

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/20/2025
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to report the elopement (when a resident leaves/escapes from a facility without a physician's order and without the staff knowing) from the facility of one out of three sampled residents (Resident 1) to the California Department of Public Health (CDPH), Ombudsman (an official appointed to investigate individuals' complaints against maladministration), and to the local law enforcement no later than 2 hours after Resident 1 went out on pass on 10/7/2025 at 12:50 PM and did not return to the facility, as per the facility's policy and procedures (P&P) titled Elopement, dated 1/2025. This failure resulted in the facility waiting until 10/8/2025 at 3 PM to notify CDPH, local law enforcement, and the Ombudsman, delaying the onsite inspection and investigation. This failure also Placed the resident at risk for worsening medical conditions, delayed care, being assaulted, accidents, injuries, and even death. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 6/11/2025 with diagnoses that included end stage heart failure (when the heart is so weak that it can no longer pump enough blood for the body's needs, even with treatment), dilated cardiomyopathy (a condition where the heart's main pumping chamber becomes enlarged, stretched, and weakened, making it harder to pump blood effectively, chronic kidney disease stage 2 (kidneys have mild damage and are working less effectively than they should, but are still filtering blood), patient's non-compliance (does not follow the rules) with medical treatment and regimen (plan) due to unspecified reason, acute pulmonary edema (when fluid suddenly builds up in the lungs, making it very difficult to breathe), cocaine (a highly addictive drug that makes a person feel intensely energetic and euphoric [an intense sense of happiness, excitement, and well-being] for a short period of time) abuse, and that the resident was on hospice (care for people nearing the end of life that focuses on comfort, pain management, and quality of life rather than on curing the disease). During a review of Resident 1's Care Plan Report dated 6/12/2025, the Care Plan Report indicated Resident 1 was a risk for elopement and falls. The Care Plan Report Indicated the facility staff was to monitor Resident 1's whereabouts frequently, document Resident 1's wandering behavior in the facility's behavior log (a record of a resident's health information), and attempt diversional activity (any pleasant, engaging activity that distracts a patient from their pain, boredom, or anxiety). During a review of Resident 1's History and Physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings) dated 9/7/2025, the H&P indicated Resident 1 had the capacity (ability) to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment tool), dated 9/15/2025, the MDS indicated Resident 1 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to walk 10 feet, for toileting, oral hygiene (brushing teeth and mouth care), and for eating. The MDS indicated Resident 1 required moderate to partial assistance (helper does less than half the effort and helps the resident lift, hold, or support themselves) for showering/bathing, putting on shoes/socks, personal (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055157	Facility ID: 055157 If continuation sheet Page 1 of 12

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene (shaving, washing/drying face and hands), and for tub/shower transfer (ability to get in and out of a tub/shower). During a review of Resident 1's Progress Notes dated 10/6/2025 at 1:07 PM, the Progress Notes indicated Resident 1 left the facility and went out on pass. During a review of Resident 1's Progress Notes for 10/7/2025, indicated the resident had not yet returned to the facility and facility staff attempted to contact the resident without success at 7:33 PM, 10:08 PM couple of times, and at 11:01 PM. During a review of Resident 1's Progress Notes for 10/8/2025, indicated the resident had not yet returned to the facility and facility staff attempted to contact the resident without success at 12:02 AM (2 attempts), 3:11 AM (2 attempts), 9:09 AM, and at 2:31 PM, the Progress Notes indicated the Social Services Director (SSD) had been trying to reach Resident 1 since 10/7/2025 at 3:07 pm. During a review of Resident 1's Order Summary Report, dated 10/9/2025, the Order Summary Report indicated Resident 1 had an order to go out on pass starting 10/1/2025. During a review of Resident 1's Progress Note dated 10/9/2025 at 4:59 PM, the Progress Note indicated RN 2 documented a late entry (when information that was forgotten or left out of an original note is added later, after the original entry was made and signed). The Progress Note indicated the effective date and time of the Progress Note was 10/7/2025 at 1:54 AM and indicated Resident 1 was discharged after he had not returned from pass since yesterday. The Progress Note indicated RN 2 had been calling Resident 1, but Resident 1 did not respond. The Progress Note indicated RN 2 informed Resident 1's emergency contact that Resident 1 had not returned from going out on pass yesterday. The Progress Note indicated RN 2 Resident 1's hospice, called the police to inform the police the facility considered Resident 1 a missing person, and notified the Ombudsman's office. During a concurrent interview and record review on 10/9/2025 at 1:02 PM with LVN 2, the