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	04/13/2026

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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews and interviews it was determined that the facility failed to report to the State Agency Office of Health Care Quality (OHCQ) a resident's elopement. This was found to be evident for 1 (Resident #1) out of 1 Resident reviewed for elopement during the complaint survey.The findings include: During a review of complaint #2977680 conducted on 04/13/26 at 7:00 AM, the complainant reported that Resident #1 left the facility premises on 04/04/26 without the knowledge of the facility, was injured from a fall, and was transported to a hospital.Patients on anticoagulants (blood thinners) who experience a head injury require immediate medical evaluation, typically via an expedited CT scan, due to a significantly high risk of delayed, fatal intracranial hemorrhage. Even minor trauma can cause bleeding, necessitating urgent reversal of anticoagulation.During a review of the Emergency Medical Services (EMS) report conducted on 04/13/26 at 8:33 AM, it was discovered that on 04/04/26 a bystander observed Resident #1 bleeding from a fall. The bystander assisted the resident to a sitting position and called 911. EMS arrived and assessed the Resident to be alert and oriented four times. The Resident advised EMS that he/she was on an anticoagulant. EMS determined that the Resident had a traumatic head injury and transported the Resident to a hospital that provided care for traumatic injuries. During an interview conducted on 04/13/2026 at approximately 9:00 AM the Director of Nursing (DON) reported that on 04/04/26 at approximately 2:45 PM the DON and Unit Manager #1 observed Resident #1 outside in front of the facility sitting in his/her wheelchair speaking to a female in Spanish. During the continued interview the DON advised that on the same day of the incident (04/04/26) at 3:15 PM the facility activated a fire drill at 3:15 PM and cleared the drill at 3:30 PM. The facility conducted a head count and realized that Resident #1 was not in the facility. The facility began a search for the resident and determined that the resident was not on the facility's premises. The Registered Nurse (RN) Supervisor contacted the Resident's spouse to see if the resident was with him/her because the spouse was in the facility earlier that day. The spouse advised that the resident was not with him/her. The RN Supervisor then called another family and left a message. The family member returned the call and advised that the resident had a fall outside the facility's grounds at a bus stop and was taken to a hospital via ambulance. During an interview conducted on 04/13/26 at approximately 9:45 AM, The Nursing Home Administrator (NHA) and the Surveyor observed the bus stop where Resident #1 fell. The NHA advised that the Resident left his/her wheelchair and ambulated to the bus stop where a bystander witnessed the resident lose his/her balance and fall.A review of the aerial map conducted on 04/13/26 at 10:00 AM showed the bus stop where Resident #1 fell was 335 ft from the facility's front door. During an interview conducted on 04/13/26 at approximately 11:00 AM, the DON stated that they did not report the incident to the State Agency OHCQ because Resident #1 was alert and oriented times 4, did not require supervision, had capacity to make decisions, was not an elopement risk, and was located within 1 hour of being missing. The Surveyor notified the NHA and DON of the concern for not reporting an elopement.

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