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	08/07/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to report an allegation of an employee-to-resident abuse within two hours to the State Survey Agency (SSA- the agency that inspects long-term care facilities for the purposes of survey and certification), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and local law enforcement (police) as per its policies on abuse for one of three sampled residents (Resident 1).This failure had the potential to place Resident 1 at risk for further abuse.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 8/11/2023, with diagnoses including Parkinson Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition characterized by weakness on one side of the body, affecting the arm, leg, hand, and or face) following cerebral infarction (a condition where brain tissue dies due to a lack of blood supply). During a review of Resident 1's Situation Background Assessment Recommendation (SBAR, technique that provides a framework for communication between members of the health care team about a resident's condition) Communication Form, dated 4/11/2025, the SBAR indicated on 4/11/2025, at 9:40 p.m., Resident 1 reported to Licensed Vocational Nurse 3 (LVN 3) that he (Resident 1) was being hit by Certified Nursing Assistant 2 (CNA 2). The SBAR indicated LVN 3 notified Registered Nurse 2 (RN 2) and the physician, and the physician ordered to monitor Resident 1 and to have two staff present when providing care.During a review of Resident 1's Progress Notes, dated 4/11/2025, the Progress Notes indicated RN 2 assessed Resident 1 after Resident 1 claimed that CNA 2 hit Resident 1. The Progress Notes indicated no pain, no new wounds or discoloration, and vital signs (including body temperature, heart rate, breathing rate, and blood pressure. These measurements help assess overall health and can indicate potential health issues) was stable.During a review of Resident 1's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 6/24/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/30/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required maximum assistance from staff for toileting, showering and dressing. During an interview on 8/7/2025, at 1:29 p.m., with the Director of Nursing (DON), the DON stated Resident 1's allegation that he (Resident 1) was hit by CNA 2 was not reported to SSA, Ombudsman and police.During an interview on 8/7/2025, at 2:11 p.m., with the Administrator (ADM), the ADM stated he (ADM) started as ADM in the facility on 4/11/2025 and was not informed of Resident 1's allegation. The ADM stated if Resident 1 claimed something occurred then it is reportable. The ADM stated allegation of hitting is an allegation of abuse and needed to be reported to SSA, Ombudsman and police. The ADM stated if allegation of abuse was not reported to SSA, Ombudsman and police, Resident 1 could be exposed to further potential abuse.During an interview on 8/7/2025, at 2:39 p.m., with the Assistant to the Administrator (AADM), the AADM stated the facility had two hours to report allegation of abuse to SSA, Ombudsman and police. The AADM stated if he (AADM) was informed he (AADM) would report it within two hours.During a concurrent interview, and record review with the ADM, facility's policy and procedure (P&P), titled, Abuse, Neglect (failing to properly care for someone or something, leading to potential harm), Exploitation (the action or fact of treating someone unfairly) or Misappropriation-Reporting and Investigating, undated and last reviewed on 4/24/2025, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following person or agencies:A. State licensing/certification agency responsible for surveying/licensing the facility.B. The local or state OmbudsmanC. The resident representative.D. Adult Protective ServiceE. Law enforcement officialsF. The resident attending physicianG. The facility's medical director.Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. The ADM stated the facility's policy was to report allegations if it involves abuse within two hours and if

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide an ongoing activity program that is resident-centered for one of three sampled residents (Resident 2).This failure had the potential to affect the Resident 2's sense of self-worth and psychosocial (the interaction between an individual's mental and emotional state [psychological] and their social environment) well-being.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 3/14/2012, with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).During a review of Resident 2's Care Plan, dated 8/27/2024, about Resident 2's risk for social isolation (a state of reduced social interaction and contact with others, often leading to feelings of loneliness and disconnection) due to decreased mobility and inability to verbalize needs, wants and preferences, the Care Plan indicated the following intervention1. assist with in-room activities such as nail grooming, aroma therapy, lotion rub, sensory and religious music.2. Room visits one on one (a direct encounter between two persons) for socialization.During a review of Resident 2's Physician Order, dated 11/21/2024, the Physician Order indicated Resident 2 may participate in activities as desired and/or as condition warrants.During a review of Resident 2's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 11/29/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 6/30/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent on staff for activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 2 had a urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) and was always incontinent (unable to control) for bowel. During a review of Resident 2's Activity Participation Review, dated 7/29/2025, the Activity Participation