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	12/16/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to meet resident's preferences for 1 of 5 residents reviewed (Resident 82). Findings include:During an observation on 12/10/25 at 11:11 a.m., Resident 82's low air loss mattress was set to a setting of 8. He indicated his bed was supposed to be set at a setting of 4. He indicated that staff came in and provided care and bumped it up to a setting of 8 and left it at 8 after his care was completed. Resident 82 indicated he was supposed to have 2 handled cups with lids due to his rheumatoid arthritis (RA) which left him with contractures of all of his limbs and made it difficult for him to hold the Styrofoam cups. Resident 82 indicated he did not use the cups because staff did not remove them to wash them. He had to tell them to wash them, and they took the cups to wash them but never brought them back. He had 3 Styrofoam cups with straws in them on his bedside. During an observation on 12/11/25 at 10:32 a.m., Resident 82's bed settings were set to 8. He indicated his bed was not comfortable for him. He continued to have Styrofoam cups with straws in them at bedside. During an observation and interview on 12/12/25 at 12:46 p.m., Resident 82 was lying on his back. His tray was sitting out of reach of him. He could not pull his overbed table with tray on it to his person due to severe contractures of finger joints and hands. His bed settings were set to 8. He indicated he wanted the bed set to the setting of 4. During an observation on 12/12/25 at 1:26 p.m., Resident's bed setting was set to 8. He had Styrofoam cups with straws in them. On 12/16/25 at 10:51 a.m., Resident 82's bed settings were at 4. He had Styrofoam cups with straws in them next to bedside. During an observation and interview on 12/16/25 at 10:51 a.m., Resident 82 had his breakfast tray on his stomach. He had three regular Styrofoam cups in his room. His rheumatoid arthritis (RA) had left him with contractures of all of his limbs and that made it difficult for him to hold the Styrofoam cups. His bed settings were set at the setting of 4. On 12/12/25 at 12:31 p.m., a record review was completed for Resident 82. He had the following diagnosis which included, but were not limited to, cellulitis of lower legs (a spreading skin infection, most commonly of the lower leg), rheumatoid arthritis, chronic viral hepatitis, iron deficiency related to anemia secondary to blood loss, hypothyroidism, and depression. Resident 82 had a care plan, dated 7/1/25, that indicated to honor his food preferences of no pork. This was not reflected in his diet orders. His diet orders, dated 7/11/25, indicated he was to have a no salt diet, special instructions: no added salt diet. Resident to use two handled cups with sippy cup lid with spout for drinks at all meals daily. During an interview on 12/12/25 at 2:01 p.m., with the Director of Nursing Services (DNS) and Assisted Director of Nursing (ADNS), the ADNS indicated he just changed the resident's bed settings to 4. On 12/16/25 Resident 82's diet order was changed to include no pork. The order for the two handled cups was discontinued. A policy titled, Preference for Daily Routine, was provided by the Executive Director (ED) on 12/15/25 at 9:32 a.m. It indicated, .To identify and develop a plan of care that reflects a resident's past and current daily customary routines. This citation relates to Intake 2634043. 3.1-3(a)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure effective communication with a hospice agency resulting in a delay in treatment for a resident who had a dislocated hip for 1 of 1 residents reviewed for hospice communication (Resident 94). Findings include:During a phone interview on 12/11/25 at 3:25 p.m. Resident 94's family indicated in February 2025 Resident 94 fell and broke her left hip, which resulted in a hemiarthroplasty (a half joint replacement surgery where only the femoral head is replaced with an artificial implant, leaving the natural hip socket intact). The resident's family indicated the resident had chronic nerve pain in her left leg and was on multiple pain medications to manage the pain. Resident 94's family indicated the resident was supposed to come to their house to celebrate Thanksgiving, but the resident was too tired, so they visited her in the evening at the facility. During that visit the resident's family member assisted Resident 94 to the bathroom and noticed that her left hip was bulging backward. The resident's family member indicated she mentioned her concern to hospice RN 11 and an unknown facility staff member and hospice ultimately