facility's policy and procedure (P&P), titled Elopement, dated 1/2025 was reviewed. LVN 2 stated the facility should have considered Resident 1 missing if he had not returned after several hours. LVN 2 stated she (LVN 2) could not answer why the facility's nursing staff did not notify local law enforcement, the Ombudsman, CDPH, and document out an unusual occurrence after the facility could not locate Resident 1 per the facility's P&P. LVN 2 stated the facility should have followed their P&P. During an interview on 10/9/2025 at 1:44 PM with RN 2, RN 2 stated she waited until the morning of 10/8/2025 before following up on Resident 1 whereabouts because Resident 1 was out on pass. RN 2 refused to answer whether she (RN 2) followed the facility's policy for elopement after not being able to locate Resident 1 after 15 minutes that required the facility to notify police, the Ombudsman, and CDPH. RN 2 stated she opted to wait until morning on 10/8/2025 to endorse to the next shift (7 AM to 3 PM shift) that Resident 1 had not returned to the facility. During a concurrent interview and record review on 10/9/2025 at 1:57 PM with RN 1, Resident 1's Care Plan Report dated 6/12/2025 RN 1 stated the facility did not create a care plan for Resident 1 for going out on pass. RN 1 stated he would consider Resident 1 missing if Resident 1 had gone out on pass and did not return any of the facility's calls to him (Resident 1). RN 1 stated based on facility policy, the facility should have searched for Resident 1 and if the staff could not locate Resident 1, the facility should have called the police, Ombudsman, CDPH, and documented an unusual occurrence. RN 1 stated the facility did not follow their policy for Resident 1. During an interview on 10/9/2025 at 3:44 PM with the DON and ADM, the ADM stated the facility would consider any resident missing if they did not return from out on pass after 24 hours. The DON stated she (DON) would consider a resident missing if the resident did not return after midnight. The DON stated the facility should have called the police, notified the Ombudsman, and CDPH when Resident 1 did not return after midnight. The DON stated anything could happen to Resident 1 while out on pass. The ADM stated Resident 1 could have gotten into an accident when Resident 1 did not return from out on pass. The ADM stated she (ADM) could not guarantee Resident 1 was safe after not returning to the facility. During an interview on 10/10/2025 at 12:02 PM with the ADM, the ADM stated the facility notified the police, Ombudsman, and CDPH on 10/8/2025 that Resident 1 did not return to the facility after going out on pass on 10/7/2025. During a concurrent interview and record review on 10/10/2025 at 12:09 PM, the facility's fax confirmation sheets dated 10/8/2025 were (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed with the ADM. The confirmation sheets indicated the facility sent a fax regarding Resident 1 not returning to the facility from out on pass on 10/7/2025 to the CDPH on 10/8/2025 at 3:39 PM and to the Ombudsman on 10/8/2025 at 3:48 PM. The ADM stated the fax confirmations sheets were proof of when the facility notified CDPH and the Ombudsman. During a review of the facility's P&P titled Elopement, dated 1/2025 was reviewed. The P&P indicated if a resident (in general) could not be located within 15 minutes, the police had to be notified, and the facility would need to document an unusual occurrence (something that happens that is not common or expected) and report the incident to CDPH.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, and record review, the facility failed to develop an individualized person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident's needs for one of three sampled residents (Resident 1). By failing to create and initiate a care plan for Resident 1's out on pass (temporary leave for a non-medical reason, such as a family visit or holiday meal) physician's order as indicated in the facility's Policy and Procedures (P&P) titled Out on Pass Policy and Procedures, dated 4/2024 and the facility's P&P titled Care Plans - Comprehensive, dated 1/2025. These deficient practices had the potential for the residents to receive inadequate care and/or supervision which could affect the residents' quality of care and cause the resident harm. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 6/11/2025 with diagnoses that included end stage heart failure (when the heart is so weak that it can no longer pump enough blood for the body's needs, even with treatment), dilated cardiomyopathy (a condition where the heart's main pumping chamber becomes enlarged, stretched, and weakened, making it harder to pump blood effectively, chronic kidney disease stage 2 (kidneys have mild damage and are working less effectively than they should, but are still filtering blood), patient's non-compliance (does not follow the rules) with medical treatment and regimen (plan) due to unspecified reason, acute pulmonary edema (when fluid suddenly builds up in the lungs, making it very difficult to breathe), cocaine (a highly addictive drug that makes a person feel intensely energetic and euphoric [an intense sense of happiness, excitement, and well-being] for a short period of time) abuse, and that the resident was on hospice (care for people nearing the end of life that focuses on comfort, pain management, and quality of life rather than on curing the disease). During a review of Resident 1's History and Physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings) dated 9/7/2025, the H&P indicated Resident 1 had the capacity (ability) to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment tool), dated 9/15/2025, the MDS indicated Resident 1 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to walk 10 feet, for toileting, oral hygiene (brushing teeth and mouth care), and for eating. The MDS indicated Resident 1 required moderate to partial assistance (helper does less than half the effort and helps the resident lift, hold, or support themselves) for showering/bathing, putting on shoes/socks, personal hygiene (shaving, washing/drying face and hands), and for tub/shower transfer (ability to get in and out of a tub/shower). During a review of Resident 1's Order Summary Report, dated 10/9/2025, the Order Summary Report indicated Resident 1 had an order to go out on pass starting 10/1/2025. During concurrent interview and record review on 10/9/2025 at 1:02 PM with Licensed Vocational Nurse (LVN 2), Resident 1's complete and active care plans were viewed. LVN 2 verified that Resident 1 did not have a plan of care for being out on pass. LVN 2 could not locate the Interdisciplinary Team (IDT, a team of health care professions, which includes the facility's medical director, Director of Nursing (DON), social worker, registered nurse, and other staff as needed who work together to establish plans of care for residents) Assessment as indicated in the policy for Out on Pass. LVN 2 stated the facility should have done an IDT. During an interview on 10/9/2025 at 1:57 PM with Registered Nurse (RN1), RN 1 verified that Resident 1 did not have a care plan for out on pass. RN 1 stated if the facility did not follow the policy for out on pass, the facility would not be able to assess Resident 1's safety and the IDT would need to determine Resident 1's ability to go out on pass. During an interview on (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/9/2025 at 3:44 PM with the Director of Nursing (DON), the DON stated that since there was not an out on pass care plan the facility would not know when Resident 1 was supposed to return. During an interview on 10/10/2025 at 10:45 AM with the Administrator (ADM), the ADM stated Resident 1's going out on pass should have been care planned. During a review of the facility's policy and procedures (P&P) titled, Out on Pass Policy and Procedures, dated 4/2024, indicated, it is the policy of the facility to meet resident's physical and psychosocial needs to go out on pass. The facility will make reasonable efforts to ensure the residents' safety and uphold resident rights. The P&P indicated when residents request to go out on pass, the IDT team will assess the resident's ability to participate in activities outside the facility. During a review of the facility's policy and procedures (P&P) titled, Care Plans - Comprehensive, dated 1/2025, indicated, the Care Planning/IDT team, with the resident and/or his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The IDT team documents the Resident Assessment Protocol (RAP - a problem-oriented framework used in nursing homes to guide additional assessment after an initial evaluation, based on specific triggered conditions) summary sheet and/or record in the clinical record: the resident's status, the team's rationale for deciding whether to proceed with care planning, and evidence the team considered the development of care planning interventions for all RAP's triggered by the MDS.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one out of three sampled residents (Resident 1), who required supervision with walking, was assessed as risk for elopement (when a resident leaves/escapes from a facility without a physician's order and without the staff knowing), and was under Hospice (compassionate care for people who are near the end of life) care, did not leave the facility unsupervised while out on pass (temporary leave for a non-medical reason, such as a family visit or holiday meal) on 10/7/2025 at 12:50 PM. By failing to: 1. Conduct an IDT (IDT, a team of health care professions, which include the facility's medical director, Director of Nursing (DON), social worker, registered nurse, and other staff as needed who work together to establish plans of care for residents) meeting in collaboration with the Hospice agency to assess Resident 1's ability to participate in activities outside the facility (unsupervised) as indicated in the facility's Policy and Procedures titled out on Pass Policy and Procedure dated 4/2024. 2. Ensure Resident 1's Physician specified in the resident's out on pass order whether Resident 1 needed to be accompanied by a responsible person and/or supervised while out on pass. 3. Ensure facility staff (licensed nurses, and Resident 1's physician) informed Resident 1 on what time to return to the facility from out on pass as indicated in the facility's policy and procedures (P&P), titled Out on Pass Policy and Procedure dated 4/2024. This failure resulted in Resident 1 leaving the facility unsupervised on 10/7/25 at 12:50 PM and eloping (aka elopement: a patient or resident leaving a healthcare facility without permission and without being properly discharged) from the facility. Placing the resident at risk for worsening medical conditions, delayed care, being assaulted, accidents, injuries, and even death. Cross Reference: F711 During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 6/11/2025 with diagnoses that