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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42782 Based on observations and interviews it was determined that the facility staff failed to ensure residents had access to their call bells to notify the staff for assistance when needed. This deficient practice was evidenced in 7 (#45, #50, #89, #122 #124, #131, & #148) of 138 residents observed without their call bell during the survey. The findings include: On 02/27/25 at 7:48 am during the surveyor's initial observation rounds the surveyor observed multiple residents without their call bell within reach. At 7:52 am the surveyor observed Resident #148's call bell on the floor near the left side of the bed. Resident #131's call bell was hanging from the call bell system on the wall. At 7:58 am Geriatric Nursing Assistant (GNA) # 23 confirmed the surveyor's findings. At 8:08 am the surveyor observed Resident #45's call bell hanging over the side of their bed. GNA #24 confirmed the surveyor's findings. At 10:41 am the surveyor observed Resident #124's call bell hanging over the side of the bed. At 10:52 the surveyor observed Resident #89's call bell on the floor. At 10:55 am the surveyor observed Resident #50's call bell on the floor near the upper left side of the bed. On 03/04/25 at 8:22 am the surveyor observed Resident #122's call bell on the floor near the left side of their bed. On 03/04/25 at 9:15 am Director of Nursing #2 was made aware the surveyor observed multiple residents without their call bell within reach. (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/25 at 10:32 am during an interview with GNA #24 the surveyor asked the GNA to describe their typical morning concerning resident care. GNA #24 verbalized they get report and do rounds to check on the residents they are assigned. He/she introduces themselves and sees if the residents need anything. The surveyor asked at what point does the GNA check to make sure the residents have their call bell and how would they know if a resident needed assistance. GNA #24 verbalized when they check on the residents, they make sure the residents call bell is close to them. If a resident presses the call bell, the room number would show up on the panel at the nurse's station. Also, there is an alarm at the nurse's station.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457 Based on observations and interviews, it was determined that facility staff failed to ensure a resident was dressed in their personal clothing as preferred. This deficient practice was evident for 1 (#287) of 138 residents observed for during the survey. The findings include: During observation of Senate Unit on 02/27/25 at 8:05 AM, the surveyor observed Resident #287 awake in bed wearing a hospital gown. A follow-up observation later that day at 2:15 PM revealed that Resident #287 was eating lunch in bed wearing a hospital gown. On 2/28/25 at 8:39 AM, the surveyor conducted rounds on Senate Unit and observed Resident #287 sitting in the dining room area, waiting for breakfast while wearing a hospital gown. The surveyor entered Resident #287's room to check the closet for personal clothing and confirmed that the resident had personal clothing available to wear. Review of Resident #287's medical record revealed that the resident was admitted to the facility on [DATE] with multiple medical conditions including generalized weakness. During a follow-up observation of Resident #287 on 03/04/25 at 8:49 AM, the surveyor asked if they prefer to be out of bed and dressed in their personal clothing. Resident #287 responded, yes. On 03/04/25 during an interview with GNA #37, he stated that he has worked with Resident #287 and that the resident requires assistance with personal care and dressing. Following the discussion with GNA #37 the surveyor informed the Director of Nursing of the observations made on 02/27/25 and 02/28/25. During observation rounds, on 03/13/25 at 10:40 AM, the surveyor observed Resident #287 in bed wearing a hospital gown. When asked if they wanted to get out of bed and wear their personal clothing, the resident replied, yes. The surveyor also noted that the resident's foley bag was on the floor without a privacy cover. Upon exiting the room, the surveyor informed Nurse #3 of these observations.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49148 Based on record review and interviews it was determined that the facility staff failed to have a system in place to ensure that copies of the resident's Advanced Directives had been obtained and maintained in the resident's medical record; and failed to ensure that advance directives were discussed with residents and/or responsible representatives and proper information was provided. This was evident for 3 (#7, #27, & #101) out of 10 residents reviewed for Advanced Directives. The findings include: An Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. 1). On 3/3/2025 at 10:56AM, a review of Resident #7's electronic medical record revealed a Discharge Planning Psychosocial Assessment which indicated yes, the resident had an Advanced Directive. Further review failed to reveal any documentation of an Advanced Directive in the resident's electronic medical record. On 3/4/2025 at 9:52AM, during an interview conducted with Social Worker (SW)#6, the Surveyor was informed that Advanced Directives are reviewed with the resident and/or resident representatives during the admission process. A Discharge Planning Psychosocial Assessment is completed and there is a question that asks Does the resident have an Advanced Directive? If the question is answered yes, the resident has an Advanced Directive in place, SW #6 would request a copy to upload in the resident's electronic medical record. If the Question is answered no, education and information would be provided to the resident and/or resident representative. During further interview with SW #6, the Surveyor reviewed the concern that Resident #7's Discharge Planning Psychosocial Assessment indicated yes, the resident had an Advanced Directive, however, there was no documentation of a written Advanced Directive in the resident's electronic medical record. If the resident or resident representative has executed a written Advanced Directive, a copy of the document must be obtained and maintained in the resident's electronic medical record readily retrievable by facility staff. The Surveyor asked SW #6 to provide a copy of Resident #7's Advanced Directive. On 3/7/2025 at approximately 2:00PM, the Director of Nursing (DON), confirmed that the facility did not have a copy of Resident #7's written Advance Directive. 50573 2.) On 03/03/25 at 11:38 AM, review of Resident #27's medical record failed to reveal documentation of an advanced directive nor indication that an advanced directive had been discussed with the resident. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/03/25 at 09:54 AM, review of Resident #101's medical record revealed a document titled, Discharge Planning Psychosocial Assessment which indicated the resident did not have an advanced directive and that the facility did not provide information to initiate an advanced directive to the resident and/or resident representative. On 03/04/25 at 09:57 AM, an interview with a Social Worker (Staff #6) revealed that when a resident is admitted , the facility asks the resident and/or resident representative if the resident has an advanced directive and if so obtains a copy. She further indicated if they do not have one, that the facility would provide the resident and/or resident representative information to initiate one and that documentation would reflect that. On 03/04/25 at 10:00 AM, the surveyor requested documentation regarding advanced directives for Resident #27 and #101. On 03/05/25 at 11:17 AM, an interview with Staff #6 revealed she does not have anything further for Resident #27. She further indicated regarding Resident #101, that the facility should have provided information regarding an advanced directive, but was unable to provided documentation that they did.

