STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457 Based on record reviews and interviews, it was determined that the facility failed to develop and implement written policies and procedures for investigating and reporting allegations of abuse. This deficient practice was evident for 1 (#25) of 4 resident reviewed for abuse during the recertification survey. The findings include: On 02/28/2025 at 9:30 AM, during an interview with the Director of Nursing (DON) #2, the surveyor asked about the facility's process for managing allegations of abuse involving residents. The DON explained that only confirmed injuries are reported to the state agency within 2 hours, and all other abuse allegations are reported by the end of the same day. The surveyor requested the facilities policy and procedures for abuse. On 02/28/25 DON #2 provided the surveyor with the facility's abuse policy. Upon review, the surveyor identified that the policy lacked information identifying how staff should identify abuse that was not directly observed. The policy did not outline procedures for interviewing all parties involved, including the alleged victim, alleged perpetrator, witness and others who might have had knowledge of the allegations. The policy also failed to specify timeframes for reporting alleged allegations. On 03/04/25 at 9:22 AM During an interview with the Administrator (NHA) #1 regarding the management of abuse involving residents, he explained that all incidents of abuse are reported within 24 hours, and any incidents involving bodily injuries are reported within 2 hours. NHA #1 also explained that all employees working at the time of the alleged incident would be interviewed by the social worker or unit manager. On 03/04/25 at 11:23 AM, review of incident report MD00211741 dated 11/13/24 indicated that Resident #25 was hospitalized on [DATE] for a scheduled left leg fracture repair surgery related to a reported fall on 08/21/24. During the hospital visit, Resident #25 informed the hospital nurse liaison that they were assaulted by a staff member on 08/21/24 resulting in a leg fracture. Further review of MD00211741 revealed the alleged victim was not interviewed and the allegation of abuse could not be verified. (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
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #25 on 03/05/25 at 9:30 AM regarding the incident on 08/21/24, the resident explained that he/she informed Unit Manager #15 about the incident and requested to be transported to the hospital due to leg pain. A portable x-ray was ordered and completed at the facility which showed no fracture. The resident reported that they continued to have pain and requested to be transported to the hospital where they were diagnosed with a fracture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42782 Based on record review and interviews, it was determined that the facility staff failed to notify the state agency of allegations of abuse within the two-hour allotted timeframe. This deficient practice was evidenced in 6 (Resident #25, #41, #108, #113, #138, & #144) of 12 facility reported incidents reviewed for allegations of abuse during the recertification survey. The findings include: 1. On 03/05/25 at 10:27 am a review of the facility reported incident (FRI) investigation related to MD000207607 revealed Resident #144 reported an alleged incident of sexual abuse that may have occurred on 07/01/24. Review of the self-report documentation revealed the staff became aware of the alleged incident on 07/03/24 at approximately 11:00 am. The alleged incident was reported to the state agency on 07/03/24 at 10:03 pm by the Smartsheet confirmation email. On 03/12/25 at 11:20 am during an interview with Director of Nursing (DON) #2 verbalized the Social Worker reported the alleged incident. DON #2 was made aware the Smartsheet report revealed Administrator #1 was made aware of the incident on 07/03/24 at 11:00 am. The incident was reported to the state agency on 07/03/24 at 10:03 pm which was outside of the 2-hour allotted timeframe. On 03/04/25 at 9:22 am during an interview with Administrator #1 the surveyor asked when incidents are reported to the state agency regarding a timeframe. Administrator #1 verbalized all incidents are reported within 24 hours. Bodily injury is reported within 2 hours along with an elopement. Some categories of incidents are reported within two hours. 49148 2. On 3/4/2025 at 9:21AM, during an interview with the Nursing Home Administrator (NHA), the Surveyors were informed that facility reported incidents (FRIs) which include allegations of abuse should be reported to the Office of Health Care Quality (OHCQ) within 2 hours. The results of the investigation should be submitted within 5 working days. On 3/10/2025 at 1:00PM, the Surveyor reviewed the investigative file for the MD00204453 of Resident #41. The Surveyor discovered that on 4/1/2024 at about 5:40PM, the resident accused Resident #240 of making sexual gestures towards him/her and also reported that he/she sexually assaulted him/her about a month prior. An additional review of the investigative file revealed that the facility submitted the initial report to the Office of Health Care Quality on 4/1/2024 at approximately 9:00PM, not within 2 hours as required. The final report was submitted to OHCQ on 4/6/2024 at approximately 2:15PM, not within 5 working days as required. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 3/10/2025 at 2:00PM, the Surveyor reviewed the investigative file for the FRI MD00213875 of Resident #108. The Surveyor discovered that on 1/23/2025 between the hours of 1:30AM to 4:30AM, the spouse of Resident #108 called the facility and made allegations of physical abuse towards the resident. An additional review of the investigative file revealed that the facility submitted the initial report to OHCQ on 1/23/2025 at 4:04PM, not within 2 hours as required. The final report was submitted to OHCQ on 1/31/2025 at 2:56PM, not within 5 working days as required. On 3/12/2025 at approximately 8:00AM, the Surveyor made the Director of Nursing aware of the concerns for timely reporting of FRI's for allegations of abuse for Resident #41 and Resident #108. 50457 4. On 02/28/2025 at 9:30 AM, during an interview with the Director of Nursing (DON) #2, the surveyor asked about the facility's process for managing allegations of abuse involving residents. The DON explained that only confirmed injuries are reported to the state agency within 2 hours, and all other abuse allegations are reported by the end of the same day. On 03/04/24 at 11:52 AM, during a review of nursing home self-report MD00211202 and review of the facility's investigation file, revealed that the alleged assault incident involving Resident #25 fracture occurred on 08/21/24. The incident was reported to the nursing facility by a third party on 10/25/24 at 9:30 AM. The nursing facility submitted the abuse allegations to the state agency on 10/25/24 at 12:56 PM which was outside the allotted 2-hour time frame for reporting allegations of abuse. 50573 5. On 3/6/24 8:48 AM, review of facility documentation for MD00208489 regarding Resident #113 revealed a Facility Reported Incident Initial Report Form. The report form indicated that the date and time when the injury of unknown origin allegation occurred was on 08/05/24 at approximately 8pm. Further review of MD00208489 documentation revealed that the initial facility report form was submitted to The Office of Health Care Quality on 08/06/24 at 4:29 PM. On 03/07/25 at 06:52 AM, the surveyor reviewed the concern with the Director of Nursing (Staff #2). 6. On 03/04/25 at 09:03 AM, the surveyor requested documentation from the facility for MD00204018 regarding bruising found on Resident #138 . On 03/04/25 at 11:53 AM, the Director of Nursing (Staff #2) indicated to the surveyor that she had no ability to provide the surveyor with documentation that indicates the facility reported the incident to the Office of Health Care Quality within 2 hours of when staff became aware of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42782 Based on record review and interviews it was determined that the facility staff failed to complete a thorough investigation of alleged incidents of abuse and an injury of unknown origin. This deficient practice was evidenced in 4 (#25, #109, #138, & #144) of 12 facility reported investigations reviewed during the recertification survey. The findings include: 1. On 03/12/25 at 10:27 am a review of the facility reported incident (FRI) investigation related to MD000207607 revealed Resident #144 reported an alleged incident of sexual abuse that may have occurred on 07/01/24. A review of the facility's investigation revealed there were multiple interviews from staff who failed to indicate their title. The surveyor requested a copy of the staffing sheet to verify interviews were done with the staff who worked during the time of the alleged incident. The staffing sheet provided by Director of Nursing (DON) #2 had the incorrect date. The surveyor was unable to confirm a thorough investigation was completed. On 03/12/25 at 10:48 am during an interview with DON #2 the surveyor asked who completed the investigation related to the incident. DON #2 verbalized completing the investigation. The surveyor verbalized the staff interviews did not indicate the discipline of the staff, and a staffing sheet was not included to verify who worked during the alleged incident. The staffing sheet provided was not the staffing sheet when the alleged incident occurred. On 03/04/25 at 9:22 am during an interview with Administrator #1 the surveyor asked what constitutes a thorough investigation according to the facility's standards. Administrator #1 verbalized everyone that was present during the alleged incident and possibly 72 hours prior would be interviewed. If an accurate or near accurate description of the alleged perpetrator was provided they would zero in on that person. Statements would be received from any witnesses including the resident's roommate and the interviews would be obtained by the Social Worker. 