included end stage heart failure (when the heart is so weak that it can no longer pump enough blood for the body's needs, even with treatment), dilated cardiomyopathy (a condition where the heart's main pumping chamber becomes enlarged, stretched, and weakened, making it harder to pump blood effectively, chronic kidney disease stage 2 (kidneys have mild damage and are working less effectively than they should, but are still filtering blood), patient's non-compliance (does not follow the rules) with medical treatment and regimen (plan) due to unspecified reason, acute pulmonary edema (when fluid suddenly builds up in the lungs, making it very difficult to breathe), cocaine (a highly addictive drug that makes a person feel intensely energetic and euphoric [an intense sense of happiness, excitement, and well-being] for a short period of time) abuse, and that the resident was on hospice (care for people nearing the end of life that focuses on comfort, pain management, and quality of life rather than on curing the disease). During a review of Resident 1's Care Plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) Report dated 6/12/2025, the Care Plan Report indicated Resident 1 was a risk for elopement and falls. The Care Plan Report Indicated the facility staff was to monitor Resident 1's whereabouts frequently, document Resident 1's wandering behavior in the facility's behavior log (a record of a resident's health information), and attempt diversional activity (any pleasant, engaging activity that distracts a patient from their pain, boredom, or anxiety). During a review of Resident 1's History and Physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings) dated 9/7/2025, the H&P indicated Resident 1 had the capacity (ability) to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment tool), dated 9/15/2025, the MDS indicated Resident 1 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completes activity) to walk 10 feet, for toileting, oral hygiene (brushing teeth and mouth care), and for eating. The MDS indicated Resident 1 required moderate to partial assistance (helper does less than half the effort and helps the resident lift, hold, or support themselves) for showering/bathing, putting on shoes/socks, personal hygiene (shaving, washing/drying face and hands), and for tub/shower transfer (ability to get in and out of a tub/shower). During a review of Resident 1's Progress Notes dated 10/6/2025 at 1:07 PM, the Progress Notes indicated Resident 1 went out on pass (10/7/2025 at 12:50 PM). During a review of Resident 1's Progress Notes, dated 10/6/2025 at 8:55 PM, the Progress Notes indicated Resident 1 went to the Social Services office, then to the housing authority (a local government agency that helps provide affordable housing to low-income people, such as families, the elderly, and individuals with disabilities) and went to a downtown auction to buy car. During a review of Resident 1's Progress Notes, dated 10/7/2025 at 12:50 PM, the Progress Notes indicated Resident 1 went out on pass to take care of his housing. During a review of Resident 1's Progress Notes for 10/7/2025, indicated the resident had not yet returned to the facility and facility staff attempted to contact the resident without success at 7:33 PM, 10:08 PM couple of times, and at 11:01 PM. During a review of Resident 1's Progress Notes for 10/8/2025, indicated the resident had not yet returned to the facility and facility staff attempted to contact the resident without success at 12:02 AM (2 attempts), 3:11 AM (2 attempts), 9:09 AM, and at 2:31 PM, the Progress Notes indicated the Social Services Director (SSD) had been trying to reach Resident 1 since 10/7/2025 at 3:07 pm. During a review of Resident 1's Progress Notes for 10/9/2025 at 9:08 AM, the progress notes indicated the resident had not yet returned to the facility and facility staff attempted to contact the resident without success at 9:08 AM (3 attempts). During a review of Resident 1's Progress Notes dated 10/9/2025 at 12:29 PM, the Progress Notes indicated the facility called the Los Angeles County Jail at 213 473 6100 and was informed Resident 1 was not at the Los Angeles County Jail. During a review of Resident 1's Order Summary Report, dated 10/9/2025, the Order Summary Report indicated Resident 1 had an order to go out on pass starting 10/1/2025. The Order Summary Report indicated Resident 1 had orders for the following medications:1. Amiodarone (medication used to get a dangerously fast or irregular heartbeat back into a [NAME]) 200 mg milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) one tablet one time a day for arrhythmia (irregular or abnormal heartbeat).2. Aspirin 81 mg chewable tablet one tablet by mouth for clot (a clump of blood that forms to stop bleeding) prevention.3. Atorvastatin (a medicine that helps lower high cholesterol) 80 mg one tablet by mouth at bedtime for hyperlipidemia (a medical condition where there are abnormally high levels of lipids [fats], such as cholesterol and triglycerides, in the blood), prevent heart attack4. Carvedilol (medication that helps reduce stress on your heart by slowing your heart rate and relaxing your blood vessels) 6.25 mg one tablet by mouth two times a day.5. Clopidogrel (blood thinner that prevents platelets, which are tiny blood cells, from clumping together to form a dangerous clot) 75 mg one tablet by mouth one time a day for inhibitor platelet (medication that stops tiny blood cells called platelets from sticking together and forming dangerous clots inside your arteries) and clot prevention. 