STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215343	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riderwood Village	3160 Gracefield Road Silver Spring, MD 20904

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, record review and interviews, it was determined that the facility staff failed to treat resident with dignity and care for resident's Activities of Daily Living (ADLs) /hygiene in a manner that promotes maintenance or enhancement of resident's quality of life. This was evident for 1 (Resident #69) out of 3 residents reviewed resident's dignity and ADLs/hygiene care during an annual survey.The findings include:Activities of Daily Livings (ADLs): Activities of daily living are activities related to personal care. They include bathing or showering, grooming, dressing, eating, using the toilet, getting in and out of bed or a chair and walking and more.On 09/15/2025 at 10:55 AM, Resident #69 was alert, and a Geriatric Nursing Assistant (GNA) earlier fed the resident. Surveyor observed this resident was in bed ungroomed; with disheveled hair, a dirty face, eye crust, and in a food-stained gown.On 09/16/2025 at 11:00 AM, The surveyor observed in the hallway and noted GNAs were in and out of Resident #69's room in past 2 hours. Further observed at 11:58 AM, this resident was still in bed not groomed, wearing a dirty gown, breakfast food above the lip. Additionally, their right eye was crusted shut with discharge. Resident #69 expressed a need for staff assistance with morning care and dressing.Record Review 9/16/2025 at 11:30 AM, Resident #69's was admitted to the facility on [DATE]. This resident had a history of moderate vascular dementia, chronic obstructive pulmonary disease, muscle wasting and atrophy. Their care plan indicated a request to honor preferences regarding hairstyle, nail care, makeup, and AM/PM rituals. Additionally, this resident required extensive assistance with ADLs.On 09/16/2025 at 12:15 PM, upon entering Resident #69's room the surveyor and Unit Manager Staff #11 noted that this resident was found still in a dirty gown, with uncombed hair, a greasy face, and food residue above the lip. In addition, eye discharge was preventing the right eye from opening. Staff #11 acknowledged these findings as unacceptable and promptly instructed staff to provide morning care and assist with dressing. Informed Staff #11 that above findings constitute a deficiency concern.During an interview, on 09/16/2025 at 12:25 PM, the Assistant Director of Nursing Staff #1 and the Administrator Trainer Staff #12 were made aware of the above findings as a deficiency concern regarding not treating the resident with dignity and the absence of morning ADLs/hygiene care. On 09/17/2025 at 2:25 PM, the Administrator reported to this surveyor that staff were re-educated.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, record review and facility policy review, it was determined that the facility failed to ensure meaningful activities to meet the needs/interests of the residents and to provide consistent resident centered/personalized activities for the dependent, confined residents in a manner that promotes maintenance or enhancement of residents' quality of life. This was evident for 2 (Resident #35 and Resident #69) out of 3 residents reviewed for ongoing resident centered activities program during an annual survey. The findings include-1) On 09/15/2025, at 10:09 AM, Resident #35 was observed in their room, awake and knee was contracted to chest. No TV, music or other activity was observed at these times. This resident was able to engage in a short conversation.Observation, on 09/16/2025 at 11:20 AM, Resident #35 was observed in bed, staff were in the room but not interacting with the resident at the time of the observation. This resident was not observed participating in or receiving visits from activity staff during the first two days of the survey.During an interview, on 09/16/2025 at 2:39 PM, the Activity Coordinator Staff #9 stated that most residents participate in two types of activity programs: group and individual activities. The calendar for group activities was provided and posted in advance. Noted the group activity schedule was from 9:00 AM and end around 4:30 PM. She continued to share that there was no set time for individual activities for those who were confined to their rooms. The Activity Director Staff #10 indicated that Resident #35 received one-to-one room visits from Staff #11. Staff #11 was not present for this interview. Surveyor requested copies of the individual Activity Log for recent 2 months of August and September.Record Review, on 09/19/2025 at 10:10 AM, Resident #35's was admitted on [DATE] to this facility with history of Parkinson's, osteoporosis, muscle wasting and atrophy, contracture of limbs, vascular moderate dementia. The care plan was examined that this resident was a Social Worker prior to retirement and interest/preferences were enjoying listening to music, spiritual/religious opportunity and family calling and visiting. This resident's assessment was