STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155525	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Nook Care Center	36 Village Drive Lawrenceburg, IN 47025

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interview, the facility failed to ensure a resident was free from a significant medication error when Resident C received Resident L's morning medications. The deficient practice resulted in the resident's hospitalization, administrations of two doses of Narcan, monitoring of vitals, and laboratory values for 1 of 3 residents reviewed for medication errors. (Resident C) Findings include:The resident's clinical record was reviewed on 11/20/2025 at 10:13 A.M. A Quarterly Minimum Data Set assessment, dated 08/27/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, diabetes, COPD (Chronic Obstructive Pulmonary Disease) and schizophrenia. The plan of care for Resident C, dated 08/19/2025 , indicated the resident had an altered respiratory status and difficulty breathing related to COPD. The interventions included, but were not limited to, administer medication/puffers as ordered. The plan of care for Resident C, dated 08/20/2025, indicated the resident used anti-convulsant medications related to neuralgia. The interventions included, but were not limited to, administer medications as ordered. The plan of care for Resident C, dated 08/20/2025, indicated the resident had dehydration or a potential fluid deficit. The interventions included, but were not limited to, administer medications as ordered. A Progress Note, dated 11/01/2025 at 8:00 A.M., indicated the resident had a medication administration error with new orders to send the resident to the emergency room (ER) for full evaluation. The resident was alert and oriented per his usual self. A Facility Triage Note, dated 11/01/2025, by NP 3 indicated Resident C inadvertently received Resident L's 9:00 A.M. medications. A Progress Note, dated 11/03/2025 at 4:05 P.M., indicated the resident had returned from the hospital. Resident C's record was reviewed on 11/20/2025 at 10:13 A.M., the physician recapitulation for Resident C's prescribed 9:00 A.M. medications indicated the resident was ordered the following medications: Dutasteride 0.5 mg, Ferrous Sulfate 325 mg, Fluoxetine 10 mg, Miralax 17 grams, pravastatin 20 mg, tamsulosin 0.4 mg (2) Benztropine Mesylate 1mg, Eliquis 5 mg, Famotidine 20 mg, Fluphenazine 10 mg, and Gabapentin 300 mg. Resident C had received his prescribed dose of insulin on the morning of 11/01/2025. (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 0760 Level of Harm - Actual harm Residents Affected - Few	Resident L's record was reviewed on 11/20/2025 at 10:18 A.M., the physician recapitulation for Resident L's prescribed 9:00 A.M. medications indicated the resident was ordered the following medications: Glipizide 5mg, Norco 5/325 mg, Levetiracetam 500 mg, Lisinopril 20 mg, Metformin 1000 mg, Propranolol 20 mg, Tramadol 50 mg, Alfuzosin extended release 10 mg, Aspirin 81 mg, Celecoxib 200 mg, Zyrtec 10 mg, Celexa 40 mg, Cyclobenzaprine 10mg, and Famotidine 20 mg. The medications Resident C inadvertently received had the following potential side effects: - Glipizide: low blood sugar, shakiness, nervousness, sweating, dizziness, fast heartbeat, weight gain, gastrointestinal issues, such as nausea, diarrhea, gas, or constipation, dizziness, or headache. - Norco: respiratory depression, nausea, vomiting, constipation, drowsiness, sleepiness, dizziness, or lightheadedness. - Levetiracetam: drowsiness, dizziness, fatigue, or irritability. - Lisinopril: dry, persistent cough, dizziness or lightheadedness, headache, excessive tiredness or weakness, nausea and/or vomiting, diarrhea, runny or stuffy nose, or rash. - Metformin: lactic acidosis, diarrhea, and nausea. - Propranolol: dizziness, fatigue, nausea, diarrhea, and cold extremities. - Tramadol: respiratory depression, nausea, vomiting, constipation, drowsiness, dizziness, headache, dry mouth, sweating, and itching. - Alfuzosin: a sudden drop in blood pressure, chest pain, dizziness, headache, and tiredness. - Aspirin: stomach upset and heartburn. - Celecoxib: chest pain, shortness of breath, and stomach bleeding and or ulcers. - Zyrtec: drowsiness, headache, and dry mouth. - Celexa: Suicidal thoughts or behaviors, heart rhythm problems, nausea, dry mouth, drowsiness, insomnia, increased sweating, diarrhea, tremor, and dizziness. - Cyclobenzaprine: heart problems, central nervous system issues, drowsiness, dry mouth, and dizziness, and - Famotidine: headache, dizziness, constipation, and diarrhea. During an interview, on 11/20/2025 at 10:56 A.M., RN 2 indicated she mistakenly gave Resident C medications that belonged to Resident L. After Resident C took the medications, she went out of his room and back to the medication cart. She looked at the computer and realized she was looking at Resident L's Electronic Health Record (EHR). Both residents looked similar, had the same first name, and lived near each other in the same hall. She immediately notified the Director of Nursing (DON). She assessed the resident and checked his vital signs, while the Assistant Director of Nursing (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	(ADON) notified the NP. The NP ordered the resident to be sent to the local hospital for evaluation. RN 2 indicated she would normally verify a resident's first and last name and date of birth before administering medications. A hospital Nurse Practitioner (NP) 4 note from the Intensive Care Unit, dated 11/02/2025 at 7:33 A.M., was provided by the DON on 11/20/2025 at 12:43 P.M. The record indicated the resident was from this long-term care facility, had received someone else's medications, oxycodone, Ultram (both opioid pain medications), that the resident did not normally take. The resident received IV (Intravenous) fluids and two doses of Narcan, a medication that reverses the effects of a narcotic, 0.4 milligrams (mg) through his IV. A Urinary Drug Screen (UDS) test confirmed the resident had opiates in his system. A follow-up visit Progress Note from facility NP 5, dated 11/04/2025, indicated the resident appeared stable with no changes in diagnoses or medications. The resident had no critical lab values prior to the medication error or on day one and day two in the hospital. During an interview, on 11/20/2025 at 10:02 A.M., the DON indicated she received a call on the morning of 11/01/2025 from the nurse that was on shift saying she accidentally gave a resident the wrong medications. The resident was assessed right away, the NP was notified, and the resident was sent to the local hospital where he was admitted for observation. The facility educated all nursing staff and implemented an audit tool to monitor medication administration. The current General Dose Preparation and Medication Administration policy, with a revision date of 01/01/2022, was provided by the DON on 11/20/2025 at 12:43 P.M. The policy indicated, .Facility staff should.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, as set forth in facility's medication schedule. The deficient practice was corrected on 11/02/2025, after the facility implemented a systemic plan of staff education, medication administration audits, and monitoring to ensure implementation of the in-servicing was monitored related to medication administration. This citation relates to Intake 2661017. 3.1-48(c)(2)