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	06/16/2025

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, record review, and facility policy review, the facility failed to assess a resident whose medication was left at bedside and who desired to self-administer medication for 1 (Resident #1) of 3 residents reviewed for medications. Findings included: A facility policy titled, Self-Administration of Medication at Bedside, dated 01/29/2024, indicated, 1. The patient may request to keep medications at bedside for self-administration in a lock box. 2. Complete Medication Self-Administration Safety Screen assessment. 3. The Interdisciplinary Team will review the assessment and together, use clinical judgement to determine if the patient is eligible. An admission Record revealed the facility admitted Resident #1 on 11/01/2024. According to the admission Record, Resident #1 had a medical history that included unspecified depression, gastro-esophageal reflux disease (GERD) without esophagitis, unspecified fracture of the orbit (area around the eye), and unspecified fracture of the facial bones. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed Resident #1 had adequate vision with the use of corrective lenses. The MDS revealed the resident did not reject care during the assessment's lookback period. The MDS revealed Resident #1 had no functional limitation in range of motion (ROM) of the upper extremities or the lower extremities. Additionally, the MDS indicated Resident #1 completed eating and oral hygiene independently, was independent moving from a lying position to sitting on the side of the bed and was independent with transfers from the bed to a chair. Resident #1's Care Plan Report, included a focus area revised on 11/11/2024, that indicated Resident #1 was at risk for pain. Interventions directed staff to administer medications as ordered (initiated 11/01/2024). The Care Plan Report had no documentation that indicated Resident #1 had been care-planned for self-administration of medication. During an observation on 06/09/2025 at 11:35 AM, medications that included Aspercreme (a lotion used to ease muscle pain), saline nasal spray, trazadone (an antidepressant medication), Tylenol ES (extra strength tablets used to treat minor pain), and Imodium (a medication to help with diarrhea) were observed at Resident #1's bedside. During a concurrent interview, Resident #1 stated they took the trazadone at bedtime to help with sleep. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's Order Summary Report, with active orders as of 06/09/2025, included an order with a start date of 05/29/2025 for acetaminophen 324 milligrams (mg), with instructions to give two tablets every six hours as needed for pain. The Order Summary Report included an order with a start date of 11/01/2024 for trazadone hydrochloride 100 mg, with instructions to give two tablets at bedtime for depression. The Order Summary Report did not include orders for saline nasal spray, Imodium, or Aspercreme. The Order Summary Report did not include orders to allow the resident to keep medication at the bedside or self-administer medication. During an observation on 06/11/2025 at 12:58 PM, Resident #1 was sitting on their bed and the medications remained at bedside. During an observation on 06/12/2025 at 10:05 AM, the medications remained at Resident #1's bedside. During a concurrent interview, Resident #1 stated the medications had been at their bedside since admission to the facility. Resident #1 stated they were aware the facility provided trazadone at bedtime, but sometimes they needed extra medication. Resident #1 stated they would like to be able to administer their own medication and added they were unable to remember a nurse assessing them for self-administration of medication. Resident #1 stated that the Tylenol at bedside controlled their pain; in addition, the staff brought Tylenol when needed. Registered Nurse (RN) #1 was interviewed on 06/12/2025 at 10:13 AM. RN #1 stated she was unaware of any resident on her assignment that self-administered their medication. RN #1 stated if a resident wanted to self-administer their medications, the nurses would have to review the medications and assess the resident to see if the resident was capable. RN #1 stated she had not observed any medication at Resident #1's bedside when she was in the room and stated she had been assigned to Resident #1 on 06/09/2025, 06/11/2025, and 06/12/2025. RN #1 stated she had received no reports from staff that Resident #1 had medication at their bedside. Certified Nursing Assistant (CNA) #2 was interviewed on 06/12/2025 at 10:15 AM and confirmed she had been assigned to care for Resident #1 on 06/11/2025. CNA #2 stated she had not observed any medication at the resident's bedside and added if there had been medication, she would have