Her diagnoses included, but were not limited to, paroxysmal atrial fibrillation (irregular heartbeat), long term use of antithrombotic (to prevent blood clots) / antiplatelets (prevent blood cells from sticking together), and dementia (brain disorder). Resident 61's medication order included, but was not limited to, aspirin (antiplatelet) 81 mg (milligram), chewable, once a day for paroxysmal atrial fibrillation. No physician order for an anticoagulant (blood thinner) was observed. Resident 61's care plan, dated 9/10/24, indicated she was at risk for bleeding and bruising related to use of antiplatelet medication. The goal was for her to remain free of adverse effects of antiplatelet medication. Resident 61's MDS, dated 9/15/24, was reviewed for medications. It indicated she was not on an antiplatelet. During an interview, on 10/7/24 at 10:51 a.m., the Regional Director of Clinical Services (RDCS) indicated Resident 61 was on was on Plavix (antiplatelet) from 9/13/24 to 9/20/24. The Centers for Medicare & Medicaid Services, Long-Term Care Facility Resident Assessment	F 0641	**Plan of Correction** **F641 – Accuracy of Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The record was updated upon notification of deficiency for Resident 61. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. MDSC and MDSA were both made aware of the coding error. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Following education, the MDS Coding Audit Tool will be kept by MDSC/Designee and will be completed weekly for 4 weeks and bi-weekly for 4 weeks after. The audit tool will be completed for 5 random MDS assessments that were completed that week and will audit the accuracy of the coding. **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**	10/24/2024

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	10/07/2024

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
	Instrument 3.0 User's Manual, Version 1.19.1, October 2024 was reviewed on 10/9/24 at 4:16 p.m. It indicated for, " ...Code all high-risk drug class medications according to their pharmacological classification ...Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period ...Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period...." 3.1-31(i)		**into place?** The MDSC/Designee will be responsible for the completion of the MDS Coding Audit Tool weekly for 4 weeks and bi-weekly for 4 weeks after. The MDS Coding Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and/or including termination of the employee responsible.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to implement a care plan for the use of Seroquel (an antipsychotic) medication for 1 of 3 residents reviewed for care plans (Resident 43). Findings include: On 10/4/24 at 10:52 a.m., a record review was completed for Resident 43. She had the following diagnoses which included but were not limited to dementia, anxiety, major depressive disorder, and bipolar disorder (a mental illness that causes extreme shifts in mood, energy, and activity levels). Resident 43's medical record lacked a care plan addressing the use of Seroquel for bi-polar disorder.	F 0656	**Plan of Correction** **F656 – Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The record/care plan was updated to correlate the use of an anti-psychotic for resident 43. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient	10/24/2024

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	10/07/2024

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
	On 10/4/23 at 1:30 p.m., during an interview with the Director of Nursing (DON), she indicated she had nothing to add for the resident not having a care plan. A policy titled, "Comprehensive Care Plans" was provided by the DON on 10/3/24 at 12:55 p.m., It indicated, " ...It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan ...Physician's orders are considered part of the comprehensive plan of care ...". 3.1-35(a)		practice. SSD, SSA and Nurse Managers were educated on our policy related to Comprehensive Care Plans. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Following education, an Anti-Psychotic Care Plan Audit was completed for all residents. The anti-psychotics will then be reviewed monthly in Behavior Management and an Audit Tool will be kept by the SSD/Designee for 6 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?** The SSD/Designee will be responsible for the completion of the Anti-Psychotic Audit Tool monthly for 6 months. The Anti-Psychotic Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and/or including termination of the employee responsible.	

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	10/07/2024

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 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident 102), who had diagnoses of dementia and an intellectual disability was adequately assessed for breakthrough pain and change of condition after a fall resulting in a delay of treatment for 1 of 2 residents reviewed for change of condition, and failed to ensure a resident with pain after a fall was sent to the hospital without delay after x-ray results confirmed a fracture for 1 of 2 residents reviewed for change of condition (Resident 40). Findings include: 1. On 10/1/24 at 11:47 a.m., Resident 102 was observed. He was seated in a specialty wheelchair (WC) and was positioned slouched/slid down in his seat. He had a visitor who sat with him and waited for lunch. On 10/1/24 at 11:51 a.m., an unidentified nursing staff member and the visitor repositioned Resident 102 in his WC. They pulled him to an upright seated position. As they pulled him up, Resident 102 called out nonsensical words and grimaced his face. During an interview on 10/1/24 at 11:55 a.m., Resident 102's visitor identified herself as his sister and indicated she visited him almost every day. She indicated, Resident 102 had Down's Syndrome (a genetic condition where a person is born with an extra chromosome which causes developmental and intellectual delays) and Alzheimer's dementia (a degenerative brain disease which affects cognitive function and	F 0684	**Plan of Correction** **F684 – Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Education was provided to all nurses and nurse managers related to pain monitoring after a fall for residents. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Nurses and Nurse Managers were educated on our policy related to Fall Management. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Following education, a Fall/Pain Audit will be kept by the DNS/Designee. The audit will be completed weekly for any falls that occurred that for someone with a dementia or other cognitive impairment diagnosis. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	10/24/2024