dependent on staff for all Activity Daily Livings needs. The activity plan was to have one-to-one visit dramas on TV, listening to music and going outside when the weather was good, but the plan was not aligned with Resident #35's meaningful special interests/care plans. Furthermore, a review of the activity staff's Activity Log from August to September 2025 revealed that only dates were recorded i.e.: 8/4, 8/6, 8/11, 8/13, 8/18, 8/20, 8/22, 8/25, 8/27 and 8/29 as 10 days out of 31 days in August. Also, 9/1, 9/3, 9/8, 9/10 and 9/15 as 5 days out of 17 days in September. Again, no specific one-to-one activity was recorded on above those dates on the Activity Logs.Interview conducted on 09/19/2025, at 10:25 AM, Activity Staff #11 stated she was assigned to Resident 35's Unit, and her working hours were from 8:30 AM to 5:00 PM and she conducted all the group activities according to the group activity schedule. She mentioned visiting all dependent residents for one-to-one visit was not conducted consistently. She also confirmed that there was no activity recorded on the Activity Log including Resident #35.Record review, on 9/19/2025 at 11:20 AM, the facility Programming/Activity Policy under section 3 revealed that offered daily are based on the resident's holistic assessment, care/service plan and the preferences of each residentThe concern regarding the failure to provide one-to-one meaningful activities to meet dependent residents' needs/interests/preferences and be consistent with dependent residents' center/personalized activities based on assessments, care plans, the facility's policy and activity's log were reviewed with the Administrator on 09/22/2025 at 9:25AM. 2) On 09/15/2025, at 10:51 AM, Resident #69 was observed in bed awake, staring at the wall not able to move and with no apparent activity (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered.Observation, on 09/16/2025 at 11:30 AM, Resident #69 was in bed. No TV, music or other activity was observed at these times, and this resident was not observed participating in or receiving visits from activity staff during the first two days of the survey.During an interview, on 09/16/2025 at 2:39 PM, the Activity Coordinator Staff #9 stated that most residents participate in two types of activity programs: group and individual activities. The calendar for group activities was provided and posted in advance. Noted the group activity schedule was from 9:00 AM and ended around 4:30 PM. She continued to share that there was no set time for individual activities for those who were confined to their rooms. The Activity Director Staff #10 indicated that Resident #69 received one-to-one room visits from Staff #11. Staff #11 was not present for this interview. Surveyor requested copies of the individual Activity Log for recent 2 months of August and September. On 9/16/25 at 3:20 PM, observed Resident #69 was dozing off while sitting in bed. During this observation, no individual activity was offered to this resident nor activity staff were present.Interview conducted on 09/19/2025, at 10:25 AM, Activity Staff #11 stated she was assigned to Resident 69's Unit, and her working hours were from 8:30 AM to 5:00 PM and she conducted all the group activities according to the group activity schedule. She mentioned visiting all dependent residents for one-to-one visit was not conducted consistently. She also confirmed that there was no activity recorded on the Activity Log.Record Review, on 09/19/2025 at 11:00 AM, Resident #69's was admitted on [DATE] to this facility with history of moderate vascular dementia, chronic obstructive pulmonary disease. and muscle wasting and atrophy. Reviewed Resident #69's care plan found that he/she enjoyed drawing, historical documentary activities, family visits and to be creative and simulated cognitively throughout the week. Additionally, she requested to honor the preferences for hairstyle, nail care makeup and AM/PM rituals. The care plan was examined but the planned activities were not aligned with Resident #69's specific meaningful interests/ preferences/care plans. Furthermore, a review of the activity staff's Activity Log from August to September 2025 revealed that only dates were recorded i.e.: 8/4, 8/6, 8/11, 8/13, 8/18, 8/20, 8/22, 8/25, 8/27 and 8/29 as 10 days out of 31 days in August. Also, 9/1, 9/3, 9/8, 9/10 and 9/15 as 5 days out of 17 days in September. Again, no specific one-to-one activity was recorded on above those dates on the Activity Logs.Record review, on 9/19/2025 at 11:20 AM, the facility Programming/Activity Policy under section 3 revealed that activities offered daily are based on the resident's holistic assessment, care/service plan and the preferences of each resident.The concern regarding the failure to provide one-to-one meaningful activities to meet dependent residents' needs/interests/preferences and be consistent with dependent residents' center/personalized activities based on assessments, care plans, the facility's policy and activity's log were reviewed with the Administrator on 09/22/2025 at 9:25AM.

