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	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Virgil Rehabilitation & Skilled Nursing Center	975 North Virgil Avenue Los Angeles, CA 90029

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on interview and record review, the facility failed to ensure one sampled resident (Resident 21) had proper documented representation to make medical decisions, as there was no conservatorship application when Resident 21 was deemed non competent. This deficient practice caused an increased risk in the resident receiving care without proper documented representation. Findings: A review of Resident 21's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including epilepsy (condition involving the brain that makes people more susceptible to having recurrent unprovoked seizures [a burst of uncontrolled signals between brain cells]), Parkinson's disease (condition that causes nerve cells in the brain to die), and dementia (condition that makes someone unable to remember, think clearly, or make decisions while doing everyday activities). A review of a notice of referral receipt from the Department of Mental Health (DMH), provided by the Social Services Assistant (SSA), indicated the facility filed for a probate conservatorship of Resident 21. The receipt indicated a Deputy Public Guardian was assigned to investigate with a visit date of 7/31/2015. A review of the Resident 21's Acknowledgment of Receipt of Advance Directive, dated 11/20/2020, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 21's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/16/2024, indicated the resident had memory problems and severe impairment in decision making. During an interview on 12/26/2024 at 8:45 AM, the Social Services Assistant (SSA) stated Resident 21 was verbal years ago and had no next of kin. The SSA stated a public guardian did initiate a visit to determine if Resident 21 was a candidate for conservatorship. The SSA provided a Notice of Referral Disposition from the DMH which indicated no petition filed; lack of imminent need for conservatorship. A future re-evaluation may be warranted. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/26/2024 at 10:10 AM, Registered Nurse / Nursing Supervisor (RNS) 2 stated Resident 21 was hospitalized in September, October, and November of 2024. RNS 2 stated after the first hospitalization , Resident 21 returned to the facility nonverbal but could open his eyes. RNS 2 stated after the second hospitalization , Resident 21 returned lethargic. RNS 2 stated after the third visit, Resident 21 returned nonverbal and nonresponsive. During a concurrent interview and record review on 12/26/2024 at 10:53 AM with the Social Services Director (SSD), the Notice of Referral Disposition Letter dated 8/5/2015 for Resident 21, a note from the SSD to the medical director regarding Resident 21's DNR status dated 12/12/24, and the Physician's Orders for Life-Sustaining Treatment (POLST) were reviewed. The SSD reviewed her note to the medical director which indicated on the POLST two physician signatures were required due to the resident not having the capacity to make decisions and no known family or friends. The SSD stated she received this information from Resident 21's primary care physician. The SSD stated the new POLST was signed by both physicians dated 12/12/2024. The SSD provided the physician's order from the primary care physician which indicated pt is DNR. The SSD stated the DNR status occurred after Resident 21's last hospital visit. The SSD reviewed the Notice of Referral Disposition Letter and noted the determination that at that time a lack of need for conservatorship, but a future re-evaluation may be warranted. The SSD stated that no new application was filed for conservatorship / public guardian since 2015. The SSD stated a new submission for conservatorship should have been submitted when Resident 21 was deemed noncompetent. During concurrent interview and record review on 12/27/2024 at 11:29 AM with the SSD and SSA, the Advanced Directive (a legal document indicating resident preference on end-of-life treatment decisions) dated 11/20/20 was reviewed. The SSA noted the advance directive indicated Resident 21 did not have the capacity to understand and make decisions. The SSA and SSD indicated that conservatorship or public guardianship should have been submitted in 2020. The SSD reviewed the MDS in 11/2020 which indicated that Resident 21 could not recall and had memory issues. The SSD and SSA stated the potential harm to the resident would be provided care without representation. During an interview on 12/27/2024 at 2:21 PM, the Director of Nursing (DON) stated that two physician's signing Resident 21's POLST, was not the policy for representation. The DON stated a conservatorship should have been applied for when Resident 21 was deemed non competent. A review of the facility's policy and procedure titled, Resident Representative, dated 1/2023, indicated if the resident was an adult a person; legal authority to make health care decision on behalf of the resident included a durable power of attorney for health decision, power of attorney for health decisions, health care decision instructions, court appointed legal guardian, and conservator.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to develop comprehensive care plans for one of six sampled residents (Resident 35 and Resident 6). For Resident 35, who had a urinary tract infection (UTI-an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney), there was no care plan developed with individualized approaches. For Resident 6, the renal insufficiency care plan was not reviewed quarterly and the intervention was not implemented. These deficient practices had the potential to result in a delay or lack of delivery of care and services. Findings: a. A review of Resident 35's Admission Record indicated that resident was admitted to the facility on [DATE] with diagnoses of, but not limited to benign prostatic hyperplasia (when prostate gland enlarges, putting pressure on the urethra), sepsis (a life-threatening blood infection), and acute kidney failure (a sudden loss of kidney function). A review of Resident 35's