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	10/07/2024

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
	memory). His sister indicated, they (she and the facility's Interdisciplinary team [IDT]) had a difficult time finding a good fit wheelchair for his stature, posture, and fluctuating mobility. Resident 102 had always used a rollator walker, but since his last fall, which had resulted in a femur fracture and required surgery, he needed to use a WC because he had not been able to regain his ability to walk and had experienced a stark decline in his overall condition. On 10/3/24 at 9:48 a.m., Resident 102 medical record was reviewed. He was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, Down's Syndrome, slowness and poor responsiveness, and epilepsy (a chronic brain disease that causes seizures, which are episodes of abnormal electrical activity in the brain). A care plan initiated on 6/28/23 which indicated he was at risk for pain due his diagnoses. Interventions included, but not limited to; notify MD if pain is unrelieved and/or worsening, observe for non-verbal signs of pain: changes in breathing, vocalizations, mood/behavior changes, eyes change expression, sad/worried face, crying, teeth clenched, changes in posture. A care plan initiated on 7/12/23 which indicated he exhibited cognitive impairment as example by, a BIMS score of less than 13. "Resident is Severely Impaired." This care plan lacked revision of individualized risks/causes of his impairment related to his diagnosis of Down Syndrome and/or dementia. A significant change Minimum Data Set (MDS) assessment, dated 8/7/24, indicated Resident 102 was moderately cognitively impaired with a Brief		**assurance program will be put into place?** The DNS/Designee will be responsible for the completion of the Fall/Pain Audit Tool monthly 4 weeks and bi-weekly for 4 weeks. The Fall/Pain Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and/or including termination of the employee responsible.	

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	10/07/2024

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
	Interview for Mental Status (BIMS) score, 7 of 15. He was interviewed for his preferences and customary daily routines and answered all but 4 of 16 questions as "very important." His Functional ability assessment indicated he was independent in his ability to walk, needed minimal assistance to eat, and was able to transfer himself with stand-by assistance. A Nurse Practitioner (NP) progress note, dated 1/23/24 at 2:10 p.m., indicated Resident 102 " ... is able to get up out of bed and ambulate with his rollator per his baseline ...." A nursing progress note, dated 2/20/24 at 5:58 a.m., indicated Resident 102 was found on floor after an unwitnessed fall and he sustained a laceration to his right brow. The NP and Director of Nursing (DON) were notified. A corresponding Fall Event assessment, dated 2/20/24 at 11:08 a.m., indicated Resident 102 stated he was using the bathroom and lost his balance and fell. An Event question, "did nurse request an ER eval," was left blank. An Event question, "Prior to the fall, when was the last time the resident was toileted or received incontinent care," was left blank. Resident 102 did not complain of pain at the time of the fall, and no new orders were received. A nursing progress note, dated 2/21/24 at 11:34 a.m., indicated Resident 102 complained of right knee pain during range of motion (ROM). He refused to get out of bed. When the NP was notified, new orders were obtained for X-Rays of his right knee, and bilateral hips. A nursing progress note, dated 2/21/24 at 5:58 p.m., indicated Resident 102 was given Tylenol			

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	10/07/2024

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
	which was somewhat effective and still refused to get out of bed. On 2/21/24 at 6:56 p.m., Resident 102's as needed (PRN) Tylenol orders were changed to scheduled Tylenol 1000 milligrams (mg) three times a day. A fall follow up nursing note, dated 2/21/24 at 9:22 p.m., indicated Resident 102 had a noted change with increased pain and resistance to right lower extremity. The NP was notified. New orders were received but not specified. A nursing progress note, dated 2/22/24 at 5:56 a.m., indicated Resident 102 continued to express pain with movement to right lower extremity and he refused to ambulate to the bathroom and refused hygiene care, but after several ques he did allow hygiene care. A NP progress note, dated 2/22/24 at 2:33 p.m., indicated, " ...[Resident 102] seen today for pain. He was found on the floor in his room on Monday with no initial complaints of pain. He is now refusing to get out of bed or ambulate. He had a R [right] knee and R [right] hip x-ray yesterday. The knee x-ray was negative. The hip x-ray showed history of AVN [Avascular necrosis (AVN), also known as osteonecrosis, is a condition where bone tissue dies due to a disruption of blood flow. It can occur in any bone, but most commonly affects the ends of long bones where they meet a joint, such as the hip)], but no acute findings. Dementia and disability makes ROS [review of symptoms] difficult. He is unable to answer questions appropriately. He has full ROM in R knee. When attempting ROM of R [right] hip he grimaces and when asked to stand/ambulate he refuses ...." The NP's Assessment/Treatment Plan indicated, " ... Check femur X-ray; schedule			

