

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Woodside Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 9101 Second Avenue Silver Spring, MD 20910	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on observations, record review and interviews it was determined that the facility failed to ensure: 1) appropriate resident information was sent to the receiving facility and 2) a resident's bed hold policy was maintained and care planned in accordance with facility policy and resident rights requirements, placing the resident at risk for misunderstanding bed hold procedures and return to facility expectations following hospitalization. This was evident for 3 (Resident #17, #6 and #77) out of 3 residents reviewed for hospitalizations. The findings include: 1. On 05/27/2026 at 11:15 AM, during unit rounding, the surveyor observed Staff #5 preparing Resident #17 to be transferred to the hospital. On 05/27/2026 at 11:55 AM, an interview with Staff #5 was conducted. When asked what documents were provided to the Emergency Medical Technician (EMT) for hospital transfer, staff reported the Facesheet, MOLST(Medical Orders for Life-Sustaining Treatment) form, lab results, and orders. She reported that she was in a rush and did not provide SBAR (Situation, Background, Assessment, and Recommendation) and care plan goals. She also added that it was not the facility's process to include comprehensive care plan goals as part of the transfer documents. On 05/27/2026 at 12:18 PM, a review of the facility's internal transfer form indicated that no care plan goals or SBAR document was sent with the resident to the hospital. On 05/27/2026 at 1:37 PM, an interview with the Director of Nursing (DON) was conducted. She acknowledged that she was not aware that comprehensive care plan goals were part of the documents that needed to be sent with a resident during hospital transfers. 2. On 5/27/2026 at 11:18 AM, record review revealed that Resident #77 was transferred to the hospital on 2/28/2026. On 5/27/2026 at 11:23 AM, documents that were sent with Resident #77 during his/her transfer to the hospital were requested. On 5/27/2026 at 12:18 PM, review of the documents received revealed that the bed-hold policy and comprehensive care plan goals were not included. On 5/27/2026 at 1:37 PM, an interview with the Director of Nursing revealed that the bed-hold policy (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had not been sent with Resident #77 during his transfer. On 5/28/2026 at 10:50 AM, an interview with the Director of Nursing revealed that the comprehensive care plan goals had not been sent out with Resident #77 either. At the same time, the concerns were addressed with the DON and she indicated that she understood. 3. On 5/26/2026 at 12:31 PM, record review revealed that Resident #6 was transferred to the hospital on 2/16/2026. On 5/27/2026 at 11:23 AM, documents that were sent with Resident #6 during his/her transfer to the hospital were requested. On 5/28/2026 at 9:31AM, review of the documents received revealed that the comprehensive care plan goals were not included. On 5/28/2026 at 10:50 AM, an interview with the Director of Nursing revealed that the comprehensive care plan goals had not been sent out with Resident #6. At the same time, the concerns were addressed with the DON and she indicated that she understood.		

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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** Based on record reviews and interviews, it was determined that the facility to code the residents' status accurately on the Minimum Data Set (MDS) assessment. This was evident for 3 (Resident #10, #72 and #8) out of 4 reviewed for accuracy of assessment during the recertification survey. The findings include: 1. On 05/27/2026 at 9:38 AM, a review of Resident #10's medical records was conducted. The review revealed that the resident had an active order for Lovenox 30 mg at bedtime. Lovenox (generic name: enoxaparin sodium) is a prescription anticoagulant, commonly referred to as a blood thinner. The review of the Medication Administration Record (MAR) for April revealed that the resident received Lovenox daily. MDS with Assessment Reference Date (ARD) of 4/16/2026 failed to indicate that the resident was on anticoagulants. On 05/28/2026 at 10:34 AM, an interview with Staff #6, MDS Coordinator, was conducted. She reported that she missed coding the anticoagulant and acknowledged that the MDS was inaccurately coded. 2. On 05/26/2026 at 9:47 AM, an interview with Resident #72 was conducted. They reported that they did not have diabetes and had never received insulin while in the facility. On 05/27/2026 at 10:27 AM, a review of Resident #72's medical records was conducted. The review of orders and MAR failed to reveal insulin administration. Review of MDS with ARD date of 2/14/2026 indicated that the resident received insulin for 5 days. On 05/28/2026 at 10:34 AM, an interview with the MDS coordinator was conducted. She stated that insulin shouldn't have been coded and confirmed that the MDS was coded inaccurately. On 05/28/2026 at 11:18 AM, the Director of Nursing was notified of the findings. 3. During screening on 5/26/26 at 10:15 AM, the surveyor observed that Resident #8 had 1/4 length bedrails on her bed. A review of Resident #8's EMR (electronic medical record) on 5/26/26 at 11:35 AM revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including, but not limited to, adult failure to thrive, dependence on supplemental oxygen and muscle weakness. Further review on 5/26/26 of Resident 8's EMR revealed Resident #8 had an admission Side Rail (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluation dated 1/8/26 at 7:41 PM and a Quarterly Side Rail Evaluation dated 4/8/2026 at 12:52 PM. The MDS with Assessment Reference Date (ARD) of 4/17/26 failed to indicate that the resident had bed rails on his/her bed The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review it was determined that the facility failed to ensure that comprehensive care plans were developed and implemented. This was found to be evident for one (Resident #9) out of eighteen residents reviewed during an annual survey. The findings include: During screening on 5/26/26 at 8:43 AM, the surveyor noted that Resident #9 had an indwelling foley bag that was covered with a dignity bag. A review of Resident #9's electronic medical record (EMR) on 5/26/26 at 12:15 PM revealed that Resident #9 was admitted to the facility on [DATE] with diagnoses including but not limited to, prostate cancer with metastases to the bone. Further review disclosed an order for an indwelling catheter for obstructive uropathy was written on 4/18/26 by MD#27 (Medical Director). On 5/27/26 at 1:35 PM, a review of Resident #9's care plan lacked evidence of any focus or interventions regarding Resident #9's obstructive uropathy necessitating an indwelling foley catheter.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview it was determined that the facility failed to maintain professional standards of practice related to oxygen orders. This was evident for 1 (Resident #82) out of 4 residents reviewed for respiratory orders. The findings include: On 5/26/2026 at 12:52 PM, an observation of Resident #82 revealed that the resident was receiving oxygen therapy. On 5/26/2026 at 12:53 PM, record review failed to reveal an active order for oxygen. On 5/28/2026 at 10:52 AM, concerns were brought up to the Director of Nursing and she indicated that she understood.		

