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	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seymour Crossing	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 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. 38239 Based on record review, interview, and observation, the facility failed to follow the physician's medication hold parameters for residents' cardiac medication administration and failed to follow the treatment orders for a resident's nephrostomy tube for 3 of 20 residents reviewed for Quality of Care. (Residents 18, 70, and 38) Findings include: 1. The clinical record for Resident 18 was reviewed on 02/26/25 at 1:30 P.M. An Annual Minimum Data Set (MDS) assessment, dated 12/26/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, heart failure, and renal insufficiency. The resident received dialysis treatments. The resident's current physician's orders included an open-ended order, with a start date of 01/20/25, to administer midodrine (a medication for low blood pressure) 5 mg (milligrams) every 6 hours as needed for a systolic (the top number) blood pressure less than 110. The resident's vital signs record and Electronic Medication Administration Record (EMAR) for January and February 2025 indicated the resident did not receive the midodrine medication when their blood pressure was assessed and below 110 on the following dates and times: - On 01/24/25 at 1:00 P.M., the resident's blood pressure was 101/69, - On 01/27/25 at 12:07 P.M., the resident's blood pressure was 106/63, - On 01/29/25 at 12:08 P.M., the resident's blood pressure was 105/64, - On 02/01/25 at 5:41 A.M., the resident's blood pressure was 106/71, - On 02/09/25 at 7:22 A.M., the resident's blood pressure was 86/51, - On 02/12/25 at 11:42 A.M., the resident's blood pressure was 103/84, and - On 02/16/25 at 6:39 A.M., the resident's blood pressure was 92/51. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 02/26/25 at 1:37 P.M., the resident indicated nursing staff checked his blood pressure a lot. His blood pressure was sometimes low after dialysis. He had an order for midodrine that was fairly new. He had only received the medication a few times. During an interview, on 02/26/25 at 2:11 P.M., the Infection Preventionist (IP) RN indicated if the resident's blood pressure was assessed and it was below 110, the medication should have been administered according to the MD order. 38769 2. The clinical record for Resident 70 was reviewed on 02/24/25 at 2:27 P.M. A Significant Change MDS assessment, dated 01/16/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension and cerebral palsy. A physician's order, dated 12/26/24 through 02/25/25, indicated the staff were to administer Lisinopril-Hydrochlorothiazide 10-12.5 mg. The staff were to hold the medication if the resident's systolic blood pressure was less than 130. The December 2024 and January 2025 EMAR/ETAR indicated the resident received the medication when their systolic blood pressure was less than 130 for the following dates and times: - On 12/27/24, when the resident's blood pressure was 122/71, - On 12/28/24, when the resident's blood pressure was 118/65, - On 12/30/24, when the resident's blood pressure was 118/72, - On 01/02/25, when the resident's blood pressure was 96/67, - On 01/03/25, when the resident's blood pressure was 123/73, - On 01/09/25, when the resident's blood pressure was 122/69, and - On 01/12/25, when the resident's blood pressure was 126/63. During an interview, on 02/26/25 at 1:53 P.M., LPN 3 indicated if a resident had hold parameters on their medications, then she would obtain the vital signs prior to administering the medications and if it was outside the parameter she would not give the medication. She would document in the EMAR that the medication was held. The current facility policy titled, General Dose Preparation and Medication Administration, dated 11/15/24, was provided by the DON on 02/26/25 at 1:37 P.M. The policy indicated, .Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident .If necessary, obtain vital signs . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an observation on 02/26/25 at 9:24 A.M., the IP prepared a clean space for supplies in the resident's room to cleanse Resident 38's nephrostomy tubes (tubes placed in the back to drain urine from the kidneys). The IP cleansed around both nephrostomy tube insertion sites (left and right side) with normal saline soaked swabs and cleansed the skin surrounding the sites, where the old bandage was removed, with wound cleanser. An open-ended physician's order, with a start date of 02/13/25, indicated the staff were to cleanse around the nephrostomy tubes with warm soap and water, rinse, gently pat dry, and apply a split boarder gauze around the nephrostomy tubes. During an interview, on 02/26/25 at 10:00 A.M., the IP indicated the resident's order was to cleanse around the tubes with soap and water. She had used normal saline because that was what their policy said. She should have followed the orders of the physician and cleansed around the tubes with soap and water. The current facility policy titled, Nephrostomy Tube Care Dressing Change, Drainage Bag Change & Irrigation with a review date of 12/2012, was provided by the IP on 02/26/25 at 10:43 A.M. The policy indicated, .Verify resident and physician orders . During an interview, on 02/26/25 at 1:56 P.M., the Regional Support indicated they did not have a policy on following physician orders. It was just standard practice. 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. 