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	10/07/2024

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
	Tylenol, Biofreeze and Lido patch." A nursing progress note, dated 2/22/24 at 10:28 p.m., indicated, Resident 102's new orders were in place, all scheduled medications had been given but he still complained of pain to his right lower extremity during movement. His family requested CT or MRI scans and the NP was notified. A new physician's order for Occupational Therapy eval and treatment was ordered on 2/22/24. An OT Evaluation and Plan of Treatment summary, dated 2/22/24, indicated, " ...referred to OT eval and treatment following recent falls ... has fallen 3 times in the last 3 months ... upon OT eval pt [patient] presents with decreased strength, endurance, unsteadiness on feet, and decreased ADL participation from baseline impacting the pt's ability to safely complete ADLs, transfers, and ambulation at maximum level of safety ...." An OT daily summary, dated 2/23/24 at 4:47 p.m., indicated, " ...patient seemed to guard right lower extremity [RLE] and was not putting foot down. Patient unable to verbalize location of pain ...." The OT note did not indicated/document that nursing staff and/or MD was notified of Resident 102 guarding RLE and not putting weight on his foot. A nursing progress note, dated 2/24/24 at 1:20 p.m., indicated Resident 102 refused in morning meal and was resistant to care. He was assisted up and brought to the dining room for lunch. Resident 102 complained of pain and limped on his right lower extremity when ambulating, so he used a WC instead. The progress note lacked documentation the NP was notified of ongoing			

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	10/07/2024

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

pain, and limping.

A nursing progress note, dated 2/25/24 at 2:00 p.m., indicated Resident 102 was "very hostile" and resisted morning care. He was aggressive towards staff and not easily redirected and was educated on "kindness." The progress note lacked documentation the NP was notified of his change of behavior.

An OT daily summary note dated 2/27/24 at 3:13 p.m., indicated Resident 102 refused to stand due to knee pain. Resident demonstrated full Functional Outcome Measure (FOM) of the right knee. When the therapist attempted to move Resident 102's leg similarly the resident reported pain and refused to move further. Resident 102 reported he needed to use the bathroom, but when taken to the bathroom he refused to transfer to toilet once in there. The note indicated nursing was notified.

The record lacked documentation that nursing notified MD of Resident 102's continuing breakthrough pain and refusal to transfer to the toilet.

A significant change MDS assessment, dated 2/28/24, indicated Resident 102's cognitive function decreased from a 7, to 3 out of 15 on his BIMS score. He was interviewed for his preferences and customary daily routines and answered only 1 of 16 questions as "very important." His Functional ability assessment indicated, he required partial to moderate assistance to walk, to use the bathroom and to transfer.

An OT daily summary note, dated 2/29/24 at 1:54 p.m., indicated, " ...patient performed therapeutic

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	10/07/2024

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

exercises using Omnicycle [the OmniCycle is a motorized therapeutic exercise system that can be used by patients with neurological, orthopedic, cardiac, or other challenges] ... patient's response included 35% activity with multiple rest breaks ... patient refused standing on this date ...."

The record lacked documentation the MD was notified that Resident 102 still refused to stand.

An OT daily summary note, dated 3/1/24 at 2:48 p.m., indicated, " ...attempted to engage pt [patient] in OmniCycle for increase lower extremity strength however pt refusing on this date ... pt agreeable to walk on this date and ambulated 57 feet ..."

A nursing progress note, dated 3/4/24 at 4:53 p.m., indicated Resident 102 had an unwitnessed fall from his WC in the dining room.

An IDT progress note, dated 3/5/24 at 11:49 a.m., indicated he fell from the wrong size WC in the dining room and the new intervention put in place was to have therapy eval him for the correct size WC.

An OT daily summary note, dated 3/5/24 at 4:23 p.m., indicated, " ...recent fall noted possibly from WC being too tall for patient ... writer was able to find a different WC and maintenance request to lower WC to lowest level for better WC for. Patient required max ques for sit to stand transfers ...."

A nursing progress note, dated 3/1/24 at 1:38 p.m., indicated an MRI had been scheduled for Resident 102 for 3/5/24.

A nursing progress note, dated 3/6/24 at 1:42 p.m.,

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	10/07/2024

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
	indicated, Resident 102 had returned from his MRI appointment and the results were received and sent to the NP. The NP gave new orders to send him to the emergency room. A Hospital Record summary, dated 3/6/24 at 5:18 p.m., indicated, " ...He had a fall approximately 2 weeks ago with MRI obtained earlier today ordered from an outside facility. Apparently this shows after subchondral collapse consistent with AVN at the right femoral head and the nondisplaced intertrochanteric femur fracture. They were brought to ER, where x-rays were done that identified nondisplaced right intertrochanteric femur fracture and AVN of the right femoral head. Orthopedics was consulted and that patient was admitted with plans for surgical stabilization ...." A nursing progress note, dated 3/11/24 at 8:07 p.m., indicated Resident 102 returned from hospital after femur fracture surgical repair with three surgical incisions covered with dressings. During a follow up interview on 10/4/24 at 11:49 a.m., Resident 102's sister indicated he had experienced a significant decline in his overall health since his last fall and surgery. At the time of the fall, because of his Down Syndrome and dementia, it had been very difficult to determine where he was hurt, how bad the pain was, or what caused the pain. His sister indicated when the x-rays all came back negative, but he still screamed out in pain, refused to get out of bed and couldn't use the bathroom, she requested an MRI. His sister indicated, because of Resident 102's Down Syndrome, he had a delayed pain response and high pain threshold, so if he said he was hurting, then it must have really been hurting. The sister talked to the facility NP and asked if he could be sent to the ER for an MRI, but the NP			