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	215164	A. Building B. Wing	03/13/2025

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42782 Based on record review and interview it was determined that the facility staff failed to ensure a resident received a skilled nursing facility beneficiary notice prior to discharge. This deficient practice was evidenced in 1 (#151) of 3 resident records for proper discharge documentation during the recertification survey. The findings include: On 03/04/25 at 10:41 am the survey provided MSW # 6 with three Skilled Nursing Facility Beneficiary forms to complete to verify the resident's received notification of discharge with the opportunity to appeal prior to their discharge. On 03/04/25 at 10:58 am MSW #6 provided documentation to verify one resident was discharged voluntarily, and two residents were not provided with a SNF Beneficiary Notice. The surveyor asked why the forms were not provided to the residents. MSW #6 verbalized the facility staff recognized there was a problem, and they are working on correcting the problem. Review of the documentation revealed Resident #151 did not receive SNF Beneficiary notice prior to being discharged .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on observations and interviews it was determined that the facility staff failed to provide a homelike environment for the residents by failing to make repairs in the residents rooms. This deficient practice was discovered during observations of 2 of 3 units in the facility during the survey. The findings are: On 02/27/25 at 7:48 am during observation rounds the surveyor observed rust on the tile behind the commode in the bathroom in room [ROOM NUMBER] and damaged drywall was behind the bed. At 10:52 am while the surveyor was in room [ROOM NUMBER], the surveyor observed the faucet in the bathroom with a steady flow of water. The surveyor was unable to turn the water off. At 10:55 am while in room [ROOM NUMBER], the surveyor observed damaged drywall below the window and there was a hole in the wall behind Resident #50's bed. At 11:10 am while in room [ROOM NUMBER] the surveyor observed missing drywall and exposed corner bead near the privacy curtain near Resident #112's bed. On 03/03/35 at 11:04 am the surveyor observed the armoire near the door in room [ROOM NUMBER] was unable to close and was hanging by the hinge. At 2:26 pm the surveyor observed damaged drywall behind Resident #58's bed. On 03/05/25 at 9:05 am during an interview with Director of Maintenance #22 who verbalized the staff reports maintenance concerns through Records system; all the staff have access to the system. The maintenance department has a preventative maintenance schedule. They divide the house in half and go room to room to see if there are any concerns. If they see any concerns the repairs will be made. The surveyor discussed the maintenance concerns observed in the building.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **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 ensure a resident's quarterly assessment was documented accurately on the Minimum Data Set (MDS). This deficient practice was evidenced for 1 (#25) resident out of in 4 residents reviewed for accurate MDS assessments during the survey. The findings include: MDS is a tool for implementing standardized assessments and for facilitating care management in nursing homes. The assessment is completed upon admission, annually, quarterly, during a significant change, and when a resident is discharged . The Resident Assessment Instrument (RAI) is a comprehensive, standardized assessment process used in long-term care facilities to identify residents' strengths, needs, and preferences, ultimately informing individualized care planning and monitoring. Review of Resident #25's medical records on 03/05/25 at 1:27 PM, revealed a physician progress note dated 9/7/24, documenting an acute comminuted fracture of the left leg. The note indicated that the resident was on pain medication, a follow up appointment was recommended by orthopedics, and a repeat X-ray of leg. The physician also noted that the plan was discussed with the staff. Review of physician progress note dated 10/22/24 revealed that Resident #25 was evaluated by orthopedics who recommended surgery of the left leg. The physician also documented a left knee immobilizer. On 03/06/2025 at 9:38AM, during an interview with MDS Coordinator #11, the surveyor asked, how updates are made to the RAI when a significant change in medical condition is identified. The MDS Coordinator #11 explained that physicians' notes are reviewed during the 60-day look back period, and new medical diagnoses or medical conditions are only captured on the MDS if there are two documented changes in the resident's condition. The surveyor informed the MDS Coordinator of the resident's leg fracture that occurred on 8/21/24, as well as the physician progress notes dates 9/7/24 and 10/22/24, which referenced the fracture and plan of care. The surveyor asked why these medical changes were not reflected in the residents' quarterly assessment dated [DATE]. She explained that the physician's document did not support updating the resident's quarterly comprehensive assessment. On 03/06/25 review of Resident #25's medical records revealed that the MDS coordinator #11 updated the resident's quarterly MDS assessment dated [DATE] to reflect the fracture. On 03/6/25 at 10:50 AM, during an interview with the Director of Nursing, the surveyor informed her that the medical diagnosis was not captured on the resident's quarterly assessment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50573 Based on record review and interview with facility staff, it was determined that the facility staff failed to ensure Preadmission Screening and Resident Review (PASARR) forms were completed correctly. This was evident in 3 (Resident #27, #79, and #101) of 4 residents reviewed for PASARR screening. The findings include: PASARR is a federal requirement ensuring individuals with serious mental illness or intellectual/developmental disabilities are not inappropriately placed in nursing homes and receive appropriate care, either in the community or a nursing facility. 1) On 03/03/25 at 11:41 AM, review of Resident #27's medical record revealed a level I PASARR dated 4/17/2024 which indicated a level II screening should have been completed. Further review of the resident's medical record failed to reveal documentation of a level II PASARR. 2) On 03/03/25 at 11:55 AM, review of Resident #79's medical record revealed a level I PASARR dated 4/17/2024 which indicated a level II screening should have been completed. Further review of the resident's medical record failed to reveal documentation of a level II PASARR. 3) On 03/03/25 at 09:49 AM, review of Resident #101's medical record revealed a PASARR dated 9/8/2024 which only had section A completed, but failed to reveal the rest of the level I screen being completed as prompted on the document. On 03/04/25 at 09:57 AM, an interview with the Social Worker (Staff #6) revealed that residents with certain diagnoses trigger boxes to be checked on the PASARR level I form that prompt the need for a level II screen. The surveyor requested information for Resident #27, #79 and #101's PASARR documentation concerns identified above. On 03/05/25 at 06:45 AM, review of a note for the surveyor from Staff #6 revealed that she was unable to provide documentation for Resident #79's PASARR level II screening and was unable to explain why only section A was completed for Resident #101. She indicated that she initiated a level II screening for both residents. On 03/05/25 at 01:17 PM, Staff #6 informed the surveyor that she was unable to provide level II PASARR screening for Resident #27. She indicated that she initiated a level II screening for him/her.

