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	06/05/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences to two of four sampled residents (Resident 3 and 4) by failing to ensure: 1. The call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for Resident 3. 2. The call light was functional for Resident 4. These failures had the potential to result in the inability of Residents 3 and 4 to call for facility staff assistance and delay in the provision of necessary care and services that could negatively affect the residents' well-being. Findings: a. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted on [DATE] with diagnoses of dementia (a progressive state of decline in mental abilities), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), repeated falls, and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's History and Physical (H&P), dated 2/21/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 3 had severely impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS also indicated Resident 3 was dependent on staff for toileting hygiene, personal hygiene, upper and lower body dressing. During a review of Resident 3's Care Plan (CP), last revised on 4/23/2025, the CP indicated Resident 3 had an Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) self-care performance deficit related to activity intolerance, dementia, limited mobility. The CP interventions indicated encouraging the Resident to use call light for assistance. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/4/2025 at 9:30a.m. with Licensed Vocational nurse (LVN) 1in Resident 3's room, Resident 3's call light was observed under the bed mattress. LVN 1 stated Resident 3 would not be able to reach the call light under the mattress. LVN 1 stated the call light should have been placed within Resident 3's reach to prevent accidents and maintain safety. b. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted on [DATE] with diagnoses of paraplegia (loss of movement and/or sensation, to some degree, of the legs), hypertension (high blood pressure), and chronic pain syndrome (a condition where persistent pain, lasting longer than 3 months, significantly impacts a resident's life, affecting their physical, mental, and emotional well-being). During a review of Resident 4's H&P, dated 4/30/2024, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's CP, last revised on 5/19/2025, the CP indicated Resident 4 was at risk for ADL and mobility decline related to paraplegia and required assistance related to pain and vision problems. The CP indicated to encourage Resident to use call light for assistance. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive functioning was moderately impaired. The MDS also indicated Resident 4 required maximal assistance with toileting hygiene, lower body dressing, and moderate assistance with upper body dressing. During a concurrent observation and interview on 6/5/2025 at 11:36a.m. with LVN 2 in Resident 4's room, Resident 4 was observed pressing the call light without the call light indicator near the room entrance turning on to indicate the call light was functioning. LVN 2 stated Resident 4's call light was not working. LVN 2 stated call light should be functioning and within Resident 4's reach for the resident to communicate with staff and prevent accidents such as falls. During an interview on 6/5/2025 at 2:45p.m. with the Director of Nursing (DON), the DON stated call lights should be functional and within residents' reach. The DON stated the failure had the potential to delay necessary assistance and care to residents. During a review of the facility-provided policy and procedure (P&P) titled, Call System, Residents, last reviewed on 4/24/2025, the P&P indicated, 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor . 4. The resident call system remains functional at all times . If visual communication is used, the lights remain functional. Any malfunction or issues with the call light, staff is to notify supervisor/Maintenance/DON/Administrator for immediate resolution and provide alternatives such as call bell, etc.

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial (relating to the interrelation of social factors and individual thoughts and behavior) needs for one of four sampled residents (Resident 1), by failing to administer medications and treatments as ordered by the physician. These deficient practices had the potential to place Resident 1 at risk for unrelieved shortness of breath, respiratory complications, and negatively affect Resident 1's well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), CHF (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in buildup of fluid in the lungs), and anxiety disorder (feeling of anxiousness that affects daily life). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/12/2025, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). During a review of Resident 1's Care Plan (CP) for CHF, last revised on 10/15/2024, the CP indicated Resident 1 had CHF and would be given cardiac medications as ordered. During a review of Resident 1's Respiratory CP, last revised on 2/18/2025, the CP indicated Resident 1 was at risk for respiratory complications. CP interventions indicated to administer medications as ordered. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order: -10/14/2025: Trelegy Ellipta Inhalation Aerosol Powder Breath Activated (Fluticasone-Umeclidinium-Vilanterol- medication used to reduce inflammation, relax muscles around the airway, and open the airways to help improve breathing, prevent symptoms such as cough and shortens of breath) 100-62.5-25 microgram /ACT (MCG/ACT-unit of measurement) 1 inhalation inhale orally one time a day for COPD. Rinse mouth out with water after each use. -10/14/2025: Bumex (Bumetanide-medication used to get rid of excess water and salt by increasing the amount of urine produced by the kidneys, used to treat conditions like heart failure) Oral Tablet 1 milligram (mg - unit of measurement). Give 1 mg by mouth one time a day for CHF. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/4/2025 at 12:30p.m. with Registered Nurse (RN) 1, Resident 1's Medication Administration Record (MAR), dated 5/2025, was reviewed. The MAR indicated on 5/10/2025 and 5/13/2025 for 9 a.m. administration time, there were no licensed staff initials in the box for Resident 1's Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT, to demonstrate the medication was administered. The MAR also indicated on 5/10/2025 and 5/13/2025 for 9 a. m. administration times, there were no licensed staff initials in the box for Resident 1's Bumex Oral Tablet 1 mg, to demonstrate the medication was administered. RN 1 stated there was no documentation on the MAR dated 5/2025 that indicated Resident 1 received LV1's Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT on 5/10/2023 9 a.m. and 5/13/2025 at 9 a.m. RN 1 also stated there was no documentation on the MAR dated 5/2025 that indicated Resident 1 received Bumex Oral Table 1 mg on 5/10/2025 at 9 a.m. and 5/13/2025 at 9 a.m. RN 1 stated the failure to administer medications as ordered could have caused shortness of breath. During an interview on 6/4/2025 at 3:30 p.m. with the Director of Nursing (DON), the DON stated the facility failed to administer Resident 1's medications and treatments as ordered by the physician. The DON stated failure to follow physicians' medication and treatment orders had the potential for Resident 1 to experience adverse effects (an undesirrable or harmful consequence that accurs as a result of a treatment, medication), exacerbation (worsening of a pre-existing medical condition) of the condition the medication is used for, respiratory complications such as shortness of breath and worsening of COPD. During a review of the facility-provided policy and procedure (P&P) titled, Administering Medications, last reviewed on 4/24/2025, the P&P indicated, 6. Medications are administered in accordance with prescriber order, including any required time frame 23. As required or indicated for a medication, the individual administering the medication records I the resident's medical record: a. the date and time the medication was administered g. the signature and title of the person administering the drug.