ordered an x-ray. After the x-ray was ordered on 11/28/25 a whole slew of miscommunications happened. The family member and Resident 94's Power of Attorney (POA) were notified of the x-ray results on 12/1/25 or 12/2/25 she could not remember exactly, and she was told the facility was aware of the results as well. Hospice RN 11 was talking to the DON to arrange transportation to the orthopedic (ortho) clinic for them to evaluate and treat Resident 94, but the Hospice RN had a hard time getting ahold of the DON and no plan was set. Resident 94's family member indicated she went to the facility to check on the Resident on 12/3/25, and when she arrived she spoke with the Licensed Practical Nurse (LPN) who was caring for Resident 94 that shift and the LPN indicated they had no idea the resident's leg was dislocated or that she had even had an x-ray done. During that visit Resident 94's family member spoke with Hospice RN 11 who indicated the facility was claiming they did not receive notification of an order for her hip to be x-rayed nor the results of the x-ray. At that time Hospice RN 11 indicated she notified the facility at the same time as she notified the resident's family. By 12/4/25 hospice was still unable to get ahold of the DON to arrange transportation to the ortho clinic, so she decided she would take the resident herself in her personal vehicle. She called and told the facility she would be there to pick the resident up at 2:00 p.m. The DON called Resident 94's family member for a care conference meeting while she was already in the facility to pick the resident up. Resident 94's family member indicated the DON attempted to help arrange last minute transport with their activity bus but other residents were on an outing utilizing the bus. Once they got to the ortho clinic the staff there indicated all they were able to do was re-x-ray the resident's leg, and it was recommended that they go to the hospital immediately. Resident 94's family member indicated they took the resident to the ER where they re-x-rayed her hip and it showed that her hip was still dislocated, and to her understanding it had been dislocated for a few weeks. The resident's family member felt like they were not notified of every fall the resident had. Resident 94's family member indicated on 12/5/25 they received a phone call from the facility asking when they would be by to pick up the resident's things. At that time, they had not disclosed to the facility that they would be moving Resident 94 to a different facility. Shortly after that they received a letter in the mail saying the facility could no longer care for Resident 94 at that time. On 12/11/25 at 1:21 p.m. Resident 94's medical record was reviewed. She was a long-term care resident on hospice (end of life care) whose diagnoses included, but were not limited to, Alzheimer's disease and aftercare following hip joint replacement surgery. A progress note, dated 11/7/25, indicated Resident 94 had an unwitnessed fall and was found sitting on the floor with her back to the side of the bed. The note explained that the resident's wheelchair was tipped on its back next to the resident and Resident 94 indicated she was getting up to go to the bathroom when she grabbed her wheelchair and fell backward. The immediate intervention for that fall was to place a call before you fall sign in the resident's room. A call before (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	you fall sign was the intervention for the fall on 5/27/25. An IDT note, dated 11/10/25, indicated the call before you fall sign was the only new intervention related to the fall Resident 94 had on 11/7/25. A progress note, dated 11/12/25, indicated Resident 94 had had a significant change in condition related to an overall decline. A progress note, dated 11/17/25, indicated Resident 94 had an unwitnessed fall and was found sitting on the floor facing the bed with her wheelchair behind her. That note explained Resident 94 indicated she was trying to transfer into her wheelchair to go to the bathroom when she fell. That note did not specify if the resident complained of pain or not. The immediate intervention for that fall was to place nonskid strips on the floor next to the bed. An IDT note, dated 11/18/25, indicated the immediate intervention for Resident 94's fall on 11/17 was to place nonskid strips at the bedside. That note indicated additional interventions were antiroll backs to be placed on the resident's wheelchair and a soft touch call light would be provided. Non-skid strips next to the bed were the intervention for Resident 94's fall on 4/13/25 and 10/11/25. Antiroll backs placed on the