50457 2. On 03/04/24 at 11:52 AM, during a review of nursing home self-report MD00211202 and review of the facility's investigation file, it was revealed that the alleged assault incident involving Resident #25 which result in fracture, occurred on 08/21/24. The incident was reported to the nursing facility on 10/25/24. Review of the facility's investigation file revealed that Resident #25 was out of the facility on 10/25/24 and would be interviewed for additional information. Further review showed that the facility failed to obtain an interview from the alleged victim and failed to notify law enforcement and required agencies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 03/4/25 the surveyor requested the facility's investigation file for Resident #109 regarding allegations of abuse. At 11:53 AM, the Director of Nursing (DON) #2 stated that the facility was unable to locate self-report MD00207914 investigation file. The surveyor then requested any documentation related to the abuse allegations. The DON explained that she was unable to locate any documents related to the incident. During an interview with the DON #2, the surveyor explained that it is the facility's responsibility to maintain thorough and accurate records of all reported incidents related to alleged violations. The DON acknowledges that it is the facility's responsibility to maintain documentation for all investigations files. 50573 4. On 03/04/25 at 09:03 AM, the surveyor requested documentation from the facility for the Facility Reported Incident (FRI) MD00204018 regarding Resident #138. On 03/04/25 at 11:53 AM, the Director of Nursing (Staff #2) indicated to the surveyor that she had no ability to provide the surveyor with documentation for FRI MD00204018 as she was unable to find the investigation documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review and interview with staff it was determined that the facility staff failed to: 1) ensure the resident's person-centered care plan was reviewed and revised in response to current interventions to meet the respiratory needs and 2) failed to ensure residents were offered the opportunity to participate in the care planning process by holding annual and quarterly care plan meetings. This was evident for 9 (#25, #38, #42, #49, #52, #54, #74, #82, & #95) out of 10 residents records reviewed for care planning during the recertification survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A tracheostomy is a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea. Surgeons place a tracheostomy tube into the hole to keep it for breathing. 1). On 3/11/2025 at 12:50PM, a review of Resident #38's electronic medical record revealed that the resident had diagnoses including, but not limited to, chronic respiratory failure, tracheostomy, and cognitive communication deficit. On 3/11/2025 at 1:00PM, the Surveyor reviewed a respiratory assessment note from 12/31/2024 and a respiratory evaluation note on 3/11/2025 both written by Respiratory Therapist (RT) #38. RT #38's recommendations included Trach care Q Shift, Change/clean inner cannula Q DAY and prn, Change drain sponges Q Shift and prn, change trach ties and trach mask Q 72 hours and prn, Change trach Q 30 month by RT, oxygen via aerosol trach collar to maintain SpO2 >/= 92%, Suction prn and for increased cough, increased secretions, decreased SpO2, Keep HOB elevated at least 30 degrees or greater at all times for aspiration precautions, Mouth care BID with 0.12% Peridex, Same trach and one size smaller at bedside for back up, Albuterol Nebulizer Q4 prn for Wheezing/SOB, and Ambu bag at bedside. On 3/11/2025 at 1:15PM, during a review of Resident #38's care plan, the Surveyor discovered the care plan failed to include the current trach size (Shiley 4), oxygen via aerosol trach collar, maintain SpO2 >/=92%, mouth care BID with 0.12%Peridex, same trach and one size smaller at bedside for back up, and Albuterol Nebulizer every 4 hours as needed for wheezing/shortness of breath. The care plan also failed to include procedures for emergencies. Further review failed to reveal physician orders to maintain SpO2 >/=92%, mouth care BID with 0.12% Peridex, and Albuterol Nebulizer every 4 hours as needed for wheezing/shortness of breath. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/13/2025 at approximately 10:00AM, during an interview with Unit Manager #39, the Surveyor was informed that the Nurse Supervisor and Unit Managers usually review and revise the resident's care plans quarterly with the MDS assessment and as needed for changes in resident care needs. On 3/13/2025 at 12:00PM, during an interview with Assistant Director of Nursing (ADON) #19, the Surveyor expressed the concern that Resident #38's care plan had not been revised to reflect their current orders and recommendations made by RT #38 in the resident's respiratory assessment note on 12/31/2024 or respiratory evaluation note on 3/11/2025. On 3/4/2025 at 9:45AM, an interview conducted with Social Worker #6 revealed that care plan meetings are held within 7-14 days of admission and then are held quarterly, usually within days of the completed MDS assessment. Care plan meetings could also be held upon request and if there was a significant change in the residents' condition. 2). On 3/7/2024 at 7:53AM, a review of Resident #54's electronic medical record revealed the resident was admitted on [DATE] and has a BIMS of 15/15, meaning cognitively intact. During continued review, the Surveyor discovered that the resident had a care plan meeting on 3/6/2025. Prior to that, the resident's last care plan meeting was on 3/18/2024, after a quarterly MDS assessment. On 3/7/2025 at 12:25PM, the Surveyor requested documentation from the Director of Nursing (DON) to show that Resident #54 had timely care plan meetings following his/her MDS assessments. The DON failed to provide that documentation. The Surveyor expressed the concern that Resident #54 had not had a care plan meeting in about a year. 50457 3). On 02/28/25 at 9:42 AM, during an interview with Resident #95, they stated that they were not aware of their plan of care and wanted to know when they would be discharged . 