

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/10/2025
NAME OF PROVIDER OR SUPPLIER  Countryside Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure the environment was free from the potential for accidents when a protective cap for a bedframe end-piece was missing which resulted in actual harm when a resident (Resident B) sustained an 18 centimeter (cm) long by 5 cm wide avulsion skin tear which required 6 sutures for 1 of 3 residents reviewed for accidents. Findings include: On 11/10/25 at 10:40 a.m., Resident B's room was observed with the Administrator (ADM) who indicated that during a transfer from her wheelchair to her bed, Resident B's leg was injured, by the metal bedframe, where there was an approximate 5-inch gap between the head of the bed frame, and the center frame. At the time of the observation, both end pieces of the frame had black protective caps in place. On 11/10/25 at 1:15 p.m., Resident B's family member indicated she had been notified of the injury but was shocked to see pictures of the extent of the injury. Resident B had sustained skins tears before, but nothing that extreme. She came to the facility the following morning to speak with staff and visit Resident B. She was told by the facility staff that upon their investigation, part of the bedframe rail had been missing an end-cap. So she went to Resident B's room, pulled off the end caps that had been replaced and could feel a jagged rough metal edge. On 11/10/25 at 1:30 p.m., Resident B's bed frame was observed. The specified end-cap was removed and there was a rough, jagged metal edge. The blue outer mattress covering also showed evidence of ripping/tearing from sitting directly over the uncapped jagged metal piece of the frame. During a confidential interview, it was indicated both caps from the bedframe were missing at the time of the accident. Resident B's leg got caught in between the gap, and the skin tore on the jagged metal edge. There was blood on the floor right under that area of the bedframe. During an interview on 11/10/25 at 1:50 p.m. the Maintenance Director indicated he was not in the facility at the time of the accident, but he and his assistant were told to do bed safety checks. During those checks, they found several other beds throughout the building that were missing the same end-cap protective pieces. The Maintenance Director called his assistant at this time, to confirm if caps were in place or not at the time of the accident. The Maintenance Assistant indicated when he checked Resident B's bed, two end-caps were missing and he replaced them immediately. The Maintenance Director was told to check and replace what was needed, but there was no plan moving forward related to continued monitoring that he was aware of at that time. On 11/10/25 at 2:40 p.m., Resident B's bedframe was observed for a final time with the Director of Nursing (DON) present. With the end cap removed, the jagged metal edge was felt and the evidence of it having been missing long enough to cause damage to the mattress cover was discussed. On 11/10/25 at 11:18 a.m. Resident B's record was reviewed. She was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, dementia, repeated falls and unsteadiness on feet. She was moved to the secured memory care unit on 9/8/25, and sustained a fall 9/9/25 which resulted in a lower extremity skin tear. An interdisciplinary team (IDT) progress note, dated 9/9/25 at 8:07 a.m., indicated Resident B had an unwitnessed fall in her room and sustained a skin tear on her lower extremity. The root cause of the fall was that the resident was trying to get up by herself, and the intervention was for her to have an Occupational Therapy evaluation. The record lacked follow-up or indication on how or where she sustained the skin tear. Upon Resident B's move to the secured memory care unit, a comprehensive care plan was initiated on 10/10/25 which indicated, Resident resides on a secured memory careunit related to diagnosis of unspecified dementia. an intervention for the plan of care was, Keep environment free from hazards. A Nurse Practitioner (NP) progress notes, dated 10/17/25 at 10:28 a.m., indicated Resident B had .dressings on her bilateral lower legs from some injuries that the nurse and staff are not aware of what could have caused it, the wound is just some scrapes that they have been changing daily right now. The record lacked follow-up or indication for how she sustained the skin tears. On 10/31/25 a new comprehensive care plan was initiated which indicated, Resident has skin tears to right knee and back of left knee. Interventions for this plan of care included, but were not limited to, Observe resident environment for potential to cause skin trauma. A nursing progress note, dated 11/5/25 at 10:27 a.m. , indicated Resident B accidentally hit her left leg against the bed frame during a transfer and sustained a laceration on her left lower extremity with moderate bleeding. The nurse applied first aide and called 911 for her to be sent out to the emergency room (ER) for further evaluation and treatment. Corresponding ER documentation, dated 11/6/25 at 2:19 a.m., indicated patient from [facility] with large deep leg laceration to left lower leg. Staff reported they were transferring patient from wheelchair to bed when laceration occurred. Bleeding controlled. The wound was reapproximated in one layer with 6 simple interrupted sutures</p>		