resident's wheelchair was the intervention for the fall Resident 94 had on 11/2/25. A progress note, dated 11/20/25, indicated Resident 94 had an unwitnessed fall and was found sitting on the floor next to her bed with her wheelchair next to her. That note explained that Resident 94 indicated she was reaching for her wheelchair when she slid off the bed. The note did not specify if the resident complained of pain or not. An IDT note, dated 11/20/25, indicated Resident 94 had an unwitnessed fall and was found sitting on the floor next to her bed. The note explained that the resident's family had attached her call light to the wall using hooks which contributed to an unsafe environment. The intervention for that fall was to remove the hooks from the wall. A progress note, dated 11/23/25, indicated Resident 94 had an unwitnessed fall and was found sitting on the floor. The note explained that Resident 94 was attempting to transfer herself from her wheelchair to her bed without assistance when she fell. That note indicated the resident's family were notified of that fall. During a phone interview on 12/11/25 at 3:25 p.m. Resident 94's family indicated they were not notified of the fall the Resident had on 11/23/25. An IDT note, dated 11/24/25, indicated the intervention for Resident 94's fall on 11/23/25 was to put a Dycem mat (non-slip mats for daily life and therapy) to her wheelchair seat. A hospice narrative note written by hospice RN 11, from a hospice progress note, dated 11/26/25 indicated, .PT [Patient] rates pain as moderate this visit. Small bruise to LLE [left lower extremity]. Patient requires assistance with all ADL's [Activities of Daily Living] except eating. sleeping up to 20 hours per day. Report given to facility Qualified Medication Aide [QMA12] . Progress notes, dated 11/27/25 and 11/28/25, indicated Resident 94 had no complaints of pain. Both progress notes were charted as a late entry on 12/4/25. A hospice nursing note, dated 11/28/25, indicated Resident 94 had moderate pain (4-6 on a pain scale of 1-10) at the time of the visit, the worst her pain had been in the 48 hours before the visit was an 8 out of 10 and the best it had been in that time was a 4 out of 10. The resident had periods of confusion, was drowsy and slept 18-20 hours a day. The note indicated the resident had limited range of motion and pain or stiffness in her lower left leg. The hospice narrative note written by hospice RN 11 indicated, . Patient rates pain as moderate this visit. patient requires assistance with all ADL's except eating. sleeping up to 20 hours per day. Report given to facility QMA [QMA 12] . SN [supervisory nurse] updated patients son.per son he and his wife are concerned about her left hip and requested an X-ray, SN communicated request to HMD [hospice medical doctor]. A hospice physician note, dated 11/28/25, indicated due to a fall, a new order for an x-ray of the left hip was placed to rule out fracture or dislocation. A progress note, dated 11/30/25, indicated Resident 94 had an unwitnessed fall and was found sitting on the floor of the bathroom after attempting to transfer herself from her wheelchair to the toilet. The note explained that Resident 94 was wearing fuzzy socks at the time of the fall, the Residents family were notified and no injuries were noted. That note did not specify if Resident 94 complained of pain or if hospice was notified of the fall. An IDT note, dated 12/1/25, indicated Resident 94 demonstrated full range of motion in all extremities and showed no signs or symptoms of injury. That note indicated the intervention for Resident 94's fall on 11/30/25 was to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place nonskid strips in front of the toilet. During an interview on 12/16/25 at 12:57 p.m. Hospice RN 11 indicated hospice was not notified of the fall Resident 94 had on 11/30/25. Fall follow-up notes, dated 12/2/25 and 12/3/25, both indicated Resident 94's range of motion had no change. A hospice nursing note, dated 12/3/25, indicated Resident 94 had moderate pain (4-6 on a pain scale of 1-10) at the time of the visit, the worst her pain had been in the 48 hours before the visit was 8 out of 10 and the best it had been in that time was a 6 out of 10. The resident had periods of confusion, was drowsy and slept 18-20 hours a day. That note indicated the changes noted for Resident 94 were a dislocated left hip, multiple falls and some falls that were unreported. The hospice narrative note written by hospice RN 11 indicated, . X-ray results showed patient has dislocation of left hip.spoke with facility director of nursing [DON] Regarding X-ray results facility