Annual Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/3/2024, indicated the resident had mild cognitive impairment (some decline in memory and thinking). The MDS further indicated Resident 35 had an indwelling catheter (a thin, flexible tube inserted into a body cavity to collect and drain fluid). A review of the Physician's Order Summary Report dated 12/23/2024 indicated Resident 35 was to receive Macrobid (antibiotic used to treat UTI) Oral Capsule 100 MG, 1 capsule by mouth two times a day for UTI for seven days. A review of the Change of Condition form dated 12/23/2024, indicated Resident 35 was noted to have foul odor in urine and was prescribed Macrobid Oral Capsule 100 MG by the physician. A review of Resident 35's care plans indicated there was no care plan developed after Resident 35 was prescribed the medication Macrobid Oral Capsule 100 MG for UTI or after the change in condition. During an interview on 12/26/2024 at 9:44 AM, the Quality Assurance nurse (QA) stated when there was a change of condition or a new medication order, the staff who received the order was responsible for initiating the care plan. The QA stated that when a new care plan was not developed after a change of condition it could affect the care being provided to the resident. During an interview with the Director of Nursing (DON) on 12/26/2024 at 9:53 AM, the DON stated that when there is a change of condition or new medication order a new care plan should be created. The DON stated that an updated care plan was important because it was used to facilitate the care for residents and provided resident centered care. A review of the facility's policy and procedure (P&P) titled, Care Plans-Comprehensive, reviewed January 2023, indicated care plans were revised as changes in the resident's condition dictate and reviewed at least quarterly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50714 b. A review of Resident 6's Admission Record (Face Sheet) indicated the facility originally admitted the resident on 1/1/2009 with diagnoses including chronic kidney disease (CKD - kidneys are gradually damaged over time, unable to filter blood properly, causing waste to build up in the body), renal dialysis (a medical procedure that essentially acts like an artificial kidney, cleaning your blood by removing waste products and excess fluid when your natural kidneys can no longer do so, using a machine to filter your blood outside your body). A review of Resident 6's MDS dated [DATE], indicated the resident was cognitively intact (able to make decisions), was wheelchair bound, and was on renal dialysis. A review of the Renal Insufficiency care plan dated 11/16/2022 indicated Resident 6 had End Stage Renal Disease and was on hemodialysis. The care plan interventions indicated to monitor Resident 6 for weight gain over two pounds a day. During an interview on 12/27/2024 at 10:42 AM, Registered Nurse Supervisor (RNS) 2 stated the facility had monthly weights and post dialysis weights for Resident 6, and did not have the daily weights to monitor weight gain over two pounds per day. The RNS 2 stated the facility was not following the care plan interventions and Resident 6 could have complications related to fluid overload (having too much fluid in your body) if not monitoring Resident 6's weight per the care plan. During an interview on 12/27/2024 at 1:29 PM, the Director of Nursing (DON) stated the care plan was important to help with directing patient care and should be done initially on admission, quarterly, for change in resident condition, and as needed. The DON stated members of the interdisciplinary team (IDT - a team of healthcare professionals from different professional fields) would update the care plan and that Resident 6's Renal Insufficiency care was last revised on 11/15/2022. The DON stated the facility did not update Resident 6's care plan after 11/16/2022 and the facility should have updated it. The DON stated if the care plan was not followed, the resident could be at risk for fluid overload or electrolyte imbalance. A review of the facility's policy and procedure (P&P) titled, Dialysis Documentation, dated 1/2023, indicated the care plan should reflect the end-stage renal disease (kidneys have become so damaged that they can no longer function properly) treatment plan to address the assessment process and treatment plan. A review of the facility's P&P titled, Care Plans- Comprehensive, dated 1/2023, indicated care plans were reviewed at least quarterly, would enhance the function of the resident, and aid in preventing or reducing declines. A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 1/2023, indicated the IDT would update the care plan at least quarterly.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on interview and record review, the facility failed to ensure the oxygen care plan for two of five sampled residents (Resident 35 and Resident 38), was reviewed and revised quarterly to reflect the resident's current status and interventions being provided to the resident. This deficient practice placed both residents at risk of unrecognized change of condition or delay in necessary intervention. Findings: a. A review of Resident 35's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (low oxygen level in the blood stream), acidosis (a condition in which there is too much acid in the body fluid), and heart failure (when the heart is unable to pump enough blood and oxygen to the body's organs). A review of the At Risk for Difficulty Breathing care plan revised on 12/1/2023, indicated Resident 35 had respiratory failure and the interventions included to elevate the head of the bed and provide oxygen as ordered. A review of the Physician's Order Summary Report dated 1/9/2024 indicated to provide Resident 35 oxygen at two liters per minute via (by) nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously every shift. A review of Resident 35's Annual Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/3/2024, indicated the resident had mild cognitive impairment (some decline in memory and thinking), was on oxygen therapy while a resident in the facility, and had a diagnosis of respiratory failure. During an interview on 12/26/2024 at 9:53 AM, the Director of Nursing (DON) stated Resident 35's At Risk for Difficulty Breathing care plan should be revised quarterly and as needed. The DON stated that an updated care plan was important because it was used to facilitate the care for residents and provided resident centered care. A review of the facility's policy and procedure titled, Care Plans-Comprehensive, dated January 2023, indicated care plans were revised as changes in the resident's condition dictate and reviewed at least quarterly. 