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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. Based on interviews and record reviews, it was determined that the facility failed to provide dependent residents with showers. This was evident for 1 (Resident #31) out of 8 reviewed for activities of daily living during the recertification survey. The findings include: On 05/26/2026 at 11:07 AM, an interview with Resident #31 was conducted. They reported that they had not had a shower in a long time because their legs are weak and relied on a wheelchair. On 05/28/2026 at 11:46 AM, a review of Resident #31's medical records was conducted. The review revealed that the resident was to shower on Wednesdays and Saturdays on evening shift. Review of the shower task indicated that the resident had not had a shower for the last 30 days. On 05/28/2026 at 12:18 PM, an interview with Staff #8 was conducted. They reported that Resident #31 was dependent on staff for activities of daily living. They further reported that when residents are offered a shower, a shower sheet should be completed and placed in the unit's shower binder. Additionally, if a resident refused a shower, the refusal must be documented on the shower sheet and on the resident's electronic medical record. On 05/28/2026 at 12:20 PM, a review of the unit's shower binder was conducted with the surveyor and Staff #8. There were no shower sheets with the Resident #31's name for the month of May. On 05/28/2026 at 12:30 PM, an interview with Staff #5 was conducted. They reported that if a resident refused showers for several days, then the nurse would notify the unit manager who then updated the care plan to include refusal of care. On 05/28/2026 at 3:02 PM, the Surveyor received additional shower sheets from the facility. The review of these documents revealed that Resident #31 was offered showers 2 times in January, there were no other records for April or May. On 05/29/2026 at 1:55 PM, an interview with the Director of Nursing (DON) was conducted. She confirmed that there was no evidence that Resident #31 was offered a shower for the month of May.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined that the facility failed to have evidence in Resident #8's care plan regarding Resident #8's limited mobility and the usage, monitoring and supervision of the bedrails. This was evident for one out of one resident (Resident # 8) reviewed for bedrails during an annual survey. The findings include: During screening on 5/26/26 at 10:15 AM, the surveyor observed that Resident #8 had 1/4 length bedrails on her bed. A review of Resident #8's EMR (electronic medical record) on 5/26/26 at 11:35 AM revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including, but not limited to, adult failure to thrive, dependence on supplemental oxygen and muscle weakness. Further review on 5/26/26 of Resident #8's admission Side Rail Evaluation dated 1/8/26 at 7:41 PM documented that Resident #8 requested the use of side rails and currently had 1/4 rail bilaterally in use on his/her bed. The Conclusion on Resident #8's admission Side rail evaluation stated, The care plan will reflect the use of side rails and interventions to minimize injury and/or entrapment. A review of Resident #8's care plan on 5/26/26 at 12:10 PM revealed that there was no documentation of the bedrails in Resident #8's care plan under the focus of limited physical mobility or self-care performance deficit related to activity intolerance. On 5/29/26 at 10:38 AM during an interview, Licensed Practical Nurse (LPN) #12 stated that Resident #8 uses the bedrails as enablers to move around in the bed. They help him/her turn and move up in the bed.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of employee personnel files and staff interview, the facility failed to complete annual performance evaluations for Geriatric Nursing Assistants (GNAs). This deficient practice was identified for 3 (GNA #23, #24, and #25) of 3 GNAs reviewed during the annual survey. The findings include: On 06/01/2026 at 11:25 AM, 3 GNA employee files were reviewed. During the review, none of the three GNA personnel files contained documentation of a completed annual performance evaluation. On 06/01/2026 at 12:54 PM, an interview with the Director of Nursing was conducted. When asked if the 3 GNAs had annual performance evaluations she stated that they had not had them done.		