DON states she had not received results . Hospice would cover the cost for an ortho consult but not transportation. Facility DON stated they could get patient in a wheelchair and transport her; however, plans were not confirmed. Patients' [family member] informed .that patient had two unwitnessed falls on Sunday [11/30]. Neither of the falls were reported to Hospice staff. Patients daughter-in-law is very frustrated with patient safety, lack of communication. was unable to locate facility DON to further discuss transportation to an ortho consult.reached out via phone in the afternoon without response as well.spoke with patient's son . he states at this point he and his wife are happy to transport patient to ortho. to have consult done and will notify Hospice prior to taking the patient for the consult. gave report to facility nurse [QMA 12] . A progress note, dated 12/4/25 at 2:30 p.m., indicated Resident 94's family member was at the facility signing her out to take her to ortho clinic due to a left hip dislocation. The record lacked documentation of how or when Resident 94's left hip was dislocated, and x-ray orders or results. A progress note, dated 12/4/25 at 8:48 p.m., indicated Resident 94 had been transferred to the local hospital for further treatment. Hospital medical records, dated 12/4/25, indicated Resident 94 arrived at the emergency room (ER) complaining of left hip pain. The resident's son was at bedside and provided a medical history for the resident. He indicated to the ER staff that his wife noticed that the resident's left hip was swollen and was painful. The resident's son indicated that in the past 6 weeks she had been walking less, and he denied any prior dislocations. Her left lower extremity showed shortening, internal rotation and an X-ray confirmed a left hip dislocation. They were not sure when the dislocation happened. She had been falling more and had lost the ability to ambulate over the last 4 weeks. The orthopedics team recommended attempting a reduction (an urgent medical procedure to realign the femoral head and socket of the hip joint). ER staff attempted to reduce the dislocation, but it was unsuccessful. Resident 94's leg remained shortened and internally rotated. The orthopedics team recommended a Computed Tomography (CT) scan (an imaging test that uses X-rays and a computer to create detailed cross-sectional slices or 3D views of your bones.). The CT scan showed a superior dislocation of the left hip cranially by 6 centimeters (cm). The orthopedic team attempted a reduction in the Operating Room (OR) which was successful. Resident 94 was admitted to the hospital on [DATE] and was discharged and went to a rehabilitation facility on 12/10/25. A progress note, dated 12/5/25, indicated a bed hold policy was mailed to Resident 94's POA. Resident 94's hospice notes for the month of November were not available on the medical record until 12/16/25. On 12/12/25 at 10:22 a.m. the Executive Director (ED) and the DON provided a soft file containing the investigation into how Resident 94's leg became dislocated. In that soft file there was a timeline of events starting on 11/23/25 along with statements from staff. The timeline read as follows: Resident 94 had a fall on 11/23/26, the resident was assessed and had no change in condition noted. On 11/24/25, 11/25/25, and 11/26/25 no change of condition was noted. On 11/27/25 no change of condition was noted, but Resident 94's family member called hospice and told them she felt something was off. They indicated the resident's family member did not notify them of any concerns. On 11/28/25 the ED was present at the facility but was not notified of any concerns related to Resident 94. On 11/30/25 Resident 94 had a fall, no change in condition was noted. On 12/1/25 and 12/2/25 no change in condition was noted. On 12/3/25 no change in condition was noted, but the DON (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was notified of Resident 94's hip dislocation by the hospice nurse. They indicated the resident's family were aware of the x-ray results but wanted to take her to the ortho clinic the next day. On 12/4/25 Resident 94 was transferred to ortho clinic by the family member's personal vehicle. In a written statement, dated 12/11/25, the Facility ED indicated she spoke with the Hospice ED on 12/8/25 and questioned why the results of the x-ray were dated 11/29/25 but the facility was not notified until 12/3/25. The Hospice ED indicated to her that the results would not have been viewed by the hospice nurse until the next business day [12/1/25] because it was over a weekend. During an interview on 12/12/25 at 10:42 