

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Four Seasons Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 Taylor Rd Columbus, IN 47203	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to notify the physician of residents' changes in condition related to blood glucose levels and weights for 4 of 10 residents reviewed for notification of change. (Residents 9, 2, 1, and 3) Findings include: 1. The clinical record for Resident 9 was reviewed on 07/07/2026 at 10:00 A.M. An admission Minimum Data Set (MDS) assessment, dated 06/10/2026, indicated the resident was moderately cognitively impaired. The resident's diagnosis included, but was not limited to, diabetes (high blood sugar). A physician's order, dated 06/05/2026 through 07/02/2026, indicated the staff were to check the resident's blood glucose level four times a day. The physician was to be notified if the resident's blood glucose was less than 70 or greater than 300. The clinical record lacked indication that the physician had been notified of the blood glucose level being greater than 300 on the following dates and times: - On 06/06/2026 at P.M., when the blood glucose was 443 and at bedtime, when the blood glucose was 341, - On 06/08/2026 at P.M., when the blood glucose was 328 and at bedtime, when the blood glucose was 312, - On 06/09/2026 at midday, when the blood glucose was 359 and at bedtime, when the blood glucose was 337, - On 06/10/2026 at midday, when the blood glucose was 430, - On 06/11/2026 at bedtime, when the blood glucose was 304, - On 06/12/2026 at bedtime, when the blood glucose was 309, - On 06/13/2026 at bedtime, when the blood glucose was 311, - On 06/14/2026 at midday, when the blood glucose was 357, at P.M., when the blood glucose was 316, and at bedtime, when the blood glucose was 329, - On 06/15/2026 at midday, when the blood glucose was 353, - On 06/17/2026 at P.M., when the blood glucose was 353, - On 06/20/2026 at A.M., when the blood glucose was 322, - On 06/21/2026 at A.M., when the blood glucose was 339, at P.M., when the blood glucose was 313, and at bedtime, when the blood glucose was 311, - On 06/22/2026 at P.M., when the blood glucose was 321, - On 06/23/2026 at midday, when the blood glucose was 360, - On 06/27/2026 at P.M., when the blood glucose was 404, and at bedtime, when the blood glucose was 389, and - On 06/28/2026 at P.M., when the blood glucose was 369, and at bedtime, when the blood glucose was 387. 2. The clinical record for Resident 2 was reviewed on 07/07/2026 at 1:46 P.M. An admission MDS assessment, dated 04/11/2026, indicated the resident was cognitively intact. The resident's diagnoses included but were not limited to, hypertension (high blood pressure) and a hip fracture. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current physician's order, with a start date of 06/04/2026, indicated the staff were to weigh the resident daily on day shift. The resident was to be weighed at the same time and on the same scale with the same personal equipment. The physician was to be notified if the resident had a weight gain of greater than 3 pounds overnight. The resident had the following gains in weight without indication the physician had been notified on the following dates: - On 06/23/2026, the resident weighed 179.4 pounds and on 06/24/2026 the resident weighed 184.2 pounds, a 4.8 pound weight gain overnight and - On 06/29/2026, the resident weighed 180 pounds and on 06/30/2026 the resident weighed 186.4 pounds, a 6.4 pound weight gain overnight. During an interview, on 07/08/2026 at 1:07 P.M., the Director of Nursing (DON) indicated the staff should have documented that the physician was notified of the resident's weight gain. 3. The clinical record for Resident 1 was reviewed on 07/07/2026 at 1:39 P.M. An admission MDS assessment, dated 06/13/2026, indicated the resident had a diagnosis of hypertension. A current, open-ended physician's order, with a start date of 06/09/2026, indicated the staff were to weigh the resident daily on day shift. The resident was to be weighed at the same time and on the same scale with the same personal equipment. The physician was to be notified if the resident had a weight gain of greater than three pounds overnight, a weight gain of greater than five pounds in one week, or a weight gain of greater than five pounds since admission to the facility. The resident had the following gains in weight without indication the physician had been notified on the following dates: - On 06/10/2026, the resident weighed 285.8 pounds and on 06/11/2026 the resident weighed 291.4 pounds, a 5.6 pound weight gain overnight, - On 06/23/2026, the resident weighed 292.6 pounds and on 06/24/2026 the resident weighed 298 pounds, a 5.4 pound weight gain overnight, - On 06/26/2026, the resident weighed 287.8 pounds and on 06/27/2026 the resident weighed 293.4 pounds, a 5.6 pound weight gain overnight, - On 06/29/2026, the resident weighed 286 pounds and on 06/30/2026 the resident weighed 297.4 pounds, an 11.4 pound weight gain overnight, and - On 07/01/2026, the resident weighed 292.5 pounds and on 07/02/2026 the resident weighed 296.2 pounds, a 3.8 pound weight gain overnight. 