STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215024	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Rehabilitation and Nursing Center	6500 Riggs Road Hyattsville, MD 20783

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 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. Based on observation, interview, and record review, the facility failed to ensure timely staff response to Resident #6's repeated verbal calls for assistance. Resident #6 called out for help for 29 minutes without staff intervention. This failure affected 1 of 1 resident reviewed for timely response to resident needs and placed the resident-who has extensive neurological, cognitive, swallowing, behavioral, and mobilityˆrelated diagnoses-at risk for unmet care needs, avoidable decline, and compromised safety.The findings include:Review of facility nursing assistant job description with a revision date of 5/23 documented, Essential Duties & Responsibilities: General Responsibilities: .Respond to call bells, signal lights, intercoms, and patient requests for assistance in a timely manner.Record review on 3/30/26 at 10:26 am revealed Resident #6 had an admission date: 8/5/23. With multiple complex diagnoses including hemiplegia following cerebral infarction affecting the left nondominant side, dementia with behavioral disturbance, dysphagia (oropharyngeal phase), cognitive communication deficit, dysarthria, psychosis, spinal stenosis, disc degeneration, adult failure to thrive, anxiety disorder, obstructive and reflux uropathy, and the presence of an artificial urinary opening. These conditions placed the resident at high risk for aspiration, impaired communication, behavioral dysregulation, urinary complications, functional dependence, and inability to selfˆadvocate.A Care Plan Review on 3/30/26 at 3:21 pm with an Initiated date of 2/13/2026 revealed the following: Fall Risk / Safety Problem: Resident #6 is at risk for falls r/t weakness. Goal: Resident #6 will not have an injury related to a fall through the review period. Interventions: Place common items within reach of the resident. Remind the resident to use their call light to ask for assistance with ADLs. Behavior / Noncompliance Problem: Resident#6 has history of combative behavior during ADLs, nonˆcompliance with OOB schedule, history of spitting on staff during ADLs, prefers bed bath vs showers. Goal: Behaviors will not cause them or other residents distress through the review period. Interventions: Involve the resident in ADLs including personal preferences. Psych consult as needed.A Quarterly Minimum Data Set (Assessment Reference Date for 2/16/26) Reviewed on 4/1/26 at 12:18 pm revealed a Brief Interview for Mental Status score: 04/15 (severe cognitive impairment), bed to chair transfer: dependent and indwelling catheter present with bowel continence listed as always incontinent.An observation on 3/31/26 at 12:52 pm revealed the surveyor observed Resident #6 calling out loudly for help from their room. At 1:11 pm - No staff had responded to the resident's repeated verbal calls for assistance. Then at 1:13 pm - The surveyor asked the front desk where the nurse or Geriatric Nursing Assistant (GNA) for the unit was located; no staff were visible in the area. At 1:16 pm - The Licensed Practical Nurse Manager approached the surveyor. The surveyor informed LPN5 that the receptionist, had been asked to call for assistance for Resident #6 and no one had attended to the resident. The manager stated there were five GNAs and two nurses scheduled, but one GNA was the scheduler and one GNA had left the floor. The manager stated staff were in other residents' rooms. The manager acknowledged they knew the resident was yelling for help, adding that the resident usually yells like that. 1:21 PM - Certified Nursing Assistant (CNA7) was observed sitting at a desk in an office. The Regional Director of Operations (RDO19) entered Resident #6's room in response to the resident's continued calling out. Following this, CNA7 who normally works as a scheduler but was covering for the absent CNA responded. Total time Resident #6 called (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out without staff response: 29 minutes. In a follow-up observation on 4/2/26 at 10:20 am-Resident #6 was observed lying in bed watching television. Staff were visible administering medications, and housekeeping staff were present in the hallway. The resident appeared in no distress.In an interview with LPN5 on 3/31/26 at 1:16 pm revealed LPN5 stated there were five GNAs and two nurses scheduled, but one GNA was the scheduler and one GNA had left the floor. The manager stated staff were in other residents' rooms. The manager acknowledged they knew Resident #6 was yelling for help, adding that the resident usually yells like that. When asked whether they answer call lights, the manager did not provide a clear response.In an interview GNA8 on 4/1/26 at 11:45 am revealed GNA8 stated the resident usually yells and they typically check on them to see what they need. GNA8 stated there are usually five CNAs scheduled but often only four were present. GNA8 stated they would check on the resident they were assigned to and see if anything is going on with them.An interview with CNA7 on 4/1/26 at 9:37 am revealed CNA7, employed at the facility for five years, described their routine of checking residents, completing vitals, assisting with feeding, and answering call lights. CNA7 stated Resident #6 frequently calls out or gestures for assistance and often requests repositioning, food items, or attention. CNA7 stated: When you pass by if they are up, they said help. They do that. We go we answer the call light. see what you need. When asked why they did not check on Resident #6 during the 3/31/26 incident, CNA7 stated: Everybody was right there. the unit manager was there. so I didn't need to. CNA7 confirmed they heard the resident screaming but assumed staff or surveyors were addressing it. CNA7 acknowledged the resident's call light was on the floor and unreachable. When asked what should typically occur when a resident calls for help, CNA7 stated: Typical is to attend to see what you need first. water, pain medicine, put the bed down, pillow, something like that. When asked what they could have done differently, CNA7 stated: Probably go back to the room a couple more times. to assist them better. These statements confirm staff heard the resident calling out but did not respond, assuming others were addressing the situation.In another interview with LPN5 on 4/2/26 at 8:21 AM they stated that for Resident #6, who was yelling for help, the expectation was that staff should have gone to check on the resident. The Unit Manager stated, That would have been the same for me. I should have checked on them.The Unit Manager stated that instead of speaking with the surveyor and LPN5 should have attended to the resident instead of RDO19 during the incident, they had the opportunity to help the resident. This interview confirms the Unit Manager acknowledged both missed opportunities to intervene and failure to follow expected practice.In an interview with the Director of Nursing (DON) on 4/2/26 at 2:28 PM. The DON stated they were aware of the incident in which Resident #6 was calling out for help and staff did not respond promptly. The DON explained that the unit manager and other staff members were involved in a situation at the time, which contributed to the delay in addressing the resident's needs. The DON acknowledged the need for better communication among staff and the importance of immediate response to resident needs.

