

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Countryside Estates		STREET ADDRESS, CITY, STATE, ZIP CODE Highway 64 East Warner, OK 74469	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, the facility failed to ensure residents did not fall during transfers for 1 (#1) of 3 sampled residents reviewed for accident hazards. The director of nursing identified 82 residents resided in the facility. Findings: A policy titled Safe Resident Handling/Transfers, revised 12/29/25, read in part, It is the policy of this facility to ensure that residents are transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. A CNA [certified nursing assistant] Care Plan (OLD) for Resident #1, dated 10/02/25, showed the resident would wrap their arms around a staff member's neck and the staff member would wrap their arms around Resident #1's torso during transfers. The care plan showed a second staff member was to be present during transfers for safety. An annual assessment for Resident #1, dated 10/03/25, showed the resident was dependent on staff for transfer. The assessment showed the resident had diagnoses including osteogenesis imperfecta (brittle bone disease) and cerebral palsy. An incident report form for Resident #1, dated 12/05/25, showed the resident fell during a staff assisted transfer from the bed to a chair. The form showed the resident was assessed and no injuries were noted. On 07/15/26 at 10:10 a.m., the chief nursing officer stated only one staff member was in the room when Resident #1 was transferred on 12/05/26. They stated the facility policy was to always utilize two staff members for transfers. On 07/15/26 at 1:30 p.m., licensed practical nurse #2 stated two staff members should be used to transfer dependent residents. On 07/15/26 at 1:40 p.m., the director of nursing stated two staff members should be used to transfer dependent residents.		

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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