

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Seymour Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S Jackson Park Dr Seymour, IN 47274	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Seymour Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S Jackson Park Dr Seymour, IN 47274	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation and interview, the facility failed to maintain a safe and comfortable homelike environment for 5 of 7 residents reviewed. (Residents B, D, E, F, and G) Findings Include:1. During an interview, on 06/26/25 at 9:16 A.M., Resident B indicated that the air conditioning in the hallway and dining room was broken. Sometimes he had to go back to his room and stay out of the hallways, because it was so hot. He stopped going to activities in the dining room, and sometimes he didn't feel like eating in the dining room because the heat was excessive. The clinical record for Resident B was reviewed on 06/26/25 at 10:39 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 05/16/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, diabetes, and asthma. During an interview, on 06/26/25 at 11:58 A.M., the Maintenance Director indicated about two months ago the air conditioning unit that cooled the B hallway, kitchen, and Dining room would not start up. A company came and looked at it, and determined it needed replaced. The project was handed over to a project manager within the company. He had not documented the temperatures he was monitoring in the building. They did not have a thermometer to monitor the air temperature he had been relying on the thermostats to tell him the temperatures in the common area rooms. 2. During an observation, on 06/26/25 at 12:02 P.M., with the Maintenance Director the thermostat in front of the nurse's station on C Hallway was observed and read 81 degrees Fahrenheit. The thermostat by the front desk in the hallway that was connected to the main dining room, (approximant 15 to 20 feet from the Main Dining Room) was observed and read 82 degrees Fahrenheit. During an observation, on 06/26/25 at 12:20 P.M., the Main Dining Room had 14 residents eating, along with five residents eating in the restorative dining room that was within the main dining room. The door to the kitchen was propped open blowing heat towards the dining room. Resident D, Resident E, Resident F, and Resident G were all sitting in the restorative dining area having staff assist them to eat their meal. During an interview, on 06/26/25 at 12:33 P.M., the Maintenance Director indicated they did not have a way to check the temperature in the main dining room at that time. He needed to go to the store and get one. The clinical record for Resident D was reviewed on 06/26/25 at 1:45 P.M. An Annual MDS assessment, dated 04/21/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, and non-Alzheimer's dementia. They required extensive staff assistance for transferring and was totally dependent on staff for all mobility. The clinical record for Resident E was reviewed on 06/26/25 at 1:50 P.M. An admission MDS assessment, dated 06/17/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, cerebral palsy, unspecified intellectual disabilities, and unspecified encephalopathy. They were in a wheelchair, and required extensive staff assistance for transferring, and were totally dependent on staff for all mobility. The clinical record for Resident F was reviewed on 06/26/25 at 1:56 P.M. An admission MDS assessment, dated 04/25/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, and dementia. They required extensive staff assistance for transferring and were in a wheelchair. The clinical record for Resident G was reviewed on 06/26/25 at 2:02 P.M. A Quarterly MDS assessment, dated 05/29/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, and non-Alzheimer's dementia. They required extensive staff assistance for transferring and were in a wheelchair. During an observation, on 06/26/25 at 1:40 P.M., the thermostat by the front desk closest to the main dining room read 83 degrees Fahrenheit. The current undated facility policy, titled Emergency Operations Plan was provided by the Director of Nursing (DON) on 06/26/25 at 1:58 P.M. The policy indicated, .2. Ambient air temperatures will be monitored and documented for various locations throughout the building such as dining areas, lounges, and sampling of resident rooms. 3. If temperatures are not maintained between 71-81 degrees Fahrenheit, Maintenance Director will obtain alternative source of heating or cooling until repairs are completed. 4. If temperature reaches 82 degrees Fahrenheit or higher, the following precautions will be put into place: Draw all shades, blinds, and curtains in the rooms exposed to direct sunlight. Remove residents from areas exposed to direct sunlight .This citation relates to Complaint IN00462258.3.1-19(f)5. 1-19(j)</p>		