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	01/23/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure a resident to resident abuse did not occur for 1 of 3 residents reviewed for abuse. (Resident D) Findings include:The clinical record for Resident D was reviewed on 01/23/2026 at 2:00 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 11/13/2025, indicated the resident was severely cognitively impaired. The resident's diagnosis included, but was not limited to, Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroyed memory, thinking skills, and the ability to carry out simple tasks). A Progress Note, dated 01/12/2026 at 11:40 A.M., indicated Resident D was involved in an altercation with another resident, and was struck causing her glasses to break. There was bruising noted on her face and bilateral arms. A Weekly Skin Assessment, dated 01/13/2026 at 3:00 P.M., indicated Resident D had bruising located on her right and left antecubital arm, left periorbital area, and to the left side of her nose. During an observation, on 01/23/2026 at 1:18 P.M., Resident D was observed sitting in a recliner in the common area by the front door. She had a half dollar sized fading bruise to the top part of her left arm. The clinical record for Resident C was reviewed on 01/23/2026 at 1:47 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/14/2025, indicated the resident was severely cognitively impaired. The resident was able to walk 150 feet with just supervision and had exhibited physical behaviors towards others for one to three days during the review period. A Progress Note, dated 01/12/2026 at 1:58 A.M., indicated Resident C was up in the hallway wandering. The staff were unable to redirect. A Progress Note, dated 01/12/2026 at 11:40 A.M., indicated Resident C became aggressive with another resident on the unit (Resident D). Resident C was noted to be yelling and grabbing another resident (Resident D). Resident C was not easily redirected with staff. A current care plan, with the start date of 03/03/2025 and revised date of 11/12/25, indicated Resident C had experienced delusions due to belief that this was her home and others needed to leave. Resident C would address others within their space. The interventions included, but was not limited to: dated 03/03/2025, staff were to intervene as necessary to protect the rights and safety of others. During an anonymous staff interview, on 01/23/2026 between 9:00 A.M. and 12:00 P.M., Staff member 2 indicated they were working on January 12th and witnessed the incident between Resident D and Resident C. While they stood at the medication cart close to the dining room they heard someone scream. When they looked up, they witnessed Resident C grabbing and swatting at Resident D at the opposite end of the hallway. They immediately rescued Resident D and relocated her next to the medication cart. Resident C was put on one-on-one observations with another staff member. Resident D had red marks on her face and arm, and her glasses were broken into three pieces. During an anonymous staff interview, on 01/23/2026 between 9:00 A.M. and 12:00 P.M., Staff Member 10 indicated Resident D was the sweetest resident on the dementia unit. She never had any behaviors or bothered anyone. Resident C is a walking behavior, and within the past two and a half months she had become more aggressive. She has had behaviors with other residents in the last couple of months. She usually (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was more verbal with her aggression towards other residents, but recently she has gotten more physical towards other residents. She will randomly walk by someone and hit them or smack them on the butt. The staff tried to always watch Resident C. The current facility policy titled, Abuse Policy with a revision date of September of 2022, was provided by the Director of Nursing on 01/23/2026 at 1:10 P.M. The policy indicated, .The resident has the right to be free from abuse. residents must not be subjected to abuse by anyone, including, but not limited to, . other residents . This citation relates to Intake 2714547. 3.1-27(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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on interview and record review, the facility failed to ensure a resident diagnosed with an irreversible brain disorder that slowly destroyed memory, thinking skills, and simple tasks received appropriate supervision and interventions to attain his or her psychosocial well-being for 1 of 3 residents reviewed for dementia care. (Resident C) Findings include:The clinical record for Resident C was reviewed on 01/23/2026 at 1:47 P.M. A Quarterly Minimum Data Set (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 with early onset (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple tasks) and non-traumatic brain dysfunction. The resident was able to walk 150 feet with just supervision and had exhibited physical behaviors towards others for one to three days during the review period. A current care plan, with the start date of 10/16/2023 and revised date of 04/01/2025, indicated Resident C had experienced verbal behaviors such as yelling and cursing at staff and others as well as physical aggression towards staff and others due to belief of others were in her home. The interventions included, but were not limited to: dated 12/12/2025, if resident becomes resistive then allow resident to calm; have other staff approach resident; offer a snack or beverage to redirect for aggression/agitation and reapproach. A current care plan, with the start date of 03/03/2025 and revised date of 11/12/25, indicated Resident C had experienced delusions due to belief that this was her home and others need to leave. Resident C will address others within their personal space. The resident experienced auditory and visual hallucinations while at an inpatient behavior facility. The interventions included, but were not limited to: dated 03/03/2025, intervene as necessary to protect the rights and safety of others; staff were to approach and speak in calm manner; and remove the resident from situation and take to alternative location as needed. A Progress Note, dated 01/09/2026 at 4:20 P.M., indicated Resident C struck a staff member. A Progress Note, dated 01/12/2026 at 1:58 A.M., indicated Resident C was up in the hallway wandering. The staff were unable to redirect. A Progress Note, dated 01/12/2026 at 11:40 A.M., indicated Resident C became aggressive with another resident on the unit. The resident was noted to be yelling and grabbing another resident. The resident was not easily redirected with staff. During an anonymous staff interview, on 01/23/2026 between 9:00 A.M. and 12:00 P.M., Staff Member 10 indicated Resident C was a walking behavior, and within the past two and a half months she has become more aggressive. She has had behaviors with other residents in the last couple of months. She usually was more verbal with her aggression towards other residents, but recently she had gotten more physical towards other residents. She would randomly walk by someone and hit them or smack them on the butt. The staff would try to watch Resident C at all times. If the resident had a behavior towards another resident it should have been documented under progress notes but some people say they chart it under behavior notes. During an anonymous staff interview, on 01/23/2026 in between 9:00 A.M. and 12:00 P.M., Staff Member 8 indicated Resident C was a wild one and had behaviors with other residents. When she was mad you had to take her away from whomever she was mad at. Sometimes that worked, but not always. The staff would try to find things to keep her busy, but nothing worked. During an anonymous staff interview, on 01/23/2026 between 9:00 A.M. and 12:00 P.M., Staff Member 5 indicated they had witnessed Resident C get physically aggressive with another resident about 3 weeks ago, and it was reported to the nurse. She was passing another resident in the common area when she screamed in their face and shoved on their shoulder causing the other resident to step backwards. During an interview, on 01/23/2026 at 10:52 A.M., Registered Nurse (RN) 3 indicated she was the Unit Manager on the Dementia Unit and that resident behaviors were (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to her. She did not believe Certified Nursing Assistants (CNA's) were able to chart behaviors, but nurses could. Anytime a resident was verbally or physically aggressive it should be documented in the resident's clinical record. Resident C was mostly aggressive with staff members not residents. She had hit staff before while providing care. During an interview, on 01/23/2026 at 11:56 A.M., the Social Services Director indicated Resident C was currently out of the facility for aggressive behaviors after an incident with another resident. There were no behavior sheets completed on Resident C. The only behaviors she was aware of were what the nurses documented in the progress notes. She had never heard of Resident C hitting other residents until the incident on 01/12/2026. During an interview, on 01/23/2026 at 1:45 P.M., the Social Services Director indicated Resident C did have an altercation with another resident in November. The current facility policy titled, Dementia - Clinical Protocol with a revision date November of 2018, was provided by the Director of Nursing on 01/23/2026 at 1:10 P.M. The policy indicated, .Progressive or persistent worsening of symptoms and increased need of staff support will be reported to IDT.The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia. This citation relates to Intake 2714547.