4.) Review of Resident #82's medical records revealed that the resident was admitted to the facility on [DATE]. An admission care plan meeting was conducted on 4/8/24, and a quarterly care plan meeting on 10/15/24. No quarterly care-planning was conducted in July of 2024. 5.) A review of Resident #49's medical records revealed the last care plan meeting was conducted on 5/21/24. 6). A review of Resident #25's medical records revealed that the last care plan meeting was completed on 5/21/24. 7.) A review of Resident #74's medical records revealed that the last care plan meeting was completed on 03/12/24. 8). A review of a complaint intake MD00206919 revealed that Resident #52 reported the social worker had failed to assist them regarding discharge planning and missing property. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/10/25 at 8:30 AM, the SW #6 provided the surveyor with emails indicating that SW #6 had communicated with another agency in September 2024 regarding the resident. The emails did not specify whether the communication was related to discharge planning, and no other documentation was provided to support that discharge planning discussion occurred. 0n 3/4/25 at 7:30AM, the surveyor requested documentation from the Director of Nursing (DON) #2 for residents #25, #49, #52, #74,# 82, and #95 confirming that a care plan was conducted and completed in a timely manner for the Residents. During an interview with both the DON #2 and Social Worker (SW) #6, they explained that a little over a month ago, the facility discovered that care plan meetings were not being completed. They further stated that this issue was currently being addressed by the facility's Quality Assurance and Performance Improvement (QAPI) team. The DON #2 confirmed that the facility failed to conduct quarterly care plan meeting for the residents. 50573 9). On 3/4/25 at 09:49 AM, an interview with the Director of Nursing (Staff #2) and Social Worker (Staff #6) revealed that the facility had identified concerns regarding care plan meetings not being done. Staff #6 indicated that care plan meetings should be done every 3 months. On 03/05/25 at 9:34 AM, the surveyor requested documentation of care plan meetings held for Resident #42 in 2024. On 03/05/25 at 12:12 PM, review of the documentation provided revealed a care plan meeting occurred on 4/1/24 and 11/7/24, but failed to reveal indication that a care plan meeting occurred in between to meet the quarterly requirement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 50457 Based on record review and interviews it was determined that the facility staff failed to adhere to professional nursing standards regarding implementing physician orders, medication administration times and documentation, and wound care orders/management and documentation. This deficient practice was evident in 8 (#25, #27, #82, #145, #79,) of 59 residents reviewed during the recertification survey. The findings include: 1. A review of Resident #82 physician's orders on 03/06/25 at 02:29 PM, revealed a current order dated 11/18/24, for weekly weights to be obtained every shift on Tuesdays for monitoring of GLP-1 medications. Further review of treatment administration records indicates that the weights were not documented as completed on 02/11/25, 02/18/25, 01/28/25, and 12/10/24, and there were no nursing notes explaining the missed weights. On 3/06/25 at 2:50 PM, during an interview with the Director of Nursing (DON) #2, when asked the expectation of nursing staff regarding physician orders, she explained that nurses are expected to follow the physician's orders. The surveyor informed the DON #2 that weights were missing for the Resident #82. The DON #2 replied that she was unable to provide an explanation for why the nursing staff failed to follow the physicians' orders. 2. On 02/27/2025 at 10:59 AM, during an interview with Resident #25, they expressed concerns about late medication administration. A review of Resident #25's medication administration audit record relieved that on 01/01/25 all 9:00 AM scheduled medications were documented as administered at 2:08 PM. On 01/03/25, the 9:00 AM medications were documented as given between 1:41 PM, and 1:44 PM. On 01/04/25 scheduled medications between 4:00 PM and 8:00 PM were documented as given between 10:19 PM, and 10:20 PM. On 03/6/25 at 11:52 AM, during an interview with the DON #2, the surveyor asked about the expectations for nursing staff regarding medication administration. She stated that staff are expected to administer scheduled medications no earlier than one hour before and no later one hour after scheduled time. The surveyor informed the DON #2 of late medication administration for Resident #25. The DON #2 acknowledged that this has been an ongoing issue with the nursing staff and state that she is currently taking action to address it. On 03/13/25 at 8:00 AM, during an interview with LPN # 21, the surveyor asked her to explain the process for medication administration. The LPN #21 stated that staff are expected to document medication administration at the time the medication is given to the resident. 