a.m. the Hospice ED indicated Hospice RN 11 visited Resident 94 on 11/28/25, and the family requested an x-ray of the Residents left hip. He indicated from what he could figure out after talking with the facility, Resident 94 received an x ray of her left hip on 11/29/25, the results were forwarded to Hospice RN 11 on 12/1/25, and she must not have seen the email until 12/3/25 when the facility was notified. The Hospice ED indicated it was the expectation of their nurses to notify facilities of test results immediately, and Hospice RN 11 was reeducated on that expectation. During an interview on 12/16/25 at 12:57 p.m. Hospice RN 11 indicated Resident 94 had had multiple falls and had become wheelchair bound over the last month or so. She indicated she had seen the resident on 11/28/25 and spoke with the Hospice MD to get an order to x-ray her left hip at the resident's family's request. On 11/29/25 the mobile x-ray company came in, and she saw the results on 12/2/25. Hospice RN 11 indicated she notified both the resident's family and the facility on 12/2/25; she was unable to recall who she spoke with at the facility. She spoke with the DON and the floor nurse for that shift on 12/3/25 to ensure they received the results of the x-ray, and they appeared shocked at that news. The DON and floor nurse indicated they were not aware the resident had an order for an x-ray. Hospice RN 11 indicated on 11/28/25 she gave report to QMA 12 and told her the x-ray had been ordered. On 12/16/25 at 2:10 p.m. a copy of a current facility policy titled, Hospice Policy dated 9/2024 was provided. That policy indicated, . It is the policy of this facility that when a resident elects the Hospice benefit, the contracted Hospice company and facility will coordinate to establish. a pattern of communication between the Hospice company, healthcare professionals, facility staff and resident/representative. Procedure:. 3. For residents who have elected the Hospice benefit, there will be. e. Hospice documentation available at the facility . 5. The social services director or designee will act as the Hospice coordinator which will be responsible for the following functions:. c. Ensuring that the facility communicates with the Hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the Hospice care with the medical care provided by other physicians. 3.1-37

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a newly admitted resident, received meals prepared and served in accordance with the physician-ordered diet requirements, resulting in a significant weight loss of 6.38 percent within approximately 30 days for 1 of 4 residents reviewed for nutrition (Resident 151). Findings include:On 12/9/25 from 11:25 a.m. until 12:05 p.m., the following was observed during dining in the memory care (MC) unit. On 12/9/25 at 11:25 a.m., Resident 151 was in a wheelchair at the table in the dining room attempting to roll herself back and occasionally groaning. At 11:33 a.m., Resident 151 did not have a drink or food in front of her and was observed grabbing at Resident 65 next to her who had a drink and hitting at her. Resident 65 yelled for help and staff moved her to another table. At 11:38 a.m. Resident 151 was given chocolate milk and was repositioned at the table. She drank all her drink quickly. Once her drink was empty, Resident 151 started reaching for her tablemate's food and crying. She attempted to take a drink but was unable to get anything out of straw since it was empty and started crying. Staff delivered her food, which was a fish sandwich and thick fries. The staff cut her sandwich in half. Resident 151 took a couple bites of fries and a small bite of the fish on the sandwich. At 11:50 a.m., the staff came with sides for Resident 151, looked at the meal ticket in front of her, and went and exchanged the sides for pureed oranges and pureed coleslaw. The staff did not replace the uneaten fish sandwich or fries that were not pureed. Resident 151's meal ticket was observed in front of her and indicated the resident was to have bite sized food. Resident 151's meal tray was observed to have a fish sandwich only cut in half, thick fries, pureed coleslaw, and pureed oranges. Resident 151 had only ate a couple tiny bites of fish and bread, and a couple tiny bites of fries. At 11:54 a.m., staff got more chocolate milk for the resident and she immediately drank it. At 11:55 a.m. staff asked if Resident 151 was done eating. The resident said, no it looks good. Staff did not cut the resident's food or assist the resident to eat. At 11:59 a.m. Resident 151 was out of chocolate milk again. She took the lid off and kept shaking the empty