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on employee file reviews and interviews with staff, it was determined that the facility failed to ensure that a Geriatric Nursing Assistant maintained a current and active certification required for employment. This was evident for 1 (GNA #23) of 5 health care professionals reviewed during the annual survey. The findings include: The Maryland Board of Nursing's Look Up A License feature serves as the primary source verification system for certification status. All Geriatric Nursing Assistants are required to maintain an active certification to work. On [DATE] at 11:25 AM, 5 employee files were reviewed. During this review the surveyor was checking that the health care professionals maintained current credentials required for their position. The employees were entered into the Look Up A License feature on the MBON website to verify the status of their required credentials. It was found that Geriatric Nursing Assistant (GNA) #23 had an expired certification with an expiration date of [DATE]. On [DATE] at 12:43 PM, a review of GNA #23's timesheets from [DATE] through [DATE] revealed that she worked 11 shifts after her certification expired on [DATE]. On [DATE] at 12:46 PM, Human Resource/ Staff Scheduler #26 was interviewed. During the interview she was asked how she kept track of employee certifications and expiration dates. She said that she kept a binder of all employee licenses/certifications and expirations and would send out reminders to staff when they were close to expiring. At this time she was made aware of the concerns related to GNA #23 working without an active certification. The Director of Nursing was also made aware of the concern on [DATE].		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility's failed to ensure Resident #2's hospice documents including the coordinated plan of care were available to facility staff. This was evident for one out of two residents reviewed for hospice services. The findings include: Facility's Coordination of Hospice Services Policy - When a resident chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental and psychological well-being. Policy Explanation and Compliance Guidelines: 1. The facility maintains written agreements with hospice providers specify the care and services to be provided and the process for hospice and nursing home communication of necessary information regarding the resident's care . Revised 2025A review of Resident #2's electronic medical record (EMR) on 5/26/26 at 12:36 PM revealed that Resident #2 was admitted to the facility on [DATE] with diagnosis including but not limited to, dementia and on 2/11/26, Resident #2 was admitted to [hospice] services with a diagnosis of idiopathic normal pressure hydrocephalus. During an interview on 5/27/26 at 12:48 PM, the Director of Nursing (DON) stated that in addition to the facility's paper chart on Resident #2, there will be a hospice chart for that resident to ensure communication between the facility staff and the Hospice personnel. DON stated, The hospice binder is usually a blue binder. I will bring it to you. A review of Resident #2's hospice binder on 5/27/26 at 1:49 PM revealed that the Your Hospice Team document was not completed with the names and contact information for those professionals involved in Resident #2's hospice care. The binder also lacked evidence of the hospice care plan, the hospice orders, a copy of Resident #2's hospice election form as well as information regarding how to access the hospice on-call system. On 5/27/26 at 2:52 PM, the Nursing Home Administrator (NHA) brought copies of Resident #2's hospice documents to the surveyor stating that they were in his office. Upon review, these documents still did not include the list and contact information for Resident #2's responsible hospice providers. During an interview on 5/27/26 at 2:10 PM, the DON confirmed that Resident #2's hospice binder did not contain these documents and thus the coordinated plan of care for Resident #2 daily care was not available to facility staff from 2/11/26 until surveyor intervention on 5/27/26.		

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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. Based on observations and interviews it was determined that the facility failed to maintain infection prevention and control practices related to sanitary ice handling by storing a cup directly inside a communal ice cooler instead of utilizing a sanitary ice scoop, creating the potential for cross contamination for residents receiving ice from the cooler. This was evident for 1 (Jamestown) out of 4 units The findings include: On 5/26/2026 at 9:05 AM, an interview with Resident #62 revealed that ice was being handled in an unsanitary manner, the resident indicated that a cup was being stored inside the ice cooler and used as a scoop and that anyone in the building had access to the cooler. On 5/26/2026 at 9:10 AM, an observation revealed that there was no dedicated scooping device available at the ice cooler located between the Williamsburg and Jamestown units. On 5/27/2026 at 11:26 AM, an observation revealed that a cup was stored inside the ice cooler and that no designated scooping device was available near the cooler. At the same time, the Licensed Practical Nurse (Staff #5) removed the cup from the ice cooler. On 5/27/2026 at 12:00 PM, an interview with Staff #5 revealed that the expectation was for the cup to be stored outside of the ice cooler. On 5/27/2026 at 12:30 PM, the concerns were addressed with the Unit Manager (Staff #7) and she indicated that she understood, On 5/27/2026 at 2:05 PM, the concerns were addressed with the Director of Nursing and she indicated that she understood.		