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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 with staff, it was determined that the facility failed to ensure that the environment of 1) resident's rooms and 2) a resident's shower chair was maintained in a manner that minimized the potential for the spread of infection. This was evident for 3 of 4 areas reviewed during the annual recertification survey. The findings include: 1) On 09/15/2025, at 11:40 AM, during an initial tour of Resident #7's bathroom and room, a grey fall mat was observed on the bathroom floor, touching the toilet. A clear plastic bag containing a black object was also seen on the bathroom floor. In Resident #7's room, a clear plastic bag was found on the floor under the medicine cabinet, containing a light green and grey chuck and a gown. On 09/15/ 2025, at 11:54 AM Staff #7, a Licensed Practical Nurse (LPN), was shown the fall mat and the plastic bags in both the bathroom and the room. Staff #7, LPN was asked about the policy/procedure for floor mats in bathrooms and linens on the floor. Staff #7 explained that aides typically bathe residents, change bed linens, and then remove the linens from the room for laundering. Staff #7, LPN was then asked about the black object in the plastic bag on the bathroom floor. After putting on gloves, Staff #7, LPN, identified it as a wheelchair cushion for Resident #7. Staff #7, LPN was also shown the plastic bag on the floor in Resident #7's room with the gown and chuck inside. Staff #7, LPN, was asked about the handling of soiled linen. Staff #7, LPN, stated that aides place soiled linen in a clear plastic bag and take it to the soiled utility room to be put down the laundry chute. Staff #7, LPN acknowledged that the floor mat, wheelchair cushion, and linens should not have been on the floor and removed all items from the room. On 09/15/2025, at 12:09 PM, during the initial tour of Resident #73's bathroom, a Geri-chair was observed with a white sheet and a pink triangular abductor wedge were on the seat. A floor mat was also observed leaning against the toilet and trash can in the bathroom. On 09 /15/2025, at 12:13 PM Staff #7, LPN, was shown the Geri-chair, pink triangular abductor wedge, and the floor mat touching the toilet. When asked if these items should be in the resident's bathroom, Staff #7, LPN, stated that furniture should not be in the bathroom, and floor mats are generally placed against the bed when the resident is out of bed and out of the room. Staff #7, LPN verbalized understanding that these items could potentially spread infection. Staff #7 then removed the items from the room and took them to the soiled utility room to be cleaned 2) On 09/18/2025 at 11:10 AM, a tour of the second-floor Spa room revealed an unclean shower chair. An interview with Staff #17 verified that the shower chair should be cleaned by care associates before and after use. Staff #17 further explained that housekeeping provided deep cleaning of the spa room each morning. At 11:15 AM, an interview with Staff#19 and the second-floor clinical manager confirmed that the shower chair should be cleaned before and after use to minimize the potential spread of infectious diseases. At 12:45 PM, the surveyor verified that the housekeeping staff cleaned the spa room. On 09/19/2025 at 4:10 PM, the Assistant Administrator, Assistant Director of Nursing (ADON) 1 and ADON 2 were made aware of these findings.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation and interviews with staff, it was determined that the facility failed to ensure that the call system cord was accessible in the resident's bathroom. This was evident for 1 (Resident #57) of 1 resident's bathroom observed during the annual survey. The findings include:On 09/16/2025 11:40 AM, the surveyor visited room [ROOM NUMBER] to verify the call bell systems at the bed and the bathroom. The surveyor noted that the call bell cord was too short and tucked behind a trashcan that was placed directly next to the toilet. At 12:50 PM, a tour of room [ROOM NUMBER] was conducted with the Assistant Director of Nursing (ADON) 1 and ADON 2. They both confirmed the call bell cord was inaccessible to the residents due to its length and the placement of the call bell cord in the resident's bathroom. On 09/19/2025 at 4:13 PM, the Assistant Administrator, Assistant Director of Nursing (ADON) 1 and ADON 2 were made aware of these findings.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation and staff interview, it was determined that the facility staff failed to ensure that handrails were on all walls in resident areas including both resident's rooms and all resident common areas. This was evident for 2 of 2 nursing units and all common areas observed during the survey. This deficient practice had the potential to affect all residents, staff, and visitors on the units. The findings include: On Tuesday, 09/16/2025 at 9:16 AM during a tour of the facility, it was noted that there were no handrails near the elevator, an activities room (Garden Room), the hallway near the dining area (Grace's Table). On 9/16/2025 at 11:35 AM, met with the Administrator and employee #8 from the [NAME] Corporation. Employee #8 stated that they thought handrails only needed to be in the areas where resident rooms were located. He was shown the regulation on the surveyors laptop and it was also emailed to him that stated that handrails had to be on both sides of the hall in all areas were residents had access. On 9/16/2025 at 2:20 PM, a tour of the areas of concern in the facility was conducted with the Administrator and Employee #8 and the areas where there were no handrails were pointed out.