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	10/07/2024

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
	suggested they get the MRI scheduled with a guaranteed date and time, instead of sending him to the ER to sit and wait for hours. His sister indicated, she agreed at the time and scheduled the MRI through his PCP (primary care provider), but in hindsight, she would have sent him to the ER since the MRI eventually revealed the femur fracture and he needed surgery. During an interview on 10/4/24 at 1:28 p.m., the NP indicated, Resident 102's sister was very involved and well informed regarding his care and she often preferred to go through his PCP because of his Down Syndrome. The NP visited Resident 102 after the fall and ordered a series of x-rays which all came back negative. The NP had a conversation with the sister about an MRI but did not document details of the conversation. When Resident 102's progress notes were reviewed where there was no documentation of physician notification, the NP indicated she would want to be notified of ongoing and/or unrelieved pain, or new changes in behavior to address the change of condition. During an interview on 10/4/24 at 1:53 p.m., the DON indicated, if a resident experienced breakthrough pain or unrelieved symptoms and changes in behavior, she would expect nursing to notify the MD to address the change of condition and receive new orders if applicable. On 10/4/24 at 12:15 p.m., the DON provided a copy of current facility policy titled, "Pain Management," revised, 7/2024. The policy indicated, " ...It is the policy of American Senior Communities to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management ...			

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	10/07/2024

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
	non-Interviewable resident- pain medications will be prescribed and given based upon nursing assessment for the following: non-verbal sounds ... facial expressions ... protective body movements or postures ... the physician will be notified of unrelieved or worsening pain ...." On 10/4/24 at 12:15 p.m., the DON provided a copy of current facility policy titled, "Resident Change of Condition Policy," revised, 11/2018. The policy indicated, " ...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ... acute medical change a. any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician. 2. On 10/3/24 at 9:39 a.m., Resident 40's record was reviewed. Her diagnoses included, but were not limited to, history of falling, non-displaced comminuted (the broken bone was more than 2 pieces) fracture of shaft of right femur (thigh bone), displaced (not in alignment) supracondylar (just above the knee joint) fracture with intercondylar (ball shaped ends of the femur) extension of lower end of right femur, right-sided hemiplegia and hemiparesis (paralysis and weakness), cognitive communication deficit, anoxic (oxygen deprivation) brain damage, cerebral infarction (stroke), intellectual disabilities (decreased acquisition of knowledge and skills), anxiety disorder, and panic disorder (unexpected and repeated episodes of intense fear accompanied by physical symptoms). A care plan, dated 4/13/24, indicated Resident 40 may yell out and become upset when her roommate was being provided care. The goal was			

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	10/07/2024

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
	for her not to exhibit this behavioral expression. An intervention indicated to talk with the resident and redirect her. A care plan, dated 6/20/24, indicated Resident 40 had a communication deficit related to anoxic brain damage, a history of cerebral vascular accident (stroke), and mental retardation (impairment in intellectual ability). The goal was for the resident to be able to effectively communicate her needs. An intervention indicated to use simple communication and avoid open-ended questions. A care plan, dated 6/25/24, indicated Resident 40 required assistance with toileting due to incontinence of bladder and bowel. An intervention indicated to assist with incontinence care as needed. A care plan, dated 7/23/24, indicated Resident 40 experienced the following behavior, she may yell out and cry in her room when she wanted something. Interventions included, but were not limited to, to address her immediate needs and ensure her safety. Resident 40's Fall Event, dated 9/9/24 at 2:06 p.m., indicated Resident 40 had an unwitnessed fall on 9/9/24 at 9:40 a.m. She was found on her right side on the floor next to her bed. She had removed her clothing and soiled disposable brief. After her fall, the nursing assessment indicated she was not experiencing any pain and had no injuries. She had been having behaviors and refusing care to be cleaned up. No progress note was found on the date and around the time of Resident 40's fall on 9/9/24 at 9:40 a.m.			

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	10/07/2024

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

A progress note, dated 9/9/24 at 2:06 p.m., indicated Resident 40 was in bed, had removed gown and disposable brief, and "played" in her bowel movement (BM). She was refusing to allow care, she was yelling and fighting with the CNA. She was covered in BM. The DNS (Director of Nursing Services) was informed and she spoke to Resident 40 regarding her behaviors. Resident 40 continued to refuse care. Her bed lowered and she was covered up. The CNA pulled the curtain and was over with resident's roommate providing care. Resident 40 raised up the height of her bed and rolled off into floor in between the beds. She was lying on her right side. She was assessed with her vital signs stable, neurological assessment started and range of motion was within normal limits for her. No injury was noted. Resident 40 was assisted up into her wheelchair and a gown was put on. The CNA was able to take her to the shower and clean her up.

A progress note, dated 9/9/24 at 10:29 p.m., indicated Resident 40 was observed sitting in her wheelchair with no complaints of pain while propelling herself in the hallway and dining room, but when the staff put her in bed, she started yelling and complaining of pain. PRN medications provided but did not help her pain. Her right knee was observed to be swollen, and she felt pain when it was touched. The Nurse Practitioner (NP) was notified with a new telephone order for an x-ray with 2 views.

