STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirage Post Acute	44445 15th St W Lancaster, CA 93534

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48142 Based on interview and record review, the facility failed to ensure a resident's open area on the right buttocks was assessed comprehensively to include the size and healing progress of wound for one of three sampled residents (Resident 2). This deficient practice could result in Resident 2 not receiving proper treatment. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 2/12/2025 with diagnoses including Huntington disease (nerve cells in the brain gradually break down and die) and anemia (blood is not carrying enough oxygen to your body's tissues). During a review of Resident 2's History and Physical Report, dated 1/24/2025, the report indicated that Resident 2 was severely impaired with thought process. During a record review of Change of Condition (COC) Evaluation, dated 4/15/2025, the COC Evaluation indicated the COC started in the afternoon of 4/15/2025 regarding Resident 2's skin wound or ulcer. The COC Evaluation indicated Resident 2 had an open area on the right buttock with no secretions, foul odor, heat to touch, or edema, no curled edges, and no signs and symptoms of infection. During a concurrent interview and record review on 5/16/2025 at 9:16 a.m., with License Vocational Nurse (LVN) 3, Resident 2's Weekly Skin Assessment was reviewed. LVN 3 stated there was no weekly skin assessments done for Resident 2, and Resident 2 must have weekly skin assessments due to Resident 2's wound. LVN 3 stated weekly skin assessments must be done to see Resident 2's wound progress and assess Resident 2's wound properly. LVN 3 stated if there were no weekly skin assessments, Resident 2's wound could get worse unnoticed. During an interview on 5/16/2025 at 12:07 p.m., with the Director of Nursing (DON), the DON stated weekly skin assessments must be done when a resident has a wound because it describes in the assessment how the wound looks like and progress of the wound healing. During a review of the current facility-provided policy and procedure titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, reviewed on 4/24/2025, the policy and procedure indicated the . the nurse shall describe and document/report the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses. During a review of the current facility-provided policy and procedure titled, Pressure Ulcers/Skin Breakdown, reviewed on 4/24/2025, the policy and procedure indicated the . the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; b. Pain assessment; c. Resident's mobility status; d. Current treatments, including support surfaces; and e. All active diagnoses.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48142 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 2) was using pressure-reducing mattress every shift to prevent wound development or promote wound healing. This deficient practice had the potential for Resident 2 to develop or worsen wound if the pressure-reducing mattress was not used. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 2/12/2025 with diagnoses including Huntington disease (nerve cells in the brain gradually break down and die) and anemia (blood is not carrying enough oxygen to your body's tissues). During a review of Resident 2's History and Physical Report, dated 1/24/2025, the report indicated that Resident 2 was severely impaired with thought process. During a record review of Change of Condition (COC) Evaluation, dated 4/15/2025, the COC Evaluation indicated the COC started in the afternoon of 4/15/2025 regarding Resident 2's skin wound or ulcer. The COC Evaluation indicated Resident 2 had an open area on the right buttock with no secretions, foul odor, heat to touch, or edema, no curled edges, and no signs and symptoms of infection. During a record review of Resident 2's Order Summary Report, dated 2/13/2025, indicated to provide pressure-reducing mattress to Resident 2. During a record review of Resident 2's care plan titled, Skin: Resident is at risk for skin breakdown, initiated on 2/12/2025, the care plan indicated an intervention to provide pressure reduction cushion to Resident 2. During a concurrent interview and record review on 5/16/2025 at 12:47 p.m., with License Vocational Nurse (LVN) 4, reviewed Resident 2's physician order, dated 2/13/2025. The physician order indicated to provide pressure reducing mattress, and reviewed medication administration dated 5/1/2025 to 5/31/2025 indicated cross marks and no signature of the nurse. LVN 4 stated the pressure reducing mattress order for Resident 2 should show in the treatment administration record and should not be in the medication administration record, because treatment nurse was the one who was assigned to check the settings of the pressure reducing mattress every shift to make sure that it was in the right settings and needs to sign for it after checking. LVN 4 stated if it was not signed it means it was not done. LVN 4 stated it was important to make sure that pressure reducing mattress setting was checked every shift to make sure it was in the right settings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure titled, Charting and Documentation, last reviewed on 4/24/2025, the policy and procedure indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48142 Based on interviews and record review, the facility failed to properly manage pain for one of three sampled residents (Resident 1) who was assessed at a higher pain score and pain medication was not administered for treatment. This deficient practice had the potential to ineffectively manage Resident 1's pain. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 3/26/2025 with diagnoses including fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing (fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing) and hypertension (high blood pressure - the force of your blood pushing against your artery walls is consistently too high) During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/1/2025, the MDS indicated Resident 1 was severely impaired with thought process and required moderate assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1's care plan on pain, dated 3/27/2025, indicated a goal that Resident 1 will express pain relief after alternative comfort measures and/or administration of medication as needed. The care plan indicated an intervention to administer medications as ordered. During a review of Resident 1's Physician's Order, dated 3/26/2025, indicated to give as follows: - Give acetaminophen tablet 650 milligram (mg - unit of measurement) by mouth every four hours as needed for mild pain one to three out of 10 using the numeric rating scale (a scale, typically from 0 to 10, where 0 represents no pain and 10 represents the worst possible pain). - Give Hydrocodone-Acetaminophen Tablet 5-325 mg one tablet by mouth every six hours as needed for severe pain seven out of 10 in the pain scale. During an interview on 5/14/2025 at 12:47 p.m., with License Vocational Nurse (LVN) 2, LVN 2 stated Resident 1's pain level was 7 of 10 and was not given any pain medication. LVN 2 stated she called pharmacy to use emergency kit pain medication and pharmacy did not allow her due to physician did not sign the authorization yet at that time. LVN 2 further stated it was important to provide pain medication for Resident 1's pain level of 7 of 10 because if not Resident 1's blood pressure could possibly go up, could have emotional distress, respiratory rate could increase, could not function with her ADLs, and will not participate in her therapy due to pain. (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/14/2025 at 2:25 p.m. with the Director of Nursing (DON), Resident 1's pain assessment was reviewed. The pain assessment indicated on 5/7/2025 at 8:52 a. m., Resident 1 had a pain level of 7 of 10. The DON stated that Resident 1 received an acetaminophen at 4 p.m. 7 hours after Resident 1's pain level of 7 of 10 at 8:52 a.m. The DON stated that LVN 2 should have told her (DON) so she (DON) can follow up with the physician and pharmacy. During a review of the facility policy and procedure titled, Pain Assessment and Management, last reviewed date of 4/24/2025, the policy and procedure indicated, The purpose of this procedure are to help the staff identify pain in the resident, develop interventions consistent with the resident's goals and needs, and address the underlying causes of pain. The medication regiment is implemented as ordered.

