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	01/06/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to monitor a resident's skin conditions related to bruising and scratches from the time of the occurrence for 1 of 19 residents reviewed for Quality of Care. (Resident 30) Findings include:During an observation, on 01/02/2026 at 2:29 P.M., Resident 30 was in her room, in the locked dementia unit, lying in bed on her right side with her eyes closed. The left side of her face had a bruise that was three to four inches long by one and a half inches wide extending from her left temple into her hairline on the top of her forehead. The bruise was green and yellow in color. She had two scratches on her forehead with red dried blood. One scratch was approximately an inch long, and one was approximately one and a half inches long. During an observation, on 01/02/2026 at 3:09 P.M., with Unit Manager (UM) 3, the Resident was in her room in bed. The bruising and scratches were visible on her head. The Unit Manager indicated she was not sure what had happened to the resident. When asked if the resident's skin condition should be charted in the resident's health record, the Unit Manager indicated sometimes staff would chart on skin sheets for a bruise of that size, she had not been informed of a recent fall or anything. She had been off work for a few days. Sometimes something would be noted in daily charting. There should have been documentation in a Progress Note. During an observation of Resident 30, on 01/02/2026 at 3:15 P.M., the Director of Nursing (DON) indicated she was not sure what had happened to the resident's face, it was her first time seeing the resident's injuries. During an interview on 01/02/2026 at 3:19 P.M., the DON indicated she would be looking into the resident's bruising/injury. During an interview, on 01/05/2026 at 3:46 P.M., Certified Nurse Aide (CNA) 6 indicated she was not aware of any incidents on the dementia unit, she did not notice the bruise on Resident 30. She worked on Sundays, Mondays, and Tuesdays. The clinical record for Resident 30 was reviewed on 01/02/2026 at 2:46 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/14/2025, indicated the resident was severely cognitively impaired. The resident was [AGE] years old. The resident used a wheelchair and needed substantial/maximal assistance from staff members for eating and dressing. The resident exhibited no behavioral symptoms during the review period.Video camera footage of the common/dining area in the Dementia Unit from the evening of 12/29/2025 was reviewed with the Administrator and Maintenance Supervisor on 01/06/2026 at 11:30 A.M. Resident 30's room was visible on the footage as well as the beginning of the hall on the unit. The following was observed: - At 8:23 P.M., Resident 30 was still in her wheelchair in front of her doorway. QMA 5 and LPN 4 were talking to Resident 30. LPN 4 was holding and appeared to be assessing the resident's left hand.- At 8:27 P.M., LPN 4 brought supplies over to Resident 30 and appeared to be cleaning the resident's left hand. LPN 4, QMA 5, and CNA 6 were all gathered around Resident 30 looking at the resident's left hand. Resident 30 started to rub the left side of her head. LPN 4 appeared to assess the resident's head, looking closely at the left side.- At 8:31 P.M., staff assisted Resident 30 back to her room. Following review of the video footage on 01/06/2026, the DON indicated she went and looked at Resident 30's hand and there was a skin impairment present. The Weekly Skin Review records for Resident 30 indicated the resident's skin was intact on 12/31/2025 and on 01/02/2026. The resident's clinical record lacked documented progress notes from 12/23/2025 through 12/31/25. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 30's Progress Notes included, but were not limited to, the following:-On 01/01/2026 at 12:20 A.M., the resident was in a pleasant mood with no behaviors noted this shift. -On 01/02/2026 at 9:53 A.M., the resident had no behaviors noted so far that shift, she was sitting in diningroom talking with other residents. -On 01/02/2026 at 5:49 P.M., the resident was assisted to bed after meals, the resident had a noted bruise and scratches to her face (this was the first note identifying the resident's injuries to her face). There was no mention of the wound on the resident's finger that was being assessed and cleaned in the video. The resident's record, dated 01/03/2026, indicated the resident had a yellow/green bruise to her face and superficial scratches to her forehead. The records lacked documentation related to the resident's left hand. During an interview, on 01/04/2026 at 7:14 P.M., QMA 5 indicated he worked passing medications on night shift on the Dementia Unit on 12/29/2025. He did not know anything about any bruises or injuries with Resident 30 or any other residents. The current Change in a Resident's Condition or Status policy, with a revision date of February 2021, was provided by the DON on 01/06/2026 at 3:30 P.M. The policy indicated, .The nurse will notify the resident's attending physician .when there has been .discovery of an injury of unknown source . record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 3.1-37(b)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to administer a resident's medication as the physician prescribe related to hypotension for 1 of 19 residents reviewed for pharmacy services. (Resident 30) Findings include:The