cup. She was not observed to attempt to eat any of her food. At 12:01 p.m., a staff member sat down with the resident and attempted to help her eat her pureed foods. No additional amount of sandwich or fries were eaten. Her chocolate milk was refilled and she drank it immediately. Resident 151's record was reviewed on 12/9/25 at 2:54 p.m. She was a newly admitted resident with diagnoses which included, but were not limited to, dysphagia, (difficulty swallowing food or liquids), metabolic encephalopathy, (a broad term for brain dysfunction), and Alzheimer's disease (degenerative brain disease that affects memory and cognition) with severe cognitive impairment. She resided on the secured memory care (MC) unit. A physician order, dated 11/11/25, directed the resident to receive a regular, soft bite-sized diet. A comprehensive care plan, initiated on 11/18/25, indicated Resident 151 was identified as at risk for malnutrition and included interventions to provide diet per physician order of regular, soft bite-sized; monitor weights; and offer substitutions if intake was less than 50 percent (%). The record demonstrated inconsistent and/or incomplete documentation of meal intakes including, but were not limited to, the following: No documentation of intake for 12/6/25 or 12/7/25. Intake documentation, dated 12/8/25, indicated Resident 151 ate 26 to 50 % of dinner. No intake was documented for breakfast or lunch. Intake documentation, dated 12/9/25 at 1:47 p.m., indicated lunch was not taken. Resident 151's weights were reviewed and revealed the following weight loss: She was admitted on [DATE] and weighed 143 pounds (lbs). On 11/21/25 and 11/25/25, she weighed 141 lbs. A December weight obtained on 12/16/25 revealed she was down to 132 lbs. Resident 151 experienced a 6.38% weight loss within approximately 30 days, which was considered clinically significant. During several interviews on 12/16/25 around 2:00 p.m., nursing staff demonstrated inconsistent understandings of what a soft-bite-size diet consisted of. Registered Nurse (RN) 5 indicated soft bite size was similar to mechanical soft (texture-modified eating plan for people who have trouble chewing or swallowing, featuring foods that are pureed, ground, finely chopped, or (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	naturally soft and moist, requiring minimal chewing to prevent choking and aspiration) and described it as kind of the new name of mechanical soft. Licensed Practical Nurse (LPN) 4 indicated for a soft-bite-size diet, the food should come from the kitchen in bite-size pieces. Certified Nursing Aide (CNA) 6 indicated when a resident's meal ticket indicated bite-sized, staff had to cut it up into bite-size pieces and that it did not come that way. During an interview on 12/16/25 at 2:20 p.m., Dietary Aide 7 indicated mechanical soft was no longer used and that soft bite-sized foods were the new term. She indicated it meant that food had to be small enough to go through the tines of a fork and that it was the kitchen's responsibility to send the meal that way. During an interview on 12/16/25 at 2:25 p.m., the Registered Dietician (RD) indicated soft and bite size replaced the national dysphagia (medical term for difficulty swallowing food and liquid) diet and was similar to mechanical soft or minced and moist. He indicated that if a resident's diet order specified soft bite size, the food should come from the kitchen already chopped or processed before being sent to the floor. He clarified that only when bite-sized instructions were listed under special instructions would floor staff be responsible for cutting food. On 12/6/25 at 3:07 p.m., the Administrator (ADM) provided a copy of the current facility policy titled Resident Weight Monitoring Policy, revised 9/2024. The policy indicated, .Upon admission, the resident's weight and height will be measured and recorded in the clinical record. The interdisciplinary team will place the following residents on weekly weights: New admission or readmission for a minimum of 4 weeks. Monthly weights will be obtained, verified for accuracy, and the weight variance report will be provided to the IDT by the 7th day of each month. Bi-Monthly Weights will be obtained at a minimum for the following residents: Residents who may be at risk for weight loss but have not experienced a significant weight loss, i.e., residents who have a pattern of decreased meal intake. Residents who have experienced a significant weight loss of 5% in 30 days. will have bi-monthly weights obtained at a minimum. The physician/health care practitioner and resident representative will be notified of unplanned significant weight loss. Any significant unexplained weight loss is considered a change in condition and must be addressed by the Interdisciplinary Team. 3.1-46