6. Lasix (a powerful water pill that removes excess fluid and salt from your body through increased urination) 40 mg by mouth two times a day for edema (when body tissues swell because of extra fluid trapped in them).7. Losartan Potassium (a blood pressure medication that prevents a hormone in your body from tightening your blood vessels) 25 mg one tablet by mouth one time a day for HTN (hypertension - high blood pressure). During an interview on 10/8/2025 at 12:03 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 wore slippers when leaving the facility. CNA 1 stated Resident 1 was given a form by LVN 1 to sign out of the facility and Resident 1 left the facility approximately at 12:50 PM on 10/7/2025. CNA 1 stated Resident 1 did not return by the time her (CNA 1) shift ended (approximately 3 pm on 10/7/2025) and would be concerned if any resident (in general) did not return to the facility on the same day. During a concurrent interview and record review on 10/9/2025 at 1:02 PM with LVN 2, Resident 1's care plans were reviewed. LVN 2 stated Resident 1 did not have a care plan for going out on pass. During a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent interview and record review on 10/9/2025 at 1:02 PM with LVN 2, the facility's policy and procedure (P&P), titled Out on Pass Policy and Procedure dated 4/2024 was reviewed. LVN 2 reviewed the policy and stated she (LVN 1) could not find an IDT assessment for Resident 1. LVN 1 stated the facility did not follow their Out on Pass Policy and Procedure and the facility should have done an IDT assessment according to the facility's P&P. LVN 2 stated the facility should have followed their P&P. During an interview on 10/9/2025 at 1:44 PM with LVN 3, LVN 3 stated he (LVN 3) was worried Resident 1 did not return after he (LVN 3) called Resident 1's daughter approximately 7 PM on 10/7/2025. LVN 3 stated he notified RN 3. LVN 3 stated RN 3 notified the facility's administrator that Resident 1 had not returned to the facility on [DATE]. LVN 3 stated he was given report from the previous shift and was informed Resident 1 had a habit of coming back late. During an interview on 10/9/2025 at 1:44 PM with RN 2, RN 2 stated she waited until the morning of 10/8/2025 before following up on Resident 1's whereabouts because Resident 1 was out on pass. RN 2 refused to answer if she (RN 2) followed the facility's policy for elopement. RN 2 stated she opted to wait until morning on 10/8/2025 to endorse to the next shift (7 AM to 3 PM shift) that Resident 1 had not returned to the facility. During a concurrent interview and record review on 10/9/2025 at 1:57 PM with RN 1, Resident 1's Care Plan Report dated 6/12/2025, RN 1 stated the facility did not create a care plan for Resident 1 for going out on pass. RN 1 stated Resident 1 should have been considered missing if Resident 1 had gone out on pass and did not return any of the facility's calls. RN 1 stated based on facility policy, the facility should have searched for Resident 1 if the staff could not locate the resident at the facility. RN 1 stated if not able to reach the resident the police, Ombudsman, and CDPH should have been called, and an unusual occurrence documented. RN 1 stated the facility did not follow their policy for Resident 1 to go out on pass because they did not perform an IDT meeting to assess Resident 1's safety and ability to go out on pass. RN 1 stated the facility did not follow their policy regarding looking for a missing resident. RN 1 stated Resident 1 could have had an accident and poor health because Resident 1 was not taking his medication. During an interview on 10/9/2025 at 2:51 PM with the facility's Social Services Director (SSD), the SSD stated she was not asked to participate in an IDT prior to going out on pass. The SSD stated Resident 1 went to an auction and purchased a car. The SSD stated Resident 1 possibly used the car to leave the facility. During an interview on 10/9/2025 with RN 3, RN 3 stated she thought Resident 1 would return from out on pass on 10/7/2025 since he came back late (after 8 PM) the day prior (10/6/2025). RN 3 stated she (RN 3) notified the facility's Director of Nursing (DON) and Administrator (ADM) when Resident 1 did not return around 11 PM on 10/7/2025. RN 3 stated she did not receive any additional instructions from the DON and ADM. During an interview on 10/9/2025 at 3:44 PM with the DON and ADM, the ADM stated a resident would be considered as missing if the resident did not return from out on pass after 24 hours. The DON stated she (DON) would consider a resident missing if the resident did not return after midnight. The ADM stated facility staff did not follow the facility's out on pass policy. The DON stated since a care plan was not created for Resident 1's out on pass, facility staff would not know when the resident was supposed to return. The DON stated the facility should have called the police, notified the Ombudsman, and CDPH when Resident 1 did not return after midnight. The ADM stated she contacted the facility at 10:35 PM on 10/7/2025 and instructed the facility staff to contact Resident 1's doctor. The ADM stated she instructed RN 3 to text Resident 1. The ADM stated RN 3 informed the ADM the resident and resident's daughter were not responding. The ADM stated the lack of response should have been a red flag. The ADM stated Resident 1 did not have an agreed upon