clinical record for Resident 3 was reviewed on 01/05/2026 at 10:58 A.M. An admission Minimum Data Set (MDS) assessment, dated 11/12/2025, indicated the resident was cognitively intact. The residents, diagnoses included, but were not limited to, fractures, cancer, heart failure, hypertension, diabetes, anxiety, and respiratory failure.An open-ended physician's order, with a start date of 12/09/2025, indicated the resident was to receive Midodrine (a hypotensive blood pressure medication) 5 milligrams (mg), three times a day with meals. The medication was to be held if the resident systolic (top number) blood pressure was 160 and over, the diastolic (bottom number) blood pressure was 100 and over, and heart rate was less than 55. The December 2025 and January 2026 Electronic Medication Administration Record (EMAR) were reviewed and indicated the resident had not received the medication when the resident's systolic blood pressure was less than 160 and the resident's diastolic blood pressure was less than 100 on the following dates and times:-On 12/24/2025 at 8:00 A.M., when the blood pressure was 149/97, -On 12/24/2025 at 12:00 P.M., when the blood pressure was 127/75, -On 12/24/2025 at 5:00 P.M., when the blood pressure was 124/77,-On 12/27/2025 at 8:00 A.M., when the blood pressure was 139/77, -On 12/27/2025 at 5:00 P.M., when the blood pressure was 137/86,-On 01/01/2026 at 8:00 A.M., when the blood pressure was 139/81, -On 01/01/2026 at 12:00 P.M., when the blood pressure was 135/69, and-On 01/01/2026 at 5:00 P.M., when the blood pressure was 104/57. The clinical record indicated the resident's heart rate was only monitored on the following dates and times from 12/24/2025 through 01/01/2026:-On 01/01/2026 at 5:20 P.M., the resident's pulse rate was 89During an interview, on 01/06/2025 at 10:48 A.M., RN 2 indicated a resident's medication should be administered per the physician's orders. If the resident's medication had specific parameters, she would obtain the vital signs prior to administering the medication. If the vital sign values were within the parameters she would administer the resident's medication. The resident's vital signs would be documented with the medication because the EMAR prompts the user to input the vital sign value before you signed out the medication. The current facility policy, titled General Dose Preparation and Medication Administration, with a revision date of 01/01/2022, was provided by the Director of Nursing on 01/06/2025 at 11:28 A.M. The policy indicated, .Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications.If necessary, obtain vital signs.3.1-37(a)

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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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to document an incident in the Electronic Health Record (EHR) and monitor a resident's skin conditions for 2 of 19 residents' records reviewed. (Resident 30 and Resident 25) Findings include:During an anonymous interview, from 12/30/25 through 01/06/26, Confident Interview 9 indicated there had been a recent incident/altercation in the locked dementia unit involving Resident 30 and Resident 25. Resident 30 had bruising and scratches on her face. An altercation involving Resident 25 and Resident 30 happened on 12/29/2025 after 6:00 P.M. During an observation, on 01/02/2026 at 2:29 P.M., Resident 30 was in her room, in the locked dementia unit, lying in bed on her right side with her eyes closed. The left side of her face had a bruise that was three to four inches long by one and a half inches wide extending from her left temple into her hairline on the top of her forehead. The bruise was green and yellow in color. She also had two scratches on her forehead with red dried blood. One scratch was approximately an inch long, and one was approximately one and a half inches long. During an observation, on 01/02/2026 at 3:09 P.M., with Unit Manager (UM) 3, the Resident was in her room in bed. The bruising and scratches were visible on her head. The Unit Manager indicated she was not sure what had happened to the resident. When asked if the resident's skin condition should be charted in the resident's health record, the Unit Manager indicated sometimes staff would chart on skin sheets for a bruise of that size, she had not been informed of a recent fall or anything. She had been off work for a few days. Sometimes something would be noted in daily charting. There should have been documentation in a Progress Note. During an interview and observation of Resident 30, on 01/02/2026 at 3:15 P.M., the Director of Nursing (DON) indicated she was not sure what had happened to the resident's face, it was her first time seeing the resident's injuries. During an interview, on 01/05/2026 at 3:46 P.M., Certified Nurse Aide (CNA) 6 indicated she was not aware of any incidents on the dementia unit, just the normal screaming and yelling. She did not notice the bruise on Resident 30. She had worked on 12/29/2025. During an interview on 01/02/2026 at 3:19 P.M., the DON indicated there should be behavior monitoring documented in the EHR if a resident had a behavior and she would be looking into the bruising/injury. During an interview with the Psych Nurse Practitioner (NP), on 01/05/2026 at 2:45 P.M., the NP indicated staff had not reported to him any aggressive behaviors towards other residents since she came back in November. The NP indicated he also routinely saw Resident 30. She