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	07/09/2025

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. Based on observation, interview, and record review, the facility failed to ensure the residents received services with reasonable accommodation of the resident needs for one of four sampled residents (Residents 4). Resident 4, who was at risk for falls, did not have the call light (an alerting device for residents to call for assistance) within the resident's reach.This deficient practice had the potential for not meeting Residents 4's needs for assistance.Findings: During a review of Resident 4's admission Record (undated), the admission Record indicated the facility admitted Resident 4 on 6/24/2011 with diagnoses including multiple sclerosis (a chronic disease where the body's immune system attacks the protective covering of nerve fibers in the brain and spinal cord), chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 4's Care Plan on injury and falls, initiated on 3/1/2020, the Care Plan indicated the resident had the potential for injury and falls. The Care Plan Interventions indicated to instruct use of call light whenever in need of assistance. place call light within reach. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 6/23/2025, the MDS indicated Resident 4's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was moderately impaired. The MDS indicated Resident 4 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) on rolling to the right and left side, eating, and personal hygiene. During a review of Resident 3's Fall Risk Assessment, dated 6/23/2025, the Fall Risk Assessment indicated the resident had a total score of 18. A total score above 16 to 42 represented a high risk for falls. During a concurrent observation and interview on 7/9/2025 at 3:28 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 4's call light was observed at the right side of the resident's bed, on the floor. LVN 2 stated a resident's call light was required for resident safety. LVN 2 stated Resident 4's call light was not within the resident's reach. LVN 2 stated Resident 4's needs had the potential not to be met if the call light was not within the resident's reach. During an interview on 7/9/2025 at 5 p.m. with the Director of Nursing (DON), the DON stated Resident 4's call light should be within the resident's reach. The DON stated Resident 4's call light not within the resident's reach had the potential to cause delay in Resident 4's care. The DON stated the facility failed to ensure the call light was within Resident 4's reach. During a review of the facility's policy and procedure (PnP) titled, Call System, Residents, last reviewed on 4/24/2025, indicated each resident is provided with a means to call staff directly for assistance from his or her bed . The PnP indicated . to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services for one of three sampled residents (Resident 4) by failing to:1. Ensure Resident 4's oxygen tubing and oxygen humidifier (a device that adds moisture to the oxygen a person is breathing in during oxygen therapy) was dated when it was changed.2. Ensure Resident 4's oxygen humidifier bottle had water in it while in use.3. Ensure Resident 4 had an oxygen supplies bag for the oxygen tubing to be kept inside when not in use.4. Ensure Resident 4 had a physician order for oxygen therapy (O2 therapy - a treatment that provides a person with supplemental or extra oxygen) before Resident 4 was provided with oxygen. These deficient practices had the potential for Resident 4 to develop respiratory (organs and structures in the body that allow a person to breathe) diseases or infections. These deficient practices had the potential to create confusion in the delivery of care and services to Resident 4.Findings: During a review of Resident 4's admission Record (undated), the admission Record indicated the facility admitted Resident 4 on 6/24/2011 with diagnoses including multiple sclerosis (a chronic disease where the body's immune system attacks the protective covering of nerve fibers in the brain and spinal cord), chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 4's Care Plan on COPD, initiated on 1/23/2025 and revised on 6/24/2025, the Care Plan indicated the resident was at risk for complications with the respiratory system. The Care Plan Interventions indicated to follow infection control protocol for universal or standard precautions. The Care Plan Interventions indicated oxygen therapy as ordered. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 6/23/2025, the MDS indicated Resident 4's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was moderately impaired. During a concurrent observation and interview on 7/9/2025 at 3:28 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 4 was observed with oxygen therapy at two liters (L - unit of measurement) per nasal cannula (a device used to deliver supplemental oxygen thru the nostril [nose])), connected to an oxygen concentrator (a device that provides extra oxygen). LVN 2 stated Resident 4's oxygen cannula was not dated. LVN 2 stated Resident 4's oxygen humidifier bottle was empty and was dated 6/28/2025. LVN 2 stated Resident 4 did not have an oxygen supplies bag in the resident's room. LVN 2 stated Resident 4's oxygen therapy supplies should be dated and changed every 7 days. During an interview on 7/9/2025 at 5 p. m. and concurrent record review of Resident 4's Physician Orders, dated 7/9/2025, reviewed with the Director of Nursing (DON), the DON stated Resident 4's Physician Order did not indicate an order for oxygen therapy. The DON stated Resident 4's oxygen cannula, oxygen humidifier bottle, and oxygen supplies bag should be dated and changed. The DON stated Resident 4 should have an oxygen therapy order before the resident received oxygen. The DON stated Resident 4 had the potential to experience shortness of breath, dryness of the nasal area, and respiratory infection. The DON stated the facility failed to ensure there was a physician's order for oxygen therapy before Resident 4 was provided with oxygen. The DON stated the facility failed to ensure Resident 4's oxygen therapy supplies were dated and changed. During a review of the facility's policy and procedure (PnP) titled, Oxygen Administration, last reviewed on 5/24/2025, the PnP indicated the purpose .to provide guidelines for safe oxygen administration. The PnP indicated to verify that there was a physician order for the procedure. The Steps in the Procedure section of the PnP indicated 12. be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through.14. Periodically re-check water level in humidifying jar. During a review of the facility's PnP titled, Departmental (Respiratory Therapy) - Prevention of Infection, last reviewed on 5/24/2025, the PnP indicated the purpose .to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. The PnP indicated .7. Store the circuit in plastic bag, marked with date and resident's name, between uses.9. Discard administration set-up every seven (7) days.

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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. (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	Based on interview and record review, the facility failed to ensure resident's pain was managed as indicated in the facility's Pain Assessment and Management policy for one of four sampled residents (Resident 2) by failing to ensure Resident 2's pain medication, ibuprofen (medication used to treat moderate pain) 400 milligrams (mg - unit of measurement), scheduled every six hours as needed, was administered according to the physician order. This deficient practice had the potential for Resident 2's unnecessary pain experienced during daily activities and had the potential to lead to a decline in Resident 2's quality of life.Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 1/22/2024 with diagnoses including osteoarthritis (condition that causes the joints to become very painful and stiff) left hip, anemia (condition in which the body does not get enough oxygen-rich blood), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 2's Physician Orders, dated 1/22/2024, the Physician Orders indicated acetaminophen 650 mg tablet every four hours as needed for mild pain (one to three on the numeric pain scale). During a review of Resident 2's Care Plan on pain or discomfort, initiated on 1/22/2024, the Care Plan indicated the resident was at risk for pain and discomfort. The Care Plan Interventions indicated to administer medication and treatment as ordered. During a review of Resident 2's Physician Orders, dated 2/5/2024, the Physician Orders indicated ibuprofen 400 mg every six hours as needed for moderate pain (four to six on the numeric pain scale). During a review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/30/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 2 received as needed pain medications for the resident's occasional pain. The MDS indicated Resident 2 received non-medication intervention for pain. During an interview on 7/9/2025 at 2:14 p.m. and concurrent review of Resident 2 Medication Administration Record (MAR), dated 6/1/2025 to 6/30/2025 and 7/1/2025 to 7/31/2025, reviewed with Registered Nurse (RN) 2, RN 2 stated Resident 2's MAR indicated the following: a. On 6/3/2025 at 11:32 a.m., Resident 2 had two out of ten on the numeric pain scale. RN 2 stated Resident 2 received ibuprofen 400 mg instead of the acetaminophen 650 mg.b. On 6/5/2025 at 8:57 a.m., Resident 2 had two out of ten on the numeric pain scale. RN 2 stated Resident 2 received ibuprofen 400 mg instead of the acetaminophen 650 mg.c. On 6/25/2025 at 10:27 a.m. and 6:02 p.m. Resident 2 had three out of ten on the numeric pain scale. RN 2 stated Resident 2 received ibuprofen 400 mg instead of the acetaminophen 650 mg.d. On 6/29/2025 at 9:15 a.m., Resident 2 had three out of ten on the numeric pain scale. RN 2 stated Resident 2 received ibuprofen 400 mg instead