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	215164	A. Building B. Wing	03/13/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50457 Based on record reviews and interviews, it was determined that the facility failed to develop a care plan to manage the resident's new medical diagnosis. This deficient practice was evident for 1 (#25) of 10 residents reviewed for comprehensive care plans during the survey. The findings include: On 3/4/25 at 7:30AM, the surveyor requested documentation from the Director of Nursing (DON) #2 indicating that a care plan was developed following Resident #25's leg fracture on 8/21/24. During an interview with both the DON #2 and Social Worker (SW) #6 on 03/04/25 at 9:00 AM, they explained that a little over a month ago, the facility discovered that care plans 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 acknowledge that no care plan was developed following the resident's fracture. Review of Resident #25's medical records on 3/4/25 at 11:52 am, revealed that the resident was transported to the emergency department, diagnosed with a leg fracture, and return to the facility 08/21/24. Further review of the medical records revealed that Resident #25's leg fracture was assessed by the physician on 09/7/24. The Physician noted that resident's assessment and plan was discussed with staff, but the resident's comprehensive care-plan did not address the resident's leg fracture until 10/6/24.

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	215164	A. Building B. Wing	03/13/2025

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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)

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	215164	A. Building B. Wing	03/13/2025

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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

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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.

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	215164	A. Building B. Wing	03/13/2025

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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)

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	215164	A. Building B. Wing	03/13/2025

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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)

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	215164	A. Building B. Wing	03/13/2025

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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

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Shady Grove Nursing and Rehabilitation Center	9701 Medical Center Drive Rockville, MD 20850

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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.

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	215164	A. Building B. Wing	03/13/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on medical record review and interviews it was determined that the facility staff failed to ensure residents were receiving showers regularly. This deficient practice was evidenced in 2 (Resident #20 & #58) of 27 residents who verbalized not receiving showers. The findings include: On 02/27/25 at 11:03 am during an interview with Resident #58 the resident verbalized they were not receiving showers regularly. On 03/03/25 at 11:42 am during an interview with Resident #20, he/she verbalized they had not received a shower since being admitted to the facility and nobody had ever asked if he/she wanted a shower. On 03/04/25 at 12:03 pm a review of the task section in Resident #20's electronic medical record (EMR) revealed, the resident was scheduled for a shower on Monday, Thursday, and PRN (as needed). There was no documentation to verify the resident had a shower since being admitted on [DATE]. Review of the MDS dated [DATE] the resident has a BIMS score of 14/15, indicating intact cognition. On 03/06/25 at 9:14 am a review of Resident #58's EMR revealed there was no documentation in the task section to indicate the resident had received showers regularly. On 03/06/25 at 10:58 am Director of Nursing (DON) #2 was made aware Resident #20 and Resident #58 were not receiving showers regularly. DON #2 verbalized each resident was scheduled to receive a shower twice a week. On their shower days the GNA is supposed to offer a shower. If a resident refused a shower the nurse should be made aware, and a note should be written.

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	215164	A. Building B. Wing	03/13/2025

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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)

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	215164	A. Building B. Wing	03/13/2025

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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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49148 Based on observations, record reviews, and interviews with staff, it was determined that the facility failed to ensure precautions were taken for residents' individual safety in need of supervision while smoking and failed to ensure smoking assessments were reviewed and revised due to a resident's current condition. This was evident for 4 (Resident #62, #63, #132, and #239) out of 15 residents reviewed for smoking. The findings include: On 2/28/2025 at 7:30AM, the Surveyor observed the facility's smoking area. There were no residents in the smoking area. On 2/28/2025 at 8:06AM, the Surveyor observed Resident #62 outside smoking. The Surveyor did not observe any staff providing supervision. There was a sign on the door that read, Supervised Smoking Times: 9:00AM-9:30AM, 11:30AM-12:00PM, 2:00PM-2:30PM, 6:00PM-6:30PM, and 9:30PM-10:00PM. 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. On 3/3/2025 at 9:00AM the Surveyor observed residents outside in the smoking area. There was no staff supervision. 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 on the assessment regarding the need for any equipment, Resident #132 needed an apron, and Resident #239 had no smoking assessment. On 3/4/2025 at 11:40AM, the Surveyor observed 4 residents outside in the smoking area. The residents possessed their own smoking materials. There was no staff supervision observed. During an interview conducted with Recreation Assistant #41 on 3/5/3035 at10:20AM, the Surveyor was informed that the residents can go out to the smoke area at any time unless there was an activity or meal in the main dining area. Recreation Assistant #41 stated that there were no residents who required independent supervision or used an apron. Recreation staff monitor the smoking area. During an interview conducted with Director of Recreation #40 on 3/5/2025 at 10:27AM, the Surveyor was informed that there were currently no smoking residents who needed independent supervision or aprons. During morning meetings, nursing staff discuss the smoking residents and update the list as needed. The Director of Recreation #40 is then informed of the changes and what residents need supervision or aprons. The smoking area should be monitored by staff during the hours of 9:00AM-9:30AM, 11:30AM-12:00PM, 2:00PM-2:30PM, 6:00PM-6:30PM, and 9:30PM-10:00PM. The Director of Recreation #40 was made aware that the Surveyor made several observations of residents outside smoking and there was no staff supervision. (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

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F 0689 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 via review of documentation 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 were not completing the smoking assessments accurately. The smoker list provided to the Surveyor was up to date because those residents had been reviewed in the morning meetings. The DON did confirm that the smoking assessments had 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.