4. The clinical Record for Resident 3 was reviewed on 07/07/2026 at 10:15 A.M. An admission MDS assessment, dated 06/15/2026, indicated the resident's diagnoses included, but were not limited to, (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heart failure and diabetes. A current, open-ended physician's order, with a start date of 06/10/2026, indicated nursing staff were to check the resident's blood glucose level before meals and at bedtime. The physician was to be notified if the resident's blood glucose was less than 70 or greater than 400. The clinical record lacked indication that the physician had been notified of the resident's blood glucose level being greater than 400 on the following dates and times: - On 06/15/2026 in the P.M., when the blood glucose was 427, - On 06/22/2026 in the A.M., when the blood glucose was 509, - On 06/23/2026 in the P.M., when the blood glucose was 439, - On 06/29/2026 at midday, when the blood glucose was 404, and - On 06/30/2026 in the P.M., when the blood glucose was 455. A current, open-ended physician's order, with a start date of 06/16/2026, indicated the resident was to receive short acting insulin three times a day based on their blood glucose level. The physician was to be notified if the resident's blood glucose level was less than 70 or greater than 350. The clinical record lacked indication that the physician had been notified of the blood glucose level being greater than 350 on the following dates and times: - On 06/17/2026 in the P.M., when the blood glucose was 375 and at bedtime, when the blood glucose level was 366, - On 06/18/2026 in the A.M., when the blood glucose was 360, - On 06/27/2026 in the A.M., when the blood glucose was 356 and, in the P.M., when the blood glucose level was 392, - On 07/05/2026 at bedtime, when the blood glucose was 366, and - On 07/07/2026 at midday, when the blood glucose was 354 and, in the P.M., when the blood glucose level was 385. During an interview, on 07/08/2026 at 10:43 A.M., Licensed Practical Nurse 20 indicated she would follow the resident's order and notify the physician if a blood glucose level was below or above the ordered parameters. Nursing could notify the MD or Nurse Practitioner (NP) via online communication. If it was on a weekend or after hours, she would call the on-call provider directly. She would also make a health status note in the resident's Electronic Health Record (EHR) that she notified the provider and if there were any new physician's orders, like to administer additional insulin, recheck (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the blood glucose level, etc. She would do the same thing if a resident's weight was outside of the ordered parameters. She would notify the provider of the weight gain and document it in the EHR, along with any new orders. During an interview, on 07/08/2026 at 11:32 A.M., the DON indicated there was an area in the residents' EHR where nursing staff could notify providers of changes in blood glucose levels, weights, etc. During an interview, on 07/08/2026 at 11:33 A.M., The Medical Records Nurse indicated she reviewed Resident 1's record and there were no electronic notifications related to weight gain. There were notifications related to Resident 3's high blood glucose levels, but just a few. If a nurse sent a notification via fax machine, those documents would be uploaded into the residents' records. There were no uploaded documents related to weight gain or blood glucose levels in the residents' EHRs. The current facility policy, titled Notification of Changes, implemented on 06/23/2025, was provided by the DON on 07/09/2026 at 11:21 A.M. The policy indicated, .The purpose of this policy is to ensure the facility.consults the resident's physician.when there is a change requiring notification. 410 IAC (Indiana Administrative Code) 3.1-5(a)(2)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to implement a resident's care planned intervention following a fall for 1 of 10 residents' care plans reviewed. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 07/07/2026 at 1:46 P.M. An admission Minimum Data Set (MDS) assessment, dated 04/11/2026, indicated the resident was cognitively intact. The resident's diagnosis included but was not limited to, a hip fracture. A Progress Note, dated 05/01/2026 at 7:45 A.M., indicated the resident had an unwitnessed fall in her room. The resident was trying to reposition herself for breakfast using her walker. The walker slid to the side and she lost her balance, falling to the left. She put her left hand out to catch herself. The resident was found on the floor on her left side with the left arm to the left side of her body. The resident had visible injuries and complaints of left wrist pain and left hip pain. The resident was sent to the local emergency room. A Progress Note, dated 05/08/2026 at 2:41 P.M., indicated the resident had returned to the facility. A Care Plan, with start date of 04/27/2026 and a revision date of 05/12/2026, indicated the resident was at risk for falls related to gait/balance problems secondary to a recent hospitalization for a fracture. The resident had an intervention, with a start date of 05/12/2026, to put a sign in the resident's room to remind them that they needed assistance with transfers. During an observation and interview, on 07/06/2026 at 1:12 P.M., the resident