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	08/23/2025

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 - Immediate jeopardy to resident health or safety 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 1) who was confused, had a diagnosis of dementia (a progressive state of decline in mental abilities), and had a history of falls, did not elope (the act of leaving a facility unsupervised and without prior authorization) the facility on 8/20/2025 at approximately 3:45 AM by failing to: -Ensure Registered Nurse 1 (RN1) and other licensed nurses (in general) identified and assessed Resident 1 as a high risk for elopement. -Ensure RN2, Licensed Vocational Nurse3 (LVN3), and LVN2 supervised Resident 1 when Resident 1 tried to leave the facility on 8/20/2025 at 3:20 AM. -Ensure RN supervisors (in general) ensured the facility's door alarms were enabled (on) as indicated in the facility's Audible (able to be heard) Battery-Operated Door Alarm policy and procedure (P&P). On approximately 8/20/2025 at 3:20 AM, RN2 and LVN3 noticed Resident 1 tried to leave the facility and redirected Resident 1 to Resident 1's room. On 8/20/2025 at approximately 3:45 AM, Certified Nursing Assistant 8 (CNA 8) reported to LVN2 Resident 1 disappeared, from the facility. On 8/20/2025 at 4:28 AM, the Emergency Medical Services (EMS-professionals who provide emergency care to people who require medical attention outside of a hospital) arrived with Resident 1 by an ambulance from a public area (unidentified) to the General Acute Care Hospital (GACH) with complaints of unsteady (not firm) gait (how a person walks), left knee pain, and unable to ambulate (walk) witnessed by bystanders (unidentified). The GACH admitted Resident 1 for evaluation of unsteady gait and confusion. These failures resulted in Resident 1's elopement on 8/20/2025 at approximately 3:45 AM, was at high risk for falls, serious harm, and the GACH admitted Resident 1 for evaluation of unsteady gait and confusion. On 8/21/2025 at 5:33 PM, the California Department of Public Health (CDPH, the Department) called an Immediate Jeopardy Situation (IJ, a situation in which the provider's non-compliance with one or more requirements of participation has caused, or likely to cause, serious injury, harm impairment, or death to a patient) in the presence of the facility's Chief Operating Officer (COO), the Administrator (ADM), and the Director of Nursing (DON) related to the failure to ensure Resident 1 did not elope from the facility on 8/20/2025 at approximately 3:45 AM and was at high risk for falls and serious harm, and placed other residents (Resident 2, Resident 3, Resident 4, and Resident 7) at risk for elopement. On 8/23/2025 at 2:51 PM, the facility provided an acceptable IJ Removal Plan (IJRP, a detailed plan that includes interventions to immediately correct the deficient practices in the IJ). While onsite at the facility, the surveyor verified and confirmed the facility's full implementation of the IJRP through observations, interviews, and record review, and determined the IJ situation regarding Resident 1's elopement was no longer present. The surveyor removed the IJ on 8/23/2025 at 3:44 PM in the presence of the ADM, the DON, the Director of Staff Development (DSD), the Infection Preventionist nurse (IP, a healthcare professional who make sure healthcare workers and patients are doing all the things they should to prevent infections), the Social Services Director (SSD), the Minimum Data Set Nurse (MDS Nurse - a nurse to documents using the resident assessment tool), the Social Service Assistant, and the Maintenance Supervisor (MS). The acceptable IJRP included the following summarized actions: On 8/21/2025, the facility readmitted Resident 1 and the admitting nurse (unidentified) updated Resident 1's elopement assessment and diagnoses. The elopement assessment indicated Resident 1 was at high-risk for elopement and the facility placed Resident 1 with one CNA (unidentified) at all times. On 8/21/2025, the DSD provided an in-service regarding elopement prevention and response to fifty-five staff(unidentified) with a plan for the DSD to perform in-services for staff who were on vacation, off schedule, and for new hires. On 8/21/2025, the MDS nurse and the facility's Medical Records (MR) staff identified four residents who were at high-risk for elopement. The facility ensured the care plans and assessments were in place for the four residents. On 8/22/2025, the facility updated Resident 1's care plan to include Resident 1 was at risk for elopement and had a history of elopement. On 8/22/2025, an emergency Quality Assurance and Performance Improvement (QAPI, a program that healthcare providers use to constantly check and improve the quality of their services) meeting was held with the facility's Medical Director, Department Heads (leaders of a specific group of people within a company, who makes sure that team's work gets done smoothly and on time), and the Administrator Consultant (ADMC) to address the facility's systemic issues (the problems with the facility's systems) on elopement. On 8/22/2025, the ADMC and the ADM updated the Audible Battery-Operated Door Alarms Policy and Procedure (P&P). On 8/22/2025, the ADMC provided an in-service to thirty-nine staff including licensed