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

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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. 49148 Based on record review and interview with resident and staff, it was determined that the facility failed to reorder a urinary sample for the purpose of diagnosing and treating which caused a delay in treatment for a resident with a Urinary Tract Infection (UTI). This was evident for 1 (Resident #18) out of 2 residents investigated for Urinary Catheters and UTI's during the survey. The findings include: On 2/27/2025 at 11:28AM, Resident #18 informed the Surveyor that they had a UTI. The resident stated that it hurt and no one did anything. The resident stated it took the staff too long to address the their concerns. On 2/28/2025 at 11:38AM, a review of Resident #18's electronic medical record revealed that the resident had a history of reoccurring UTI's. The resident had orders for continued medication therapy with cranberry tablets 450MG, 1 tablet by mouth one time a day and Hiprex 1GM, 1 tablet by mouth two times a day. A change in condition note for 2/18/2025 at 12:47PM stated that resident seemed different than usual. A physician order was placed for a urinalysis and a culture and sensitivity STAT lab collection to rule out UTI. The recent urine culture was collected on 2/19/2025 and the results on 2/23/2025 confirmed the resident had a UTI. The resident started treatment with Ceftriaxone Sodium intramuscularly on 2/20/2025 and then Zosyn 3.375gram intravenously every 6 hours for UTI for 7 days starting on 2/24/2025. On 3/11/2024 at 7:44AM, during a review of Resident #18's electronic medical record, the Surveyor discovered a physician order dated 1/31/2025 for a urinalysis and culture and sensitivity lab collection one time only to rule out UTI because the resident complained of pain while voiding. A Third eye Health note from 2/1/2025 at 12:05AM stated that the physician reviewed the urinalysis results which noted small blood and small leukocyte esterase. The urine culture results reported on 2/3/2025 at 4:00PM stated that the sample was contaminated and suggested a repeat culture. A continued review of Resident #18's electronic medical record failed to reveal documentation of a repeat urine culture and failed to reveal orders for treatment until 2/19/2024. An interview with the DON on 3/11/2025 at 9:26AM revealed that the nurses call the physician when the laboratory results come back, especially if they are abnormal. The physicians can also look up the results. If the physician reviews the results and place new orders, the nurse will confirm the orders in the resident's electronic medical record. The Surveyor reviewed the concern with the DON that the resident had a urine culture to test for a UTI on 1/31/2025, and the results were abnormal due to a contaminated sample. The laboratory suggested sending a repeat sample. A repeat urine culture was not ordered for the resident until 2/19/2025 after increased symptoms.

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
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 49148 Based on observation, record review, and interviews with resident and staff, it was determined that the facility staff failed to provide additional nourishment to a resident as ordered by the physician and failed to ensure a resident's diet was appropriate for their medical needs. This was evident for 2 (#98, #287) out of 5 residents reviewed for nutrition during the survey. The findings include: 1). On 2/27/2025 at 10:50AM, during an interview with Resident #98, the Surveyor was informed that he/she was supposed to get double portions for all his/her meals. The resident stated that his/her meal trays do not come with double portions and the meal ticket does not state double portions. The resident expressed the concern that due to his/her condition, they get really hungry, especially at breakfast. On 2/27/2025 at 12:00PM a review of Resident #98's electronic medical record revealed an active order for a Regular diet, Regular texture, Thin Liquids consistency, double portion. Further review revealed a Nutrition/Dietary Note dated 2/13/2025, which mentions Current diet order is Regular diet, Regular texture, Thin Liquids consistency (double Portions). Remains appropriate for optimal intake. During an interview with the Director of Nursing (DON) on 2/27/2025 at 12:05PM, the Surveyor was informed that the dietary staff and the kitchen staff have been working with Resident #98 on getting double portions. The Surveyor expressed the concern that the resident had an active order for double portion and was not receiving them. On 2/28/2025 at 9:24AM, Resident #98 informed the Surveyor that they had a conversation with the Dietary Manager #8, on 2/27/2025 in the afternoon, about not receiving double portions. The resident stated that he/she did not receive double portions on his/her breakfast tray this morning. He/she received one egg casserole and a piece of toast. On 3/3/2024 at 1:28PM, during an interview with Resident #98, the Surveyor observed the saved meal tickets for dinner on 2/28/2025, breakfast on 3/1/2025, and lunch on 3/1/2025. Each meal ticket noted a regular diet and failed to note double portions. During an interview conducted with Dietary Manager #8 on 3/4/2025 at 1:42PM, the Surveyor confirmed that Resident #98 had an active diet order for Regular diet, Regular texture, Thin Liquids consistency, double portion. The Surveyor also confirmed that any resident with an order for double portions, the meal ticket should state and reflect the double portions. That was how the dietary staff would know how to make the resident's plate at mealtimes. The Surveyor showed the Dietary Manager #8 Resident #98's meal tickets which failed to notate double portions. The Surveyor also made the Dietary Manger #8 aware the resident stated that he/she spoke with him on 2/27/2025 about this issue and the resident still received regular portions on his/her tray. 50457 (continued on next page)

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	215164	A. Building B. Wing	03/13/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2). On 02/27/25 at 02:12 PM, during an interview with Resident #287, the surveyor observed a lunch tray containing mechanical soft textured food and a container of two sliced peaches and one whole cherry. The surveyor also noted that the resident was missing several teeth. On 2/27/25 at 2:16 PM, a review of Resident #287's orders revealed a diet order for dysphagia mechanically altered texture and thin liquids consistency. On 2/27/25 at 2:21 PM, during an interview with Licensed Practical Nurse (LPN) #4 the surveyor inquired about Resident #287's diet order. LPN #4 stated that the resident was on a soft diet, the surveyor asked her to view the tray. The LPN #4 confirmed regular texture peaches were present on the tray. When asked who was responsible for ensuring the correct food consistency, LPN # 4 stated it is the responsibility of both the GNAs and the assigned nurse. During an interview with Dietary Manager #8 on 03/04/25 at 01:31 PM during an interview he explained that the dietary aide is responsible for reading the meal tickets and informing the chef of the food items and texture to be plated. He acknowledges that the kitchen staff is responsible for ensuring the plated meals are correct before leaving the kitchen. He also acknowledged that the peaches listed on the resident's meal ticket were sliced canned peaches not diced or mechanical soft peaches.

