

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/13/2025
NAME OF PROVIDER OR SUPPLIER  Virgil Rehabilitation & Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  975 North Virgil Avenue Los Angeles, CA 90029	

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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>42342</p> <p>Based on interview and record review the facility failed for one of three sampled residents (Resident 1), to inform about Medicare co pay upon admission.</p> <p>This deficient practice caused the Resident 1's representative (RR) to be surprised by a bill and violated their right to be informed.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated the facility admitted Resident 1 on 1/8/2025 with diagnoses including pneumonia (an infection/inflammation in the lungs), adult failure to thrive (FTT- a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), dementia (a progressive state of decline in mental abilities) and anxiety (condition of chronic worry and fear).</p> <p>A review of Resident 1's Minimum Data Set (MDS- a resident assessment) dated 1/15/2025 indicated Resident 1's cognition was not intact. Resident 1 required maximal assist (helper does more than half the effort to complete the activity) with toileting, bathing, dressing.</p> <p>A review of Resident 1's physician order dated 1/24/2025 indicated Resident 1 may be transferred from facility A to facility B.</p> <p>On 1/31/2025 The California Department of Public Health (CDPH) received a complaint alleging the facility sent a bill for Resident 1's Medicare co pay with no warning.</p> <p>During a concurrent interview and record review on 2/12/2025 at 10:31 a.m. with the RR, Resident 1's statement dated 1/24/2025 was reviewed. Resident 1's statement indicated from 1/8/2025-1/23/2025 the facility billed the amount of \$209.50 per day for Medicare Co-insurance and the total amount due was \$3,352.00. The RR stated this bill was received by mail from the facility after Resident 1 had been transferred to facility B. The RR stated, I went to the facility to sign admission papers about three or four days after Resident 1 was admitted and no one informed me of this copayment. The RR stated, I was under the impression Resident 1's stay was covered. I did not find out about this co payment until I got the bill in the mail after Resident 1 was transferred to facility B .</p> <p>(continued on next page)</p>

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)		
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/12/2025 at 11:31 a.m. with the business office manager (BOM), Resident 1's Medicare eligibility response dated 1/8/2025 was reviewed. Resident 1's Medicare eligibility response indicated Resident 1 used 79/100 days for skilled nursing stay. Resident 1 had 21 days of coverage left with a co pay of \$209.50. The BOM stated, Upon admission I run the eligibility report to verify their insurance then we have an interdisciplinary team (IDT) meeting and inform the Resident of their copay and if their insurance will cover their stay . The BOM stated, I did not inform the RR of the Medicare co pay at admission I just sent the bill out after Resident 1 was transferred to facility B.</p> <p>During an interview on 2/12/2025 at 12:34 p.m. with the social services assistant (SSA), The SSA stated, I attended the IDT meeting with the RR (who attended via phone) and the BOM was not a part of this meeting . The SSA stated, During the meeting we talked about the cost for Resident 1, the BOM informed Resident 1 had approximately 21 days of Medicare coverage remaining, so it was my understanding that Resident 1's stay here was completely covered . The SSA further stated, When the RR came into the facility to sign the admission paperwork, we discussed her cots again that her stay would be covered, we did not discuss Resident 1's Medicare co pay nor did we discuss the cost of Resident 1 would have stayed past the 21 days .</p> <p>A review of the facility's policy and procedures titled, Admission to the Facility , revised 1/2023, the P&amp;P indicated: Our admission policies apply to all residents admitted to the facility regardless of race, color, creed, national origin, age, sex, religion, handicap, ancestry, marital or veteran status, and/or payment source.</p> <p>4. The objectives of our admissions policies are to:</p> <p>a. Provide uniform guidelines for admitting residents to the facility;</p> <p>b. Admit residents who can be adequately cared for by the facility;</p> <p>c. Address concerns of residents and families during the admission process;</p> <p>d. Review with the resident, and/or his/her representative (sponsor), the facility's policies and procedures relating to resident rights, resident care, financial obligations, visiting hours, etc.; and</p> <p>e. Assure that the facility receives appropriate medical and financial records prior to or upon the resident's admission.</p>		