50296 b. A review of Resident 38's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including history of traumatic brain injury (occurs when an external force impacts the head or body) and acquired deformity of the head. A review of Resident 38's care plan titled, Communication Problem related to Spanish as primary language and the Communication problem related to Impaired Cognition was last revised 4/9/2021. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 38's MDS dated [DATE], indicated the resident had poor recall and was unoriented. The MDS indicated the resident did not have psychosis. During an observation on 12/23/2024 at 11:15 am, in Resident 38's room, Resident 38 sat in a wheelchair in his room, with his eyes closed. Certified Nurse Assistant (CNA) 7 interpreted due to Resident 38's primary language was Spanish. Resident 38 indicated by shaking his head yes that he liked the care and the food. Resident 38 indicated by shaking his head yes that he participated in activities. CNA 7 stated the staff check on Resident 38 every 1-2 hours to attend to his needs. During observation on 12/24/2024 at 10:17 am in Resident 38's room, a Spanish communication board was located above the resident's bed and was attached to the wall. During an interview on 12/24/2024 at 1:35 PM the Quality Assurance / Interdisciplinary Team Nurse (QA) reviewed Resident 38's Communication care plans and stated the care plan had been revised on 12/16/2024, but the date did not show the revision in the actual care plan. The QA stated that they needed to speak with the Information Technologist (IT) regarding why the update did not display on the care plan. During a concurrent interview, the MDSN stated, If the care plans were not updated how can we know the intervention for the resident was working and how to take care of them. During an interview on 12/26/2024 at 11:40 AM, after review of Resident 38's Communication care plans, the facility's Information Technologist (IT) stated that on the main page of the care plan task, the date revised would not be the date of revision for a specific care plan. The IT stated a revision date would reflect when there was a change to the care plan such as a doctor's order changing the care plan. During an interview on 12/27/2024 at 11:46 AM with the QA and the MDSN, the QA agreed with the IT's statement regarding changes to the care plan when a doctor's order or a change of condition occurred which would reflect the date of revision. The MDSN and QA stated the potential harm to the resident could be improper care to the resident without an updated care plan. During an interview on 12/27/2024 at 11:56 AM, the Registered Nurse/Nursing Supervisor (RNS) 1 stated the care plans should be updated when there was a change of condition, quarterly and new orders. RNS 1 stated the potential harm to Resident 38 without an updated care plan would be the resident would not be able to communicate properly. During an interview on 12/27/2024 at 2:21 PM, the Director of Nursing (DON) stated care plans were to be revised quarterly, as needed, and when there was a change of condition. The DON stated, We don't know if the resident has improved or not, when asked the importance of updating the care plan timely. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 1/2023, indicated the Interdisciplinary Team must review and update the care plan when a change of condition has occurred, the desired outcome is not met, the resident is readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident 69) received proper oral care. The failure had the potential for Resident 69 to experience bad breath, infection, and lack of eating. Findings: A review of Resident 69's admission record indicated the resident was admitted to the facility on [DATE] with a diagnoses including reduced mobility, muscle weakness, and age-related physical debility (quality or state of being weak, feeble, or infirm). A review of Resident 69's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/26/24 indicated the resident was alert and oriented. and required substantial / maximal assistance with eating, oral hygiene, and personal hygiene. During observation on 12/23/24 at 10:22 AM in Resident 69's room, the resident was lying in bed watching TV. Resident 69 indicated by shaking her head yes that she liked the care. Resident 69 indicated by shaking her head yes that she had her call light within reach and communicated by typing on her telephone. During a concurrent observation and interview on 12/23/24 at 12:40 PM, with Restorative Nurse Assistant (RNA) 1 in Resident 69's room, RNA 1 offered to assist Resident 69 with feeding. Resident 69 refused assistance with feeding twice. Before exiting the room, Resident 69 smiled and on the top row of her teeth, there appeared a creamy substance on the resident's teeth. During concurrent interview and record review on 12/26/24 at 10:35 AM with Certified Nurse Assistant (CNA) 2, Resident 69's Oral Care task spreadsheet dated 12/24 was reviewed. The Oral Care task spreadsheet indicated the resident needed either no help, limited assistance, or total dependence. The spreadsheet indicated the resident refused once. CNA 2 stated that she offered oral care assistance to Resident 69, but Resident 69 refused. CNA 2 confirmed that according to the spreadsheet, Resident 69 refused once which indicated that oral care had been performed on the other days. CNA 2 stated when the resident refused, it should be documented in the oral care task spreadsheet. During an interview on 12/26/24 at 1:28 PM Resident 69 indicated by shaking her head yes that she brushed her teeth, and the staff assist with mouth care. Resident 69 showed her teeth which appeared to have cream colored substance present. During concurrent interview and record review on 12/27/24 at 11:34 AM with Licensed Vocational Nurse (LVN) 1, Resident's Oral Care task spreadsheet dated 12/24 was reviewed. LVN 1 stated the CNA's have not reported to her that Resident 69 refused oral care. LVN 1 stated the CNA's need to report any refusal of care. LVN 1 stated the check mark on the Oral Care task spreadsheet, indicated that the task was done, LVN 1 stated if the resident refused the check marks should be marked under Resident Refused. LVN 1 stated without proper oral care, the resident could experience infection, bad breath, and may not eat. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent interview and record review on 12/27/24 at 2:21 PM with the Director of Nursing (DON), the Oral Care Task spreadsheet, dated 12/24 was reviewed. The DON was informed that Resident 69's upper teeth had creamy colored substance and that CNA 2 stated Resident 69 refused oral care. The DON confirmed on the Oral Care task spreadsheet that Resident 69, per the check marks under either no help, limited assistance, or total dependence, received oral care. The DON stated the risk to the resident not receiving oral care would be unsanitary mouth and infection. A review of the facility's policy and procedure titled, Mouth Care, dated 1/24, indicated documentation of mouth care included the date and time provided and name and title of staff providing care. The policy indicated that if the resident refused, the reason and intervention taken should be documented and the supervisor should be notified.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 35) received two liters of oxygen continuously, per the physician's order. This deficient practice had the potential to result in respiratory distress (difficulty breathing) for Resident 35. Findings: A review of Resident 35's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including respiratory failure with hypoxia (low oxygen level in the blood stream), acidosis (a condition in which there is too much acid in the body fluid), and heart failure (when the heart is unable to pump enough blood and oxygen to the body's organs). A review of Resident 35's care plan revised on 12/1/2023, indicated the resident was at risk for difficulty breathing related to respiratory failure. The interventions included to elevate the head of the bed and provide oxygen as ordered. A review of the Physician's Order Summary Report dated 1/9/2024, indicated to provide oxygen at two liters per minute via (by) nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously every shift. A review of Resident 35's Annual Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/3/2024, indicated the resident had mild cognitive impairment (some decline in memory and thinking). The MDS indicated Resident 35 was on oxygen therapy while a resident in the facility and had a diagnosis of respiratory failure. During an observation on 12/23/2024 at 11:05 AM in Resident 35's room, the resident had their head of bed at 45 degrees and was on oxygen via nasal cannula connected to an oxygen concentrator (a medical device that extracts oxygen from the air and delivers it to a patient through a mask or nasal cannula). Upon checking the oxygen concentrator, the oxygen concentrator was not on. Resident 35 then proceeded to press the button to turn on the oxygen concentrator and oxygen concentrator showed two liters of oxygen per minute. During an interview on 12/23/2024 at 11:15 AM, the Licensed Vocational Nurse (LVN) 1 stated Resident 35 should be on continuous oxygen at two liters per minute via nasal cannula. LVN 1 stated the oxygen concentrator should be checked at the beginning of every shift and that Resident 35 could become hypoxic if they did not receive oxygen continuously. During an interview on 12/27/2024 at 1:21 PM, the Director of Nursing (DON) stated the LVN was responsible for checking the resident's oxygen concentrators every shift to ensure that it was working and that Resident 35 received the oxygen as ordered. The DON stated that by not receiving oxygen as ordered the resident was at risk for respiratory distress. A review of the facility's policy and procedure titled, Oxygen Administration, dated January 2023, indicated to observe the resident periodically to be sure oxygen was being tolerated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to: -Ensure carvedilol (a medication used to treat high blood pressure) bubble pack (a medication card containing tablets or capsules provided by pharmacy to the facility) hold parameters (parameters instructed by physician to follow to administer or not to administer high blood pressure medication to resident based on blood pressure reading) for blood pressure matched accurately with the hold parameters for blood pressure in facility's physician order, affecting one of four sampled residents (Resident 36) during medication pass observation. -Ensure metformin (a medication used to treat Diabetes Mellitus [DM - a disorder characterized by difficulty in blood sugar control and poor wound healing]) was administered within one hour of the prescribed time of administration, as per facility's policy and procedure (P&P) titled, Administering Medications, dated 1/2023, affecting one of four sampled residents (Resident 8) during medication pass observation. -Ensure availability of Visine - A solution ([generic name - naphazoline-pheniramine eye drops], a medication used to treat irritation and dry eyes) for Resident 8 when needed, affecting one of four sampled residents during medication pass observation. These deficient practices failed to administer and stock medications in accordance with physician orders or professional standards of practice with the potential to cause hyperglycemia (high blood glucose), medication errors, eye complications and hospitalization . Findings: a. A review of Resident 36's Admission Record indicated the facility admitted the resident on 6/23/2022 with diagnoses including hypertensive (high blood pressure) heart disease with heart failure (heart disorder which causes the heart to not pump the blood efficiently). A review of the Physician's Order Summary Report dated 11/29/2024, indicated Resident 36 to receive Carvedilol tablet 12.5 milligrams (mg - a unit of measure for mass) 1 tablet by mouth one time a day for HTN (hypertension) hold if systolic blood pressure ([SBP] - the pressure caused by heart while contracting) less than (<) 100 and heart rate (HR) less than 60, give with food, start date 6/25/2022. A review of Resident 36's Minimum Data Set (MDS, a federally mandated assessment tool) dated 12/16/2024, indicated the resident's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 36 needed maximal assistance from facility staff for showering, and moderate to supervision level of assistance for eating, oral hygiene, toileting, dressing and personal hygiene. (continued on next page)

