

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2025
NAME OF PROVIDER OR SUPPLIER Woodside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3601 Lakewood Blvd Naples, FL 34112	
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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility's policies and procedures, staff and resident interviews, the facility failed to respond timely to residents' request for assistance for 2 (Residents #750 and #799) of 3 residents observed. The findings included: On 11/12/25 at 5:52 a.m., during a tour of the [NAME] Hall the call light of room [ROOM NUMBER] was observed on. Licensed Practical Nurse (LPN) Staff A and LPN Staff B were observed in the hallway passing medications. A Certified Nursing Assistant (CNA) walked past the room and entered another resident's room. The call light remained on and unanswered until the Social Service Director was observed answering the call light at 6:09 a.m. On 11/12/25 at 6:20 a.m., Resident #750 was heard yelling out loudly for help for approximately 15 minutes. The call light was not on. No staff were observed in the hallway. Review of the clinical record revealed Resident #750 had an admission date of 8/11/24. Diagnoses included history of falling, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of the Quarterly Minimum Data Set (MDS) (standardized assessment tool that measures health status in nursing home residents) dated 8/2/25 revealed the resident was dependent on staff for toilet hygiene and transfers. The MDS specified the resident was frequently incontinent of urine and always incontinent of bowels. Resident #750 scored 15 on the Brief Interview for Mental Status, indicative of intact cognition. On 11/12/25 at 9:40 a.m., in an interview Resident #750 said at night no one comes to help, that is why he yells for help. The resident said he pushes the call light button, and it can take hours for staff to answer. He said he could not get out of bed on his own and did not walk. Resident #750 said he keeps his urinal on the table here and it fills up quickly. If he tries to use it the urine will spill, so he calls the staff to empty it. The resident said when he has a bowel movement, they don't come. Last night no one came and he was yelling because he needed the urinal to be emptied so the urine did not spill on him when he tried to use it. He said, No one ever comes in when I push the red button. On 11/12/25 at 9:12 a.m., Resident #799's emergency call light was observed on and beeping. Staff were observed walk past the resident's room. On 11/12/25 at 9:15 a.m., with the resident's permission, Resident #799 was observed in front of the toilet sitting in his wheelchair. The resident had no clothes on and was holding a soiled incontinent brief. Resident #799 said he needed help. On 11/12/25 at 9:25 a.m., the resident's call light was off. Resident #799 was observed sitting in the wheelchair. He was still not wearing any clothes and said no one had come to help him. He said he had been waiting for a long time and was yelling loudly for help. On 11/12/25 at 9:30 a.m., Registered Nurse (RN) Staff C was observed right next door from Resident #799's room with the medication cart. In an interview RN Staff C said, I turned the call light off because he is in the bathroom and needs help. I told the CNA. She was busy but knows and will come and take care of him because I told her. On 11/12/25 at 9:37 a.m., Resident #799 remained in the bathroom, yelling out for help. On 11/13/25 at 8:02 a.m., in an interview Resident #799 said, The call light is never answered and it happens just about every day. They just come in turn the light off and don't say anything. Yesterday was terrible, it was pretty bad. I had to go so badly to have a bowel movement and I went in my pants because no one came. They did not come for about an hour. The service here is terrible and it is worse on the night shift. I always wait over an (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hour. It makes me feel sad. I don't like to be like that, like I was yesterday, with stool on me. Review of the clinical record revealed Resident #799 was an [AGE] year-old male admitted on [DATE] with diagnoses including chronic kidney disease stage 3, type 2 diabetes mellitus, and hypertensive heart disease. Review of the admission MDS dated [DATE], documented that the resident was frequently incontinent of bowel and bladder and was not on a training program. The MDS specified the resident required substantial to maximum assistance with transfers to the toilet. The MDS documented a BIMS score of 08 indicating the resident's cognition was moderately impaired. The care plan initiated 10/23/25 identified Resident #799 had an activities of daily living (ADL) selfcare deficit related to fatigue, and chronic medical conditions. The goal for the resident specified he would not have a decline in ADL functioning through next review date. The interventions instructed staff to encourage and educate resident with increased independence as tolerated and assist with all ADL tasks as indicated, including transfers, toileting tasks, and personal/oral hygiene. Toileting: the resident will need extensive help of one or two staff. The resident will probably need you to wipe, redress, and wash their hands. Be prepared with 2 people to assist for resident safety during the transfer. On 11/13/25 at 8:30 a.m., in an interview RN Staff C said the call lights are to be answered as soon as you realize it is on. As soon as possible, take care of the resident. On 11/13/25 at 8:50 a.m., in an interview the Administrator said the call light response is a no pass zone, meaning everyone was to answer the call lights and not walk past them. He said, We have provided education, and the Leadership Staff are to be out on the floor making sure call lights are answered. It continues to be a problem, and we are working on it. A review of the training provided by the facility on 11/3/25 on call lights and customer service, documented it was very important that you must answer all call lights in a timely manner. Please knock on the door and wait for answer, enter room with a smile, a smile goes a long way, even if it's not your section, they are all our residents. A total of 23 employees received the training.