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	215164	A. Building B. Wing	03/13/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49148 Based on observations, record review, and interviews it was determined that the facility staff failed to failed to ensure each resident has a sufficient supply of prescribed pain medication and ensure a resident's pain was addressed. This was evident for 2 (#54, #74) of 4 residents reviewed for pain management during the survey. The findings include: 1). On 2/27/2025 at 10:25AM during an interview with Resident #54, the Surveyor was informed that the facility continuously runs out of the resident's pain medication that can be received as needed every 6 hours. The resident stated that his/her pain cannot be managed appropriately when this happens. The resident prefers to take his/her pain medication every 6 hours to effectively manage pain. Resident #54 stated that the facility ran out of his/her pain medication over the past weekend, 2/22/2025-2/23/2025. On 3/4/2025 at 11:28AM, during a review of Resident #54's electronic medical record, the Surveyor discovered that the resident was taking Oxycodone HCl 20MG (Controlled Drug), 1 tablet by mouth every 6 hours as needed for pain. On 3/4/2025 at 12:11PM during an interview with the Director of Nursing (DON), the Surveyor was informed that the expectation for pain management is the assess a resident's pain, where is the pain, what is the duration of pain, and to provide non-pharmacological interventions and medication interventions as necessary. The resident's pain score should be documented in the electronic medical record prior to administering any pain medication and the nurse should follow up with the resident to see how effective the medication was. The residents are expected to get their pain medication as ordered by the physician. On 3/4/2025 at 12:15PM, a review of the resident's electronic medical record revealed a Third Eye Health Note dated 2/22/2025 at 9:06PM. The primary chief complaint was a medication request per resident. A communication from the resident was received via nurse requesting a medication. Oxycodone 20mg 1 tab Q6, #12 sent to pharmacy for an order refill. On 3/6/2025 at 10:09AM, the Surveyor conducted an interview with Registered Nurse (RN) #20 to find out the process for reordering a resident's medication to prevent them from missing a dose. The Surveyor was informed that if a medication gets down 5 doses left over, the nurse should put in a request to the pharmacy for a reorder delivery or to put in a request to the physician for a new prescription, if needed. The physician will send the prescription to the pharmacy electronically. On 3/6/2025 at 10:15AM, the Surveyor reviewed the narcotic count sheets for Resident #54's Oxycodone 20MG for February 2025. On narcotic sheet No. 32, the Surveyor noted the resident's last dose was 2/22/2025 at 8:00AM. The amount left was 0. On narcotic sheet No. 40, the Surveyor noted Oxycodone 20MG was received on 2/23/2025 and a dose was given on 2/24/2025 at 3:00PM. There was no other documentation of narcotic sheets from 2/22/2025-2/23/2025. (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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/2025 at 2:00PM an interview with the DON confirmed that the nursing staff often wait until the last dose before placing a reorder for medications. The DON confirmed that Resident #54's Oxycodone 20MG had not been administered in a timely manner because of delayed acquisition of the medication on 2/22/2025 through 2/23/2025. The resident was aware and had mentioned it to the staff. Once the nursing staff realizes the resident's medication was down to 5 doses, the expectation is to reorder the medication or obtain a prescription from the physician to reorder the medication. 50457 2). 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. Further review showed that NP #9 documented bilateral foot pain rated 10 out of 10, which had started a few days ago. The wound pain at rest was also documented as a 10. There was no documentation from NP #9 indicating a plan to address pain. On 03/04/2025 at 2:35 PM, during an interview with NP #9 regarding Resident #74's documented pain, she stated that she does not order pain medication but informs the care team of her recommendations. When asked who she specifically informed, she stated that she notified Nurse #3 on 02/27/25. The NP #9 mentioned that she ordered diagnostic imaging and was waiting for the results before addressing the resident's pain. On 03/4/25 at 2:51 PM, during an interview with Nurse #3, he reported that he was not informed of the resident's pain. He explained that NP #9 documents her recommendations and then informs the care team of the plan. The Nurse #3 stated that the care provided is based on the NP #9's recommendations. Since no recommendation for pain medication was documented, he was unaware of the resident's pain concern. On 03/04/25 at 2:58 PM, the surveyor informed the Director of Nursing of the pain management concerns related to Resident #74. Following the surveyor's inquiry regarding pain management for Resident #74, an order was placed on 03/04/25 at 3:15 PM for Tylenol every eight hours as need for pain. An additional order was placed for scheduled Tylenol twice daily for 14 days.

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	215164	A. Building B. Wing	03/13/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 50573 Based on observation, record review and interview with facility staff, it was determined that the facility failed to obtain informed consent prior to the initiation of a resident's bed rails. This was evident for 1 (Resident #113) of 1 resident reviewed for accident hazards. The findings include: Bedrails or side rails are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them. On 03/03/25 at 08:17 AM, an observation revealed Resident #113 in bed with bilateral enabler bed rails On 03/04/25 at 12:16 PM, an interview with the Director of Nursing (Staff #2) revealed consent is obtained prior to initiation of the enabler bed rails. The surveyor requested documentation of consent obtained for Resident #113's enabler bed rails. On 03/04/25 at 01:00 PM, review of the document titled, Bed Side Rail Tool dated 12/2/24 revealed a check box was marked that consent was obtained from the resident and resident representative, but did not indicate the resident representative which consent was obtained from. On 03/05/25 at 08:58 AM, an interview with the Director of Nursing revealed that she was unable to indicate to the resident representative which consent was obtained from and that the expectation was for staff to indicate the name of who the consent was obtained from for the consent to be considered received.