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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** Based on observation, interview, and record review, the facility failed to ensure staff followed infection prevention and control practices during feedingˆtube care for 1 of 1 residents reviewed for enteral feeding (Resident #18). Staff failed to perform hand hygiene, failed to change gloves after environmental contact, placed supplies on unclean surfaces, did not follow Enhanced Barrier Precautions, and did not check gastric residuals as ordered. These failures increased the risk of contamination and infection for a resident dependent on a gastrostomy tube. The findings include:Record review on 3/31/26 at 11:35 am revealed Resident #18 was originally admitted on [DATE] with the following diagnoses: Gastrostomy malfunction, Dysphagia following cerebral infarction, Other, esophagitis with bleeding, Hemiplegia and hemiparesis following cerebral infarction affecting the left nondominant side. These conditions place the resident at increased risk for infection and complications related to enteral feeding. Physician Orders Record review revealed: Diet: NPO diet, NPO texture, NPO consistency; Gˆtube feeding only (order dated 1/26/26). Enteral Feeding Order: Check residual prior to feeding. If residual >120 mL, hold feeding for 1 hour and recheck. If still >120 mL, call the physician. Enhanced Barrier Precautions: PPE required during highˆcontact care (Foley catheter care, tube feeding, wound care) every shift.In an observation on 3/31/26 at 1:02 pm revealed, Registered Nurse (RN12) was observed performing feedingˆtube care for Resident #18: No hand hygiene before donning gloves. Touched bed controls, linens, and overˆbed table with gloved hands, then handled the feeding tube without changing gloves. Placed the syringe used for flushing directly on the resident's linens, then reused it. Did not clean the bedside table before placing supplies. Did not follow Enhanced Barrier Precautions. Closed the resident's door with gloved hands. Touched the water pitcher, restroom door handle, and faucet with the same gloved hands. Did not aspirate or check residuals before feeding, contrary to physician orders. Did not change gloves or perform hand hygiene at any point during the procedure.In a staff Interview with Registered Nurse (RN12) on 4/1/26 at 1:43 p.m. RN12 stated their usual tubeˆfeeding procedure includes: closing the door before entering, greeting the resident, performing hand hygiene, checking residuals, when asked whether they performed these steps during the observed procedure, RN12 confirmed they did not. RN12 also acknowledged they did not clean the bedside table or follow the expected doorˆclosing protocol after gathering supplies.An interview with Licensed Practical Nurse Manager (LPN5) on 4/2/26 at 8:21 am revealed that the nurse manager stated: I do hand hygiene before I come in the room and exiting the room, and before setting up the feed. When informed of the observation, they acknowledged that the nurse did not follow expected practice.During an interview with the Infection Preventionist (IP20) on 4/2/26 at 2:02 p.m. IP20 stated: Staff are expected to perform hand washing before procedures. Staff must follow Enhanced Barrier Precautions, including gowning. When gloves become contaminated, staff must remove them and perform hand hygiene. When moving from clean to dirty tasks, hand hygiene is required. Handˆhygiene monitoring is conducted through spot checks every shift. The IP provided oneˆonˆone coaching when incorrect technique was observed. Staff were expected to maintain privacy during procedures, including closing doors. These expectations were not followed during the observed tubeˆfeeding procedures.In an interview with the Director of Nursing (DON2) on 4/2/26 at 2:28 p.m. The DON stated: Tubeˆfeeding procedures were not followed, and the nurse acknowledged the mistake. Staff are expected to: aspirate and check residuals, administer medications separately, flush with water after each medication, change gloves after each medication and when contaminated. DON2 confirmed the nurse would be reˆeducated and that the facility would do the education of all the nurses again.