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of the Resident Council Meeting Minutes and resident and staff interviews, the facility failed to act promptly upon the grievances expressed by the residents and the Resident Council group. The findings included: A review of the Resident Council meeting minutes for August 2025 through November 2025 revealed ongoing concerns related to call light response time. On 8/19/25 the Resident Council New Business documented Staff need to make sure call lights are always in reach. CNA's (Certified Nursing Assistants) need education on call light answering. Residents would like quicker call light response on weekends. There was no documentation to address the concerns with the call light response time. On 9/16/25 the Council meeting minutes documented expressed under new business Regarding weekend CNA's some residents cannot get as quick of a response to call lights; more mobile residents will help locate them. Is this appropriate? There was no documented response from the facility to address the concerns. On 10/7/25 the Resident Council meeting minutes documented under New Business, CNA's are turning off call lights and not coming back or following through with what they said they would do. Wait times for CNA's are up to 30 to 45 minutes, especially if they are doing showers. Weekends are worse. There was no documented response from the facility to address the concerns. On 10/21/25 the Resident Council minutes documented Review of previous meeting, outstanding issues. Nursing still needs to answer, waiting for responses. There was no documented response from the facility to address the concerns. On 11/4/25 the Resident Council meeting minutes documented under New Business, Education for all staff on reminding them to make sure call light is within reach. Some residents complained that the customer service overnight is not what they would like, and call lights are not answered promptly. There was no documented response from the facility to address the concerns. On 11/12/25 at 8:50 a.m., in an interview Resident #850 (Resident Council President) said the staff do not even come in the room to answer the call light. They just reach their hand in the door and turn it off. The Resident demonstrated how the call system light was located inside of the door on the left side of the wall. She said, They just reach in and shut it off. If I really need something, I just go to the nurse's station and look for help because I can walk. On 11/13/25 at 11:00 a.m., in an interview, the Social Service Director said she knew call lights were a concern and they were working on it. The Social Service Director did not have documentation of how the facility addressed the repeated concerns related to call light response voiced by the Resident Council from August through November 2025. She said, If I hear of a concern from the Council, then I write a grievance for it and deliver it to the appropriate person to resolve it.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of the facility nursing assignments and staff interviews, the facility failed to have a designated Licensed Nurse to serve as a charge nurse on the 11:00 p.m., to 7:00 a.m. shift as required. The findings included: On 11/12/25 at 5:35 a.m., Licensed Practical (LPN) Nurse Staff A answered the door upon arrival to the facility. A request was made to speak with the designated charge nurse. In an interview, LPN Staff A said there was no charge nurse assigned to the 11:00 p.m., to 7:00 a.m., shift. LPN Staff A said there has never been an assigned charge nurse on the night shift. She said if an emergency occurred the staff were to contact the Director of Nursing (DON). On 11/12/25 at 5:50 a.m., in an interview LPN Staff B confirmed there was no designated charge nurse on duty for the shift. She said there never is a designated licensed nurse to serve as a charge nurse for the night shift. Staff B said, If we have a problem we call the DON. On 11/12/25 at 6:45 a.m., in an interview LPN Staff E said there was no charge nurse assigned on the night shift. She said they call the DON for emergencies. Review of the 11-7 shift nurse assignments from 11/5/25 through 11/12/25 revealed there was no designated charge nurse assigned for the night shift. On 11/13/25 at 1:23 p.m., in an interview the DON said the facility did not have an assigned charge nurse as required on the 11:00 p.m. - 7 a.m., shift, the staff just call the DON.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, policy review and record review, the facility failed to ensure that 2 (Residents #800 and #900) of 4 residents sampled were free of significant medication errors. The findings included: 1. Review of facility Policy 5.0 Reordering, Changing, and Discontinued Medication Orders (Effective Date blank) revealed Policy: The facility will communicate any medication reorders, changes, or discontinuations to the pharmacy in accordance with pharmacy guidelines and state/federal regulations; thus ensuring standardized process of communication. Procedure: A. All orders must clearly be communicated to the pharmacy by the facility. This includes resident's full name (first and last). B. Reorder/Refill orders. 