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	12/16/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure staff monitored a Gastrointestinal Tube (Gtube) (a feeding tube inserted through the belly directly into the stomach) feeding pump appropriately and ensured the resident received appropriate medications and positioning related to the Gtube for 1 of 1 residents reviewed for Gtube management (Resident 74). Findings include: On 12/10/25 at 9:37 a.m. Resident 74 was observed as he lay on his back in bed. He was unable to answer most questions, and he appeared to have limited mobility of his right side. As Resident 74 tried to speak, the inside of his mouth was observed. There appeared to be a thick yellow colored film over his teeth and tongue. Jevity (a brand of high-protein, fiber-fortified liquid nutrition) 1.5 kilocalories (k/cal) (the standard unit for measuring energy in food, often just called a calorie) was hanging and running at 50 milliliters per hour (ml/hr) along with a bag of free water for a flush. Upon observation of Resident 74's room, there was no Enhanced Barrier Precautions (EBP) sign outside of or on his side of the room, his call light was observed on the floor next to his bed and the head of his bed was raised to approximately 15 degrees. On 12/12/25 at 12:43 p.m. Resident 74 was observed as he lay in bed resting with his eyes closed. There was not an EBP sign outside of or on his side of the room. At this time the feeding pump was observed. Jevity 1.5 k/cal was hanging with a bag of free water, and the pump was beeping. There was an error message on the pump screen that indicated the pump had been idle for 10 minutes and to press continue. There was also a continue button in the bottom left side of the screen and an alarm bell symbol that had a line through it on the upper left side of the screen presumably to silence the alarm. The bottle of Jevity appeared to be nearly full and the tubing appeared to be empty or have only water in it. The tubing was connected to the resident's Gtube. Resident 74 woke when he was spoken to. When he yawned, he opened his mouth wide revealing a tick yellow substance caked on his gums and teeth, thick stringy mucus, and a yellow film on his tongue. On 12/12/225 at 12:50 p.m. Certified Nurse's Aide (CNA) 10 came in to check on Resident 74 and his roommate. CNA 10 indicated Resident 74 had an order of nothing by mouth (NPO). She indicated they did oral care with mouth swabs and water when he needed it done. CNA 10 indicated she would get some supplies to do oral care now. CNA 10 then adjusted Residen74's blankets and then went to the pump and appeared to touch something on the screen of the pump. At this time the pump stopped beeping. Before exiting the room, the pump began to beep again. CNA 10 walked out of the room and shut the door behind her, with the door shut you could not hear the beeping unless you stood right next to the door. CNA10 did not notify Resident 74's nurse that his pump was beeping. On 12/12/25 at 1:08 p.m. CNA10 was observed going back into Resident 74's room with oral care supplies. She closed the door behind her. On 12/12/25 at 1:11 p.m. CNA10 was observed as she came out of Resident 74's room with a bag of trash. She closed the door behind her and was observed walking out of view. She did not speak to any nurse. On 12/12/25 1:12 p.m. a staff member was observed pushing a food tray cart down the hall stopping at Resident 74's room. The staff member entered the room briefly and came out with Resident 74's roommates' lunch tray. She closed the door behind her. She did not notify anyone the pump was beeping. This staff member was not seen on the hallway again during this observation. This staff member was not in the room for a reasonable amount of time for her to have restarted the pump. On 12/12/25 at 1:14 p.m. CNA10 was observed speaking with the Assistant Director of Nursing (ADON) and two nurses. She did not notify them of any feeding pump issues. On 12/12/25 at 1:15 p.m. a continuous observation of Resident 74's room was initiated. During this observation no staff members went in or came out of Resident 74's room. On 12/12/25 at 2:14 PM Resident 74's feeding pump was observed, and it appeared to have been restarted and was running. The Jevity bottle appeared to have a noticeable decrease in amount. During an interview on 12/12/25 at 2:45 p.m. the Executive Director (ED) and the Director of Nursing (DON) indicated CNAs were not allowed to touch feeding pumps and should notify a nurse immediately (continued on next page)