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	215164	A. Building B. Wing	03/13/2025

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 49148 Based on observation, record review, and interview with staff, it was determined that that facility failed to ensure a resident had orders in place to maintain immediate care needs of a resident with a Foley Catheter. This was evident for 1 resident (Resident #127) reviewed for indwelling catheters during the annual survey. The findings include: An indwelling (Foley) catheter is a thin, hollow tube inserted through the urethra into the urinary bladder to collect and drain urine. On 2/27/2025 at approximately 10:45AM, during an interview with Resident #127, the Surveyor discovered that the resident's Foley catheter was removed on 2/26/2025. The resident verbalized the need to urinate but was unable to and was not experiencing any abdominal pain at the time. The resident stated that he/she would let the nurse know if he/she was in pain. On 3/5/2025 at approximately 12:00PM, a review of Resident #127's electronic medical record revealed that orders for Foley catheter size and Foley catheter care and maintenance were discontinued on 2/28/2025. Further review revealed a medical progress note dated 2/27/2025 which stated Pt seen and examined. Not in distress. Foley removed previous day and patient tolerating voiding trail. Denies abdominal pain. Discussed with primary RN. On 2/28/2025, a medical progress note stated Pt seen c/o abd [abdominal] pain and suprapubic tenderness. Reported decreased urinary output. Foley reinserted and had about 400cc urine. Foley Catheter kept. Will request for Urology consult again. On 3/5/2025 at approximately 12:30PM, the Surveyor observed Resident #127 sitting up in bed with Foley catheter tubing and drainage bag hanging on the left side of the bed frame. During an interview with the resident, the Surveyor was informed that the resident was unable to void much the day after the catheter was removed. The resident was on voiding trial, but that night the resident stated that he/she was in so much pain and was given Tylenol, which helped. The next day, the resident had increased abdominal pain, and they inserted a catheter to drain urine into a basin. They decided to reinsert the Foley catheter. A review of Resident #127's electronic medical record on 3/5/2025 at approximately 1:00PM failed to reveal physician orders for Foley catheter size, Foley catheter care and maintenance, or a Urology consult. On 3/7/2025 at approximately 12:25PM, during an interview with the Director of Nursing (DON), the Surveyor was informed that a resident with an indwelling (Foley) catheter should have orders in place for Foley catheter size and Foley catheter care and maintenance. A Urology consult should be ordered per request. The Surveyor expressed the concern that Resident #127 did not have any orders in place to address his/her reinserted Foley catheter. On 3/7/2025 at approximately 2:00PM, the DON provided the Surveyor with a copy of Resident #127's physician orders for Foley catheter size and Foley catheter care and maintenance ordered on 3/7/2025.

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

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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
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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. 49148 Based on observation, record review, and interview with staff, it was determined that the facility 1) failed to ensure that an account of all controlled drugs was complete and accurate. This was found to be evident for 1 out of 4 narcotic lock boxes located in the medication carts observed during the medication storage facility task; and 2) failed to timely identify and remove a discontinued controlled drug from the narcotic box for disposition. This was evident for 1 (Resident #102) out of 3 residents reviewed for pain management during the survey. The findings include: 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. 1. On 3/6/2025 at 10:09AM, during an interview conducted with Registered Nurse (RN) #20, the Surveyor was informed that narcotic counts for controlled drugs must be done by the incoming nurse and the outgoing nurse at change of shift. The nurses would verify the controlled drug count was accurate and sign the count on the narcotic record form in the Controlled Substance Record Book at the medication cart. The Surveyor observed the process of narcotic count with RN#20. During the narcotic count, RN #20 realized that he did not sigh off on Vimpat 100mg for Resident #44 after administering the medication. RN #20 was asked the procedure for administration of a narcotic and stated that when administering a controlled drug, the nurse should complete the narcotic report sheet at the same time the medication was given to keep the count accurate and at the time the medication is removed for the blister pack, the narcotic sheet should be signed off with the date, time, amount on hand, amount used, method of administration, amount remaining, and a signature. RN #20 admitted the mistake of not recording at the time of medication administration. On 3/7/2025 at 12:25PM, the Director of Nursing (DON) was made aware of the Surveyor's observation during the review of the narcotic count with RN #20. 2. 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. (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. The DON provided the Surveyor with the Medication Error Report with a statement from LPN #36. The Medication Error Report stated the medication ordered was Oxycodone 10mg every 4 hours as needed for pain and that the medication given was Oxycodone 15mg every 6 hours as needed for pain. The Oxycodone 15mg blister pack was still in the narcotic lockbox. LPN #36 pulled the medication, administered it to Resident #102, and signed off on the narcotic record sheet in the Controlled Substance record book. LPN #36 was unable to document the administration in the resident's electronic medical record because the order had been discontinued. LPN #36 filled out the Medication Error Report with a detailed explanation of the medication error and signed. The DON stated that she did not know the incident occurred and had never seen the Medication Error report until 3/10/25.