of the acetaminophen 650 mg.e. On 7/5/2025 at 9:56 a.m., Resident 2 had three out of ten on the numeric pain scale. RN 2 stated Resident 2 received ibuprofen 400 mg instead of the acetaminophen 650 mg.f. On 7/7/2025 at 8:57 a.m., Resident 2 had two out of ten on the numeric pain scale. RN 2 stated Resident 2 received ibuprofen 400 mg instead of the acetaminophen 650 mg.RN 2 stated Resident 2 received the pain medication that was not appropriate for the resident's pain level. RN 2 stated Resident 2 received a pain medication that was not according to the Physician Order. RN 2 stated Resident 2's pain had the potential not to be managed. During an interview on 7/9/2025 at 5 p.m. with the Director of Nursing (DON), the DON stated Resident 2 received a pain medication that was not appropriate for the resident's pain level. The DON stated Resident 2 had the potential for inaccurate pain assessment. The DON stated the facility failed to follow the Physician Order on Resident 2's pain management. During a review of the facility's policy and procedure (PnP) titled, Administering Medications, last reviewed on 4/24/2025, the PnP indicated medications are administered in accordance with prescriber orders, including any required time frame. During a review of the facility's PnP titled, Administering Pain Medications, last reviewed on 4/24/2025, the PnP defined pain management as .the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. The PnP indicated administer pain medications as ordered.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the medical records of one of four sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to:1. Ensure Licensed Vocational Nurse (LVN) 4 documented Resident 1's Change in Condition (CIC) monitoring indicating the correct date.2. Ensure Certified Nursing Assistants (CNAs) documented Residents 1's percentage (% - per one hundred) of food eaten every meal (breakfast, lunch, and dinner).3. Ensure CNAs accurately documented Resident 1's bladder (a hallow organ that stores urine in the body) continence. These deficient practices resulted in inaccurate information on Residents 1's medical records and had the potential for delayed and inaccurate medical interventions.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 1/14/2021, with diagnoses including Guillain-Barre syndrome (a condition in which the body's immune system attacks the nerves), age-related osteoporosis (a condition where bones become weaker and more brittle with age), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. During a review of Resident 1's Progress Notes, dated 6/19/2025, the Progress Notes indicated on 6/19/2025 at 11:01 a.m., Resident 1 had a CIC. Resident 1's Progress Notes indicated LVN 4 documented a 72-hour monitoring on 6/19/2025 at 1:43 a.m., 9 hours and 18 mins before the resident's CIC. During an interview on 7/9/2025 at 12:39 p.m. and concurrent record review of Resident 1's Bladder Continence Task and Nutritional Task, dated 6/11/2025 to 7/9/2025, reviewed with Registered Nurse (RN) 1, RN 1 stated the Bladder Continence Task section indicated the following:a. On 6/13/2025, 6/16/2025, and 7/6/2025, the 3 p.m. to 11 p.m. shift did not document Resident 1's bladder continence status. b. On 6/14/2025 and 6/19/2025, the 7 a.m. to 3 p.m. shift did not document Resident 1's bladder continence status. c. On 7/3/2025, the 11 p.m. to 7 a.m. shift did not document Resident 1's bladder continence status. RN 1 stated Resident 1's Nutritional Task indicated the following: a. On 6/13/2025 and 6/16/2025, Resident 1 did not have a documented dinner meal intake.b. On 6/14/2025 and 6/19/2025, Resident 1 did not have a documented lunch meal intake.c. On 6/19/2025, Resident 1 did not have a documented breakfast meal intake.d. On 7/1/2025, Resident 1's documented breakfast and lunch meal intake were 51% to 75%, both at 1:15 p.m.e. On 7/5/2025, Resident 1's documented breakfast and lunch meal intake were 76% to 100%, both at 1:23 p.m.f. On 7/7/2025, Resident 1's documented breakfast and lunch meal intake were 76% to 100%, both at 12:58 p.m.RN 1 stated Resident 1's bladder continence should be documented every shift. RN 1 stated Resident 1's documented Bladder Continence Task and Nutritional Task were inaccurate and incomplete. During an interview on 7/9/2025 at 5 p.m. with the Director of Nursing (DON), the DON stated documentation in Resident 1's medical records should be accurate and complete. The DON stated incomplete and inaccurate documentation had the potential for residents' inaccurate plan of care and treatment. The DON stated the facility failed to ensure complete and timely documentation on the residents' medical records. During a review of the facility's policy and procedure (PnP) titled, Charting and Documentation, last reviewed on 4/24/2025, the PnP indicated the following information is to be documented in the resident medical record: a. objective observations.f. progress toward or changes in the care plan goals and objectives.