38769 Based on record review and interview, the facility failed to document meal consumptions for 2 of 4 residents reviewed for nutrition. (Residents 16 and 36) Findings include: 1. The clinical record for Resident 16 was reviewed on 02/24/25 at 10:13 A.M. A Significant Change Minimum Data Set (MDS) assessment, dated 01/31/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, non-Alzheimer's dementia, anxiety, and depression. The resident's meal consumption records lacked documented values on the following dates and times: - 01/10/25 at dinner, - 01/11/25 at lunch, - 01/15/25 at dinner, - 01/17/25 at dinner, - 01/22/25 at lunch, - 01/24/25 at breakfast and dinner, - 02/07/25 at lunch, - 02/08/25 at lunch, - 02/14/25 at lunch, and - 02/21/25 at breakfast and lunch. 2. The clinical record for Resident 36 was reviewed on 02/24/25 at 12:53 P.M. A Significant Change MDS assessment, dated 12/24/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, Non-Alzheimer's dementia, and depression. The resident had weight loss and was not on a prescribed weight loss regimen. The resident's meal consumption records lacked documented values on the following dates and times: - 01/10/25 at dinner, - 01/11/25 at lunch, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 01/15/25 at dinner, - 01/17/25 at dinner, - 01/22/25 at lunch, - 01/24/25 at breakfast and dinner, - 02/07/25 at lunch, - 02/08/25 at lunch, - 02/14/25 at lunch, - 02/21/25 at breakfast and lunch, and - 02/23/25 at lunch. During an interview, on 02/26/25 at 10:32 A.M., Certified Nurse Aide (CNA) 4 indicated after each resident meal the staff were to document their meal consumption into the computer system. The current facility policy titled, Delivery and Documentation of Meal Service and Between Meal Nourishment, was provided by the Director of Nursing (DON) on 02/26/25 at 1:37 P.M. The policy indicated, . It is the policy of this facility that residents receive their meals and nourishments in a timely, courteous, and helpful manner as well as accurately document nutritional intake and food substitutes .Reviewing and documenting food and fluid intake following each meal . 3.1-46(a)(1)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 33613 Based on interview and record review, the facility failed to provide the required Registered Nurse (RN) on duty for eight consecutive hours a day for 2 of the 16 days reviewed. Findings include: The as worked nursing schedule from July to September 2024 indicated there had not been an RN on duty for eight consecutive hours on Saturday, 09/28/24, and Sunday, 09/29/24. During an interview on 02/26/25 at 3:25 P.M., the Director of Nursing (DON) indicated the schedule usually had an RN on duty for 8 hours each day. She was unsure why those two days did not have coverage. During an interview on 02/26/25 at 3:29 P.M., the Administrator indicated the facility did not have a policy for RN coverage, they followed State and Federal regulations. The facility did not currently have any nursing waivers. 3.1-17(b)(3)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 33613 Based on interview and record review, the facility failed to follow pharmacy recommendations for 1 of 6 residents reviewed for medication irregularities. (Resident 65) Findings include: The clinical record for Resident 65 was reviewed on 02/24/25 at 11:14 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/06/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, cirrhosis, malnutrition, and anemia. A Pharmacy Consultation Report, issued on 01/2/25, indicated the resident received iron replacement therapy with ferrous sulfate 325 milligrams (mg) given every other day. The recommendation was to optimize the iron therapy with Ferrex 150 mg to be given daily and discontinue the ferrous sulfate. The recommendation was signed by the pharmacist on 01/02/25. The physician responded on 02/07/25 and agreed with the recommendation. The February 2025, Electronic Medication Administration Record (EMAR) indicated the resident's ferrous sulfate had continued to be given every other day and the EMAR lacked the physician's new order for Ferrex 150 mg every day. During an interview on 02/26/25 at 2:00 P.M., The IP Nurse indicated the signed recommendations were given to the nurse working on the resident's hall to transcribe the physician order. She wasn't sure why the medication changes weren't made for this resident. The current facility policy, titled Medication Regimen Reviews and Pharmacy Recommendations, with a revised date of 10/2018, was provided by the Director of Nursing on 02/26/25 at 2:41 P.M. The policy indicated, .Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving .once reviewed by the physician the pharmacy recommendations will be filed in the resident's medical record . 3.1-25(i)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38769 Based on observation, interview, and record review, the facility failed to prevent medication errors for 1 of 4 residents reviewed for medication administration. (Resident 69) Findings include: During an observation of medication administration on 02/24/25 at 11:46 A.M., Licensed Practical Nurse (LPN) 2 indicated she needed to administer insulin to Resident 69. The LPN opened the top drawer of the medication cart, removed a vial of insulin, an alcohol swab, and a syringe. She wiped the top of the vial with the alcohol swab, inserted the needle and drew up 2 units into the syringe. The LPN placed the vial back into the drawer and locked it. She never turned on the computer to look at the resident's insulin order. At 11:48 A. M., the LPN went into the resident's room and was asked to not administer the medication and to verify the order. At 11:49 A.M., LPN 2 went back to the medication cart and turned on the computer to Resident 69's Electronic Medication Administration Record (EMAR). The LPN indicated the resident's blood sugar had been 207. She documented the blood sugar value into the insulin sliding scale order and determined the resident needed 6 units of insulin. The LPN indicated the resident's insulin sliding scale order must have changed recently and