was a sweet lady. He saw her on 12/08/2025 and today. She usually came out of her room for activities and meals. He usually came to the facility in the morning, and she was usually out in the common area at that time of day. The clinical record for Resident 25 was reviewed on 01/06/2026 at 12:38 P.M. A Quarterly MDS assessment, dated 12/14/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, and depression. The resident had physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) that occurred for 1 to 3 days of the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7-day review period. The resident had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) that occurred for 1 to 3 days of the 7-day review period. Resident 25's Progress Note, dated 12/29/2025 at 12:30 A.M., indicated Resident was noted with behaviors this evening, staff redirected. During an interview, on 01/02/2026 at 3:16 P.M., UM 3 indicated she reviewed Resident 25's record. There was some recent behavior charting in the resident's progress notes that was not normal charting for the resident. There was no indication what the behavior charting was about. If nursing staff were charting no behaviors, there was a reason. If a resident exhibited behaviors, it should be documented in the progress notes what type of behavior the resident exhibited. It should be descriptive and it would be documented every shift. The clinical record for Resident 30 was reviewed on 01/02/2026 at 2:46 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/14/2025, indicated the resident was severely cognitively impaired. The resident was [AGE] years old. The resident used a wheelchair and needed substantial/maximal assistance from staff members for eating and dressing. The resident exhibited no behavioral symptoms during the review period. Resident 30's Progress Note, dated 01/02/2026 at 5:49 P.M., indicated the resident was assisted to bed after meals. She was noted with a bruise and scratches to face (this was the first note identifying the resident's injuries to her face). Resident 30's clinical record lacked progress notes documented from 12/23/2025 through 12/31/25. Resident 30's clinical record lacked documentation regarding what led to her skin impairments and the monitoring of her skin impairments in a timely manner. The Weekly Skin Review records for Resident 30 indicated the resident's skin was intact on 12/31/2025 and on 01/02/2026. The review record dated 01/03/2026, indicated the resident had a yellow/green bruise to her face and superficial scratches to her forehead. The records lacked documentation related to the resident's left hand. During an interview, on 01/04/2026 at 7:14 P.M., QMA 5 indicated he worked passing medications on night shift on the Dementia Unit on 12/29/2025. He didn't know anything about any altercations between any of the residents. He did not know anything about any bruises or injuries with Resident 30 or any other residents. Normally residents just got loud with each other, not physical with each other. Video camera footage of the common/dining area in the Dementia Unit from the evening of 12/29/2025 was reviewed with the Administrator and Maintenance Supervisor on 01/06/2026 at 11:30 A.M. Resident 30's room was visible on the footage as well as the beginning of the hall on the unit. The following was observed: - At 7:36 P.M., Resident 30 was in her room. Resident 25 was observed looking into Resident 30's room. - At 7:42 P.M., Resident 25 was not near Resident 30's room. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- At 8:05 P.M., Resident 30 was in her wheelchair in the doorway of her room. Resident 25 was near the doorway to Resident 30's room. - At 8:11 P.M., Resident 30 wheeled herself towards the hallway past her room, out of view of the camera. Resident 25 was not within view of the camera. - At 8:13 P.M., CNA 6 and QMA 5 were sitting across from each other at a table in the common area. There were no residents in the common area. - At 8:16 P.M., CNA 6 and QMA 5 got up quickly from the table and went towards the hallway. - At 8:19 P.M., Resident 30 wheeled herself back from the hallway and stopped in the doorway in front of her room. - At 8:23 P.M., Resident 30 was still in her wheelchair in front of her doorway. QMA 5 and LPN 4 were talking to Resident 30. LPN 4 was holding and appeared to be assessing the resident's left hand. - At 8:27 P.M., LPN 4 brought supplies over to Resident 30 and appeared to be cleaning the resident's left hand. LPN 4, QMA 5, and CNA 6 were all gathered around Resident 30 looking at the resident's left hand. Resident 30 started to rub the left side of her head. LPN 4 appeared to assess the resident's head, looking closely at the left side. - At 8:31 P.M., staff assisted Resident 30 back to her room. During an interview, on 01/06/2026 at 12:54 P.M., the Maintenance Supervisor indicated there was also a camera in the hallway in the Dementia Unit that would have recorded activity in the hall outside of the resident's rooms, but he was unable to access that video for review. Following review of the video footage on 01/06/2026, the DON indicated she went and looked at Resident 30's hand and there was a skin impairment present. The current Change in a Resident's Condition or Status policy, with a revision date of February 2021, was provided by the DON on 01/06/2026 at 3:30 P.M. The policy indicated, .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. 3.1-50(a)(1) 3.1-50(a)(2)