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	055157	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Virgil Rehabilitation & Skilled Nursing Center	975 North Virgil Avenue Los Angeles, CA 90029

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Physician's Order Summary Report, dated 12/26/2024, indicated for Resident 36 to receive Carvedilol tablet 12.5 mg, give 1 tablet by mouth one time a day for HTN hold if SBP less than 110 and HR less than 60 give with food, start date 12/27/2024. Carvedilol tablet 12.5 mg, give 1 tablet by mouth one time a day for HTN hold if SBP less than 100 and HR less than 60 give with food, start date 6/25/2022. During an observation of medication administration on 12/26/2024 between 8:10 AM and 8:25 AM with Licensed Vocational Nurse (LVN) 5, LVN 5 prepared and administered the following medications for Resident 36. -One tablet of aspirin (a medication used to prevent blood clot) 325 mg -One tablet of carvedilol 12.5 mg, indicating hold parameters to be hold if SBP less than 110 or HR less than 60 on medication bubble pack. -One capsule of docusate sodium (a medication used to relieve constipation) 100 mg -One tablet of Entresto ([generic name - combination of sacubitril-valsartan] a medication used to treat high blood pressure and heart failure) 24-26 mg. -One tablet of Farxiga ([generic name - dapagliflozin] a medication used to improve diabetes and heart disease) 10 mg. -One tablet of furosemide (a medication used to treat high blood pressure and fluid buildup in extremities) 20 mg. -Two tablets of vitamin D (a vitamin used to treat lack of vitamin D) 25 micrograms (mcg - a unit of measurement for mass) 1000 international units (IU - a unit of measurement for mass). During a medication reconciliation review on 12/26/2024 at 10:33 AM, Resident 36's order summary report with active physician's orders and medication administration observations were reviewed. The active physician's order for carvedilol 12.5 mg indicated the hold parameters for blood pressure to be hold if SBP less than 100 and HR less than 60. The observed medication bubble pack during administration indicated hold parameters for blood pressure for carvedilol 12.5 mg were hold if SBP less than 110 or HR less than 60. A review of Medication Administration Record (MAR) dated 12/1/2024 to 12/31/2024 indicated the facility administered carvedilol 12.5 mg to Resident 36 on 12/2/2024 for SBP reading of 107. During a concurrent interview and record review on 12/26/2024 at 12:18 PM with LVN 5, Resident 36's carvedilol 12.5 mg medication bubble pack and facility's electronic medication administration record (eMAR) were reviewed. LVN 5 stated Resident 36's carvedilol 12.5 mg medication bubble pack instructions for blood pressure hold parameters hold if SBP less than 110 or HR less than 60 did not match with physician's orders hold if SBP less than 100 and HR less than 60. LVN 5 stated she would contact physician to clarify instructions for hold parameters. LVN 5 stated there was a risk for medication error because the order and bubble pack did not accurately match, and different facility nurses could follow different parameters increasing the risk for medication error and blood pressure abnormalities for Resident 36. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/27/2024 at 10:06 AM, the Director of Nursing (DON) stated facility staff should have clarified the order with the physician before carvedilol was administered to Resident 36. The DON stated if the eMAR and pharmacy label had different hold parameters, the facility staff could follow different orders and would cause medication errors and changes in Resident 36's blood pressure. b. A review of Resident 8's admission record indicated the facility originally admitted the resident on 1/1/2009 and readmitted on [DATE] with diagnoses including Type II Diabetes Mellitus without complications. A review of Resident 8's MDS, dated [DATE], indicated the resident's cognition was intact and needed clean up assistance from facility staff for eating. The MDS indicated Resident 8 needed moderate assistance to supervision assistance from facility staff for toileting, upper body dressing, personal hygiene, and oral hygiene, and needed maximal assistance for lower body dressing and wearing footwear. A review of the Physician's Order Summary Report, dated 12/26/2024, indicated Resident 8 to receive Metformin hydrochloride (HCl) tablet 1000 mg, give 1000 mg by mouth two times a day for DM management takes with food, start date 3/21/2019. Visine-A Solution 0.025-0.3% (naphazoline-pheniramine) instill 1 drop in both eyes every 6 hours as needed for itchiness, start date 5/4/2017. During an observation on 12/26/2024 between 9:09 AM and 9:23 AM with Registered Nurse / Nursing Supervisor (RNS) 1, RNS 1 prepared and administered the following medications for Resident 8: -One tablet of metformin 1000 mg -Two capsules of docusate sodium 100 mg -One capsule of fish oil (a supplement used to improve heart health) 1000 mg -One capsule of gabapentin (a medication used to treat seizures and nerve pain) 300 mg -One tablet of multivitamin with minerals -Two tablets of Vitamin D 25 1000 IU. During an observation on 12/26/2024 at 9:23 AM in Resident 8's room, the resident complained of eye irritation and discomfort to RNS 1. RNS 1 stated she would check Resident 8's physician's orders and follow up with physician if needed regarding Resident 8's eye irritation and discomfort. During a medication reconciliation review on 12/26/2024 at 10:33 AM, Resident 8's metformin 1000 mg order details indicated