STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055157	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Virgil Rehabilitation & Skilled Nursing Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was closely monitored (constant observation) to prevent a fall (refers to unintentionally coming to rest on the ground, floor, or other lower level, but not because of an overwhelming external force). The facility was aware that Resident 1 was confused (is the inability to think as clearly or quickly as you normally do), legally blind (severe vision loss), at high risk for falls, at risk for elopement (leaving a facility unsupervised and unnoticed), restless (feeling uneasy, agitated, or unable to relax or stay still), and was unable to sit still. As a result, Resident 1 had a fall witnessed by Resident 2 (unidentified date and time) that resulted for Resident 1 to sustain a left hip fracture (broken bone). On 7/22/2025 at 11:30 PM, Resident 1 was transported to the General Acute Care Hospital (GACH) where Resident 1 was admitted and underwent a left femur (thighbone) intramedullary (inside of a bone) rodding (bones or bone fragments are repositioned into their normal positions) surgery with general anesthesia (a temporary loss of feeling and complete loss of awareness that feels like a very deep sleep).Findings: During a review of Resident 1's admission Record, the admission Record indicted the facility admitted Resident 1 on 5/15/2025 with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness, dementia (a progressive state of decline in mental abilities), other abnormalities of gait (your pattern of walking) and mobility (the ability to move), abnormal posture (the way you hold your body), age-related osteoporosis (a condition in which bones become weak and brittle), vitamin D deficiency (when the body does not have enough vitamin D and primarily causes issues with your bones and muscles), and sensorineural hearing loss (when the inner ear or the nerve connecting the ear to the brain is damaged, making it hard to hear clearly) bilateral (both ears/sides). During a review of Resident 1's Fall Risk Assessment (a tool to figure out how likely someone is to fall, especially for older adults) dated 5/15/2025, the Fall Risk Assessment indicated Resident 1 was legally blind and at high risk for falls. The Fall Risk Assessment indicated Resident 1 was disoriented (confused) at all times to name, place, and time and had balance (being able to stay upright and/or steady) problems while standing and while walking. The Fall Risk Assessment indicated to provide frequent visual monitoring (monitor by watching) and to anticipate (expecting something to happen and often to prepare for it in advance) needs in a timely manner. During a review of Resident 1's Care Plan Report (a structured and individualized document that spells out how a facility will meet a resident's health or personal care needs), dated 5/15/2025, the Care Plan Report indicated Resident 1 was at risk for fall related to Alzheimer's, dementia, and legally blind. The Care Plan Report indicated the goal was to minimize (limit) the occurrence (something that happens or takes place) of falls and /or injury for Resident 1. The Care Plan Report indicated the nursing interventions (an action taken to prevent, treat, or manage a health problem) were to provide Resident 1 with a safe environment, bilateral (both sides) floor mat (cushioned pad you put on the floor next to a bed in case someone falls to reduce the chance of injury), keep the call light (a device used by a patient to signal his or her need for assistance) within Resident 1's reach and answer the call light promptly (with no delay), and place Resident 1's bed in the low position. During a review of Resident 1's Physical Therapy notes dated 5/15/2025, the Physical Therapy notes indicated Resident 1 needed maximum assistance (the individual receiving care can participate in a task or activity, but requires significant assistance from a caregiver or therapist, typically performing only 25% or less of the work according to healthcare resources) to walk 25 feet (take steps for a distance of 25 feet in a straight line). The Physical Therapy notes indicated Resident 1 had balance deficits (having trouble staying steady on your feet). During a review of Resident 1's Care Plan Report dated 5/16/2025, the Care Plan Report indicated Resident 1 was at risk for elopement risk as evidenced by impaired cognition (someone has difficulty with thinking, learning, remembering, or making decisions), memory impairment (problems with remembering things). The Care Plan Report indicated Resident 1 would ambulate (walk) with assistance, and used medication that could cause confusion and disorientation (lack of awareness). The Care Plan Report indicated the nursing intervention was to monitor Resident 1's location (whereabouts) every __ (blank) min (minute). The Care Plan Report indicated to document wandering (move about aimlessly or without any destination) behavior and attempted diversional interventions (refers to the use of recreational and leisure activities to help patients cope with their medical conditions) in behavior log. The Care Plan Report indicated the nursing intervention was to provide Resident 1 with assistance during ambulation (the ability to walk or move from place to place). The Care Plan Report indicated the goal was to