50573 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A PICC line is a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart. PICC line dressing is crucial to prevent catheter tube-related infections and other complications, ensuring the line remains functional and safe for medication delivery. A wound vac is a medical device that uses a certain pressure to promote wound healing. It consists of a pump, tubing, and a special dressing that is placed over the wound. 3. On 3/10/24 at 7:36 AM, review of MD00204602 revealed a concern regarding Resident #145's PICC line dressing changes in May of 2024. On 3/10/25 at 10:36 AM, record review revealed Resident #145 had an order dated 5/6/24 for a PICC line to be inserted. On 3/10/25 at 10:40 AM, further record review failed to reveal that the resident received a dressing change from when the PICC line was inserted on 5/6/24 until the PICC line was discontinued on 5/30/24. On 03/10/25 at 11:08 AM, an interview with the Director of Nursing (Staff #2) revealed that when a resident has a PICC line, it is standard for the resident to have an order for a weekly dressing change and as needed. The surveyor requested documentation that would indicate Resident #145 received a dressing change from when he/she had the PICC line from 5/6/25 until 5/30/25. On 03/11/25 at 08:35 AM, the Director of Nursing (Staff #2) indicated to the surveyor that she had no further documentation to provide, it was an error, and the resident should have had an order for the dressing to be changed weekly and as needed. 4. On 3/10/24 at 7:36 AM, review of MD00204602 revealed a concern regarding Resident #145's regarding his/her wound vac being changed in May of 2024. On 3/11/25 at 10:36 AM, record review revealed Resident #145 had an order that indicated for the right ankle wound dressing change every 3 days on wound vac days. The order was for Mondays, Wednesdays, and Fridays. The order was dated for Thursday 5/2/24 for a start date of Monday 5/6/24, which skipped Friday 5/3/24 following the order date. On 03/11/25 at 08:00 AM, the surveyor reviewed the finding with the Director of Nursing (Staff #2), she indicated that the nurse who put in the order must have put the order in wrong, and that it should have started Friday 5/3/24 following the order date. 5. On 03/10/25 at 08:51 AM, an interview with the Director of Nursing (Staff #2) revealed that when residents are identified to have significant cognitive decline on the Minimum Data Set (MDS) Assessment, that the MDS coordinator should request the resident be reevaluated for decision making ability. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. MDS assessments must be accurate to ensure that each resident receives the care they need. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/25 at 12:28 PM, review of Resident #27's medical record revealed a document titled, Physicians Certifications Related to Medical Condition, Decision Making, and Treatment Limitations dated 9/23/2015 that indicated the resident was evaluated and had the ability to make their own decisions. On 03/10/25 at 12:30 PM, further record review revealed section C (cognitive patterns) of an Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 12/3/23. The section indicated that the resident had a Brief Interview for Mental Status (BIMS) of 15. A Brief Interview for Mental Status (BIMS) is a tool used to screen and identify the cognitive condition of residents in a long-term care facility. The BIMS score ranges from 0 to 15. Scores from 0-7 indicate severe cognitive impairment, 8-12 indicate mild cognitive impairment, 3-15 indicate intact cognition. On 03/10/25 at 12:32 PM, review of Resident #27's medical record revealed an Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 3/6/24. Review of section C (cognitive pattern) revealed that the resident had a BIMS of 7. On 03/10/25 at 12:35 PM, further review of the resident's medical record failed to reveal indication that the resident was reevaluated for decision making ability. On 03/10/25 at 1:12 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #2). She indicated that the resident should have been reevaluated for decision making ability. 6. On 03/05/25 at 10:39 AM, review of Resident #79's medical record revealed she/he had an active order for Risperidone with an indication schizophrenia. Schizophrenia is a diagnosis characterized by persistent mind symptoms, such as seeing things that others cannot see, having crazy thoughts, and/or having hard-to-follow speech and ideas. Risperidone is an antipsychotic medication (mind medicine) that can treat schizophrenia symptoms, very high and very low mood, agitation, and aggression. On 03/05/25 at 12:30 PM, further review of Resident #79's medical record revealed a diagnosis of schizoaffective disorder, but failed to reveal indication that the resident had an active diagnosis of schizophrenia. Schizoaffective disorder is a diagnosis characterized by the persistent mind symptoms as seen with schizophrenia, but also includes mood changes such as very high or very low mood. Schizophrenia and schizoaffective disorder are two separate psychiatric conditions that are two distinct diagnoses. On 03/05/25 at 12:35 