3. Verbal Orders: Refill orders can be submitted verbally. The following information must be communicated to the pharmacy: Facility, unit, physician, customer's full name, room number, prescription number to be refilled, medication name, medication strength, name of person placing the call to Specialty Rx, Inc. 4. Electronic Orders: Refill orders can be submitted electronically from a prescriber through their ecribing software or through the facilities electronic medication administration record (EMAR) system. A clinical record review revealed that Resident #900 was admitted to the facility on [DATE] with diagnoses of primary generalized osteoarthritis (also known as arthritis, a breakdown of the joints which causes pain), presence of right artificial hip joint (also known as hip replacement), chronic obstructive pulmonary disease (a chronic lung disease), and generalized anxiety disorder. Review of the Quarterly Minimum Data Set (standardized assessment tool that measures health status in nursing home residents) dated 9/30/25 revealed the resident was cognitively intact. On 11/12/25 at 7:45 a.m., in an interview Resident #900 said the facility did not have her eye ointment for several days. A clinical record review revealed that resident #900 had an order on 9/15/25 for Pataday Ophthalmic Solution 0.7%, instill one drop in both eyes in the morning (eye allergy itch relief medication). The start date was 9/16/25. Review of the medication administration record (MAR) revealed the Pataday Ophthalmic Solution was not given because it was on order from pharmacy on 9/16, 9/17, 9/19, 9/20, 9/23, 9/25, 9/26, 9/28-30, 10/3, 10/4, 10/7 and 10/9. The medication was discontinued on 10/10/25. A clinical record review revealed that resident #900 had an order on 9/26/25 for Pataday Ophthalmic Solution 0.7%, instill one drop in both eyes in the morning (eye allergy itch relief medication). The start date was 9/27/25. Review of the MAR revealed that the Pataday Ophthalmic Solution was not given because it was on order from pharmacy 9/27-9/30, 10/3, 10/4, 10/7, 10/9-12, 10/23, 10/24, 10/28, 10/31, 11/2, 11/4, and 11/7-11/9. The medication was discontinued on 11/10/25. On 11/13/25 at 9:50am, Staff H, RN said medications were often missing when she first started working at the facility 3 months ago. 2. On 11/12/25 at 9:00 a.m., in an interview Resident #800 said I am on intravenous (IV) antibiotics, and they never have the medication. I receive it every other day and I don't get it because it has not (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	come in from Pharmacy and then my cycle has to start over. I don't know why they don't order it a day in advance because they know I get it every other day, but they don't have it here. Review of the physician orders documented an order dated 10/18/25 for Cubicin Solution (an antibiotic) Reconstituted 500 milligrams (mg). Use 500 mg intravenously every 48 hours for osteomyelitis until 11/11/2025. A review of the medication administration record (MAR) for October 2025 revealed on 10/19/25 the documentation indicated the medication was not administered and was reordered on 10/24/25. Further review of the MAR revealed the Cubicin Solution was not administered on 10/26/25, 10/28/25 and 10/30/25. Review of the nursing progress note dated 10/26/25 documented the Cubicin was not administered, awaiting pharmacy delivery. There was no documentation the physician was notified of the missed dose. The nursing progress note dated 10/28/25 documented patient refused, stated that the last dose was administered yesterday at 6 a.m. Nurse Practitioner notified and okay to reschedule start on 10/29/25 at 6:00 a.m. Resident aware and agreed with the changes. The nursing progress note dated 10/30/25 documented Cuibcin Solution Reconstituted 500 mg was not administer as the medication was completed on 10/29/25. A review of the November MAR documented a start dated of 10/31/25 for Cuibcin Solution Reconstituted 500 mg IV every 48 hours with a discontinue date of 11/3/25. On 11/2/25 the MAR indicated the medication was not administered. A review of the nursing progress note dated 11/2/25 documented the medication was not administered, awaiting Cubicin from pharmacy. The medication was reordered on 11/5/25 to continue until 11/11/25.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy and procedure and staff interviews, the facility failed to ensure medications were stored in locked compartments when not in use in 1 ([NAME] Hallway) of 3 hallways observed to prevent unauthorized access to medications. The findings included: Review of the facility policy and procedure titled, Medication Storage and Labeling revised 1/2024 revealed, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Procedure: Drugs and biologicals used in the facility are stored in locked compartments. Only persons authorized to prepare and administer medications have access to locked medications. On 11/12/25 at 5:40 a.m., during the initial tour of the facility, observation of the [NAME] Unit Hallway revealed two medication carts: The first cart had two prefilled syringes of Normal Saline Solution 0.9%, a bottle of powdered Cefazolin (antibiotic) 2 grams for Resident #700, and an intravenous bag of 50 milliliters normal saline that were unlocked and unattended on top of the medication cart. Photographic evidence obtained. On 11/12/25 at 5:44 a.m., Licensed Practical Nurse (LPN) Staff A was observed coming out of a resident's room. In an interview LPN Staff A verified the 2 prefilled syringes of Normal Saline Solution 0.9%, the bottle of powdered Cefazolin 2 grams and the 50 milliliters bag of normal saline were left unattended and unlocked on top of the medication cart. She said she should have locked them in the medication cart. A second medication cart located approximately 10 feet from the first cart was observed unlocked and unattended. Photographic evidence obtained. On 11/12/25 at 5:45 a.m., observation of the medication cart with LPN Staff A revealed the cart contained residents' medications. In an interview, LPN Staff A verified the medication cart was unlocked and unattended and said, Other nurses use the cart too. LPN Staff A walked away, left the cart unlocked and unattended. On 11/13/25 at 5:50 a.m., LPN Staff B verified the medication cart remained unlocked and unattended. In an interview, LPN Staff B said the medication cart should always be locked when not in use. On 11/12/25 at 1:57 p.m., during an interview, the Assistant Director of Nursing and the Administrator were informed of the observation of the medications left unsecured and unattended on the [NAME] Unit Hallway. The ADON and Administrator did not provide additional information or explanation related to the unsecured medications observed on the [NAME] Hall Unit.		