metformin to be administered as 1000 mg two times a day scheduled at 7:30 AM and 5:30 PM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/26/2024 at 12:31 PM with RNS 1, the medication administration details were reviewed. The medication administration details indicated medication scheduled for administration at 7:30 AM and was documented as administered at 9:23 AM. RNS 1 stated Resident 8's metformin was prescribed to be administered at 7:30 AM and facility staff was allowed to administer latest by 8:30 AM. RNS 1 stated she administered metformin for Resident 8 late by at almost one hour. RNS 1 stated there was a risk for Resident 8 to become hyperglycemic and could lead to hospitalization . During an interview on 12/26/2024 at 12:31 PM with RNS 1, RNS 1 stated it was her mistake and apologized for not being able to have Visine eye drops for Resident 8 available when needed and when Resident 8 asked for it. RNS 1 stated although it was an as needed (PRN) medication, facility was supposed to have the medication available to be administered to Resident 8. RNS 1 stated Resident 8 could experience eye irritation and worsening of eye discomfort. During an interview on 12/27/2024 at 10:06 AM, the DON stated metformin for Resident 8 should have been administered within one hour of scheduled medication time according to facility's policy. The DON stated there was a risk of hyperglycemia and hospitalization for Resident 8 if metformin was not given in timely manner. The DON stated Resident 8's Visine eye drops should have been available in stock in medication cart although it was prescribed as needed. The DON stated there was a risk for Resident 8 to experience itchiness and redness in the eyes because facility could not administer Visine eye drops. A review of the facility's policy and procedures (P&P) titled, Administering Medications, dated as reviewed 1/2023, indicated Medications shall be administered in a safe and timely manner, and as prescribed. The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Medications must be administered in accordance with the orders, including any required time frame. The P&P indicated, Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The P&P indicated, If a resident uses PRN (as needed) medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation .and consider whether a standing dose of medication is clinically indicated.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49130 Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for one of four sampled residents (Resident 8). Resident 8 was not administered metformin (a medication used to treat Diabetes Mellitus [DM - a disorder characterized by difficulty in blood sugar control and poor wound healing]) within one hour of the prescribed time and was not provided Visine-A solution ([generic name - naphazoline-pheniramine eye drops], a medication used to treat irritation and dry eyes) in accordance with the physician's orders. These deficient practices caused a medication administration error rate of 6.67%, exceeding the five (5) percent threshold. Findings: A review of Resident 8's Admission Record indicated the facility originally admitted Resident 8 on 1/1/2009 and readmitted Resident 8 on 7/14/2009 with diagnoses including Type II Diabetes Mellitus without complications. A review of Resident 8's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/20/2024, indicated the resident's cognition was intact and needed clean up assistance from facility staff for eating. The MDS indicated Resident 8 needed moderate assistance to supervision assistance from facility staff for toileting, upper body dressing, personal hygiene, and oral hygiene, and needed maximal assistance for lower body dressing and wearing footwear. A review of the Physician's Order Summary Report dated 12/26/2024, indicated Resident 8 was to receive Metformin hydrochloride (HCl) tablet 1000 milligrams (mg - a unit of measurement for mass), 1000 mg by mouth two times a day for DM management, start date 3/21/2019 and Visine-A Solution 0.025-0.3% (naphazoline-pheniramine) instill 1 drop in both eyes every 6 hours as needed for itchiness, start date 5/4/2017. During an observation on 12/26/2024 between 9:09 AM and 9:23 AM with Registered Nurse / Nursing Supervisor (RNS) 1, RNS 1 prepared and administered the following medications for Resident 8: -One tablet of metformin 1000 mg -Two capsules of docusate sodium (a medication used to relieve constipation) 100 mg -One capsule of fish oil (a supplement used to improve heart health) 1000 mg -One capsule of gabapentin (a medication used to treat seizures and nerve pain) 300 mg -One tablet of multivitamin with minerals -Two tablets of Vitamin D 25 1000 international units (IU - a unit of measurement for mass). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/26/2024 at 9:23 AM in Resident 8's room, the resident complained of eye irritation and discomfort to RNS 1. RNS 1 stated she would check Resident 8's physician's orders and follow up with physician if needed regarding Resident 8's eye irritation and discomfort. During a medication reconciliation review on 12/26/2024 at 10:33 AM, Resident 8's metformin 1000 mg order details indicated metformin to be administered as 1000 mg two times a day scheduled at 7:30 AM and 5:30 PM. During a concurrent interview and record review on 12/26/2024 at 12:31 PM with RNS 1, the medication administration details were reviewed. The medication administration details indicated medication scheduled for administration at 7:30 AM and was documented as administered at 9:23 AM. RNS 1 stated Resident 8's metformin was prescribed to be administered at 7:30 AM and facility staff was allowed to administer latest by 8:30 AM. RNS 1 stated she administered metformin for Resident 8 late by at almost one hour. RNS 1 stated there was a risk for Resident 8 to become hyperglycemic and could lead to hospitalization . During an interview on 12/26/2024 at 12:31 PM, RNS 1 stated it was her mistake and apologized for not being able to have Visine eye drops for Resident 8 available when needed and when Resident 8 asked for it. RNS 1 stated although it was an as needed (PRN) medication, facility was supposed to have the medication available to be