PM, review of most recent psychiatric (mental health) visit notes by Nurse Practitioner (Staff #25) dated 2/28/25 revealed the resident had active medications including risperidone with an indication of schizoaffective disorder with mood changes. On 03/06/25 at 01:03 PM, a phone interview with Nurse Practitioner (Staff #25) revealed that the physician must have put in the medication order with an indication of schizophrenia and that she had thoughts to change the indication. She indicated that it was easier to understand a medication order indication if it was an active diagnosis in the medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/07/25 at 07:03 AM, further review of the residents medical record revealed the risperidone order indication was changed to a diagnosis of behavioral disturbances.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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. 50457 Based on observations, record reviews, and interviews, it was determined that the facility staff failed to ensure a recommendation for diagnostic testing was completed, a resident was weighed monthly as ordered, and a resident representative was notified when a resident fell . This deficient practice was evident for 3 (#27, #42 #74) 27 residents reviewed during the recertification survey. The findings include: 1). During the initial tour of Senate unit on 2/27/25 at 7:38 AM, the surveyor heard Resident #74 crying. Upon entering the resident's room, the resident stated that both of their feet were in pain. On 2/27/25 at 12:58 PM, a review of the resident's medical records revealed a wound consult by Nurse Practitioner (NP) #9. The progress note indicated that Resident #74 was assessed on 02/27/25 for a new wound on the left heel and diagnostic imaging was recommended. On 03/04/25 a review of Resident #74's medical record revealed that the recommended diagnostic imaging had not been ordered. Review of Resident #74's medical records on 03/04/25, revealed that NP #9 reassessed the residents wound on 03/03/25 but did not mention the previously recommended diagnostic imaging of the left heel from 02/27/25. On 3/4/25, the surveyor informed the Director of Nursing (DON) #2 that Resident #74 had been recommended for diagnostic imaging by NP #9 on 02/27/25, but no order has been placed. The DON #2 stated that she would follow up to determine the status. On 03/04/2025 at 2:35 PM, during an interview with NP #9 regarding treatment plan for resident #74, she explained that she ordered an ultrasound and was waiting for the results to determine the residents' plan of care. The surveyor asked why she did not follow up on diagnostic imaging during her visit with the resident on 03/03/25, NP #9 stated that she informed the care team of the residents' plan of care. After surveyor inquired about the status of the diagnostic imaging on 03/05/25, the DON #2 provided documentation at 8:56 AM that a stat order had been placed for duplex scan to rule out peripheral arterial disease. On 03/12/25 at 10:39 AM, during an interview with Nurse Unit Manager (UM) #15, the surveyor asked the process for ensuring consulting providers recommendations are followed. She explained that the provider sends an email to unit managers and supervisors regarding recommendation. The surveyor asked about the delay in ordering diagnostic imaging for Resident #74. The UM #15 confirmed she received the email but was unable to explain why the recommendation was not completed. 50573 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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	2). On 03/03/25 at 11:27 AM, review of Resident #27's medical record revealed an active order for monthly weights. On 03/03/25 at 11:30 AM, review of Resident #27's documented weights failed to reveal indication that a weight was done in December of 2024. Further review of Resident #27's medical record at the same time failed to reveal indication that the resident refused to be weighed in December 2024. On 03/04/25 at 12:24 PM, an interview with Licensed Practical Nurse (Staff #18) revealed that the expectation of staff was to weigh residents based on their weight order and document it. She further indicated if a resident refused to be weighed that it would be documented. On 03/05/25 at 07:20 AM, an interview with the Director of Nursing (Staff #2) revealed that residents should be weighed according to their weight order. The surveyor reviewed the concern. 3). On 03/03/25 at 08:33 AM, an interview with Resident #42 revealed that he/she recently had fallen in the shower. On 03/04/25 at 10:31 AM, review of Resident #42's medical record failed to reveal documentation regarding a fall. On 03/04/25 at 10:29 AM, the surveyor requested documentation from the facility regarding Resident #42's recent fall in the shower. On 03/04/25 at 11:47 AM, the surveyor reviewed the fall documentation provided by the Director of Nursing (Staff #2). The documentation titled Witnessed Fall indicated it occurred on 2/28/25 but failed to reveal indication that the resident's representative was notified of the fall. On 03/04/25 at 11:49 AM, an interview with the Director of Nursing (Staff #2) revealed that staff were expected to notify the family/resident representative when a resident falls. She indicated that staff failed to notify Resident #42's