called the nurse to the room. CNA #3 was interviewed on 06/12/2025 at 11:00 AM and stated if she saw medication at a resident's bedside, she would take the medication to the nurse. CNA #3 stated she had not seen any medication at Resident #1's bedside and confirmed she had been in the resident's room earlier in the day. At that time, CNA #2 and CNA #3 went to Resident #1's room and on return confirmed there was medication by the resident's bed. CNA #2 and CNA #3 stated the medication should not have been there. CNA #2 and CNA #3 reported RN #1 was in the resident's room and had not noticed the medication. The Director of Nursing (DON) was interviewed on 06/12/2025 at 11:28 AM and stated she had one resident in the facility that had been assessed and had orders to self-administered medication, but it was not Resident #1. The DON stated that if medications were observed at a resident's bedside, the staff were expected to remove the medication and then follow the process for obtaining orders and assessing the resident for self-administration. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/2025 at 11:35 AM, the DON reported the medication had been removed from Resident #1's room and stated again she would have expected the staff to see the medication when they entered the room and then remove the medication. The DON stated the staff had tunnel vision and concentrated on the task at hand.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure nonverbal and/or cognitively impaired residents were assessed during an abuse investigation for 1 of 2 abuse investigations reviewed. Findings included: A facility policy titled, Reporting Requirements/Investigations, dated 02/05/2023, indicated, Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. The policy indicated, The Administrator and/or Director of Nursing would immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigation protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations. A document titled, Maryland Department of Health Office of Health Care Quality Facility Reported Incident [FRI] Initial Report Form, dated 03/22/2025 at 12:30 PM, indicated Resident #6 stated they had been physically abused. The report indicated a male staff member was suspended, all staff who worked the unit for the previous 48 hours where Resident #6 resided were interviewed, and other residents on the same hallway were interviewed. The facility's investigation included Investigative Reporting Written Statement forms dated 03/22/2025 that revealed two residents were unable to speak and one resident was unable to answer. The facility's investigation did not include assessments of non-verbal or cognitively impaired residents. During an interview on 06/12/2025 at 12:39 PM, the Director of Nursing (DON) stated she could not confirm that residents who could not talk or were cognitively impaired were assessed during the sexual abuse investigation. The DON stated she should have assessed the cognitively impaired residents and did not. The DON stated that after being asked and considering those residents she would say a thorough investigation was not completed. The DON stated she expected a thorough investigation to be completed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, facility policy review, and review of manufacturer's guidelines for mechanical lifts and for mechanical lift slings, the facility failed to follow the guidelines for operation of the mechanical lift for 1 (Resident #2) of 2 residents observed that were transferred with a sling. The failure to follow the facility policy and guidelines supplied by the manufacturer contributed to Resident #2 sustaining a severely comminuted (a fracture of a bone into three or more pieces usually from high impact trauma or a fall from heights) fracture. Findings included: A facility policy titled, Mechanical Lift, dated 01/29/2024, revealed the section titled, Procedure, included, 2. Two trained staff must assist with mechanical lift and transfer. The policy revealed, 4. Follow manufacturer's guidelines for use. An admission Record revealed the facility admitted Resident #2 on 12/17/2015. According to the admission Record, Resident #2 had a medical history that included anoxic brain damage not elsewhere classified, unspecified hemiplegia (partial paralysis on one side of the body) affecting the right dominant side, and right-hand and left-hand contractures. The admission Record did not include a diagnosis of osteoporosis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/17/2025, revealed Resident #2 had severe impairment in cognitive skills for daily decision-making per a Staff Assessment for Mental Status (SAMS). The MDS revealed Resident #2 had no speech. The MDS revealed the resident rarely/never understood others and rarely/never made themself understood. The MDS revealed the resident's vision was highly impaired, and no corrective lenses were used. The MDS indicated Resident #2 had functional limitations in range of motion (ROM) of bilateral upper extremities and bilateral lower extremities. The MDS revealed Resident #2 was dependent upon staff for all activities of daily living and mobility. The MDS indicated Resident #2 had not sustained any falls during the assessment's lookback period. Resident #2's Care Plan Report, included a focus area revised on 01/24/2023, that indicated the resident had an activities of daily living self-care performance deficit. Interventions directed staff to transfer the resident with a mechanical lift (revised 09/26/2022). The Care Plan Report included a focus area revised on 01/24/2023, that indicated Resident #2 was at risk for falls. Interventions indicated staff should be educated to use the mechanical device, and the resident was a total lift for all transfers, using two staff to assist with the lift (revised on 09/26/2022). Resident #2's Weight Summary revealed that on 05/25/2025 Resident #2 weighed 160 pounds and had a height of 66 inches. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An undated Proactive (name of a brand of medical equipment) Patient Sling Reference Guide, indicated, It is very important to use the correct sized sling and make sure it is fitted properly prior to lifting. The guide indicated, - The position achieved by adjusting the loops will depend upon the height and build of the patient. The guide included a Size &(and) Weight Range Guide that indicated Please note the following sling guide is a recommendation only. A full risk assessment must be done prior to any sling being selected. This will ensure safety for the patient and caregiver. The guide revealed that a medium size sling should be used for a resident that was 125 to 200 pounds and 63 to 68 inches tall. An Invacare Reliant 450/600 (a type of mechanical lift) user manual, dated 2022, indicated BEFORE using this product, this manual MUST be read and saved for future reference. The manual revealed the section titled, 2.2 Operating Information, indicated, -Invacare slings and patient lift accessories are specifically designed to be used in conjunction with Invacare patient lifts. Slings and accessories designed by other manufacturers are not to be utilized as a component of the Invacare patient lift system. The manual revealed the section titled, 2.2.4, Lift Operations, indicated, -Although Invacare recommends that two assistants be used for all lifting preparation and transferring-from and transferring-to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the healthcare professional for each individual case. Resident #2's Progress Notes, dated 05/08/2025 at 9:22 PM, revealed a Situation, Background, Assessment, and Recommendation (SBAR) form was completed, which indicated Resident #2 had an other change in condition. The SBAR indicated Resident #2 experienced pain, and the resident's right leg was swollen, warm to touch, and had discoloration. The SBAR revealed the provider was notified, and staff were waiting to hear from the provider. Resident #2's Pain Assessment, dated 05/08/2025 at 9:37 PM, revealed the section titled, E. Indicators of Pain or Possible Pain, revealed the box for Facial expressions was checked. The assessment revealed Registered Nurse (RN) #4 gave the resident Tylenol (a mild pain reliever). Resident #2's Progress Notes, dated 05/08/2025 at 10:40 PM, revealed Resident #2's power of attorney (POA) was notified about the resident's change in condition and the resident's hospital transfer. Resident #2's Progress Notes, dated 05/09/2025 at 4:15 AM, revealed that Resident #2 remained in the emergency room (ER). Resident #2's Progress Notes, dated 05/09/2025 at 2:51 PM, revealed Resident #2 had been admitted to the hospital with a right femoral displaced fracture (a break in the upper bone of the leg with the bones not in alignment) and had received a blood transfusion. A SNF/NF [Skilled Nursing Facility/Nursing Facility] to Hospital Transfer Form, dated 05/08/2025 at 9:52 PM, indicated the reason for Resident #2's transfer was a suspected fracture. The form indicated the resident was alert, disoriented, but could follow simple instructions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #2's ED [emergency department] Note-Physician, dated 05/08/2025, indicated Resident #2 had been transferred due to swelling of the right knee and generalized pain. The note indicated that the resident had normocytic anemia due to blood loss and a complex, right distal femur fracture with an associated hematoma. The note indicated Resident #2's right leg was diffusely edematous with distal pulses well-preserved. The note indicated the source of the normocytic anemia was unclear although the anemia may be associated with the hematoma that developed from the fracture. A hospital History and Physical, dated 05/09/2025, revealed Resident #2's findings from a computed tomography (CT) scan (a type of X-ray technique used to create detailed images), included diagnoses of a severely comminuted and displaced rapture of the distal femoral metaphysis with marked external rotation of the distal fragment and moderate hemorrhage between the fracture fragments. During a telephone interview on 06/10/2025 at 10:26 AM, Resident Representative (RR) #5, Resident #2's representative, stated Resident #2 was able to move their arm or leg but was unable to turn in bed independently, and was dependent upon staff for everything. RR #5 stated staff reported to them that Resident #2's fracture must have occurred during care. RR #5 stated Resident #2's roommate, Resident #24, reported that they had told the nurse that they did not like the staff person putting Resident #2 in the lift alone. RR #5 stated Resident #24 reported to them that when the staff member swung Resident #2 around in the lift, Resident #2 yelled out. RR #5 stated she had relayed what Resident #24 had reported to the two Social Workers. During an interview on 06/10/2025 at 11:15 AM, Resident #24 confirmed they had been the roommate of Resident #2 on 05/08/2025. Resident #24 stated a female, day shift, certified nursing assistant (CNA) had transferred Resident #2 alone, but Resident #24 would not divulge the staff member's name. Resident #24 stated Resident #2 was unable to speak, but they were able to tell Resident #2 was in pain by the grimace on their face. Resident #24 stated they had given a statement to RN #6 about what they had witnessed and how Resident #2 sustained the fracture, but they were unsure what RN #6 had put in the statement. A quarterly MDS, with an ARD of 05/24/2025, revealed Resident #24 had a BIMS score of 15, which indicated the resident had intact cognition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/10/2025 at 11:31 AM, CNA #7 stated she had been assigned to care for Resident #2 on 05/07/2025 during the 7:00 AM to 3:00 PM shift. CNA #7 stated Resident #2 had no purposeful movement but did have jerking movements. CNA #7 stated she had cared for Resident #2 for over a year and felt she knew the resident. She described Resident #2 as making noises but had no sounds or facial grimaces that indicated pain. CNA #7 stated that during the care of the resident she had checked the resident's skin and had not seen any bruising or anything out of the ordinary. CNA #7 stated Resident #2 was care planned to get out of bed on Mondays, Wednesdays, and Fridays and stated she had transferred the resident out of bed on Wednesday, 05/07/2025, by herself, although she knew it was the facility policy to have two staff members when using the mechanical lift. CNA #7 stated she had not asked other CNAs to help her because it was a hectic day and stated she had not asked the assigned nurse or the Director of Nursing (DON) to help because she knew they were busy. CNA #7 stated the room was small and not suitable for transferring the resident with both the mechanical lift and the geriatric (geri) chair in the room, so she left Resident #2's chair in the hallway. CNA #7 stated that as she moved Resident #2 out of the room, she was also trying to move any items out of the way, noting she had to angle the chair and the bed to make sure the lift fit between the wall and the roommate's bed. CNA #7 stated Resident #2 had jerking movements as the resident was moved from the bed to the chair but had not been severe enough to fall out of the lift. CNA #7 stated that during the resident's jerking movements, she had made sure the resident's arms and legs had not touched any items in the room. CNA #7 demonstrated how she had moved the foot of Resident #2's bed over, angled the lift, placed Resident #2 on the sling for the lift, backed the resident out of the room, and placed the resident in the chair in the hallway. CNA #7 stated she held the sling to try to keep Resident #2 from jerking uncontrollably. During an interview on 06/10/2025 at 1:50 PM, Licensed Practical Nurse (LPN) #8 stated she had been assigned to Resident #2 on 05/07/2025 and 05/08/2025. LPN #8 stated the facility policy indicated two staff members were needed to transfer a resident with the mechanical lift, and if there were no other staff available, she expected the CNA to ask her for assistance. LPN #8 stated CNA #7 had not requested her assistance with Resident #2's transfer. LPN #8 stated Resident #2 had both purposeful and spastic movements. LPN #8 stated that when she would give the resident their tube feeding, Resident #2 would try to push her arm out of the way. LPN #8 stated the resident smiled when spoken to and would grind teeth or moan when they were in pain. During an interview on 06/10/2025 at 2:27 PM, CNA #7 stated she chose the sling that was used with the mechanical lift by the size of the resident and the length and width of the sling. CNA #7 stated the facility used different types of slings and used three different types of mechanical lifts. CNA #7 identified the Invacare Reliant as the mechanical lift she had used to transfer Resident #2. CNA #7 stated she measured the sling against the resident's body to keep the resident's head and body safe. CNA #7 stated she remembered the type of sling she had used and got the sling that was labeled Proactive. CNA #7 stated all the slings in the building could be used on all the lifts in the building. An observation of the sling that CNA #7 stated she had used on Resident #2 revealed a tag that indicated the sling had a maximum weight of 600 pounds; the sling had three tabs on each side that were purple, green, and blue in color. CNA #7 stated she was hired on 03/05/2024, and since then no one had observed her skills using a mechanical lift. CNA #7 stated the only time she had not had someone helping her transfer a resident was when she had transferred Resident #2. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/10/2025 at 3:16 PM, RN #4 stated he had been assigned to Resident #2 on 05/08/2025 during the 3:00 PM to 11:00 PM shift. He stated that on that night around 10:00 PM, CNA #9 had reported there was something wrong with Resident #2's leg. RN #4 stated that when he assessed the resident, he found the resident's right leg was shorter than the left leg (a shorter leg is one sign of a fracture) and was swollen. He stated the resident's leg was pink in color and warmer to touch than the other leg. RN #4 stated Resident #2 grimaced when moved. RN #4 stated he called RN #10, the nurse supervisor, and RN #10 told him Resident #2's leg looked fractured. RN #4 stated that RN #10 made calls to the primary care provider (PCP) and made arrangements to transfer the resident. RN #4 stated Resident #2 was transferred to the hospital. RN #4 stated he did not find out until 05/09/2025 that Resident #2's leg was fractured. During an interview on 06/10/2025 at 3:43 PM, CNA #9 stated that when she cared for Resident #2 on 05/08/2025 during the 3:00 PM to 11:00 PM shift, she noticed the resident's leg was big and warm. CNA #9 stated she notified RN #4. CNA #9 stated that when she turned Resident #2, the resident made a face she described as not a happy face. During an interview on 06/10/2025 at 4:02 PM, RN #10 stated that on 05/08/2025 during the 3:00 PM to 11:00 PM shift, RN #4 notified him that Resident #2's leg was swollen and warm and the resident was in pain. RN #10 stated Resident #2's leg was paler and slightly bent, but he had not noticed any bruising. He stated he called the PCP, and the resident was transferred to the hospital. During an interview on 06/10/2025 at 4:09 PM, the Central Supply Coordinator (CSC) stated the slings for the lifts were not interchangeable and that a sling with a weight limit of 600 pounds was for a bariatric resident. He stated the lift sling used was based on the size of the resident. He stated he was unable to find a posted sizing chart for the slings, and added staff usually looked at the resident and chose a sling that was appropriate. During an interview on 06/11/2025 at 8:30 AM, RN #6 stated he was the unit manager during the day, but his hours of work varied. RN #6 stated he assisted with interviewing staff and residents after the incident with Resident #2. He stated he had interviewed Resident #24, who had been Resident #2's roommate. RN #6 stated Resident #24 had been confused about when the incident happened, and he was unsure what Resident #24 had seen. RN #6 stated Resident #24 told him Resident #2 had been transferred with only one staff member using the mechanical lift. RN #6 stated he knew the policy indicated two staff members were to use the mechanical lift. RN #6 stated he wrote Resident #24's statement and handed the entire stack of statements to the DON During an interview on 06/11/2025 at 10:01 AM, the CSC stated there were three mechanical lifts currently in service and added that all the lifts were different. He stated the lift slings could be interchanged between all three lifts since they were all connected to the lifts in the same way. He stated the slings could be interchanged since each sling had four differently colored loops that correlated to the weight of the resident. On review of the sizing chart for the Proactive chart, the CSC noted that the colors on the chart did not match the color of the loops on the sling. The DON entered the room with a sizing chart that was from a different manufacturer. The colors on the sizing chart did not correlate to the loop colors on the sling. The DON stated if the staff chose the wrong size sling the resident would be constricted or could fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A representative from Invacare customer support was interviewed by telephone on 06/11/2025 at 10:30 AM and stated he suggested facilities only use the sling sold by the Invacare company since that was the only sling that had been tested by the company with the identified lift. He stated if facilities used another brand of sling with the Invacare mechanical lift there was a possibility it could cause harm to the residents. A member of Proactive customer support was interviewed by telephone on 06/11/2025 at 10:40 AM. The Proactive customer support member stated the weight capacity was the same for all the lifts slings sold by the company, with a maximum of 600 pounds. She stated the loops were color coded for positioning and not weight, and the full body sling could be used for any sized resident. She stated there should be no issues encountered when using a different brand mechanical lift with the Proactive sling. During an interview on 06/11/2025 at 2:02 PM, the Director of Rehabilitation (DOR) stated the rehabilitation department was not involved in choosing the sling used by residents for mechanical lift transfers. During an interview on 06/12/2025 at 8:03 AM, the Assistant Director of Nursing (ADON) stated mechanical lift training was done on the floor with the CNA preceptor (another CNA), and she did not observe those. The ADON stated staff were taught there always had to be two staff members present when transferring a resident with a mechanical lift to provide safety for the resident, and only one person would not be able to safely maneuver the mechanical lift. During an interview on 06/12/2025 at 8:41 AM, the DON stated that after she found out about Resident #2's fracture, she initiated training on abuse and mechanical lift transfers for the nursing department. She stated she had read Resident #24's statement but had doubted Resident #24's statement since the resident had a history of not being truthful. She stated that now she felt she should have investigated the resident's statement more. The DON stated that she had not known CNA #7 had transferred Resident #2 alone and added CNA #7 had stated previously that someone had helped her transfer the resident. The DON stated staff had been trained to choose a sling for the lift based on the resident's height and weight, and until yesterday when she called the Proactive company, she had been unaware one sling size fit all. The DON reviewed the Proactive color graph listing weights and heights with colored codes and stated she had called the company again since the two sets of information on one instruction sheet was confusing. She stated she had not received a return call. The DON stated she had not requested a return demonstration from the CNAs that had transferred Resident #2 on 05/07/2025 but did not think the use of the available sling had anything to do with the fracture. The DON stated it may be possible that when CNA #7 moved the resident alone that could have contributed to the fracture. The DON stated Resident #2 had co-morbidities such as long-term use of anticoagulants and being bed bound, and the resident's Vitamin D level was low. During a telephone interview on 06/12/2025 at 9:33 AM, the Medical Director stated he had reviewed Resident #2's chart and the fracture was due to undiagnosed and untreated osteoporosis secondary to the resident's bed bound status and a low Vitamin D along with hormonal changes. He stated there were residents that incurred fractures with minimal trauma. (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	06/16/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/12/2025 at 3:59 PM, the ADON stated she used a video provided by the therapy department for mechanical lift training. The ADON stated that other than knowing the video concentrated on body mechanics, she did not know what was included in the video. At that time, the video was reviewed, and it was noted that the lift and the slings used in the video were different from the lifts and slings used by the facility. The ADON stated she told staff it was not the same lift and showed the staff the ones used by the facility. She stated she had seen the manuals but had not read them. The ADON stated the loops on the slings were for balance only, and weight, height, and girth were secondary. The ADON stated the therapy department only supplied the video for lift training and did not have a role in deciding which loop or sling residents required. The ADON stated no one was responsible for making sure the loops used for individual residents by the CNAs were correct. During an interview on 06/13/2025 at 11:12 AM, the DON stated she had been unaware that the manufacturer's instructions included using the slings made by the same company to avoid injury. The DON stated she was unaware the video for lift training had not used the lifts or slings used by the facility and thought the video was more about teaching techniques to lift transfers. She stated in hindsight that the ADON should have reviewed the material she taught. The DON stated not following the manufacturer's recommendations when using the lift and sling may cause harm and added the only time the therapy department had input into residents' transfers with lifts was when the staff from the department assisted with the transfers. During a telephone interview on 06/16/2025 at 10:41 AM, PCP #38, Resident #2's PCP, stated the resident was bedbound, which placed Resident #2 at a higher risk of developing osteoporosis and fragile bones that could fracture with turning the resident during care. He stated he was unsure how much force would be needed to result in a comminuted fracture.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to ensure a medication error rate of less than 5 percent (%). There were 2 errors out of 30 opportunities, which resulted in a 6.66% medication error rate affecting 1 (Resident #16) of 7 residents observed during medication administration. Findings included: A facility policy titled, Administration Procedures for All Medications, revised 08/2020, indicated, Medication will be administered in a safe and effective manner. An Instructions for Use Tresiba ([NAME]-Si-bah) (insulin degludec) injection, for subcutaneous use FlexTouch Pen 200 units/ml [milliliter], revised 07/2022, indicated, Priming your Tresiba FlexTouch Pen: Step 7: Turn the dose selector to select 2 units. Step 8: Hold the pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows '0'. The '0' must line up with the dose pointer. A drop of insulin should be seen at the needle tip. An admission Record indicated the facility admitted Resident #16 on 12/31/2024. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus with hyperglycemia and long-term use of insulin. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/06/2025, revealed Resident #16 had moderate impairment in cognitive skills for daily decision-making per a Staff Assessment for Mental Status (SAMS). The MDS revealed the resident had a diagnosis of diabetes mellitus and received insulin injections daily during the assessment's seven-day lookback period. Resident #16's Care Plan Report, included a focus area created 01/01/2025, that indicated the resident had diabetes mellitus and was at risk for complications and blood glucose fluctuations related to a diagnosis of diabetes mellitus with insulin. Interventions directed staff to administer medications per physician order (created 01/01/2025). Resident #16's Order Summary Report with active orders as of 06/12/2025, revealed an order dated 02/05/2025 for Tresiba FlexTouch (insulin) pen 200 unit/ml, with instructions to inject 32 units subcutaneously in the morning. During an observation of medication pass on 06/11/2025 at 10:27 AM, Licensed Practical Nurse (LPN) #37 prepared Resident #16's medications, including Tresiba FlexTouch 200 unit/ml pen. LPN #37 cleaned the pen with an alcohol swab, attached the needle to the pen, then turned to 32 on the indicator and administered the insulin. LPN #37 did not prime the needle before administering the insulin. During an observation of medication pass on 06/12/2025 at 8:16 AM, LPN #20 prepared Resident #16's medications, including Tresiba FlexTouch 200 unit/ml pen. LPN #20 cleaned the pen with an alcohol swab, attached the needle, then turned the indicator to 32. LPN #20 did not prime the needle before administering the insulin. LPN #20 was asked about priming the needle, and she stated that once the top was pulled off the needle, the insulin was there in the needle, so there was no need to prime it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 06/16/2025 at 10:20 AM, Pharmacist #39, who was the facility pharmacy consultant, stated she would have to pull the packet insert for Tresiba, but usually the needle should be primed prior to administration. During an interview on 06/16/2025 at 12:16 PM, the Assistant Director of Nursing (ADON) stated when administering Tresiba FlexTouch pen staff are to open the insulin pen, attach the needle, cleanse the area, turn the dial on the pen to the units that were ordered, inject the needle in the skin and push down until the pen clicks, wait a few seconds, then remove from the administration site. The ADON stated the needle did not have to be primed because they did not want to waste insulin. The ADON reviewed the Tresiba FlexTouch pen 200 units/ml instructions for use, then stated they should be priming the needle before they administered the insulin to ensure the correct dose was administered. During an interview on 06/16/2025 at 12:45 PM, the Director of Nursing (DON) stated she expected air to be removed from the needle prior to insulin administration.