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	215164	A. Building B. Wing	03/13/2025

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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. 49148 Based on medication administration observation, record review, and interviews with staff, it was determined that the licensed facility staff failed to ensure medication error rate of less than 5 percent. This was evident for 2 (Resident #96 and Resident #18) out of 5 residents observed during the medication administration task which resulted in an error rate of 11.54 percent. The findings include: 1. On 3/7/2025 at 9:19AM, the Surveyor conducted a medication administration observation with Licensed Practical Nurse (LPN) #21. LPN #21 prepared 8 pills in a medication cup for Resident #96. The resident was due for a Voltaren External gel to the right shoulder. LPN #21 informed the Surveyor that the resident likes to use the topical gel at night and would not be administering that medication. The Surveyor asked LPN #21 the process for documentation if a resident does not want a medication at the time of administration. LPN #21 informed the Surveyor that the medication would not be signed off as administered and a notation would be made in the electronic medical record regarding why. The resident accepted the medications with no concern. On 3/10/2025 at approximately 10:45AM, a review of Resident #96's Medication Administration Report revealed that LPN #21 checked off the Voltaren External gel as administered. On 3/11/2025 at approximately 9:00 AM, the Surveyor reviewed the Medication Administration Audit report for Resident #96. The report showed that LPN #21 signed off on the Voltaren External gel on 3/7/2025 at 9:27AM. The Surveyor did not observe LPN #21 administer that medication. 2. On 3/7/2025 at 9:28AM, the Surveyor observed LPN #21 prepared 8 pills in a medicine cup to administer to Resident #18. That included Cranberry Juice 425mg tablets, a dietary supplement. The resident accepted the medications with no concern. On 3/10/2025 at approximately 10:50AM, a review of the medication orders for Resident #18 revealed an order for Cranberry Oral capsule 450mg. The review failed to reveal an order for Cranberry Juice 425mg. The Medication Administration report for 3/7/2025 showed that LPN #21 checked off Lidocaine External aerosol as administered. The Surveyor did not observe LPN #21 administered that medication. On 3/10/2025 at 11:30AM the Surveyor informed the Director of Nursing (DON) that Resident #18 was given Cranberry Juice 425mg instead of Cranberry 450mg as ordered. On 3/11/2025 at approximately 9:10AM, the Surveyor reviewed Medication Administration Audit Report for Resident #18. The report showed that on 3/7/2025 at 9:38AM, the resident received a Lidocaine External aerosol to the right heel and hands topically for pain. The Surveyor did not observe the resident received that medication. On 3/11/2025 at 9:20AM, an interview with Resident #18 revealed that the nursing staff have not been administering the Lidocaine aerosol and he/she really needs it for the pain in the right heel. (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
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/2025 at approximately 1:00PM, the Surveyor review the findings from the medication administration on 3/7/2025 with the DON. The Surveyor expressed the concern that Resident #96 was documented as administered Voltaren External gel on 3/7/2025 at 9:27AM yet never received it at that time. The Surveyor informed the DON that the resident stated that he/she likes to use it at night. The Surveyor also expressed the concern that Resident #18 received Cranberry Juice 425mg instead of Cranberry 450mg and has not been receiving the Lidocaine external aerosol, however, it was being documented as given. The DON stated she would follow up with LPN #21, Resident #96, and Resident #18.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49148 Based on observation and interviews with staff, it was determined that the facility failed to ensure that all medications and medical treatment supplies were stored safely and labeled properly. This was evident for 1 room (Resident #98) out of 30 rooms observed and 1 medication cart out of 4 medication carts reviewed during the survey. The findings include: 1. On 2/27/2025 at 10:50AM the Surveyor observed Resident #98's nightstand and noted two small plastic jars of c-hydro1%-nystat-znox 1:1:1 cream labeled for Resident #98 and labeled refrigerate, and a small plastic jar of zinc oxide cream with no label. On 2/28/2025 at 1:50PM the Surveyor observed Resident #98's nightstand and noted two small plastic jars of c-hydro1%-nystat-znox 1:1:1 cream labeled for Resident #98 and labeled refrigerate, and a small plastic jar of zinc oxide cream with no label. These were the same medicated creams observed on 2/27/2025 and they were in the same location on the resident's nightstand. On 2/28/2025 at 1:58PM, during an interview, the Surveyor made Licensed Practical Nurse (LPN) #21 aware that Resident #98's hydro1%-nystat-znox 1:1:1 cream, labeled refrigerate, and zinc oxide cream, with no label, were observed on the resident's nightstand on 2/27/2025 and 2/28/2025. LPN #21 informed the Surveyor that the medicated creams are at the bedside for wound care. The Surveyor and LPN #21 confirmed that the medicated creams should not remain at the resident's bedside, the hydro1%-nystat-znox 1:1:1 cream should be properly stored in the refrigerator when not in use, and the zinc oxide should be properly labeled for the resident and with a date opened. Controlled Drugs 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. 2. On 3/6/2025 at 10:30AM, a review of the Capital unit's Controlled Substance Record Book revealed a narcotic count sheet No. 24 for Resident #102's Oxycodone IR 15mg tablet. The order was for the resident to get one tablet by mouth every six hours as needed for severe pain. The Surveyor reviewed the last two administrations for 2/17/2025 at 9:45PM with a count of 16 remaining tablets and on 3/3/2025 at 1:40AM with a remaining count of 15 tablets. Under medication destroyed section, the quantity destroyed was 15. On 3/7/2025 at 11:00AM, a review of Resident #102 electronic medical record revealed an order for Oxycodone HCl [Oxycodone IR] tablet 15mg with a discontinued date of 2/18/2025. A review of the resident's Medication administration Record (MAR) for February 2025 revealed a last administration date of 2/17/2025. A review of the resident's MAR for March 2025 failed to reveal an order for Oxycodone HCl [Oxycodone IR] tablet 15mg. (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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/2025 at 12:25PM, during an interview with the Director of Nursing (DON) #2, the Surveyor expressed the concern that LPN #36 administered a dose of Oxycodone IR 15mg to Resident #102 on 3/3/2025 after the medication had been discontinued on 2/18/2025 and the medication remained in the narcotic medication cart after it was discontinued on 2/17/2025, which lead to the medication administration error. The DON confirmed the Surveyor's findings on the narcotic count sheet No. 24 and stated she was unaware and would investigate the incident. On 3/10/2025 at 7:51AM, the DON informed the Surveyor that the Oxycodone IR 15mg was in the narcotic medication cart on 3/3/2025 and LPN #36 administered it to Resident #102. The expectation, to avoid medication administration errors, is to immediately remove a discontinued medication from the medication cart and destroy the remaining tablets per facility's medication destruction policy.