representative of the fall that occurred on 2/28/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 50457 Based on record reviews, and interviews, it was determined that facility staff failed to ensure the physician notes reflected a review of the residents total care. This deficient practice was evident for 1 (#82) of 27 residents reviewed for physician services during the surveyor. The findings include: On 03/03/25 at 12:53 PM during a review of complaint intake MD00205108 the complainant reported concerns related to Resident #82's dietary needs and medication management as it relates to the resident's a medical diagnosis of irritable bowel syndrome (IBS). Review of Resident #82 medical records on 03/03/25 at 12:55 PM, failed to reveal a documented medical diagnosis of IBS. On 03/11/2025 at 8:28 AM, a review of Resident #82's medical records revealed that the resident was evaluated by their gastroenterologist on 07/15/24. The specialist recommends discontinuing two medications and starting two new ones, and implementation of a dairy free diet based on the resident's IBS symptoms. Further review showed the recommendations were communicated to the nursing facility staff on 07/15/24 at 4:38 PM and the facility's physician confirmed the new orders. A review of the Physician #16's progress note dated 07/18/24 indicated that Resident #82 had seen a gastroenterologist and started on new medication. The physician recommended follow up with gastroenterology, but there was no documentation regarding the resident's diagnosis of IBS or any mention of the resident's dietary needs. During an interview with Physician #16 on 03/11/25 at 10:46 AM, the surveyor informed the physician of the findings. Physician #16 explained that he disagreed with the gastroenterology's diagnosis of IBS, but acknowledged that he failed to document his clinical judgement or an alternative treatment plan. The surveyor explained that the lack of contributed to the facility's failure to implement the recommended dietary orders and update the resident's plan of care. The physician agreed that the lack of documentation could impact the residents' care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42782 Based on medical record review and interviews it was determined that the facility staff failed to 1) document a resident's personal belongings, 2) failed to maintain medical records in accordance with accepted professional standards and practices, and 3) failed to ensure residents' medical records were accurate and reflected their status. This deficient practice was evidenced in 9 (#41, #42, #58, #62, #63, #101, #102, #132, #239) of 29 resident record reviewed for accuracy of inventory during the recertification survey. The findings include: 1. On 02/27/25 at 11:03 am Resident #58 reported their white Nike Size 10 tennis shoes were missing and the facility staff had not replaced them. On 03/05/25 at 8:45 am the surveyor made Social Worker (MSW) #6 regarding Resident #58 reported their tennis were missing. The surveyor asked if a grievance was filed by Resident #58 concerning their missing tennis shoes. On 03/05/25 at 9:47 am MSW #6 provided three separate copies of Resident #58 Inventory of Personal Effects forms dated 05/11/21, 11/04/22, and 03/16/23. A note was written on each form indicating the resident did not have belongings in the facility. In addition, there was not a grievance form on file concerning Resident #58 missing tennis shoes. On 03/05/25 at 9:54 am the surveyor and Unit Manager went to Resident #58 room to assess if the resident had personal belongings in their room. The surveyor observed the resident's dresser had two drawers full of clothing along with clothing in their armoire. On 03/06/25 at 11:05 am Director of Nursing #2 reported the inventory sheet should be completed upon admission and when items are brought into the facility, they should be included on the form. When the family brings in items they are expected to stop at the nurse's station to let them know, so the inventory sheet could be updated. 49148 2. On 2/28/2025 at 1:00PM, the Surveyor reviewed the facility's Smoker List as of 2/26/2025. According to the list, all residents identified as smokers did not need an apron, did not need supervision, had a nursing assessment for smoking, and a care plan for smoking. A review of the electronic medical record for Resident #62, #63, #132, and #239 on 3/4/2025 at 10:44AM revealed that Resident #62 needed supervision and an apron, Resident #63 needed supervision and was missing documentation for the need for any equipment, Resident #132 needed an apron, and Resident #239 had no smoking assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 - Some	On 3/5/2025 at 11:04AM, an interview with the Director of Nursing (DON), the Surveyor was informed that the facility currently has no residents who require independent supervision and/or used aprons. The DON and the Surveyor confirmed that Resident #62 needed supervision and an apron, Resident #63 needed supervision and was missing documentation for the need for any equipment, Resident #132 needed an apron, and Resident #239 had no smoking assessment. The DON stated that the nursing staff are not completing the smoking assessments accurately. The smoker list provided to the Surveyor was up to date because those residents have been reviewed in the morning meetings. The DON did confirm that the smoking assessments have not been completed accurately nor updated to reflect the resident current smoking status. The DON stated the Assistant Director of Nursing (ADON) #19 would be completing an audit of the smoker list. On 3/10/2025 at 9:00AM, the Surveyor reviewed the audited smoker list. According to the audit Resident #62 and Resident #132 needed supervision and/smokers apron. 