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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. 48142 Based on interview and record review, the facility failed to order pain medication and follow up with the physician to sign the narcotic (type of drug that can dull pain) authorization for one of three sample residents (Resident 1). These deficient practices increased the risk that Resident 1 could have with delayed medication treatment leading to untreated pain. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 3/26/2025 with diagnoses including fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing (fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing) and hypertension (high blood pressure - the force of your blood pushing against your artery walls is consistently too high) During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/1/2025, the MDS indicated Resident 1 was severely impaired with thought process and required moderate assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1's care plan on pain, dated 3/27/2025, indicated goal that Resident 1 will express pain relief after alternative comfort measures and/or administration of medication as needed. The care plan indicated an intervention to administer medications as ordered. During a review of Physician's Order, dated 3/26/2025, the order indicated to give as follows: - Give acetaminophen tablet 650 milligram (mg - unit of measurement) by mouth every four hours as needed for mild pain one to three out of 10 using the numeric rating scale (a scale, typically from 0 to 10, where 0 represents no pain and 10 represents the worst possible pain). - Give Hydrocodone-Acetaminophen Tablet 5-325 mg one tablet by mouth every six hours as needed for severe pain seven out of 10 using the pain scale. During an interview on 5/14/2025 at 12:47 p.m., with License Vocational Nurse (LVN) 2, LVN 2 stated Resident 1's pain level was 7 of 10 and was not given any pain medication. LVN 2 stated she called pharmacy to use emergency kit pain medication and pharmacy did not allow her due to physician did not sign the authorization yet at this time. LVN 2 stated it was important to provide pain medication for Resident 1's pain level of 7 of 10 because if not Resident 1's blood pressure could possibly go up, could have emotional distress, respiratory rate could increase, could not function with her ADLs, and will not participate in her therapy due to pain. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/14/2025 at 2:25 p.m. with the Director of Nursing (DON), Resident 1's pain assessment was reviewed. The pain assessment indicated on 5/7/2025 at 8:52 a. m., Resident 1 had a pain level of 7 of 10. The DON stated that Resident 1 received an acetaminophen at 4 p.m. seven hours after Resident 1's pain level of 7 of 10 at 8:52 a.m. The DON stated that LVN 2 should have told her (DON) so she (DON) can follow up with the physician and pharmacy. During a concurrent interview and record review on 5/15/2025 at 3:42 p.m., with the DON, reviewed a document titled, Quality Assurance Action Plan Template Change in Pharmacy, dated 4/9/2025. The document indicated the following: Systems Changes: - Update internal protocols for medication ordering and communication with pharmacy. - Integrate new pharmacy's electronic systems with facility EMR (if applicable). - Develop a step-by-step transition guide. Monitoring: - Daily medication delivery and administration audits for the first 2 weeks post-transition. - Monitor resident outcomes and incident reports related to medications. - Weekly pharmacy service feedback meeting with staff and administration for 1 month. - Any findings or concerns will be discussed by the Director of Nursing or designee to ensure long-term sustainability of new pharmacy service monthly for three months then quarterly after for a year. The DON stated that the infection preventionist helped her to check the carts to check for the missing narcotic, make rounds and ask the nurses if they have missing medication. The DON stated that she does not know why staff missed Resident 1's medications. The DON stated the license nurse was in charge in ordering and following up the medication from the pharmacy, and license nurses know that they should order it as soon as they only have five pills left. The DON further stated that the facility policy and procedures did not indicate how many pills were left before requesting a new refill, but that was the usual practice. During a review of the current facility-provided undated policy and procedure titled, Medication Orders, the policy and procedure indicated, Before a controlled drug can be dispensed, the pharmacy must be in receipt of a prescription from a person lawfully authorized to prescribe. A chart order is not equivalent to a prescription for controlled drugs. Therefore, the prescriber issuing the chart order must also provide the pharmacist with a valid prescription to ensure delivery of medication.