indicated she had fallen in the facility and had broken her wrist. There were no signs observed hanging in the resident's room to remind the resident to call for assistance. During an observation, on 07/09/2026 at 9:17 A.M., the resident was sitting in her recliner in her room, she was getting ready for the day. There were no visible signs hanging in the resident's room. During an interview, on 07/09/2026 at 9:31 A.M., Licensed Practical Nurse (LPN) 12 indicated when a resident had a fall, she would complete the appropriate paperwork, phone calls, and have an immediate intervention put into place for the resident. The management team would review the fall and determine if the intervention was appropriate or if they needed to change it. If the intervention was to be changed, then they would let the nurse know and they would pass it along to other nurses and aides. During an interview, on 07/09/2026 at 10:42 A.M., Medical Records indicated when a resident had a fall a new intervention would be added to the resident's care plan. After Resident 2 fell in May, the new intervention was to put a sign in the resident's room. The management staff would be responsible for putting the interventions in place in the resident's room. During an observation and interview, on 07/09/2026 at 10:51 A.M., there was no visible signs hanging in Resident 2's room. Medical Records indicated the sign would usually be hung by the T.V. but there were no signs anywhere in the resident's room or the bathroom. There should have been a sign in the resident's room. The current facility policy titled, Falls with a revision date of February 2023, was provided by the Director of Nursing on 07/09/2026 at 12:48 P.M. The policy indicated, Charge Nurses are responsible to ensure that interventions are implemented as discussed. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(a)		

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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. Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for a cardiac medication for 1 of 10 residents reviewed for quality of care. (Resident 14) Findings include: Resident 14's clinical record was reviewed on 07/06/2026 at 2:24 P.M. A 5-day Minimum Data Set (MDS) assessment, dated 06/25/2026, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, high blood pressure. A current, open-ended physician's order, with a start date of 06/24/2026, indicated the resident was to receive atenolol 25 mg (milligrams), one time a day for high blood pressure. Nursing staff were to hold (not administer) the medication when the resident's systolic blood pressure (SBP, the top number) was less than 100. The Electronic Health Record indicated the medication was given on the following dates when the resident's vital signs were outside of the prescribed parameters: - On 06/26/2026, the resident's SBP was 97, - On 06/28/2026, the resident's SBP was 97, - On 07/02/2026, the resident's SBP was 88, - On 07/05/2026, the resident's SBP was 99, and - On 07/06/2026, the resident's SBP was 96. During an interview, on 07/07/2026 at 11:25 A.M., RN 11 indicated either she or the Certified Nurse Aide (CNA) would obtain the resident's vital signs each morning. She would usually make sure the vital signs were obtained 30 minutes prior to the medications being administered. The CNAs would document the vital signs on a paper form then transfer the information into the computer. If anything was out of range, she would not administer the medication. There was a place in the Electronic Medication Administration Record (EMAR) to indicate the medication was not administered and the reason it was held. The current facility policy titled Medication Administration, with a revision date of 02/12/2023, was provided by the Director of Nursing on 07/08/2026 at 1:30 P.M. The policy indicated, .Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)		

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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. Based on record review and interview, the facility failed to follow physician's orders related to obtaining residents' weights for 2 of 3 residents reviewed for nutrition. (Residents 2 and 3) Findings include: 1. The clinical record for Resident 2 was reviewed on 07/07/2026 at 1:46 P.M. An admission Minimum Data Set (MDS) assessment, dated 04/11/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension (high blood pressure) and a hip fracture. A current physician's order, with a start date of 06/04/2026, indicated the staff were to weigh the resident daily on day shift. The resident was to be weighed at the same time and on the same scale with the same personal equipment. The clinical record lacked documented weights for the resident on 06/21/2026 and 07/04/2026. During an interview, on 07/08/2028 at 1:07 P.M., the Director of Nursing (DON) indicated the resident's weights should have been documented. 