3. Controlled Drugs (narcotics) are substances that have an accepted medical use, have the potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. On 03/06/2025 at 10:23AM, a review of the narcotic count sheet for Resident #102 revealed that the resident's Oxycodone IR 15mg was signed off as given on 2/17/2025 at 9:45PM and then on 3/3/2025 at 1:40AM. On 3/7/2025 at 11:23AM, a review of Resident #102's electronic medical record revealed that the resident's Oxycodone IR 15mg was discontinued on 2/18/2025. Further review failed to reveal documentation that the medication was administered on 3/3/2025. During an interview with the DON, the Surveyor requested documentation of administration. On 3/10/2025 at 7:51AM, the DON informed the Surveyor that LPN #36 did administer the Oxycodone IR 15mg to resident #102 on 3/3/2025 at 1:40AM. LPN #36 was unable to document the administration in the resident's electronic medical record because the order had been discontinued. 4. On 3/12/2025 at 10:00AM, a review of Resident #41's Medication Administration Record revealed that Licensed Practical Nurse (LPN) #42 documented 7 for all medication administered to the resident on 2/3/2025, 2/6/2025, 2/10/2025, 2/12/2025, 2/17/2025, and 2/24/2025 during the 3:00PM-11:00PM shift. According to the medication administration chart codes, 7 indicates sleeping. On 3/12/2025 at 11:28AM, the Surveyor conducted an interview with the DON. The Surveyor expressed the concern that Resident #41 was not administered their medications on the days that LPN #42 worked the 3:00PM-11:00PM shift because they were sleeping. The DON stated she would follow up with LPN #42 to determine what occurred on the nights she worked with Resident #41. On 3/13/2025 at 8:23 AM, the DON informed the Surveyor that she spoke with Resident #41 and LPN #42. They both stated that the resident received his/her medication on those day LPN #42 worked the 3:00PM-11:00PM shift. LPN #42 inaccurately documented 7 instead of a check (to indicate administered) due to the time of day she was administering the medication. The DON stated she conducted an audit for all the residents LPN #42 worked with in February 2025 and provided LPN #42 with education on documentation in the Medication Administration Record. 50573 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215164	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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 - Some	5. On 03/06/25 at 09:03 AM, an observation of Resident #42 revealed he/she was in their wheelchair and dressed. On 03/06/25 at 01:22 PM, record review of the resident's shower documentation for the day revealed an order which indicated, Shower scheduled day shift Monday/Thursday and PRN (as needed) every day shift every Mon, Thu which was signed off by Registered Nurse (Staff #20). On 03/06/25 at 01:24 PM, an interview with Resident #42 revealed he/she had not showered yet that day. On 03/06/25 at 01:34 PM, an interview with Registered Nurse (Staff #20) revealed the expectation is for staff to sign off on orders, including shower orders when it was completed and done. Staff #20 indicated that Resident #42 had not showered that day and that the resident usually got their shower in the evening. Further interview at the same time with Staff #20 revealed he was unable to indicate to the surveyor why he signed off on Resident #42's shower when it was not done. On 03/07/25 at 06:52 AM, an interview with the Director of Nursing (Staff #2) revealed that the resident always had gotten his/her shower in the evening, but just happened to be on the list and ordered to receive it on days. She further indicated that Staff #20 should not have signed off on the shower prior to it being done. 6. On On 03/07/25 at 09:41 AM, review of Resident #101's medical record revealed an active order, Check and change oxygen tubing weekly and PRN every night shift every sat for per protocol date the oxygen tubing. At the same time, further review of Resident #101's medical record revealed an active order which indicated to check the resident's gastric tube for proper placement prior to each feeding, flush or medication administration, three times a day. A gastric tube is a surgically placed tube that delivers nutrition, fluids, and medications directly into the stomach through a small opening in the abdomen, without using the mouth. On 03/07/25 at 01:08 PM an observation of Resident #101 revealed he/she was in a wheelchair and on room air. On 03/10/25 at 07:20 AM, an interview with Licensed Practical Nurse (Staff #18) revealed the resident was not on oxygen nor does he/she get tube fed or medications through his/her gastric tube. She indicated that the resident had received oxygen and was previously tube fed, but that it had been awhile. On 03/10/25 at 07:51 AM, the surveyor reviewed the concern with the Director of Nursing (Staff #2).