return time. The ADM confirmed by stating the facility did not provide Resident 1 with medications upon leaving the facility on 10/7/2025. The DON stated anything could happen to Resident 1 while out on pass. The ADM stated Resident 1 could have gotten into an accident. The ADM stated she (ADM) could not guarantee Resident 1 was safe after not returning to the facility. During a concurrent interview and record review on 10/9/2025 at 3:44 PM with the DON, Resident 1's Medication Administration Record dated 10/9/2025 (MAR - a logbook, either on paper or a computer, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Virgil Rehabilitation & Skilled Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 975 North Virgil Avenue Los Angeles, CA 90029	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that healthcare staff uses to track all the medicines a patient has been given) was reviewed. The DON stated Resident 1 did not receive Carvedilol 6.25 mg on 10/7/2025 at 5 PM because Resident 1 was out on pass. The DON stated Resident 1 should have been given Carvedilol 6.25 mg on 10/7/2025 at 5 PM because Resident 1 could have had a heart issue without the medication. During a telephone interview on 10/10/2025 at 11:13 AM with the Hospice Doctor (HD), the HD stated he was the Medical Director for Resident 1's hospice and was Resident 1's hospice doctor. The HD stated he could not recall 100 % giving the order for Resident 1 to go out on pass. The HD stated Resident 1 had 6 months to live due to heart failure issues. The HD stated he (HD) was not aware Resident 1 had an out on pass order and would not have allowed Resident 1 to go out independently (by himself) and should have been accompanied by a responsible party (the person responsible for Resident 1). The HD stated the facility did not inform him (HD) Resident 1 had a car or could drive himself. The HD stated he did not know Resident 1 was independent. The HD stated the facility did not invite HD to participate in an IDT meeting. The HD stated Resident 1 should not have been allowed to be out on pass for longer than four hours and should have gone out with a responsible party. The HD stated he would never place an order for out on pass without a specified time for return. During a follow up telephone interview on 10/10/2025 at 11:22 AM with the HD, the HD called to say Resident 1 was supposed to be out on pass with a family member. During a review of the facility's policy and procedures (P&P) titled Elopement Policy & Procedure with a review date of 1/2025, the policy indicated It is the responsibility of the staff to initiate a search as soon as any resident is noted to be missing. The policy indicated: A. The resident/responsible person is encouraged to give the Facility reasonable notice when anticipating going out on pass.B. The resident/responsible person will verbally notify a Licensed Nurse prior to going out on pass and will sign out on Resident Out on Pass Log. C. The resident/responsible person will return to the Facility at the agreed upon time, or else notify the Facility of any unexpected delay in return to the Facility. D. The resident/responsible person will report any unusual occurrence that took place during the out on pass period. During a review of the facility's P&P titled Out on Pass Policy and Procedure with an update date of 4/2024, the policy indicated When a resident requests to go out on pass, the interdisciplinary Team (IDT) will assess the resident's ability to participate in activities outside the Facility, while taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications. The IDT assessment will be documented in the IDT notes. The policy indicated The Attending Physician and Psychiatrist (if applicable) will review the IDT's assessment and evaluate the resident's ability to participate in activities outside the Facility, while taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications. The policy indicated The Attending Physician's order should indicate whether the resident needs to be accompanied by a responsible person while out on pass. The resident must be accompanied by a responsible person when leaving the Facility unless the Attending Physician determines that the resident is capable of being on an independent pass. During a review of the facility's P&P titled Physician orders and Telephone Orders with a review date of 1/2025, the policy indicated All orders must be specific and complete with all necessary details to carry out the prescribed order without any questions. Each order shall include the diagnosis/condition to support the order.		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow its policy and procedures (P&P), titled Out on Pass Policy and Procedure dated 4/2024 and P&P titled Physician orders and Telephone Orders with a review date of 1/2025, for one of three sampled residents (Resident 1) allowed to go out on pass (temporary leave for a non-medical reason, such as a family visit or holiday meal). By failing to ensure: 1. Resident 1's physician completed a medical evaluation of a resident's condition and reviewed the appropriateness of the resident's ability to safely leave the facility unsupervised and without direct access to facility staff. This failure resulted in Resident 1 leaving the facility unsupervised on 10/7/2025 at 12:50 PM and eloping (aka elopement: a patient or resident leaving a healthcare facility without permission and without being properly discharged) from the facility. Placing the