STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675042	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seymour Rehabilitation and Healthcare	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records on each resident that were complete and accurately documented for 2 (Resident #1, and #3) of 5 residents reviewed for medical records. The facility failed to ensure Residents #1 and #3 had accurate daily BS assessments and insulin injection documented in the medical record. These failures could place residents at risk due to inaccurate assessments.Findings included: Record review of Resident #1's face sheet dated 12/30/2025 revealed a [AGE] year-old female, originally admitted to facility on 11/11/24 with most recent readmission on [DATE] and the following diagnoses: Dementia (mental decline caused by different diseases), type 2 diabetes (insulin resistance). Record review of Resident #1's MDS revealed, Section C-Cognitive Behavior BIMS score of 4 (severe cognitive impairment), Section N-Insulin Injections. Record review of Resident #1's Care Plan dated 9/4/25 revealed Resident #1 diabetes- monitor BS, diabetic diet. Record review of Resident #1's Medication order reflected: Lyumjev Kwik Pen 100 UNIT/ML Solution pen-injectorInject as per sliding scale: if 151 - 200 = 2 units ; 201 -250 = 4 units ; 251 - 300 = 6 units ; 301 -350 = 8 units; 351 - 400 = 10 units ; 401 - 450 = 12 units 451 and greater give 14 units and notify MD, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (too much sugar in blood) Hold if BS less than 90 and notify MD. Record review of Resident #1's MAR for insulin injection revealed that on 12/11/25 the 8:00PM Blood Sugar Check and insulin injection were not documented in the MAR. Record review of Resident #3's face sheet dated 01/02/2026 revealed a [AGE] year-old female, originally admitted to facility on 3/31/25 with most recent readmission on [DATE] and the following diagnoses: Type 2 diabetes (insulin resistance). Record review of Resident #3's MDS dated [DATE] revealed, Section C-Cognitive Behavior BIMS score of 15 (cognitively intact), Section N-Insulin Injections. Record review of Resident #3's Care Plan dated 10/3/25 revealed Resident #3 diabetes- monitor BS, diabetic diet. Record review of Resident #3's Medication order reflected: Lyumjev Kwik Pen 100 UNIT/ML Solution pen-injectorInject as per sliding scale: if 151 - 200 = 2 units ; 201 -250 = 4 units ; 251 - 300 = 6 units ; 301 -350 = 8 units; 351 - 400 = 10 units ; 401 - 450 = 12 units 451 and greater give 14 units and notify MD, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA (E11.65) Hold if BS less than 90 and notify MD. Record review of Resident #3's MAR for insulin injection revealed that on 12/11/25 the 8:00PM Blood Sugar Check and insulin injection were not documented in the MAR. Record review of Resident #3 MAR revealed that on 12/11/25 LVN B was the nurse that was on duty and took BS and provided insulin injection. In an interview on 12/31/25 at 10:00am LVN B (by phone), stated she only works at facility part-time. LVN B recalled working at facility on 12/11/25, and stated she did check Resident #1 and #3's BS and administered Insulin. LVN B stated that Resident #1 had a BS of 189 and received 2 units of insulin, and Resident #3 had a BS of 146 and insulin was withheld at that time. LVN B stated she wrote the BS and insulin dosage on paper but forgot to document in the MAR. LVN B stated that she only works PRN, and it is hectic for her to chart as she goes so, she writes notes on paper and charts later. LVN B stated that charting needs to be done once the task is completed and stated most the time she is able to chart right after the task but at times gets behind and charting is done later during the shift. At an interview on 1/2/26 at 2:40pm, DON stated that it is the facility's expectation that charting be completed after a task and or assessment has been completed or soon afterwards as to not forget documenting.