

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2025
NAME OF PROVIDER OR SUPPLIER Mirage Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) received medication as prescribed. This deficient practice had the potential for Resident 1 to be negatively affected. Findings: During a review of Resident 1's admission Record (AD), the AD indicated the facility admitted Resident 1 on 6/11/2025 with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and essential (primary) hypertension (HTN-high blood pressure). During a review of Resident 1 Physician Orders, dated 6/13/2025 the Physician Orders indicated Miralax (an over-the-counter medication used to relieve occasional constipation) oral powder 17 grams (g- a unit of measurement) give 1 scoop by mouth one time a day for bowel management mix well with optimal amounts of fluid until dissolved. Hold for loose stool. During a review of Resident 1's Bowel Continence for 6/2025, the Bowel Continence indicated the following:- 6/14/2025 11-7 a.m. shift Resident 1 had a bowel movement (BM), incontinent, loose/diarrhea, small.- 6/21/2025 3-11 p.m. shift Resident 1 had a BM, incontinent, loose/diarrhea, and large.- 6/22/2025 7-3 p.m. shift Resident 1 had BM, incontinent, loose/diarrhea, and medium.- 6/22/2025 3-11 p.m. shift Resident 1 had BM, incontinent, loose/diarrhea, and large.- 6/22/2025 11-7 a.m. shift Resident 1 had BM, incontinent, loose/diarrhea, and large.- 6/23/2025 3-11 p.m. shift Resident 1 had two BM, incontinent, loose/diarrhea, and large.- 6/25/2025 11-7 a.m. shift Resident 1 had BM, incontinent, loose/diarrhea, and large. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 6/2025, the MAR indicated Resident 1 order for Miralax 17 g 1 scoop by mouth one time a day for bowel management mix well with optimal amounts of fluid until dissolved. Hold for loose stool. The MAR indicated Resident 1 received Miralax 17 g daily from 6/13/2025 until 6/26/2025. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/17/2025, the MDS indicated Resident 1 understood and was understood. The MDS indicated Resident 1 was dependent (helper does all the effort) with oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene and required substantial to maximal assistance (the helper does more than half the effort) with eating. The MDS further indicated Resident 1 always incontinent (not being able to control when you pee or poop) with urine and bowel. During a review of Resident 1's Change in Condition (COC) Evaluation, dated 6/26/2025 at 12:56 p.m., the COC Evaluation indicated Resident 1 had weight loss of 8.9 pounds (lbs.- a unit of measurement) in one (1) week. Resident 1 verbalized she has had episodes of loose stool for four (4) days, Miralax routine changed to as needed. During a review of Resident 1's COC Evaluation dated 6/28/2025 at 1:12 p.m., the COC Evaluation indicated Resident 1 called 911 on self. Resident 1 on monitoring for loose stool, Resident 1 had scheduled transportation to General Acute Care Hospital (GACH) 1, following morning at 11 a.m., Resident 1 made aware prior to night shift however resident called 911 to be treated earlier. Resident 1 transferred to GACH 2, Family Member and Medical Doctor (MD), notified at this time. During a review of Resident 1's GACH 2 Emergency Documentation dated 6/28/2025, the GACH 2 Emergency Documentation indicated Resident 1 complained of diarrhea for two days with abdominal pain, occurring about ten (10) times per day. GACH 2's medical decision making indicated Resident 1 diagnosed with infectious colitis. During an interview on 7/14/2025 at 11:45 a.m. with Resident 1, Resident 1 stated she called 911 herself because she (Resident 1) had diarrhea for more than 7 days. Resident 1 stated she was told she had some type of infection in the hospital. During a concurrent interview and record review of Resident 1's MAR for June 2025 and Bowel Continence for 6/2025, on 7/15/2025 at 10:23 a.m. with the Director of Nursing (DON), the DON stated when nurses need to know if residents had a bowel movement it is endorsed during the change of shift, and by the CNAs if the residents have had any loose BMs. The DON stated Resident 1 is alert and the nurse could ask Resident 1 if she had diarrhea or loose stool prior to administering the medication Miralax. The DON stated it is the nurses' job to communicate with the residents to find out if the resident has had a bowel movement or not. The DON reviewed Resident 1's MAR and Bowel Continence for 6/2025, the DON stated Resident 1 was administered Miralax even though she did have loose and or diarrhea, Miralax should not have been given. The DON stated Resident 1 will continue to have loose stool and diarrhea, can lead to colitis, could lead to electrolytes being imbalanced. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed on 4/24/2025, the P&P indicated medications are administered in a safe and</p>		