resident at risk for worsening medical conditions, delayed care, being assaulted, accidents, injuries, and even death. Cross Reference: F689 During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 6/11/2025 with diagnoses that included end stage heart failure (when the heart is so weak that it can no longer pump enough blood for the body's needs, even with treatment), dilated cardiomyopathy (a condition where the heart's main pumping chamber becomes enlarged, stretched, and weakened, making it harder to pump blood effectively, chronic kidney disease stage 2 (kidneys have mild damage and are working less effectively than they should, but are still filtering blood), patient's non-compliance (does not follow the rules) with medical treatment and regimen (plan) due to unspecified reason, acute pulmonary edema (when fluid suddenly builds up in the lungs, making it very difficult to breathe), cocaine (a highly addictive drug that makes a person feel intensely energetic and euphoric [an intense sense of happiness, excitement, and well-being] for a short period of time) abuse, and that the resident was on hospice (care for people nearing the end of life that focuses on comfort, pain management, and quality of life rather than on curing the disease). During a review of Resident 1's Care Plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) Report dated 6/12/2025, the Care Plan Report indicated Resident 1 was a risk for elopement and falls. The Care Plan Report Indicated the facility staff was to monitor Resident 1's whereabouts frequently, document Resident 1's wandering behavior in the facility's behavior log (a record of a resident's health information), and attempt diversional activity (any pleasant, engaging activity that distracts a patient from their pain, boredom, or anxiety). During a review of Resident 1's History and Physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings) dated 9/7/2025, the H&P indicated Resident 1 had the capacity (ability) to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment tool), dated 9/15/2025, the MDS indicated Resident 1 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 1 required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to walk 10 feet, for toileting, oral hygiene (brushing teeth and mouth care), and for eating. The MDS indicated Resident 1 required moderate to partial assistance (helper does less than half the effort and helps the resident lift, hold, or support themselves) for showering/bathing, putting on shoes/socks, personal hygiene (shaving, washing/drying face and hands), and for tub/shower transfer (ability to get in and out of a tub/shower). During a review of Resident 1's Progress Notes dated 10/6/2025 at 1:07 PM, the Progress Notes indicated Resident 1 went out on pass (10/7/2025 at 12:50 PM). During a review of Resident 1's Progress Notes for 10/7/2025, indicated the resident had not yet returned to the facility and facility staff attempted to contact the resident without success at 7:33 PM, 10:08 PM couple of (continued on next page)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times, and at 11:01 PM. During a review of Resident 1's Progress Notes for 10/8/2025, indicated the resident had not yet returned to the facility and facility staff attempted to contact the resident without success at 12:02 AM (2 attempts), 3:11 AM (2 attempts), 9:09 AM, and at 2:31 PM, the Progress Notes indicated the Social Services Director (SSD) had been trying to reach Resident 1 since 10/7/2025 at 3:07 pm. During a review of Resident 1's Progress Notes for 10/9/2025 at 9:08 AM, the progress notes indicated the resident had not yet returned to the facility and facility staff attempted to contact the resident without success at 9:08 AM (3 attempts). During a review of Resident 1's Order Summary Report, dated 10/9/2025, the Order Summary Report indicated Resident 1 had an order to go out on pass starting 10/1/2025. The Order Summary Report indicated Resident 1 had orders for the following medications:1. Amiodarone (medication used to get a dangerously fast or irregular heartbeat back into a [NAME]) 200 mg milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) one tablet one time a day for arrhythmia (irregular or abnormal heartbeat).2. Aspirin 81 mg chewable tablet one tablet by mouth for clot (a clump of blood that forms to stop bleeding) prevention.3. Atorvastatin (a medicine that helps lower high cholesterol) 80 mg one tablet by mouth at bedtime for hyperlipidemia (a medical condition where there are abnormally high levels of lipids [fats], such as cholesterol and triglycerides, in the blood), prevent heart attack4. Carvedilol (medication that helps reduce stress on your heart by slowing your heart rate and relaxing your blood vessels) 6.25 mg one tablet by mouth two times a day.5. Clopidogrel (blood thinner that prevents platelets, which are tiny blood cells, from clumping together to form a dangerous clot) 75 mg one tablet by mouth one time a day for inhibitor platelet (medication that stops tiny blood cells called platelets from sticking together and forming dangerous clots inside your arteries) and clot prevention. 