

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a complete discharge plan for a resident with diabetes and a wound from the facility for 1 of 3 residents reviewed (Resident B). Findings include: On 7/10/26 at 8:32 a.m., a record review was completed for Resident B. He had the following diagnoses which included, but were not limited to, left below knee amputation, type 2 diabetes (a chronic condition where your body either doesn't produce enough insulin or resists it), heart disease, peripheral vascular disease (a slow, progressive disorder of the blood vessels outside the heart and brain), generalized anxiety disorder, and legal blindness. Resident admitted to the facility on [DATE] after an amputation of his left leg below the knee. He had a history of crushing his left foot with a ladder and the hardware from the surgery never healed correctly, resulting in an amputation. Resident B used crutches in the facility and used a wheelchair to get around in the facility. He received therapy and was discharged from therapy on 5/16/26 due to meeting his goals. He continued to have a wound to his left amputation surgical site that was being treated by the wound clinic. Resident B had a care plan, dated 6/5/26, indicating his goals were to return to the community. His discharge location was undetermined; he recently experienced homelessness and had planned to discharge to a shelter when medically stable. The goal was for Resident B to be discharged to a safe, appropriate environment. Resident B had a care plan, dated 5/20/26, indicating he had impaired skin integrity related to surgical wound to left below knee amputation site. The goal was for the wound to heal without complications. An email from the Business Office Manager (BOM), dated 5/28/26 at 9:58 a.m., indicated Resident B indicated his sister was helping him with Medicaid and disability. A progress note from the BOM on 5/28/26 at 10:38 a.m., indicated the BOM had a conversation with Resident B regarding the Medicaid process. Resident B was adamant that his sister was helping him with Medicaid and Social Security Disability Insurance (SSDI). He indicated he did not need assistance and offered other options. He indicated he was discharging home. A progress note, dated 6/30/26 at 1:56 p.m., indicated Resident B planned on discharging to a hotel. Resident B indicated he decided to discharge to hotel instead of returning to the shelter or living with friends. A progress note, dated 6/29/26 at 12:22 p.m., indicated remained with goal to return to community when the prosthesis process was completed. Resident B continued with wound to stump and was receiving active treatment. He went to the wound clinic weekly for care. The prosthesis was on hold due to his wound; wound was improving. Resident B's record lacked documentation of involvement by Resident B's family or friends in discharge planning. The record lacked documentation of discussions of how the resident would obtain food, medications, and transportation to wound clinic appointments upon discharge. On 7/10/26 at 10:05 a.m., during an interview with Social Services, she indicated Resident B admitted after his amputation. Prior to admission, Resident B was couch surfing. Resident B was (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	completely independent, and he made the decision that it was time to be discharged from the facility. He was leaving the facility with friends for visits and only taking crutches with him. He indicated he did not desire home health services. His medications were called into a local pharmacy. The facility sent resident with a 3 day supply of medications. They discharged him to a local hotel and paid for 3 nights. He needed a wheelchair after discharge, so the facility took him a wheelchair. From there, she indicated he was going to his mother's house. On 7/10/26 at 10:14 a.m., during an interview, the Occupational Therapy (OT) indicated Resident B was admitted to the facility with physical therapy (PT) only because he was independent with OT. His preference was to use crutches. After discharge, Resident B requested a wheelchair, so the facility gave him one. He was going on leave of absence with family over the weekend and only took crutches. He transferred independently in and out of cars, on and off toilet. He was focused on a prosthetic limb, but his wound was not fully healed to begin the process, it was going to be some time before his wound healed. On 7/10/26 at 11:04 a.m., during an interview, Resident B indicated he did not have a home to go to. He indicated he took his medications and was out of his medications now. He had insulin with him but was not taking it because he must eat certain foods. He indicated he was at a shelter downtown. He indicated his mother had passed away in 2020. On 7/10/26 at 11:46 a.m., during an interview with the Executive Director (ED), she indicated Resident B had a managed Medicaid plan. The insurance cut him from services. The facility offered private pay which the resident denied because he did not want to pay. He agreed to discharge. The facility paid for a 3-day hotel stay. On 7/10/26 at 11:51 a.m., during an interview, Resident B's friend indicated Resident B went to the hotel for 3 days, then to his daughters for 2 days, then his sister's for a day, and then his brother's for 1 day before being admitted to a free clinic that would ensure he received proper medical care until his needs were met. She indicated Resident B was very independent and wanted to get back to work. She indicated there were family dynamics and Resident B could no longer stay with his family. On 7/10/26 at 12:00 p.m., during an interview with the free clinic, the Clinic Coordinator indicated Resident B would have his medications set up in a box on a weekly basis by a nurse. He indicated the resident would get to his appointments by a medical cab. On 7/10/26 at 12:42 p.m., during an interview with the Medical Assistant at the wound clinic, she indicated Resident B made it to his appointments on 7/2/26 and 7/9/26. On 7/10/26 at 12:55 p.m., during an interview with Resident B's insurance company. The nurse indicated he was denied further coverage for the facility on 6/30/26 because it was no longer medically necessary for him. She indicated she spoke to the Director of Nursing (DON) at the facility, and a referral was called in to the free clinic where Resident B was admitted on [DATE]. A policy titled, Discharge Planning, was provided by the ED on 7/13/26 at 10:26 a.m. It indicated, .It is the policy of the community to implement an effective, interdisciplinary discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Discharge planning will include an ongoing person-centered evaluation of needs, caregiver support, goals and preferences.		