

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Seymour Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  1110 Westview Dr Seymour, TX 76380	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944</b></p> <p>Based on interview, and record review, the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good personal hygiene for 1 of 6 residents (Resident #6), reviewed for activities of daily living.</p> <p>The facility failed to provide timely incontinence care for Resident #6.</p> <p>These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, skin breakdown, and a decreased quality of life.</p> <p>Findings included:</p> <p>Resident #6</p> <p>Review of Resident #6's Face Sheet, not dated, revealed a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included: Obesity, abdominal hernia (a condition where a portion of an organ or tissue protrudes through a weak spot in the abdominal wall, often appearing as a bulge or lump), attention to colostomy (describes care for a surgical incised stoma through the abdomen and into the bowel to allow stool to exit the body to a colostomy bag instead of the rectum).</p> <p>Review of the Quarterly Minimum Data Set (MDS) for Resident #6 dated 4/22/25 reflected a BIMS score of 15 which indicated the resident was cognitively intact. Resident #6 was assessed to be frequently incontinent of bladder and had a colostomy. She required extensive assist of 1 for personal hygiene.</p> <p>Record review of Resident #6's care plan revealed the following:</p> <p>Focus: Resident is incontinent of bladder at night only related to impaired mobility, and activity impairment</p> <p>Goal: Resident will be clean, dry and odor free.</p> <p>Interventions: briefs or incontinence products as needed for protection, Incontinent at night check frequently for wetness and soiling and change as needed.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Focus: Resident has ADL self-care deficit related to impaired mobility related to functional limitations due to impaired mobility.</p> <p>Interventions: toileting - extensive assistance of one. Dated Initiated 5/3/25 and revised 5/16/25</p> <p>In an interview on 5.15.25 at 1:30 PM, CNA B said she had concerns about the night shift aide that she relieved this morning. She stated Resident #6 was pulling her call light when she came on shift and that she was upset because she was soaked through to the mattress and was very wet. She stated she had told the nurse on duty about it, and she stated she said she would ask LVN A about it. She stated it has happened before and usually happens with this rotation of aides that she relieves (which was CNA D and CNA E). Stated she believes they neglect their duties because they are friends with the charge nurse, who was LVN A, and she would take up for them.</p> <p>In an interview on 5/15/25 at 1:45 PM CNA C stated she had concerns about the night shift aides that she relieved morning. She stated Resident #6 was pulling her call light when she came on shift on 5.15.25 and Resident #6 was upset because, she was soaked through to the mattress and was very wet when she went in to answer the light. She stated she believed this occurred because CNA E didn't like to do their job. She stated she had told the DON of her concerns.</p> <p>In an interview on 5/15/25 4:30 PM, the DON said it was her expectation for resident's to be changed when needed. She stated she was going to speak with the aides regarding the residents' concerns and. She stated she did not know why it happened. She stated she would look into it.</p> <p>In an interview with CNA D at 6:30 PM on 5.15.25 she said she did not check on Resident #6 that morning. She stated CNA E was supposed to check on her. She stated she and CNA E divided the incontinent residents up for last bed check on the morning of 5.15.25 that they make at about 5 am and CNA E did Resident #6. She stated she had never had concerns regarding her coworkers being neglectful. She stated not changing a resident could cause skin breakdown or infection.</p> <p>In an interview with CNA E at 6:45 PM on 5.15.25 she stated she did not check on Resident #6 that morning before she got off. She stated CNA D was supposed to check on her. She stated they divided the incontinent residents up and she checked on 11 residents but didn't check on Resident #6. She stated she had never had concerns regarding her coworkers being neglectful. She stated they usually didn't check on Resident #6 unless she called, because Resident #6 had asked them not to wake her at night.</p> <p>In an interview with Resident #6 on 5.16.25 at 9:00 AM she stated that she called for assistance twice on 5.15.25 due to urinary incontinence and no one came until after 7:00 AM. She stated she asked the nurse LVN A for someone to change her while LVN A was performing colostomy care. She stated LVN A told her she would get the Nurse. She stated nobody ever came and it was the day shift CNA's that changed her. She stated that she did not think that the girls did it on purpose to be neglectful. She stated she thinks they just overlooked her. Stated it has never happened before. She stated it made her feel uncomfortable physically, but it didn't hurt her emotionally. She stated she had been a nurse's aide herself and she knew how it was when you got busy. Sometimes people just forget what they are doing. She stated she did fall back asleep while she waited. She also stated she had never asked the aides not to check on her at night, which was when she needed them.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5.16.25 at 9:30 AM the Administrator stated she would expect the nurse to change the resident if she had time or to ensure that an aide cared for the resident. She stated she believed the failure occurred because of the lack of monitoring on the nurses' part and the aides' lack of communication. She stated she had reported the alleged neglect to the state and had suspended the CNA's effective yesterday evening (5.15.25) until the completion of her investigation. She stated she had done an Inservice on abuse and neglect, and reporting and a one-on-one counseling with CNA B for not reporting to her immediately.</p> <p>Record Review of the facility policy Activities of Daily Living (ADLs) Guidelines revised 2.10.2020, revealed the following [in part] .</p> <p>Policy Statement</p> <p>Anticipated Outcome</p> <p>Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene.'</p> <p>Residents participate in and receive the following person-centered care:</p> <p>Toileting/Continence: toileting or receiving assistance with toileting or receiving incontinence care.</p>