6. Lasix (a powerful water pill that removes excess fluid and salt from your body through increased urination) 40 mg by mouth two times a day for edema (when body tissues swell because of extra fluid trapped in them).7. Losartan Potassium (a blood pressure medication that prevents a hormone in your body from tightening your blood vessels) 25 mg one tablet by mouth one time a day for HTN (hypertension - high blood pressure). During a concurrent interview and record review on 10/9/2025 at 1:02 PM with LVN 2, the facility's policy and procedure (P&P), titled Out on Pass Policy and Procedure dated 4/2024 was reviewed. LVN 1 stated she (LVN 1) could not find an IDT assessment for Resident 1. LVN 1 stated the facility did not follow their Out on Pass Policy and Procedure and the facility should have done an IDT assessment according to the facility's P&P. LVN 2 stated the facility should have followed their P&P. During a concurrent interview and record review on 10/9/2025 at 1:57 PM with RN 1, RN 1 stated the facility did not follow their policy for Resident 1 to go out on pass because they did not perform an IDT meeting to assess Resident 1's safety and ability to go out on pass. RN 1 stated the facility did not follow their policy regarding the facility looking for a missing resident. RN 1 stated Resident 1 could have an accident and could have poor health because Resident 1 was not taking his medication. During an interview on 10/9/2025 at 3:44 PM with the DON and ADM, the ADM stated a resident would be considered as missing if the resident did not return from out on pass after 24 hours. The DON stated she (DON) would consider a resident missing if the resident did not return after midnight. The ADM stated facility staff did not follow the facility's out on pass policy. The DON stated since a care plan was not created for Resident 1's out on pass. The ADM stated Resident 1 did not have an agreed upon return time. The ADM confirmed by stating the facility did not provide Resident 1 with medications upon leaving the facility on 10/7/2025. The DON stated anything could happen to Resident 1 while out on pass. The ADM stated Resident 1 could have gotten into an accident. The ADM stated she (ADM) could not guarantee Resident 1 was safe after not returning to the facility. During an interview on 10/10/2025 at 11:46 AM with RN 1, RN 1 stated he was not sure what the facility's policy for going out on pass was. RN 1 stated the facility allowed residents (in general) to go out on leave independently (by themselves). RN 1 stated he placed the order may go out on pass on 10/1/2025 for Resident 1. RN 1 stated the order he placed for may go out on pass for Resident 1 was not clear. RN 1 stated he (RN 1) did not clarify the may go out on pass order, the order (continued on next page)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was vague and put Resident 1 at jeopardy (risk) because there was no agreed upon time for Resident 1 to return to the facility after going out on pass. RN 1 stated the facility did not follow their out on pass policy because the facility did not conduct an IDT meeting before allowing Resident 1 to go out on pass by himself. During a telephone interview on 10/10/2025 at 11:13 AM with the Hospice Doctor (HD), the HD stated he was the Medical Director for Resident 1's hospice and was Resident 1's hospice doctor. The HD stated he could not recall 100 % giving the order for Resident 1 to go out on pass. The HD stated Resident 1 had 6 months to live due to heart failure issues. The HD stated he (HD) was not aware Resident 1 had an out on pass order and would not have allowed Resident 1 to go out independently (by himself) and should have been accompanied by a responsible party (the person responsible for Resident 1). The HD stated the facility did not inform him (HD) Resident 1 had a car or could drive himself. The HD stated he did not know Resident 1 was independent. The HD stated the facility did not invite HD to participate in an IDT meeting. The HD stated Resident 1 should not have been allowed to be out on pass for longer than four hours and should have gone out with a responsible party. The HD stated he would never place an order for out on pass without a specified time for return. During a follow up telephone interview on 10/10/2025 at 11:22 AM with the HD, the HD called to say Resident 1 was supposed to be out on pass with a family member. During a review of the facility's P&P titled Out on Pass Policy and Procedure with an update date of 4/2024, the policy indicated When a resident requests to go out on pass, the interdisciplinary Team (IDT) will assess the resident's ability to participate in activities outside the Facility, while taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications. The IDT assessment will be documented in the IDT notes. The policy indicated The Attending Physician and Psychiatrist (if applicable) will review the IDT's assessment and evaluate the resident's ability to participate in activities outside the Facility, while taking into consideration the resident's decision-making capacity, physical disabilities, and ability to take medications. The policy indicated The Attending Physician's order should indicate whether the resident needs to be accompanied by a responsible person while out on pass. The resident must be accompanied by a responsible person when leaving the Facility unless the Attending Physician determines that the resident is capable of being on an independent pass. During a review of the facility's P&P titled Physician orders and Telephone Orders with a review date of 1/2025, the policy indicated All orders must be specific and complete with all necessary details to carry out the prescribed order without any questions. Each order shall include the diagnosis/condition to support the order.		