The results of her right knee x-ray, dated 9/10/24 at 1:20 a.m., indicated Resident 40 had a transverse fracture involving her right distal femur with mild callus and modest posterior angulation and displacement. The joint showed no dislocation. There was associate joint effusion

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	10/07/2024

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
	swelling(define). Soft tissue swelling was seen. The conclusion was right knee fracture. Resident 40's pain medication orders included, but were not limited to, scheduled acetaminophen 500 mg (milligram) three times a day at 7:00 a.m., 3:00 p.m., and 11:00 p.m., ibuprofen 400 mg, every 6 hours PRN (as needed), and hydrocodone-acetaminophen 5-325 mg three times a day at 8:00 a.m., 12:00 p.m., and 9:00 p.m. Resident 40's medication administration record (MAR) indicated: a. Hydrocodone-acetaminophen 5-325 mg was given three times on 9/9/24. b. Acetaminophen 500 mg was given three times as scheduled on 9/9/24. c. Ibuprofen 400 mg was administered due to Resident 40's complaint of right knee pain at the level 6 on a pain scale of 0 - 10. One ibuprofen was provided on 9/9/24 at 9:43 p.m. The medication effectiveness was assessed on 9/10/24 at 6:24 a.m. as somewhat effective. A progress note, dated 9/10/24 at 8:02 a.m., indicated the facility attempted to call and notify the Resident's brother and left a message to call the facility back. The resident continued with behaviors, most of the redirections had been unsuccessful since yesterday with the resident only accepting redirection one time since yesterday during the day. A progress note, dated 9/10/24 at 8:42 a.m., indicated Resident 40 was observed "playing" in her BM. BM was observed all over the resident and the sheets. She had removed her gown and disposable brief and threw them on the floor. The CNA attempted to clean up the resident, but she was combative. She was observed thrashing			

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	10/07/2024

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
	about to, "throw self out of bed." She was redirected to allow the CNA to provide care. Resident's brother notified. A progress note, dated 9/10/24 at 9:49 a.m., indicated Resident 40 was sent to the ED (emergency department) for evaluation and treatment related to the fracture. CNA (bus driver) accompanied the resident. The resident went to the hospital via the facility bus. The bus driver was also a CNA who stayed with the resident in hospital emergency room waiting room until her brother arrived. On 9/10/24 at 11:08 a.m., the interdisciplinary team (IDT) fall review note indicated Resident 40 had a fall on 9/9/24 at 9:40 a.m. The resident was in bed prior to fall waiting for the wound physician. The resident did not place call light on for assistance. She started yelling out and screaming to get out of bed. Nursing staff explained she had to be seen by the wound doctor and then she would be able to get up for breakfast. Nursing staff went back in the resident's room, and she had, "played" in her feces. Nursing staff explained she was going to receive a shower to clean up. She agreed. Her bed was lowered to the appropriate level and staff was assisting her roommate to get up. Resident 40 raised her bed to a higher level and rolled out of the bed. No injuries were noted at the time. Resident 40 complained of latent pain and the on-call provider paged for the facility to get an x-ray. The x-ray results indicated a transverse fracture involving right distal femur with mild callus (hardened skin) and modest posterior angulation (abnormal bend) and displacement. ER evaluation indicated she would be admitted. The determination of the root cause of the fall was the resident did not want to wait on the wound physician and wanted to get out of bed. The			

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	10/07/2024

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
	resident "played" in her feces to have staff come in and get her up. On 9/10/24 at 3:55 p.m., the bus driver/CNA called from the hospital and indicated Resident 40 was being admitted. On 9/10/24 at 3:59 p.m., the IDT behavior review note indicated Resident 40 had removed her gown in her room, while on her bed, and started "playing" in her bowel movement. The immediate intervention was for staff to educate her on the importance of not doing that behavior. The assessment of a potential correlation to the root cause was Resident 40 had unmet needs. The resident's soiled brief needed to be changed. The root cause of her behavioral expression was she was upset about her roommate getting up for the day before she did. She was to remain in bed so the wound physician could see her. A document titled, "Hospital-ER Transfer Form, dated 9/11/24 at 12:59 p.m., indicated the time of Resident 40's transfer, due to femur fracture, was 9/10/24 at 9:30 a.m. She was transferred to the emergency room by the facility bus. A progress note was included, it indicated on 9/11/24 at 3:48 p.m., the IDT description of Resident 40's behavior was "playing" in her BM and attempting to throw herself out of bed. The staff had encouraged her to allow them to provide peri care. A potential correlation to the root cause was unmet needs because the resident needed to be changed. An ED (emergency department) physician's note, dated 9/10/24, indicated she saw Resident 40 at 3:31 p.m. She indicated Resident 40 told her she fell onto the floor and had pain in her right knee. An assessment of her right lower extremity (RLE)			