proceeded to get new supplies to administer 6 units instead of 2 units. The nurse then went to the resident's room and administered 6 units to the resident. During an interview, on 02/26/25 at 11:36 A.M., LPN 3 indicated, when administering medications to residents, the nurse should follow the five rights of medication administration. The five rights were the right resident, right medication, right dose, right route, and right time. The clinical record for Resident 69 included a current, open-ended, physician's order, with a start date of 02/19/24, for the resident to be administered Aspart insulin per sliding scale. The sliding scale indicated the resident was to receive the following insulin per their blood sugar test results: - For a blood sugar result of 0 to 150, the resident was to have 0 units. - For a blood sugar result of 151 to 200, the resident was to have 3 units. - For a blood sugar result of 201 to 250, the resident was to have 6 units. - For a blood sugar result of 251 to 300, the resident was to have 9 units. - For a blood sugar result of 301 to 350, the resident was to have 12 units. - For a blood sugar result of 351 to 400, the resident was to have 15 units. - If the resident's blood sugar was greater than 400, the resident was to have 18 units, and the provider was to be notified. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current facility policy titled, General Dose Preparation and Medication Administration, with a revision date of 11/15/24, was provided by the DON (Director of Nursing) on 02/26/25 at 1:37 P.M. The policy indicated, .Only prepare medications for one resident at a time, using a 3-way-check (i.e., comparing the medication to the MAR and to the prescription label) .Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident . The current facility policy titled, Medication Error, with a revision date of 11/2018, was provided by the DON on 02/26/25 at 1:37 P.M. The policy indicated, .It is the policy of this provider to ensure residents residing in the facility are free of medication errors . 3.1-48(c)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 38769 Based on interview and record review, the facility failed to prevent a significant medication error for 1 of 5 residents reviewed for unnecessary medications. (Resident 278) Findings include: During an interview on 02/25/25 at 10:34 A.M., Licensed Practical Nurse (LPN) 5 indicated residents' laboratory (labs) collections were sent out to a company in Indianapolis or Kentucky and not kept local. The company would come, obtain the labs, and take them with them. They came to the facility Monday through Friday. The nurse was able to look at the residents' clinical record for the lab results, fax the results to the Nurse Practitioner (NP), and put a copy in the NP's binder at the facility. For residents that needed a PT/INR (Prothrombin Time/International Normalized Ratio, a test to measure how quickly your blood clots), the NP would order the lab test. The results were called to the physician before the next dose of medication was administered because the facility needed to know if the medication dose needed to be changed. During an interview on 02/26/25 at 10:46 A.M., the NP indicated she required the facility to send the residents' PT/INR results to her office the same day the lab was obtained to be able to either keep the same dose or change the dose for that night. The clinical record for Resident 278 was reviewed on 02/25/25 at 9:23 A.M. An Admission MDS (Minimum Data Set) assessment, dated 02/13/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, diabetes, anxiety, depression, and cerebrovascular accident. A physician's order, dated 02/14/25, indicated the staff were to obtain a PT/INR and it was to be sent to the local hospital for Coumadin therapy. A physician's order, dated 02/10/25 through 02/18/25, indicated the resident was to be administer Coumadin (Warfarin), 7.5 mg (milligrams), daily at 5:00 P.M. The February 2025 Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) indicated the residents PT/INR was obtained on 02/14/25. A Lab Report for a PT/INR indicated the lab was drawn on 02/14/25 at 10:05 A.M., and received in the lab on 02/15/25 at 12:04 A.M. The results, dated 02/15/25 at 8:59 A.M., indicated the PT/INR was high. The clinical record lacked any indication the physician was notified of the PT/INR results until 02/17/25. The February 2025 EMAR/ETAR indicated the resident had received the Coumadin medication of 7.5 mg, from 02/14/25 through 02/16/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/25/25 at 2:54 P.M., the Director of Nursing (DON) indicated the resident's PT/INR lab was completed on Friday, 02/14/25. The facility didn't receive the results until the following Monday, on 02/17/25. The staff should have called the NP on Friday, 02/14/25, before administering the Coumadin medication due to not having the PT/INR results. All of the staff had been educated on obtaining PT/INR results before administering the medication to see what the physician would like to do and to started monitoring residents that took Coumadin. The current facility policy titled, Coumadin/Warfarin Monitoring Policy and Tracking Log, with a revised date of 11/2018, was provided by the DON on 02/25/25 at 3:36 P.M. The policy indicated, .Residents who require Coumadin Therapy are receiving adequate monitoring .Prior to administering the Coumadin/Warfarin dose the licensed nurse should verify the most current PT/INR . The deficient practice was corrected, on (02/17/25, prior to the start of the survey and was therefore Past Noncompliance. The facility reviewed all the residents' laboratory results for timeliness, educated staff, and implemented a process to monitor the residents' ordered laboratory test and laboratory results for physician notification. 3.1-48(c)(2)