STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155792	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Meadows	762 N Dan Jones Rd Avon, IN 46123

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure a resident (Resident D) with chronic Urinary Tract Infections (UTIs) and a nephrostomy tube (a thin, flexible tube inserted into the kidney to drain urine directly into a collection bag) had accurate medical orders and was receiving perineal care regularly for 1 of 1 residents reviewed for bowl and bladder concerns.Findings include:On 9/29/25 at 12:22 p. m. Resident D was observed as she lay in bed. Her bed did not have a fitted sheet, only a flat sheet, and all her pillows were without pillowcases. The resident indicated she had put her call light on at 8:00 a.m. to be changed but they had not come in to change her yet. Resident D was very tearful and indicated she was in so much pain and had told the facility about her concerns many times but nothing got better.On 9/29/25 at 12:47 p.m. Certified Nursing Assistant (CNA) 2 indicated to Resident D that she had gotten busy but was coming in now to change the resident's brief. As CNA 2 pulled back Resident D's sheet, the resident's brief and sheet were visibly soiled. As CNA 2 was changing Resident D, a strong ammonia urine smell permeated the room, and the brief was observed to be completely saturated with urine. Resident D had a nephrostomy tube on her left side with what appeared to be a blue bordered foam dressing. The dressing was dated 9/27. CNA 2 changed Resident D's brief, put down a dry towel underneath her and then left to get clean linen for her bed.On 9/29/25 at 1:00 p.m. Resident D's medical record was reviewed. She was a long term care resident whose diagnoses included but were not limited to cancer of the breast with metastasis and chronic urinary tract infections (UTI).Resident D had an active order to cleanse around the nephrostomy tube, apply betadine the area, apply a dry dressing, and monitor for signs and symptoms of infection once daily and as needed for soilage.A social services Minimum Data Set (MDS) assessment, dated 9/22/25, indicated the resident scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) assessment. This score indicated intact cognition, meaning the individual's thinking and memory were functioning normally with no or very little impairmentResident D's Point of Care (POC) (the area in the Resident medical record where staff chart tasks performed by or for the Resident) history related to bowl and bladder care was reviewed for the month of September 2025. The POC history indicated 19 out of 28 days Resident D was incontinent 3 times per day, and 9 out of 28 days Resident D was incontinent 2 times per day. There were no continent toileting episodes charted. The documentation indicated the resident was receiving incontinent care only 2 to 3 times a day for the month of December.Resident D had a care plan related to her having chronic UTIs dated 1/20/25. The interventions for this care plan included, but were not limited to, assist with incontinent care. Resident D had a care plan related to her having a nephrostomy tube dated 1/20/25. The interventions for this care plan included, but were not limited, to change dressing as ordered, flush tube as ordered and keep the system a closed system as much as possible.Resident D had a care plan related to her needing assistance with toileting and incontinent care dated 1/20/25. The interventions for this care plan included, but were not limited to, assist with incontinent care as needed, and check and change every two hours and as needed for incontinence.At the time of exit there were no care plans or documentation in the record indicating Resident D had adverse behaviors related to refusal of incontinence care, toileting, personal hygiene or false accusations.During an interview on 9/29/25 at 1:27 p.m. the Director of Nursing (DON) indicated Resident D's nephrostomy tube was currently dislodged and would be replaced soon at the hospital. She indicated she was going to check Resident D's orders to see what the current orders were for the nephrostomy tube. The DON indicated the tube did not have a bag attached to it because it was not draining due to the dislodgment.During an interview on 9/29/25 at 1:36 p.m. the DON indicated she was going to clean up Resident D's orders, because the current order should have been to only change the dressing as needed for soilage and to flush the tube as needed.During an interview on 9/29/25 at 2:31 p.m. the Unit Manager (UM) indicated Resident D's current nephrostomy tube that was in place was a new tube and was working properly as far as she knew. She indicated she was just about to change the dressing for Resident D's nephrostomy tube, because to her knowledge the dressing was to be changed, and the tube was to be flushed daily and as needed. The UM indicated the nephrostomy tube was not connected to a bag at this time because her other kidney was functioning properly and she was urinating as normal, so the nephrostomy tube was not draining. She indicated if it did start to drain staff would then connect a drainage bag and account for the output from the tube. The UM also indicated Resident D was not on a bowel and bladder program because the resident did not know when she needed to go, she could only feel when she had already voided. She was on a standard two hour check and change schedule During an interview on