2. The clinical Record for Resident 3 was reviewed on 07/07/2026 at 10:15 A.M. An admission MDS assessment, dated 06/15/2026, indicated the resident's diagnoses included, but were not limited to, heart failure and diabetes. A current, open-ended physician's order, with a start date of 06/10/2026, indicated the staff were to weigh the resident daily on day shift. The resident was to be weighed at the same time and on the same scale with the same personal equipment. The clinical record lacked documented weights for the resident on the following dates: 06/10/2026, 06/11/2026, 06/12/2026, 06/21/2026, 07/01/2026, 07/02/2026, and 07/04/2026. During an interview, on 07/09/2026 at 11:30 A.M., the DON indicated the facility did not have a policy related to obtaining residents' weights or following physician's orders. 410 IAC (Indiana Administrative Code) 3.1-37(a)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on interview, observation, and record review, the facility failed to appropriately manage a resident's respiratory needs for 1 of 1 resident reviewed for respiratory care. (Resident 10) Findings include: During an interview and observation, on 07/06/2026 at 11:10 A.M., Resident 10 indicated she required supplemental oxygen. She used it at home before she came to the facility and wore it all the time in the facility. The resident was sitting in a chair in her room. Oxygen tubing was in place under the resident's nose and connected to an oxygen concentrator set to administer three liters of oxygen per minute. An undated humidifier bottle was attached to the concentrator. The resident was not sure how often staff changed her oxygen tubing or the humidifier bottle. The resident was observed seated in the main dining room on 07/07/2026 at 11:39 A.M. The resident's oxygen tubing was in place and connected to a portable oxygen concentrator hanging from the back of the resident's chair. The resident was observed sitting in her chair in her room on 07/08/2026 at 10:40 A.M. The resident's oxygen tubing was in place and attached to the oxygen concentrator in her room. The concentrator was set to administer three liters. The resident's record was reviewed on 07/06/2026 at 2:32 P.M. An admission (Minimum Data Set) MDS assessment, dated 06/25/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, pneumonitis (inflammation of the walls of the tiny air sacs in the lungs) due to inhalation of food and vomit, pneumonia, and respiratory failure. The resident's current physician's orders were reviewed and lacked an order for supplemental oxygen. During an interview, on 07/08/2026 at 10:48 A.M., Licensed Practical Nurse (LPN) 20 indicated if a resident used supplemental oxygen, there would be a physician's order for it. There would be an order for the oxygen that would include the appropriate flow rate and parameters to keep the resident's oxygen levels within a certain range. There would be orders for oxygen tubing care and humidifier care. The LPN didn't usually work on the resident's hall, and she was not very familiar with her. Nurses had a 24-hour report document that included important information about the residents, like if they wore oxygen or etc. There was no indication on the 24-hour report document that the resident required supplemental oxygen. There were no physician's orders in the resident's clinical record that indicated she used supplemental oxygen. The current facility policy, titled Oxygen Administration, dated 10/2022, was provided by the Director of Nursing on 07/09/2026 at 10:31 A.M. The policy indicated, .Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 410 IAC (Indiana Administrative Code) 3.1-47(a)(6)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review and interview, the facility failed to verify the accuracy of a resident's healthcare physician/Nurse Practitioner (NP) order/assessment related to the resident's medication regimen for 1 of 10 resident records reviewed. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 07/07/2026 at 1:46 P.M. An admission Minimum Data Set (MDS) assessment, dated 04/11/2026, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension (high blood pressure), anxiety, and depression. A Psychiatry Initial Consult Note, dated 04/15/2026, indicated the resident didn't feel like her current depression medication was working. It was discussed to start Lexapro (an antidepressant). The assessment and plan were to start the resident on Lexapro 10 milligrams (mg) once daily. New orders for the visit were Lexapro 10 mg daily. A physician's order, dated 04/16/2026 through 05/04/2026, indicated the resident was to receive Lexapro 20 mg daily. The order was entered into the Electronic Health Record by the Psychiatric Nurse Practitioner. The April 2026 Electronic Medication Administration Record (EMAR) indicated the resident had received Lexapro 20 mg daily from 04/16/2026 through 05/04/2026. During an interview, on 07/08/2026 at 1:15 P.M., Medical Records indicated when the Psychiatric NP came to the facility and assessed residents, she would usually transcribe new orders. The nurse would approve the order and send it to the pharmacy. The facility did not always review the NP's notes after they were transcribed into the system. If the resident's order in the EMAR was different than the order in the transcribed assessment note, the facility should have verified if the NP wanted the 10 mg or 20 mg of Lexapro to be given. During an interview, on 07/08/2026, the Director of Nursing indicated the facility did not have a policy related to reviewing physician notes. 410 IAC (Indiana Administrative Code) 16.2-3.1-22(C)(2)		