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	05/08/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record reviews, and interviews, the facility failed to obtain, document and administer medications according to procedures that ensure accurate, safe dispensing of medications. This was evident for 4 residents (#57, #70, #98 and #141) out of 10 reviewed for medications.The findings included:1. On 05/04/2026 at 9:35 AM, the surveyor observed Resident #57 taking pills while no nurse was in the room. Resident #57 stated, They don't always leave my pills but this time they did. At 9:40 AM on 05/04/2026, RN #15 entered the room to check if Resident #57 had taken their medications. RN #15 stated, Resident #57 is good to take medications alone. 2. On 05/04/2026 at 11:40 AM, the surveyor observed Resident #141 sitting on the side of the bed pouring liquid into the nebulizer. No staff member was present. Resident #141's family member stated, My parent administers albuterol so it can be taken immediately when needed. The facility evaluated and assessed the resident as independent to administer albuterol. A record review at 9:32 AM on 05/06/2026 revealed no documentation that the facility evaluated Residents #57 or #141 for self-administration of medications. The surveyor requested that the Director of Nursing (DON) provide documentation showing the facility evaluated the residents for self-medication. On 05/07/2026 at 9:29 AM, the DON stated that they could not provide documentation of assessment to self-administer medications for Residents #57 and #141. 3. On 5/4/26 at 9:29 AM, the surveyor conducted an interview with Resident #98 and during the interview Resident #98 stated that the facility often ran out of his/her medications. Next the surveyor reviewed Resident #98's Medication Administration Record (MAR) from January 2026. The review revealed that Resident #98 was ordered to have lamotrigine 25mg in the morning for bipolar. On 1/20/26 a (9) was coded see progress notes, on 1/21/26 the administration was left blank, on 1/22/26 (2) was coded for refusal and on 1/21/26 administration was left blank again. On review of Resident #89's April 2026 MAR hydroxyzine was marked (9) see progress notes on 4/7/26 with an administration time of 7 PM, and again on 4/8/26 but the administration time was 9 PM. On 5/5/26 at 1:59 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that in January there was three days in which Resident #98 was not given lamotrigine as ordered and in April, two days where Resident #98 was not (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	05/08/2026

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given hydroxyzine as ordered. The DON stated that when the facility changed their pharmacy automatic renewals were not always prompted when a medication ran out but recently the facility reviewed medication order and believed they fixed the system. She stated she would look into the lamotrigine. On 5/6/26 at 9:51 AM, the surveyor conducted a follow-up interview with DON. The DON stated that Resident #98 had been refusing the medication and the medications time was adjusted shortly after. The surveyor reviewed with the DON that on 1/22/26 the staff documented refused however there was no documentation on the other day as to the reason the medication was not given, even with the code see progress note. The surveyor asked if there was no documentation, was the medications given? The DON confirmed if there was no documentation she would assume the medication was not given. 4. On 5/7/26 at 9:04 AM, the surveyor observed Licensed Practical Nurse (LPN) #9 prepare and administer a stool softener, probiotic, oral pain mediation and an inhaler to Resident #70. Following the observation the surveyor reviewed Resident #70's Medication Administration Record (MAR). The review revealed that voltaren external gel was also signed out in the 9 AM time slot, however, the application to the medication was not observed with the other 9 AM medications. On 5/8/26 at 6 AM, the surveyor requested Resident #70's Medications Administration Audit Report. On review of the report the surveyor noted that the medications observed given at 9:04 AM, were documented as given at 9:51 AM, along with the vollaren external gel. On 5/8/26 at 8:04 AM, the surveyor conducted an interview the LPN #9 and Unit Manager (UM) #3. During the interview the surveyor reviewed the concerns that the documented administration of medications was not consistent with the time they were observed administered. LPN #9 confirmed that she had gone into Resident #70's room multiple times to administer medications, however signed them all out at the same time once they were all given. UM #3 then stated that it was the expectation that staff document medications at the time of administration and confirmed this expectation with LPN #9.