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	155792	A. Building B. Wing	12/16/2025

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Countryside Meadows	762 N Dan Jones Rd Avon, IN 46123

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if there were pump issues. They indicated they would investigate the issue and see if they could figure out who turned the pump back on and who the staff member with the food cart was. On 12/12/25 at 3:05 p.m. the ED indicated the staff member with the food cart was a Qualified Medication Aide (QMA). She indicated both CNA 10 and the QMA said they did not touch the pump. The ED indicated she was looking for their policy to see if the facility allowed QMAs to adjust feeding pumps. On 12/15/25 at 9:41 a.m. Resident 74's medical record was reviewed. He was a long-term care resident whose diagnoses included, but were not limited to, cerebral palsy (a permanent group of neurological conditions caused by non-progressive damage to a developing brain, affecting movement, posture, balance, and muscle coordination) and dysphagia (difficulty swallowing food or liquids). Resident 74 had an active order to be NPO, dated 9/30/25, with no stop date. Resident 74 had an active order for oral care every shift, dated 9/30/25, with no stop date. Resident 74 had an active order for the head of his bed to be at 30 degrees at all times, dated 9/30/25, with no stop date. Resident 74 had active orders for polyethylene glycol (MiraLAX) (a powder laxative), oxybutin chloride (a prescription medication used to treat symptoms of an overactive bladder), cholecalciferol (vitamin D) and aspirin that indicated to administer them orally all dated 9/30/25 with no stop dates. The medication orders lacked documentation indicating they could be placed in the Gtube. On 12/15/25 at 2:08 p.m. Resident 74 was observed as he lay in bed resting with his eyes closed. There was a cup of water on his bedside table on the right side of his bed, and there was an EBP sign taped to the wall above his bed. On 12/10/25 at 3:03 p.m. a copy of a current facility policy titled, Enhanced Barrier Precautions (EBP) dated 3/2025 was provided. This policy indicated, .Enhanced barrier precautions are used for: Resident(s) with. indwelling medical devices. Indwelling medical device examples include:.Feeding tube. On 12/15/25 at 9:29 a.m. a copy of a current facility procedure guide titled, Kangaroo ePump Enteral Feeding Pump Operations dated 3/2019 was provided. This procedure guide indicated, .Nursing Skills Competency. The policy lacked documentation that QMAs or CNAs could adjust feeding pumps. At the time of exit a policy pertaining to QMAs ability to adjust feeding pumps was not provided. 3.1-44(a)(1)3.1-44(a)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure all medications were stored and dated properly and all medication labels were fully intact displaying the entire prescription in medication carts for 2 of 4 medication carts reviewed for medication storage. Findings include:On 12/16/25 at 10:53 a.m. the front 500 hall medication cart was reviewed with the Clinical Educator. Findings were as follows:1. There was a vial of lidocaine (a common local anesthetic that numbs specific body areas to block pain signals) for Resident 113 that had been opened. Upon review there was no open date on the bottle.On 12/16/25 at 11:00 a.m. the Clinical Educator indicated the lidocaine bottle shouldn't have been in the bag in which it was found in and it should have had an open date. She indicated she would dispose of it properly.On 12/16/25 at 11:15 a.m. the 300-hall medication cart was reviewed with the Clinical Educator. Findings were as follows:1. There was a bottle of pirfenidone (an oral antifibrotic medication used primarily to treat adults with idiopathic pulmonary fibrosis) for Resident 48, with half of its prescription label torn off so that only part of the prescription was visible.On 12/16/25 at 11:25 a.m. the Clinical Educator indicated she would let the Director of Nursing (DON) know and contact the pharmacy for a new prescription label.On 12/16/25 at 2:10 p.m. a copy of a current facility policy titled, Medication Storage and Expiration Policy dated 11/2024 was provided. This policy indicated, .The facility should store medications.consistent with applicable state and federal laws and regulations. 9. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) .10. c. If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.The provided policy lacked guidance for torn or destroyed prescription labels.3.1-25(j)3.1-25(m)3.1-25(n)