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	10/07/2024

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
	showed knee deformity, with swelling and ecchymosis (bruising), and distal femur TTP (tenderness to palpitation). She will be admitted to the hospital for an internist and orthopedic follow-ups. The hospital x-ray indicated, " ...impacted supracondylar fracture distal femur ...." A care plan, dated 9/20/24, indicated Resident 40 was determined to be intellectually disabled (effects learning, problem solving, and everyday tasks) and mentally ill (conditions involving (changes in emotions, thinking and/or behavior). The goal was her to have her mental health needs met. An intervention was to have continue current mental health services. A care plan, dated 9/20/24, indicated Resident 40 exhibited cognitive impairment (problems with thinking, learning, remembering, use of judgment and making decisions) as evidence by a brief interview for mental status (BIMS) less than 13. The resident was severely impaired. An intervention was to provide the resident with prompts and cues as needed. A care plan, dated 9/24/24, indicated Resident 40 required assistance with ADLs (activities of daily living) including bed mobility, transfers, and toileting related to decreased mobility, cognitive deficits, right sided hemiplegia, and retardation. A care plan, revised on 10/1/24, indicated Resident 40 was at risk for falls due to a history of falls, cognitive deficits, communication deficit, anoxic brain damage, developmental delay, anxiety, and panic attacks. The goal was to reduce her fall risk factors to avoid significant injury. Interventions included her being placed on the morning get-up schedule per her request to be up early and she will be seen first by the wound			

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	10/07/2024

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
	physician so she can get up for the day. During an interview, on 10/2/24 at 2:25 p.m., the DNS indicated their mobile x-ray service would call and fax the results of an x-ray to the facility. She indicated she did not keep the faxes, so she did not know when the fax arrived at the facility. The doctor should have been notified when the x-ray results came in. During an interview, on 10/2/24 at 2:29 p.m., the Regional Director of Clinical Support (RDCS) indicated the SBAR communication (physician communication tool to provide the situation, background, assessment, and recommendation) with the physician indicated Resident 40's x-ray was abnormal on 9/10 at 9:46 am. During an interview, on 10/3/24 at 11:22 a.m., the DNS indicated the x-ray results was reported back to the facility on 9/10/24 at 1:20 a.m. She indicated she did not know the time because she did not keep the faxes. She indicated the staff was aware of the x-ray at 2:01 a.m. and notified the Nurse Practitioner (NP). The NP responded with, "Send out. During an interview, on 10/3/24 at 11:52 a.m., Resident 40's brother indicated the facility called and indicated she fell out of bed and injured her knee. The facility had the x-ray results, and her leg was fractured. They called the morning it happened and indicated she was going to the emergency room (ER). He was annoyed that she had to wait in the ER lobby for 5 hours before being seen. He did not know why the facility sent her to the ER by the facility bus. He clearly stated he did not request that she go to the ER by the facility bus.			

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	10/07/2024

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 a phone interview, on 10/3/24 at 1:30 p.m., the local mobile x-ray company Representative 18 indicated when they received a positive result (fracture), they called the facility with the results. On 10/4/24 at 9:55 a.m., the DNS indicated the facility used progress notes and SBAR for tracking behaviors. We had no specific tracking device for behaviors. During an interview on 10/4/24 at 2:15 p.m., the DNS asked Resident 40 to stay in bed because the wound physician would be coming around. The resident was playing in her feces with her BM everywhere. CNA 17 was in Resident 40's room working with her roommate. She told Resident 40 she would give her a shower next. Resident 40's raised the level of her bed and toppled out onto the floor. The DNS indicated she was not aware of the resident raising the bed before then. The wound physician had made it to her hallway, but she did not know if he was able to see her or not. SBAR documentation, dated 9/9/24 at 10:19 p.m., between the facility and the NP, was provided by the RDCS, on 10/7/24 at 10:30 a.m. It indicated Resident 40 had a fall this morning, she was not complaining of pain while she propelled herself in the hallways and dining room, but when she was put in bed, she started yelling and complaining of pain. Her PRN medication was provided but did not relieve her pain. Her right knee was observed to be swollen, and she felt pain when it was touched. Requesting a STAT (immediate) order for a right knee x-ray. SBAR documentation, dated 9/10/24 at 2:01 a.m., between the facility and the NP, was provided by the RDCS, on 10/7/24 at 10:30 a.m. It indicated Resident 40 had a right distal femur displaced			

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	10/07/2024

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
	fracture. The new order was received to, "Send out." SBAR documentation, dated 9/10/24 at 9:00 a.m., between the facility and the physician, was provided by the RDCS, on 10/7/24 at 10:30 a.m. It indicated Resident 40 had an abnormal x-ray of her femur. She was unstable, likely to get worse, bedside clinician requests to, "send to ED for eval (evaluation) and tx (treatment) r/t (related to) distal femur rx (fracture)." On 10/7/24 at 10:30 a.m., the RDCS provided an email, dated 10/3/24, from the Medical Director. It indicated, " ...The result of the radiograph (x-ray) was transmitted to the provider on call with response to send out the patient for assessment based on the finding of the right distal femur fracture ...she was transported by facility bus to the Emergency Department for further assessment. Her care was transitioned to both internal medicine and orthopedics ...she was maintaining stability without significant pain ...she arrived at the ER about 9 am ...(she) was formally assessed there until [sic] 3 pm. It was determined that she would need surgery, but no immediate intervention was provided other than being placed in a hinged brace ...." During an interview, on 10/7/24 at 10:39 a.m., the Executive Director (ED) indicated regardless of whether Resident 40's roommate was getting care, the resident needed to stay in bed so the wound physician could she her on his rounds. She was seen by the wound physician consistently. During an interview with the ED, on 10/7/24 at 10:42 a.m., a request was made to interview the facility bus driver/CNA (certified nurse aide) who drove the resident to the hospital and stayed with			

