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	09/05/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 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 dignity for one of nine sample resident (Resident 7) by failing to ensure that the staff (Licensed Vocational Nurse 5) address Resident 7 by name and not being called honey and to ensure four staff (three Certified Nursing Assistants and 1 Occupational Therapist) were talking in English all the time in the hallways. These deficient practices had the potential to affect residents' sense of self-worth and self-esteem. A. During a review of Resident 7's admission Record, the admission Record indicated the facility admitted Resident 7 on 9/3/2025 with diagnoses of hypertension (high blood pressure) and difficulty of walking. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 9/9/2025, the MDS indicated Resident 7 had intact 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 an observation on 9/4/2025 at 10 a.m. outside Resident 7's room, observed and heard that Licensed Vocational Nurse (LVN) 5 called Resident 7 honey when Resident 7 was asking for his medication. During a concurrent observation and interview on 9/4/2025 at 10:05 a.m., observed and heard LVN 5 called Resident 7 honey again. LVN 5 stated LVN 5 did call Resident 7 honey, and his name is Resident 7 not honey when ask what LVN 7 called Resident 7. During an interview on 9/4/2025 at 10:35 a.m. with LVN 5, LVN 5 stated that LVN 5 should not call nicknames to any residents unless it was care planned and resident's preference. LVN 5 stated Resident 7 might not like it and may feel disrespected. During an interview on 9/5/2025 at 1:30 p.m. with the Director of Nursing (DON), the DON stated that LVN 5 should not call Resident 7 honey because that was a dignity issue and all the staff needs to respect residents by always addressing them by their names. During a review of the facility policy and procedure titled, Dignity, last review date of 4/24/2025, the policy and procedure indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. B. During a concurrent observation and interview on 9/5/2025 at 2:47 p.m. with Certified Nursing Assistant (CNA) 6, observed in the hallway outside residents' room that CNA 6 was talking to a staff member walking in the hallway in a different dialect. CNA 6 stated that she responded to the staff with her own dialect because the staff was talking to CNA 6 in their own dialect. CNA 6 stated that CNA 6 should always talk in English all the time because not all the residents can speak their dialect. CNA 6 stated they do not want the residents to feel that staff are talking about them. During a concurrent observation and interview on 9/5/2025 at 2:50 p.m. with CNA 7 and CNA 8 in the hallway outside residents' room, observed CNA 7 and CNA 8 talking in their own dialect while CNA 7 was charting outside residents' room. CNA 8 stated they should not talk in the hallway with our dialect because not all the resident speaks their dialect and they do not want them (residents) to feel that staff were talking about them.During an interview on 9/5/2025 at 1:30 p.m. with the DON, the DON stated the staff should talk in English all the time when around residents' area as a courtesy and respect to the residents.During a review of the facility's policy and procedure titled, Courtesy, last review date of 4/24/2025, the policy and procedure indicated, Communication courtesy is required at all times. Establish and follow first language communication policy to follow at all times.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a nasal spray (delivers a fine mist of medicine directly into your nose) was not left at a resident's bedside table and the resident was assessed for self-administration of medication for one of three sampled residents (Resident 5). This deficient practice had the potential to place the other residents at risk to misuse the medication.Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility admitted Resident 5 on 8/22/2025 with diagnoses including diabetes mellitus (a chronic condition where the body has trouble regulating blood sugar (glucose) levels) and hypertension (high blood pressure).During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 8/28/2025, the MDS indicated Resident 5's thought process was intact and required supervision from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a concurrent observation and interview on 9/3/2025 at 12:40 p.m. with Resident 5 inside Resident 5's room, observed a bottle of nasal spray on the top of Resident 5's bedside table. Resident 5 stated she last used it this morning and Resident 5's daughters were the ones who brought the medication to her for her nose.During a concurrent observation and interview on 9/3/2025 at 12:45 p.m. with Certified Nursing Assistant (CNA) 10, CNA 10 stated that a bottle of nasal spray was on top of Resident 5's bedside table.During a concurrent observation and interview on 9/3/2025 at 12:59 p.m. with License Vocational Nurse (LVN) 4, observed a bottle of nasal spray on top of Resident 5's bedside table. LVN 4 stated that she was not aware that Resident 5 had a bottle of nasal spray at the bedside table. LVN 4 stated that Resident 5 should not keep a medication at bedside table because other residents could take it and it is possible for other residents to have an adverse reaction that could lead to death from the medication.During an interview on 9/5/2025 at 1:30 p.m. with the Director of Nursing (DON). The DON stated that it was important the Resident 5 must be assessed first before allowing Resident 5 to self-administer her own medication. The DON stated there is a potential it could cause an accident because other residents could access the medication from Resident 5's bedside table. The DON stated the medication must be stored in a secure location.During a review of the facility's policy and procedure titled, Self- Administration of Medications, last review date of 4/29/2025, the policy and procedure indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Self- administered medications are stored in a safe and secure place, which is not accessible by other residents.