Review indicated Resident 2 was bed-bound and did not attend group activities. The Activity Participation Review indicated Resident 2 likes to have her (Resident 2)'s nails done, listens to gospel music, bible readings and aroma therapy.During a review of Resident 2's Documentation Survey Report, dated 7/2025, the Documentation Survey Report indicated 18 days of 7/2025 was left blank for one-on-one activity visit, on the following days: 7/3/2025, 7/5/2025, 7/6/2025, 7/8/2025, 7/12/2025 to 7/16/2025, 7/18/2025 to 7/20/2025, 7/22/2025, 7/24/2025, 7/26/2205 to 7/29/2025 and 7/31/2025.During a concurrent interview, and record review on 8/7/2025, at 12:38 p.m., with the Activity Director (AD), Resident 2's Documentation Survey Report dated 7/2025, was reviewed. The AD stated Documentation Survey Report is Resident 2's activity attendance. The AD stated there were multiple days that were left blank. The AD stated if left blank, it means activity was not provided. The AD stated activity should be offered at least three times weekly. The AD stated if activity was not provided Resident 2 can feel isolated.During an interview on 8/7/2025, at 12:49 p.m., with Activity Assistant (AA), AA stated activity was provided to Resident 2 five times a week and activity provided is documented in Resident 2's medical chart. AA stated the days the activity was left blank was because sometimes she (AA) gets busy with other residents and does not have time to return to her (Resident 2). AA stated sometimes she (AA) only says hi and good morning and if Resident 2 looks asleep, she (AA) moves on to the next resident.During an interview on 8/7/2025, at 1:08 p.m., with the AD, the AD stated saying hi and good morning is not an activity. The AD stated Resident 2 needed assigned and in-depth room visit. The AD stated AA should follow the activity planned for Resident 2 and document if unable. The AD stated in dept activity room visits includes:a. Lotion rubs (hand rubs)b. Music appreciationc. Visual cues (television, flowers)d. Scented synthetic flowerse. Reading stories to residentf. Talking to resident (one sided conversation)g. Bible StoriesDuring an interview on 8/7/2025, at 1:29 p.m., with the Director of Nursing (DON), the DON stated providing activity is a daily thing and should be provided to residents unless refused. The DON stated not offering and not providing activity for five consecutive days (7/12/2025 to 7/16/2025) was not good. The DON stated Resident 2's social and emotional interaction could be affected by not providing activity. The DON stated Resident 2 could develop social isolation.During a review of facility's policy and procedure (P&P), titled, Activity Programs, dated 7/24/2025, was reviewed. The P&P indicated

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure the residents received care consistent with professional standards of practice for one of three sampled residents (Resident 1) by failing to obtain a physician order for oxygen (air we breathe and is used by our bodies to produce energy) use before oxygen administration.This failure had the potential to place Resident 1 at risk of receiving more oxygen than required and could negatively impact Resident 1's well-being. Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility initially admitted Resident 1 on 8/11/2023, with diagnoses including Parkinson Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), difficulty in walking and shortness of breath.During a review of Resident 1's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 6/24/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/30/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required maximum assistance from staff for toileting, showering and dressing. During a review of Resident 1's Physician Order, dated 7/27 /2025, the Physician's Order indicated no order for oxygen use.During a review of Resident 1's Weights and Vitals Summary, dated 7/28/2025 to 8/7/2025, the Weights and Vitals Summary indicated Residen1 was on daily oxygen from 7/28/2025 to 8/7/2025.During a review of Resident 1's Care Plan on Oxygen Therapy, dated and revised on 8/5/2025, the Care Plan indicated an intervention to give medications as ordered by the physician.During a concurrent observation, and interview on 8/7/2025, at 9:13 a.m., with Resident 1 inside Resident 1's room. Observed Resident 1's oxygen at two liters per minute and the nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was not connected to Resident 1. Resident 1 stated he (Resident 1) used oxygen but just does not need it at this time.During a concurrent observation, and interview on 8/7/2025, at 9:20 a.m., with Certified Nursing Assistant 1 (CNA 1), inside Resident 1's room. CNA 1 stated Resident 1 uses oxygen but takes it off at times.During a concurrent interview, and record review on 8/7/2025, at 9:22 a.m., with the Unit Manager (UM), Resident 1's current Physician's Orders, and Weights and Vitals Summary, dated 7/27/2025, to 8/7/2025 was reviewed. The UM stated Resident 1 was in General Acute Care Hospital (GACH) from 7/23/2025, to 7/27/2025. The UM stated there were no physician orders for the use of oxygen from 7/27/2025, when Resident 1 was readmitted back to the facility.During an interview on 8/7/2025, at 10:40 a.m., with Registered Nurse 1 (RN 1), RN 1 stated use of oxygen needed a physician order. RN 1 stated nurses should have checked the physician order for oxygen use before providing oxygen to Resident 1. RN 1 stated without a physician order, nurses would not be able to know how many liters, and in what way oxygen should be delivered to Resident 1 and for how long oxygen will be used. RN 1 stated Resident 1 could experience over oxygenation (also known as oxygen toxicity, occurs when the body's tissues are exposed to excessively high levels of oxygen. While oxygen is essential for life, too