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	10/07/2024

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
	her until her brother arrived. She indicated the bus driver no longer worked there and she would provide the phone number. No phone number was provided prior to exit. During a phone interview, on 10/7/24 at 1:53 p.m., a local mobile x-ray company medical records representative 19 indicated the facility contacted them for an x-ray on 9/9/24 at 11:16 p.m. Their x-ray technician arrived at the facility on 9/10/24 at 12:40 a.m., and completed the x-ray at 12:48 a.m. The x-ray was read, and the facility contacted by fax of a positive result (fracture) at 1:24 a.m. On 10/8/24 at 8:29 a.m., an email was received from the local mobile x-ray medical records representative. The email indicated the facility was not set up to receive phone calls, emails, or text alert when a positive result (fracture) was obtained. Therefore, the result of Resident 40's fractured femur was faxed only. A current policy, titled, "Fall Management Policy," dated 08/2022, was provided by the Director of Nursing Services (DNS), on 10/3/24 at 1:00 p.m. A review of the policy, indicated, " ...It is the policy of American Senior Communities to ensure resident residing within the facility re ceived adequate supervision and or assistance to prevent injury related to falls ...If the resident experienced an injury from the fall, contact facility DNS/ED ...Contact the physician will be contact immediately, if there are injuries, and orders will be obtained ...If there are no injuries, notify the physician during normal business hours ...The family will be notified immediately by the charge nurse of falls with injury ...if there			

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	10/07/2024

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
	are no injuries , notify the family during day or evening hours...."3.1-37(a)3.1-37(b)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure that medications were not left unsupervised in a resident's room for 1 of 1 random observation (Resident 49) and failed to implement fall prevention interventions for a resident (Resident 37) for 1 of 3 residents reviewed for falls. Findings include: 1. On 10/2/24 at 10:32 a.m., a record review was completed for Resident 49. He had the following diagnoses which included but were not limited to type 2 diabetes mellitus (DM), hypertension (HTN), obstructive sleep apnea (OSA), hyperlipidemia (HLD), and generalized anxiety disorder (GAD). During an observation on 10/1/24 at 11:42 a.m., Resident 49 was in transmission-based precautions (TBP). Upon entering his room, it was noted he had a clear, plastic cup with approximately 8 pills inside the cup. Resident 49 indicated those were his morning medications. Resident 49's record lacked a self-medication administration assessment. During an interview with the Director of Nursing (DON) on 10/4/24 at 1:30 p.m., she indicated Resident 49 should not have had his medications left at bedside. A policy titled, "General Dose Preparation and Medication Administration" was provided by the	F 0689	**Plan of Correction** **F689 – Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents who found to have been affected by the deficient practice?** The medications at bed side were removed and the fall interventions were placed when deficiency was reported. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents 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 deficient practice does not recur?** Education was provided for all nursing staff. A Fall Intervention/Meds at Bedside Audit Tool will be kept by ED/DNS/Designee and will be completed weekly for 4 weeks and bi-weekly for 4 weeks after. The audit tool will be completed for 10 random residents throughout the week.	10/24/2024

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	10/07/2024

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
	DON on 10/3/24 at 1:42 p.m. It indicated, " ...Observe the resident's consumption of medication(s) ..." 2. On 10/2/24 a record review was completed for Resident 37. She had the following diagnoses which included but were not limited to osteoarthritis, HTN, HLD, and unspecified injury to the muscle. She had a history of falls with a care plan indicating she was at risk for falls due to: decreased mobility, incontinency, history of falls, cognition, age, refuses eye glasses at times and related to diagnoses of mental retardation, atrial fibrillation (a type of irregular heartbeat that causes the heart to beat faster and in an irregular pattern), seizures, intermittent explosive disorder, HTN, hypokalemia (low potassium), history of hyponatremia (when the level of sodium in your blood is lower than normal), osteoarthritis (OA), allergic rhinitis (allergies), tendon injury, hypertrophy of bone (a medical condition that causes abnormal bone growth and enlargement), fatigue, urinary tract infection (UTI), depression, constipation, history of COVID-19, fracture of left ulna, and malnutrition. Interventions included adding brake extenders to her wheel chair on 11/22/22 and bright colored tape to wheelchair brakes on 2/12/23. During an observation on 10/3/24 at 12:22 p.m., she did not have brake extenders or colored tape to her brakes on her wheelchair as care planned. She had written orders on 3/22/23 for brake extenders and on 2/8/23 for bright colored tape to wheelchair brakes.		**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?** The ED will be responsible for the completion of the Fall Intervention/Meds and Bedside Audit Tool weekly for 4 weeks and bi-weekly for 4 weeks after. The Fall Intervention/Meds and Bedside Light Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and/or including termination of the employee responsible.	