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	215164	A. Building B. Wing	03/13/2025

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 42782 Based on observation, medical record review, and interviews it was determined that the facility staff failed to ensure that a resident who had poor dentition received dental services. This deficient practice was evidenced in 1 (#80) of 2 resident records reviewed for dental care during the recertification survey. The findings include: On 03/03/25 at 11:04 am the surveyor attempted to interview Resident #80 and observed the resident had poor dentition. On 03/05/25 at 9:24 am the surveyor asked Administrator #1 how the facility ensures that the residents are offered dental care. Administrator #1 verbalized dental care was offered to each resident. The resident or family member can make a request to be seen and the resident would be added to the caseload. On 03/05/25 at 2:10 pm Director of Nursing #2 informed the surveyor Resident #80 had not been seen by a dentist.

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	215164	A. Building B. Wing	03/13/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42782 Based on observations and interviews it was determined that the kitchen staff failed to store and label food to prevent potential foodborne illnesses, cover their hair to prevent food contamination, and failed to properly thaw food in the refrigerator. This deficient practice was discovered during the recertification survey. The findings include: On 02/27/25 at 8:34 am during the initial kitchen tour, the surveyor observed Dietary Aid #26 in the kitchen wearing a grey knitted hat with their hair exposed. Further observation of the freezer revealed: 1. an opened unlabeled and undated bag of exposed pepperoni 2. an opened undated bag of veggie patties 3. an opened box of hot dogs 4. an opened undated box of breaded oysters 5. a box of uncovered Tilapia dated 02/20/25 6. two bags of undated shrimp On 02/27/24 at 8:49 am when the surveyor checked the refrigerator and observed an undated and exposed American cheese and a box of un-thawed chicken on a sheet pan with a red substance on the fourth shelf on the left. During the surveyor's observations the issues were brought to the attention of Dietary Aid #28 and [NAME] # 27 who were made aware of the surveyor's findings. On 02/27 25 at 9:01 am during an interview Kitchen Manager #8 the surveyor reported the concerns about the staff without a hairnet and the issues with storing the food in the freezer and refrigerator. Kitchen Manager #8 verbalized all staff are expected to wear a hairnet while in the kitchen. An in-service was recently done, and the staff were made aware of the requirements to effectively run the kitchen and for food storage problems in the freezer and refrigerator.

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	215164	A. Building B. Wing	03/13/2025

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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)

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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)

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	215164	A. Building B. Wing	03/13/2025

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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).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457 Based on observations and interviews, it was determined that facility staff failed to ensure availability of personal protective equipment (PPE) for enhanced barrier precautions (EBP) residents, and use appropriate infection control practice upon entering a resident's rooms. This was evident for 6 out of 18 rooms observed for PPE residents and 1 room observed for hand hygiene during the survey. The findings include: On Monday 03/10/25, the surveyor observed that gloves were missing from PPE carts outside of the following resident rooms: 7:34 AM room [ROOM NUMBER]B-EBP no gloves 7:35 AM room [ROOM NUMBER]A-EBP no gloves 7:36 AM room [ROOM NUMBER]-EBP no gloves 7:37 AM room [ROOM NUMBER]B-EBP no gloves 7:37 AM room [ROOM NUMBER]B-EBP no gloves 7:41 AM room [ROOM NUMBER]B-EBP no gloves On 03/10/25 at 7:46 AM, the surveyor observed central supply staff #35 restocking PPE carts outside resident rooms with gloves. During an interview with the central supply staff #35 on 03/10/25 at 7:47 AM, the surveyor informed him of the observation regarding the missing gloves. The staff #35 stated that he restocks PPE carts daily during the weekdays and when he is off the weekends, the supervisor have access to the supply key and are responsible for restocking any missing or low stock equipment. During observation rounds on 03/10/25 at 8:04 AM, the surveyor observed LPN #18, enter room [ROOM NUMBER] Bed A without performing hand hygiene. A sign on the door indicated that resident in Bed A was on EBP. While in the room, LPN #18 was seen adjusting equipment above the resident's bed and did not wash or sanitize her hands during that time. The surveyor observed LPN #18 use hand sanitizer only upon exiting the room. When asked about the expectations for staff entering and exiting a resident's room, LPN #18 stated that staff are expected to perform hand hygiene both entering an exiting he resident's room. On 03/10/25 at 8:06 AM, the surveyor informed the Director of Nursing #2 of the observations.

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	215164	A. Building B. Wing	03/13/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 42782 Based on observations and interviews it was determined that the facility staff failed to make necessary repair in the kitchen. This deficient practice was discovered during the recertification survey. The findings include: On 03/12/25 at 8:45 am while walking through the kitchen with Kitchen Manager #8 the surveyor observed missing insulation and metal inside and outside of the distal portion of the refrigerator's entry. There were four different areas in the kitchen with missing tile on the walls. At 9:00 am the surveyor reviewed the maintenance issues in the kitchen with Administrator #1 who verbalized they were working on correcting the maintenance concerns in the kitchen.

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	215164	A. Building B. Wing	03/13/2025

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 50573 Based on observation, record review and staff interview, it was determined the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails to identify areas of possible entrapment. This was evident for 1 (Resident #113) of 1 resident reviewed for accidents hazards. The findings include: Bedrails or side rails are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them. On 03/03/25 at 08:17 AM, an observation revealed Resident #113 in bed with bilateral enabler bed rails On 03/04/25 at 12:16 PM, an interview with the Director of Nursing (Staff #2) revealed residents are assessed quarterly on the need for the enabler rails. She indicated that they are assessed for entrapment quarterly. The surveyor requested documentation regarding the entrapment risk assessment completed for Resident #113 ' s enabler bed rails. On 03/04/25 at 01:00 PM, review of the document titled, Bed Side Rail Tool dated 12/2/24 failed to reveal indication that entrapment risks were assessed. On 03/05/25 at 08:59 AM, an interview with the Director of Maintenance, revealed that maintenance would assess the resident enabler bed rails for entrapment often, but that they would not document it.