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer an antibiotic as ordered by the physician for one of three sample residents (Resident 1). This deficient practice had the potential for Resident 1's health condition to be untreated that can lead to physical harm. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility initially admitted Resident 1 on 2/12/2025 and readmitted on [DATE] with diagnoses including an encounter for attention to gastrostomy (a surgically created opening into the stomach) and chronic obstructive pulmonary disease (a permanent lung condition that makes it progressively harder to breathe because airways and air sacs in the lungs are damaged and narrowed). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 8/21/2025, the MDS indicated Resident 1 was severely impaired with thought process and required dependent 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 General Acute Care Hospital (GACH) Discharge Summary Order, dated 8/27/2025, the GACH Discharge Summary Order indicated Resident 1 to start taking fluconazole (a medication that treats infections caused by fungus or yeast) 200 milligrams (mg - metric unit of weight) 1 tablet daily for seven days. During a review of Resident 1's Order Summary, with order date of 8/28/2025, the Order Summary indicated to give one tablet of fluconazole 200 mg one time a day for sepsis (when your body has an extreme, life-threatening reaction to an infection that causes widespread inflammation and can lead to organs failing) for seven days, with indicated start date of 8/29/2025. During a review of Resident 1's Nursing Admission/readmission Evaluation/Assessment, dated 8/28/2025 at 9 a.m., the Nursing Admission/readmission Evaluation/Assessment indicated that Resident 1 was transferred to the facility via ambulance from GACH 1. During a review of Resident 1's Situation Background Appearance Review (SBAR) Communication Form, dated 8/28/2025 at 4 p.m., the SBAR Communication Form indicated at 4:30 p.m. Resident 1 was noted with blood pressure of 210/99 millimeter of Mercury (mmHg - unit of measurement) and pulse rate of 99 and Resident 1 was sent out to GACH 1 via ambulance after calling 911 (the number to call for emergency services) at 4:36 p.m. for further evaluation. During a concurrent interview and record review on 9/4/2025 at 1:55 p.m. with Registered Nurse (RN) 1, Resident 1's Nursing Admission/readmission Evaluation/Assessment, dated 8/28/2025, Medication Administration Record dated 8/2025, GACH Discharge summary dated [DATE], and Order Summary dated 8/28/2025 were reviewed. RN 1 stated Resident 1 got readmitted in the facility on 8/28/2025 at 9 a.m. RN 1 stated that Resident 1 did not receive fluconazole on 8/28/2025. RN 1 stated that the GACH Discharge Summary indicated to give fluconazole 200 mg one tablet daily for seven days. RN 1 stated that Order Summary dated 8/28/2025 to give one tablet of fluconazole 200 mg one time a day for Sepsis for seven days, indicated a start date of 8/29/2025. RN 1 stated that fluconazole antibiotic order must be given and carried out within four hours after receiving the order and should not start the next day due to the possibility that Resident 1's condition could decline, and Resident 1's sepsis could recur and could make Resident 1's condition worst. During a concurrent interview and record review on 9/5/2025 at 12:04 p.m. with RN 2, Resident 1's fluconazole order dated 8/28/2025 and Discharge Documentation dated 8/27/2025 were reviewed. RN 2 stated RN 2 was the one who carried out the Fluconazole order with a start date of 8/29/2025 at 9 a.m. under the assumption that the first dose was given from the hospital. During a concurrent interview and record review on 9/5/2025 at 12:31 p.m. with RN 2 and the Director of Nursing (DON), Resident 1's GACH Discharge summary dated [DATE] was reviewed. The DON stated that the antibiotic fluconazole can be started the next day if the staff received an endorsement from GACH that the first dose was already given from GACH 1. During a concurrent interview and record review on 9/5/2025 at 1 p.m. with RN 1, RN 2 and the Director of Nursing (DON), Resident 1's GACH Discharge summary dated [DATE] was reviewed. RN 1 stated that GACH 1 did not give any report and Resident 1 just showed up in the facility with Resident 1's admission packet. RN 1 stated she (RN 1) just depended on the discharge packet given by GACH 1. RN 1 stated that antibiotic order must be carried out within four hours after receiving the order since the antibiotic was available in an emergency kit. RN 2 stated that the antibiotic of Resident 1 must be given and carried out within four to six hours. RN 1 stated Resident 1 stayed in the facility for eight hours before discharging back to GACH 1. RN 2 stated that the facility failed to follow the physician's order due to miscommunication, failure to clarify the order from GACH 1 if first dose of antibiotic was already given. During an interview on 9/5/2025 at 1:30 p.m.