STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seymour Crossing	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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. The facility failed to prevent misappropriation of a resident's money (Resident B) and the misappropriation of residents' pain medications (Residents C, D, F, and G) for 5 of 5 residents reviewed for misappropriation.Findings include:1.During an interview on 01/12/26 at 9:03 A.M. Resident B indicated she had over 4 hundred dollars stolen out of the top drawer of her dresser in the far-right corner of her room. She noticed it was missing last week and reported it to the staff working demanding to speak to the police. The police were called, and management said they would review the cameras to see who had entered her room. Resident B indicated she never left her room unless she was getting a shower or using the restroom. She had no roommate, and no family visits, so she had no idea who could have taken the money. She had a close friend who worked at the facility who counted the money with her the day after Christmas and there was 5 hundred and 10 dollars in the envelop. Then when her and the friend recounted the money at the end of last week there was only a little over 70 dollars left in the envelope.The clinical record for Resident B was reviewed on 01/12/26 at 11:45 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/12/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, hypertension, and anemia. During an interview, on 01/12/26 at 9:44 A.M., Licensed Practical Nurse (LPN) 6 indicated she was close friends with Resident B and had counted the money with her on 12/26/25. There was 5 hundred and 10 dollars in the envelope. They both counted it and she wrote the amount on the outside of the envelope. On Friday 01/09/26 the resident asked LPN 6 to get her money out for her, and when they counted it together there was only 77 dollars left in the envelope. They searched her entire room and could not find it. They then alerted other staff members working in the building that Resident B had money missing, and no one was able to find it. This happened around 2:00 P.M. on Friday. The police were called and all the appropriate people in management were notified that the money was missing. Resident B had no family that visited her, and the only time she left her room was to get a shower. During an observation and interview, on 01/12/26 at 3:45 P.M., Resident B's money envelop was provided by the Administrator. The envelope had the date of 12/16/25 with $557 written and then marked out followed by 12/26/25 $510 written on it. The Administrator explained 77 dollars was still in the envelope meaning 433 dollars was still unaccounted/missing. During an interview, on 01/12/26 at 10:01 A.M., the administrator indicated he did not know Resident B had that much money in her personal procession, and he would have offered a lock box if he had known. The resident did not have family involved but had been close friends with LPN 6 for years.During an interview, on 01/12/26 at 2:35 P.M., the Business Office Manager indicated Resident B had a check written out of her account at the facility for 767 dollars to LPN 6 on 12/16/25. She indicated that LPN 6 went and cashed checks for Resident B and then would bring the resident back the cash. The facility only allowed residents to get up to 50 dollars in cash per day anything over 50 dollars the facility would write the resident a check and then the resident's family could cash it for them. During an observation and record review, on 01/12/26 (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 01/12/2026
NAME OF PROVIDER OR SUPPLIER Seymour Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S Jackson Park Dr Seymour, IN 47274	

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 2:37 P.M., a copy of the original check written from the business office related to the withdrawn from Resident B's account was observed. The check was from the petty cash account, dated 12/16/25, with the pay to order of listed as (LPN 6's name), and in the memo comment was Resident B's name. The check was written for seven hundred sixty-seven dollars and no cents.The resident statement account record, dated 12/16/25, indicated Resident B was advanced 767 dollars and the balance left was .81 (81 cents) in the account.During an interview, on 01/12/26 at 2:31 P.M., LPN 6 indicated Resident B made a large withdraw in December for over 7 hundred dollars and had the check written to her. The resident wanted the money to purchase some Christmas gifts for a friend and had a gift mailed to a loved one who lived out of State. After these purchases were made there was still 5 hundred and 10 dollars left in the envelope. During an interview, on 01/12/26 at 2:54 P.M., the Director of Nursing and the Administrator indicated the facility would provide transportation with the facility bus when a resident needed transportation for banking. They both were unaware the check was written for Resident B in LPN 6's name.2.a.The clinical record for Resident D was reviewed on 01/12/26 at 2:15 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 08/05/2025, indicated the resident was cognitively intact. The resident's diagnosis included, but was not limited to, Cerebral palsy an COPD.During an interview on 01/12/26 at 1:50 P.M. , Resident D indicated they did receive pain medications from the staff regularly, and it is always on time. She had never received any additional pills outside of her normal schedule. An open-ended physician's order, with a start date of 08/23/2024, indicated the resident received hydrocodone-acetaminophen, 5-325 mg, give one tablet every eight hours as needed for pain.The September 2025 Medication Administration Record for Resident D indicated LPN 6 administered one dose of narcotic pain medication on 09/27/25 at 9:30 A.M. Review of the September 2025 controlled substance record indicated LPN 2 signed out to administered