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	10/07/2024

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 interview with the Director of Nursing (DON) on 10/4/24 at 1:30 p.m., she indicated Resident 37 should have had brake extenders and bright tape to her brakes of her wheelchair. A policy titled; "Interdisciplinary Care Plan (IDT) Comprehensive Care Plan Policy," was provided by the DON on 10/3/24 at 12:55 p.m. It indicated, " ...Care plan problems, goals, and interventions must be reviewed and revised by the interdisciplinary team periodically and following completion of each minimum data set (MDS) assessment ..." 3.1-45(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to initiate a pharmacy recommendation for 1 of 5 residents reviewed for pharmacy requests (Resident 13). Findings include: On 10/3/24 at 11:56 a.m., a record review was completed for Resident 13. She had the following diagnoses which included dementia, insomnia, major depression, and gastroesophageal reflux disease (GERD). A pharmacy recommendation was made on 6/21/24 to reevaluate the continued need for omeprazole (a medication for GERD) discontinue and initiate famotidine (a medication for GERD) 20 mg once daily with the end goal of discontinuation. The physician accepted the recommendation and left instructions to implement the recommendation as written.	F 0757	**Plan of Correction** **F757 – Drug Regimen is Free from Unnecessary Drugs** **What corrective action(s) will be accomplished for those residents who found to have been affected by the deficient practice?** The recommendation was reviewed, and the medication change was made upon the notification of deficiency. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. A 1x audit of all current pharmacy	10/24/2024

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	10/07/2024

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
	The facility failed to implement the new order for famotidine 20 mg daily. On 10/4/24 at 2:10 p.m., the Director of Nursing (DON) was interviewed. She indicated she could not find where famotidine was ever initiated but did find where Tums as needed (PRN) was initiated instead. A policy titled; "General Dose Preparation and Medication Administration" was provided by the DON on 10/3/24 at 1:42 p.m. The policy did not discuss pharmacy recommendations and new order changes. 3.1-48(a)(1) 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6)		recommendations and those residents that need immediate attention will be addressed **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Education was provided to all nurse managers. A Pharmacy Recommendation Audit Tool will be kept by DNS/Designee and will be completed monthly for 6 months for 10 random pharmacy recommendations. **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?** The DNS/Designee will be responsible for the completion of the Pharmacy Recommendation Audit Tool for 6 months. The Pharmacy Recommendation Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and/or including termination of the employee responsible.	

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	10/07/2024

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 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and record review, the facility failed to ensure medications were labeled and dated for 3 of 3 medication carts reviewed for medications (Resident 47, 49, 56, 83, 86, 106, 112, and 278). Findings include: On 10/1/24 at 1:53 p.m., the 500 back hall medication cart was observed with Qualified Medical Assistant (QMA) 11. The findings were: a The facility tuberculin serum was opened 8/20/24 and expired on 9/20/24. b. Resident 83's was sent to the facility on 9/20/24 but had no opened date. c. Resident 86's had latanoprost was observed in the medication cart with only his name and date to indicate when it was opened d. Resident 112's had budesonide-formoterol with no date. The 500 front medication cart was observed with Registered Nurse (RN) 20. The findings were: a Resident 56's breyna 160-4.5 mcg (microgram) and fluticasone 50 mcg spray, had no open dates. b. Resident 47's had a nasal spray with no open date. The 100 front medication cart was observed with RN 12. The findings were: a Resident 278's lispro insulin was expired on 8/24/24. b. Resident 49's lispro insulin had no prescription label or open date. c. Expired novolog with no name was opened on 9/1/23. d. Resident 106's latanoprost 0.05% was sent on	F 0761	**Plan of Correction** **F761 – Label/Storage Drugs and Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The non-dated medications were removed from the medication cart upon notification of deficiency. An in-service was completed with all nurses and nurse managers about medication storage regulations and policy. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents 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 deficient practice does not recur?** Following education, the Medication Storage Audit Tool will be kept by the DNS/Designee and will be completed weekly for 4 weeks and bi-weekly for 4 weeks after. The audit tool will be completed for 1 random medication cart per week. **How the corrective action (s)**	10/24/2024

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	10/07/2024

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
	9/13/24, it had no open date. e. Resident 106's dorzolamide-timolol drops did not have an open date. f. Resident 106's rhopressa 0.02% ophthalmic solution had no open date. A current policy, titled, "LTC Facility Pharmacy Services and Procedures Manual," was provided by the Executive Director (ED), on 10/2/24 at 12:37 p.m. A review of the policy, indicated, " ...The facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines ...Facility staff should record the date opened on the primary medication container ...when the medication has a shortened expiration date once opened ...." 3.1-25(j)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Designee will be responsible for the completion of the Medication Storage Audit Tool weekly for 4 weeks and bi-weekly for 6 weeks after. The Medication Storage Audit Tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and/or including termination of the employee responsible.	