much of it can become harmful and even toxic).During an interview on 8/7/2025, at 10:56 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated she (LVN 2) was the assigned nurse for Resident 1. LVN 2 stated Resident 1 was on oxygen this morning beginning of her (LVN 2) shift at 7 a.m. During a concurrent interview, and record review on 8/7/2025, at 1:29 p.m., with the Director of Nursing (DON), facility's policy and procedure (P&P), titled, Physician's Medication and Treatment Orders, dated and revised on 7/24/2025, was reviewed. The P&P indicated, Orders for medication and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Drug (medications) and biological orders must be recorded on the physician order sheet in the resident's chart. The DON stated the nurses failed to obtain a physician order for Resident 1's use of oxygen. The DON stated nurses could not administer oxygen without a physician order. The DON stated oxygen is a medication that needed a physician order before use. The DON stated Resident 1 could be overwhelmed and get agitated with the use of oxygen without a physician order.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to implement its infection control measures for one of three sampled residents (Resident 3) who was on enhanced barrier precaution (EBP-wearing a protective gown and gloves whenever you are doing close-contact care with a patient who might be carrying these germs) by failing to ensure Certified Nursing Assistant 3 (CNA 3) wore protective gown while proving care.This failure had the potential for cross contamination (unintentional transfer of bacteria or germs or other contaminants from one surface to another) of infection among residents and staff. Findings:During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 7/5/2025, with diagnoses including unspecified (unconfirmed) organism sepsis (a life-threatening blood infection), urinary tract infection (UTI- an infection in the bladder/urinary tract), and stage three pressure ulcer (Full-thickness loss of skin. Dead and black tissue may be visible) of the buttocks. During a review of Resident 3's History and Physical (H&P a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 7/8/2025, 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 7/11/2025, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 3 was dependent on staff for toileting, showering, dressing and personal hygiene.During a review of Resident 3's Physician Order, dated 8/7/2025, the Physician Order indicated enhanced barrier precaution during high contact resident care activities secondary to wound management every shift.During a review of Resident 3's Care Plan on enhanced barrier precaution, dated 8/7/2025, the Care Plan indicated an intervention to use personal protective equipment (PPE wearable equipment that is intended to protect healthcare personnel and the public from exposure to or contact with infectious agents-like gown, gloves and face-shield as indicated) during high-contact resident care activities like dressing, bathing, showering, transferring, hygiene, linen changes, brief changes, toileting assistance, device care or wound care.During a concurrent observation, and interview on 8/7/2025, at 9:02 a.m., with Licensed Vocational Nurse 4 (LVN 4), inside Resident 3's room. Observed an EBP signage posted by the door with isolation gown and gloves on an isolation organizer hanging by Resident 3's door. LVN 4 stated Resident 3 was on EBP due to pressure ulcer wounds.During a concurrent observation, and interview on 8/7/2025, at 9:38 a.m., with Certified Nursing Assistant 3 (CNA 3) inside Resident 3's room. Observed CNA 3 repositioned Resident 3's head to the left side wearing gloves. CNA 3 stated on 8/7/2025, at 7:30 a.m. she (CNA 3) had provided and changed Resident 3's incontinent brief wearing only gloves and not wearing a gown. CNA 3 stated she (CNA 3) was not aware that Resident 3 was on EBP. CNA 3 stated she (CNA 3) did not pay attention and did not see the EBP signage by Resident 3's door. CNA 3 stated Licensed Vocational Nurse 4 did not inform her (CNA 3) that Resident 3 was on EBP. CNA 3 stated if she (CNA 3) was informed she (CNA 3) would use gloves and gown when providing care for residents on EBP.During an interview on 8/7/2025, at 10:15 a.m. with the Treatment Nurse (TN), the TN stated Resident 3 had stage four (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) sacral wound and right heel necrotic (dead or dying tissue) wound. The TN stated Resident 3 was on EBP and staff providing care should wear gowns and gloves.During an interview on 8/7/2025, at 11:08 a.m., with Infection Preventionist 2 (IP 2), IP 2 stated residents with indwelling catheter (a tube inserted into the bladder to drain urine) or with chronic (persisting for a long time or constantly recurring) wounds that needed dressing change are on EBP. IP 2 stated the facility posted the EBP signage on the resident's door and an orange circle sticker by resident's name to remind staff that resident is on EBP. IP 2 stated CNA 3 should have worn the gloves and gown when providing incontinent care to prevent transmission of infection.During an interview on 8/7/2025, at 12:08 p.m., with the Director of Staff Development (DSD), the DSD stated CNA 3 should be aware of who was on EBP to prevent spread of infection.During an interview on 8/7/2025, at 1:29 p.m., with the Director of Nursing (DON), the DON stated CNA 3 should wear a gown and gloves when providing direct care like changing incontinent brief to prevent spread of infection.During a review of facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 2001, and last reviewed on 4/24/2025, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDRO- a germ that is resistant to many antibiotics) to residents 2. Enhanced barrier precautions apply when: b. A resident is not known to