Resident D's narcotic pain medication on 09/27/25 at 0800 (scribbled), 09/27/25 at 0850, and 09/27/25 at 1350. b.The clinical record for Resident C was reviewed on 01/12/26 at 3:00 P.M. An (MDS) assessment, dated 07/01/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, heart failure, hypertension, diabetes, depression, and Chronic Obstructive Pulmonary Disease (COPD). An open-ended physician's order, with a start date of 07/10/2025, indicated the resident was to receive hydrocodone-acetaminophen (narcotic pain medication), 5-325 milligrams (mg), one tablet every 12 hours (hrs) for left shoulder pain.The August 2025 controlled substance record indicated Resident C was administered a dose of the narcotic pain medication from LPN 2 on 08/25/25 at 8:00 A.M. and 1:20 P.M. The August 2025 medication administration record, indicated the resident's medication administration record lacked any documentation related to LPN 2 administration of the resident's narcotic pain medication on 08/25/25 at 8:00 A.M. and 1:20 P.M. The September 2025 medication administration record, indicated Resident C received hydrocodone-acetaminophen by LPN 2 between September 11 through September 16, 2025, on the following dates and times: 09/11/25 at 9:09 A.M. , 09/13/25 at 9:32 A.M., 09/14/25 at 9:07 A.M., 09/15/25 at 8:00 A.M., and 09/16/25 at 8:00 A.M. Review of the September 2025 controlled substance record indicated, from September 11 through September 16, 2025, Resident C was administered a dose of the narcotic pain medication by LPN 2 on the following dates and times: 09/11/25 at 8:10 A.M., 09/11/25 at 12:15 P.M., 09/12/25 at 8:10, 09/12/25 at 8:00, 09/13/25 at 8:00, 09/13/25 at 12:50 P.M, 09/13/25 at 1:30 P.M., 09/14/25 at 8:09 A.M., 09/15/25 at 7:43, 09/15/25 at 9:10, 09/15/25 at 12:50, 09/16/25 at 8:09 A.M., 09/16/25 at 10:10 A.M., and 09/16/25 at 1:30 P.M.c.The clinical record for Resident F was reviewed on 01/12/26 at 1:40 P.M. An (MDS) assessment, dated 08/06/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), depression, anxiety, and heart (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Seymour Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 707 S Jackson Park Dr Seymour, IN 47274	

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failure. A current physician's order, with a start date of 01/15/2025, indicated the resident was to receive oxycodone-acetaminophen (narcotic pain medication), 7.5-325 milligrams (mg), one tablet every 6 hours as needed for moderate to sever pain.The September 2025 medication administration record, indicated Resident F received oxycodone-acetaminophen by LPN 2 between on the following dates and times: 09/17/25 at 10:05 A.M.; and 09/25/25 at 10:22 A.M.Review of the September 2025 controlled substance record indicated, Resident F was administered a dose of the narcotic pain medication by LPN 2 on the following dates and times: 09/17/25 at 6:30, at 1:10 P.M.; and 09/25/25 at 6:50, 10:10, 1:41 P.M.d.The clinical record for Resident G was reviewed on 01/12/26 at 1:50 P.M. An (MDS) assessment, dated 09/02/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, COPD, stroke, depression, diabetes, and hypertension. A current physician's order, with a start date of 06/02/25, indicated the resident was to receive oxycodone-acetaminophen (narcotic pain medication), 10-325 milligrams (mg), one tablet every 6 hours as needed for moderate to sever pain.The September 2025 medication administration record, indicated Resident G received oxycodone-acetaminophen by LPN 2 on the following dates and times: 09/20/25 at 1:03 P.M. and 6:40 A.M.; and 09/24/25 at 8:41 A.M. (noted as effective). Review of the September 2025 controlled substance record indicated for Resident G indicated LPN 2 administered the resident's oxycodone on the following dates and times: 09/20/25 at 8:40, 10:10; 09/21/25 at 6:40, 11:00, at 1:30 P.M.; and 09/24/25 at 6:04, 10:18, and 1:44 P.M.During an interview, on 01/12/26 at 10:10 A.M., the Administrator and Director of Nursing (DON) indicated that LPN 2 began working at the facility the beginning of August 2025. Nothing flagged on her license upon hire, and she was with a nurse on orientation the first few weeks and did great. It was reported to the DON that it appeared LPN 2 signed out too many pills one weekend in September. Upon investigation the DON determined there were multiple instances where LPN 2 had signed out multiple pills in between scheduled doses of narcotics to residents. Interviews with residents involved determined they had all received their scheduled medications, but they did not receive any additional doses in between. The DON and Administrator confronted LPN2 with documentation showing medications being signed outside of the scheduled doses. LPN 2 admitted that she had been taking medications since about two weeks after she started at the facility. She admitted to taking them for herself, and that she knew she needed to get help. LPN 2 was terminated from the facility at that time. During an interview an observation, on 01/12/26 at 1:52 P.M., RN 7 indicated that narcotics were always kept in the medication carts on the units under a double lock and key. Medications were kept in numbered cards, and every time they were administered they were documented in the narcotic count book. A random count was observed of RN7's cart, and all narcotic counts were correct. A handwritten statement was provided by the DON on 01/12/26 at 2:10 P.M. The statement written by LPN 2 indicated the LPN began taking narcotic medications from the residents at the facility for self-use two weeks after being hired. The statement was signed by LPN 2 and dated 09/29/25 at 1:14 P.M. The current facility policy titled, Abuse Prohibition, Reporting, and Investigation, with a revision date of June 2023, was provided by the Administrator on 01/12/26 at 3:40 P.M. The policy indicated, .Misappropriation of Resident Funds or Property - Deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent.