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	12/19/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure proper securement of a suprapubic catheter for 1 (Resident #19) of 2 residents observed with a suprapubic catheter during the complaint survey, resulting in catheter dislodgement, urine saturation of the bed, and resident discomfort.The Findings Include: Review of facility policy, titled Nursing Care and Services dated 1/29/2024 documented, that the center will utilize Mosby's Textbook for Long-Term Care Assistants by Kostelnick and/or Clinical Nursing Skills & Techniques by [NAME], [NAME], and Ostendorff, as a reference for nursing services and skills not otherwise provided in the Policies and Procedures Manuals.Review of the medical record for Resident #19 revealed an admission date of 5/2/2022. Diagnoses included paraplegia, neuromuscular dysfunction of bladder, overactive bladder, other female genital tract fistulae, unspecified injury T1 level of thoracic spinal cord, disorder of kidney and ureter, 1 through stage 4 chronic kidney disease.Review of Resident #19's Care Plan revealed interventions related to care of resident's suprapubic catheter but no mention of assessing securement of the tubing. Review of Resident's #19's Quarterly Minimum Data Set assessment (MDS) dated [DATE] showed a BIMS score of 15. Resident #19 was dependent on staff regarding activities of daily living (ADL).On 12/17/2025 at 9:38 am during an observation of perineal care for Resident #19 revealed, the resident was in their bed. The resident was noted to have a suprapubic catheter in place. The catheter tubing was not secured to the resident's leg with an anchor or stabilization device.On 12/18/2025 at 9:36 am during an observation of Resident #19 revealed, the resident was in their bed. The resident did not have their catheter tubing secured to the resident's leg with an anchor or stabilization device.During an interview on 12/17/2025 at 1:25 pm, Resident #19 approached the surveyor to talk about not having a securement device for their catheter tubing. The resident stated that it bothers them to not have the tubing secured, because it frequently becomes disconnected and leaks urine. During an interview on 12/18/2025 at 9:36 am with Resident #19 revealed, the resident did not have a securement device for their catheter tubing. The resident also reported that the catheter tubing became disconnected, resulting in urine leakage that saturated the resident's bed linens. During an interview on 12/18/2025 at 10:54 am with Central Supply (CS) #24 revealed, that the unit has not been low on securement devices, and no one has requested that any be brought to the unit.During an interview on 12/18/2025 at 11:00 am with Unit Manager (UM) #23 revealed, there were no securement devices in the stock supply room, there were five in UM #23's locked office. UM #23 reported that one had been given to License Practical Nurse (LPN) #6 for Resident #19. When asked why one had not been provided to the resident on the previous day UM #23 stated that one had been given to another nurse the day before and UM #23 had no explanation why the securement device had not been placed on the resident. During an interview on 12/18/2025 at 5:00 pm the Director of Nursing (DON) #2 stated that they would be going around and would check all residents who had catheters and made sure they had them, and one would also be kept at bedside.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and a review of facility policies, the facility failed to ensure staff followed an infection prevention can control program designed to provide a safe and sanitary environment for two (2) of two (2) residents (Resident # 18 and Resident # 19) observed for perineal care during the complaint survey .The Findings Include: Review of facility policy, titled Handwashing Requirements dated 2/6/2020 documented, All staff are trained in proper technique upon hire, annually, and PRN, and are monitored for proper handwashing practices. Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections.D. Gloves.3. Change gloves during patient care when moving from a contaminated body site to a clean body site.1) Review of the medical record for Resident #18 revealed an admission date of 11/21/2025. Diagnoses included end stage renal disease, dependence on renal dialysis, encounter for attention to tracheostomy, encounter for attention to gastrostomy, pressure ulcer of sacral region, stage 4, contracture, right hand, contracture left hand, benign prostatic hyperplasia with lower urinary tract symptoms, other symptoms and signs involving cognitive functions and awareness, acquired absence of right leg above knee, acquired absence of left leg above knee.Review of Resident's #18's admission Minimum Data Set assessment (MDS) dated [DATE] showed a BIMS score of 14. Resident #18 was dependent on staff regarding activities of daily living (ADL).On 12/16/2025 at 1:32 pm during an observation of perineal care for Resident #18 revealed, the resident was in their bed. The resident was noted to have a suprapubic catheter in place. Geriatric Nursing Aide (GNA) #21, double gloved, and put on another pair of gloves instead of performing hand hygiene and washing hands. GNA #21 wiped the end of resident's genitals and handed dirty cloth to GNA #20, then GNA #20 handed a cloth to GNA #21, with no glove change in between. Then both GNAs changed gloves with no hand hygiene. GNA #20 wiped Resident #18's buttocks while visible fecal matter remained present. The GNA used both hands during the cleansing process with the disposable wipes and did not apply a moisture barrier or protective cream to the resident's buttocks after care was completed. GNA #21 removed the soiled incontinence pad from underneath the resident and brought the soiled pad over the top of the resident's body prior to disposal. GNA #21 held the catheter tubing above the connector, and GNA #20 wiped around the catheter site and place a new gauze on the site. GNA #21 wiped the left shoulder of the resident where secretions from the resident's tracheostomy had dripped, and then put a new gown on the resident with no glove change or hand hygiene in between.In an interview on 12/16/2025 at 2:02 pm with GNA #20, reported they forgot to have a basin with soap and water to use for the cleaning the resident's suprapubic area.2) Review of the medical record for Resident #19 revealed an admission date of 5/2/2022. Diagnoses included paraplegia, neuromuscular dysfunction of bladder, overactive bladder, other genital tract fistulae, unspecified injury T1 level of thoracic spinal cord, disorder of kidney and ureter, 1 through stage 4 chronic kidney disease.Review of Resident's #19's Quarterly Minimum Data Set assessment (MDS) dated [DATE] showed a BIMS score of 15. Resident #19 was dependent on staff regarding activities of daily living (ADL).On 12/17/2025 at 9:38 am during an observation of perineal care for Resident #19 revealed, the resident was in their bed. The resident was noted to have a suprapubic catheter in place. GNA #21 performed no hand hygiene prior to donning two (2) sets of gloves. Upon entering the room, the catheter collection bag was sitting in the trash can on the floor. GNA #22 took the collection bag out of the trash can and drained the bag into a urinal and then hung the collection on the frame of the resident's bed. GNA #21 brought in wash cloths for perineal care and placed them in a chair with other items and no protective barrier. GNA #22 retrieved a basin and filled with water. GNA #22 touched the resident's soiled brief then touched both hands together with no glove change. The GNA's rolled the resident onto their right side and wiped fecal matter down the buttock, then wiped between the buttocks, and subsequently wiped the resident's back using a wet wash cloth without changing gloves.During an interview on 12/17/2025 at 1:50 pm with Unit Manager (UM) #23 reported, the expectation with perineal care is that the staff use hand sanitizer. When doing catheter care UM #23 stated that they should use a wash cloth and water, and should wash their hands and change gloves. UM #23 also said that they are not to use double gloves, that they will educate staff and that they have a basin, they are supposed to put wash cloths in the basin and usually they put wash cloths on a table and make sure the table is clean. UM #23 added that for female residents that staff should only wipe in one direction, and that they will definitely do some education on that topic, and that the collection bags are not kept in trash bins.During an interview on 12/17/2025 at