administered to Resident 8. RNS 1 stated Resident 8 could experience eye irritation and worsening of eye discomfort. During an interview on 12/27/2024 at 10:06 AM, the Director of Nursing (DON) stated metformin for Resident 8 should have been administered within one hour of scheduled medication time according to facility's policy. The DON stated there was a risk of hyperglycemia and hospitalization for Resident 8 if metformin was not given in timely manner. The DON stated Resident 8's Visine eye drops should have been available in stock in medication cart although it was prescribed as needed. The DON stated there was a risk for Resident 8 to experience itchiness and redness in the eyes because facility could not administer Visine eye drops. A review of the facility's policy and procedures (P&P) titled, Administering Medications, dated as reviewed 1/2023, indicated Medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. The P&P indicated, Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The P&P indicated, If a resident uses PRN (as needed) medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation .and consider whether a standing dose of medication is clinically indicated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure storage and/or labeling of Resident 19's lorazepam (a controlled substance [a medication with a high potential for abuse] used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) 2 milligrams (mg - a unit of measurement for mass) per milliliters (mL - a unit of measurement for volume) concentrate per manufacturer's requirements in one of two inspected medication carts (Station 3 Medication Cart). This deficient practice had the potential to result in Resident 19 receiving lorazepam that had become expired, ineffective, or toxic due to improper storage and labeling possibly leading to anxiety and/or hospitalization due to health complications. Findings: A review of Resident 19's Admission Record indicated the facility originally admitted the resident on [DATE] and readmitted on [DATE] with diagnoses including encounter for palliative care (a care to provide comfort and improve quality of care for patients and families facing life threatening serious illness) and anxiety disorder, unspecified. A review of Resident 19's History and Physical, dated [DATE] indicated the resident did not have the capacity to understand and make decisions. A review of Resident 19's Minimum Data Set (MDS, a federally mandated assessment tool) dated [DATE] indicated the resident's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was severely impaired. The MDS indicated Resident 19 was dependent or needed maximal assistance from facility staff for activities of daily living such as eating, oral hygiene, toileting hygiene, showering, dressing and personal hygiene. A review of the Physician's Order Summary Report dated [DATE], indicated Resident 19 was to receive lorazepam oral concentrate 2 mg/mL, give 0.5 mL sublingually (under the tongue) every 4 hours as needed for anxiety for 14 days manifested by (m/b) mild to moderate agitation, end date [DATE]. and lorazepam oral concentrate 2 mg/mL, give 1 mL sublingually every 4 hours as needed for anxiety m/b severe agitation. A review of the Physician's Order Summary Report, dated [DATE], did not indicate any orders for lorazepam oral concentrate 2 mg/mL for Resident 19. During a concurrent inspection and interview on [DATE] at 2:58 PM with Licensed Vocational Nurse (LVN) 8 of the Station 3 Medication Cart, Resident 19's lorazepam oral concentrate 2 mg/mL in the quantity of 19.5 mL volume was found in the medication cart without an opened date label, which was not in accordance with manufacturer's specifications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the manufacturer's product labeling, lorazepam oral concentrate 2 mg/mL should be stored in refrigerator at 2-to 8 degrees Celsius [(C) a unit of temperature] (36 to 46-degree Fahrenheit [(F) a unit of temperature] and an opened bottle should be discarded after 90 days. During a concurrent interview, inspection, and record review on [DATE] at 2:58 PM with LVN 8 of the Station 3 Medication Cart, Resident 19's lorazepam oral concentrate 2 mg/mL Controlled Drug Record ([CDR] - a log signed by the nurse with the date and time each time a controlled substance is given to a resident) was reviewed. The CDR indicated and LVN 8 stated the last dose of lorazepam oral concentrate was documented to be administered on [DATE] at 12 PM. During a concurrent interview, LVN 8 stated the lorazepam oral concentrate 2 mg/mL was not labeled with an open date and should have an open date documented on the label otherwise there was no way to determine expiration date of the mediation after it was opened and removed from the refrigerator. LVN 8 stated the lorazepam oral concentrate 2 mg/mL should be stored in the refrigerator. LVN 8 stated due to improper storage, the lorazepam oral concentrate would not be safe and effective to be administered to Resident 19. LVN 8 stated Resident 19 would need to be monitored and assessed for anxiety and agitation. LVN 8 stated she would have to hand over the medication to the Director of Nursing (DON) for disposal and it was important to follow proper storage, labeling and disposal because lorazepam is a controlled substance with high risk of abuse, misuse, and diversion. During an interview on [DATE] at 10:23 AM, the DON stated lorazepam oral concentrate 2 mg/mL should have an open date on the container and stored in refrigerator according to manufacturer's requirements. The DON stated the medication would not be effective and safe to be administered to Resident 19 because the quality of medication could be compromised, and Resident 19 would not be treated for agitation or behavioral symptoms. A review of the facility's policy and procedure (P&P) titled, Medication Storage and Labeling, dated as reviewed ,d+[DATE], indicated All drugs will be labeled and stored in a manner consistent with manufacturer's published specifications, federal and state regulations, and to enhance accurate and safe medication administration by the facility staff. Drugs requiring refrigeration shall be stored in a refrigerator between 2 C (36 F) and 8 C (46 F).

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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** 49130 Based on observation, interview, and record review, the facility failed to maintain infection control practices for one of four sampled residents (Resident 8) by failing to ensure sanitary environment in resident care areas. Resident 8's male urinal was full of urine and stored on the bedside cart along with other resident's belongings. This deficient practice had the potential to result in transmission of infectious microorganisms and increase the risk of infection for Resident 8. Findings: A review of Resident 8's Admission Record indicated the facility originally admitted the resident on 1/1/2009 and readmitted on [DATE] with diagnoses including Type II Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications and encounter for screening for other viral diseases. A review of Resident 8's Minimum Data Set (MDS, a federally mandated assessment tool), dated 11/20/2024, indicated the resident's cognition was intact and required clean up assistance from facility staff for eating. The MDS indicated Resident 8 needed moderate assistance to supervision assistance from facility staff for toileting, upper body dressing, personal hygiene, and oral hygiene, and needed maximal assistance for lower body dressing and wearing footwear. During an observation on 12/26/2024 between 9:09 AM and 9:23 AM with Registered Nurse / Nursing Supervisor (RNS) 1 in Resident 8's room during medication administration, there was an open male urinal (a portable container that can be used by resident to urinate in) containing yellow liquid placed on the bedside table along with a blue drinking water container, a water bottle, and a mobile phone next to Resident 8's bed. RNS 1 administered the prepared medications to Resident 8. During an interview on 12/26/2024 at 12:31 PM, RNS 1 stated the male urinal should have been emptied out and not stored on the bedside cart along with other resident's belongings. RNS 1 stated there was a risk for infection and cross contamination. RNS 1 stated Resident 8 was not fully mobile, but facility staff should have cleaned out male urinal to prevent spread of infection. During an interview on 12/27/2024 at 10:36 AM the Director of Nursing (DON) stated Certified Nurse Assistant (CNA), housekeeping and Licensed Vocational Nurse (LVN) should have ensured Resident 8's care areas were clean and sanitary. The DON stated by placing the urinal on the bedside table, there was a possibility of infection and risk for medication contamination. The DON stated facility staff should have followed standard precautions to prevent infection that included cleaning the resident care areas, disinfecting, and keeping the areas clear of bodily fluids that could increase the risk of infection. A review of the facility's policy and procedures (P&P) titled, Infection Control Guidelines for All Nursing Procedures, dated 8/2022, indicated Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard Precautions apply to blood, body fluids, secretions, excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Standard Precautions, dated 1/2024, indicated Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents.

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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 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on observation, interview, and record review, the facility failed to ensure rooms meet the requirement of no more than 4 beds per room for four sampled resident rooms (room [ROOM NUMBER], 218, 219, and 312). This deficient practice had the potential to affect the delivery of care and safety of the residents. Findings: During observation and interview on 11/27/24 at 3:14 PM with Resident 44, Resident 44 was in a room with 4 beds, stated he had enough space for privacy and family to visit. Resident 44 stated his roommate was not in the room but his roommate was able to come in and out freely. During an interview on 11/27/24 at 3.21 PM, Certified Nurse Assistant (CNA) 1 stated she was assigned to room [ROOM NUMBER] and 308. CNA 1 stated she felt there was enough space for her to perform her duties in each room. CNA 1 stated especially in room [ROOM NUMBER] because she used the Hoyer lift (electronically operated patient lift for the safe lifting of heavier patients) for Resident 44, and she could get the lift in the room without any problems. A review of the room waiver request letter dated 1/30/24, indicated the room waiver was approved for room [ROOM NUMBER], 218, 219, and 312 with more than 4 beds. A review of the facility's policy and procedure (P&P) titled, Resident Room Size, dated 1/2024, indicated the residents would have at a minimum of 80 square feet of living space and no more than 4 residents to a room. Any room not meeting the requirements would require a room waiver from CDPH.