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review, the facility failed to ensure that one of nine sample resident's (Resident 2) call light was working properly.This deficient practice had the potential to place Resident 2 at risk for an accident like a fall due to not being able to call for help/assistance.Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 8/26/2025 with a diagnosis of hypertension (high blood pressure) and history of falling.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 9/1/2025, the MDS indicated Resident 2 had intact 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 concurrent observation and interview on 9/3/2025 at 11:40 a.m. with Resident 2 inside Resident 2's room, Resident 2 stated that her call light was not working since she got admitted and was using her roommate's call light for Resident 2 to call for help. Resident 2 demonstrated to use her call light and observed that after pressing the call light button the call light was not turning on outside Resident 2's room.During a concurrent observation and interview on 9/3/2025 at 11:47 a.m. with License Vocational Nurse (LVN) 1, observed LVN 1 tried to use Resident 2's call light and observed that the light was not turning on. LVN 1 stated that Resident 2's call light did not turn on outside Resident 2's room. LVN 1 stated that it was important that the call light was working all the time to be able to attend to Resident 2's needs right away and if not, there was a risk of Resident 2's decline that could lead to injury. During an interview on 9/5/2025 at 1:30 p.m. with the Director of Nursing (DON), the DON stated that it was important that the call light was working all the time and this could potentially have a lapse in communication between staff and residents. The DON stated that the staff might not be able to meet the residents' needs immediately.During a review of the facility policy and procedure titled, Call System, Resident, last review date of 4/29/2025, the policy and procedure indicated, The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. The resident call system is routinely maintained and tested by maintenance department.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a written authorization or approval from the Department of Healthcare Access and Information (HCAI, previously known as the Office of Statewide Health Planning and Development of OSHPD) prior to the use of portable air-conditioning (AC- a machine that forces cool air into a building) unit. HCAI is the state agency that reviews and approves plans for construction, repairs, renovations, and remodeling made in healthcare facilities to comply with State Building Codes. In addition, the facility failed to notify the Department (Licensing/Certification), within five days of the commencement of any construction/alterations to the skilled nursing facility.This deficient practice placed residents at risk for any safety issues related to the unauthorized use of the portable AC unit. Findings: During an observation on 9/4/2025, at 10:18 a.m., observed room [ROOM NUMBER] with a portable air conditioner (AC) unit actively operating. Observed the portable AC units' ducts (tubes or pipes that carry air in and out of the building) going through the window to the exterior of the building. During a concurrent observation and interview on 9/4/2025 at 10:20 a.m., with Maintenance Assistant (MA), in room [ROOM NUMBER], the MA stated there was a portable AC unit installed with vent attached to the wall secured to window paneling with duct tape.During an interview on 9/4/2025 at 10:28 a.m. with Maintenance Supervisor (MS), the MS stated that per Administrator there was no permit from HCAI, and the Heating, Ventilation, and Air Conditioning (HVAC - refers to the integrated system of equipment that controls the temperature and quality of air within a building) was installed temporarily due to the hot weather. The MS stated that there were 9 units of HVACs in the whole building. The MS stated that the facility did not have any problem with the AC but was just blowing low air and they will just need to check the duct. The MA stated that there was only one portable AC installed in the whole facility. The MA also stated that the AC of the facility was working and has no problem. The MA stated the portable AC was installed due to resident request. During an interview on 9/4/2025 at 12:07 p.m., with the Administrator and Operation Assistant 1, the Administrator stated that HVAC had no permit from HCAI and did not contact HCAI. The Administrator stated he did not know what HCAI was and who was HCAI. The Administrator stated that the facility started using the HVAC on 4/22/2025 after receiving the heat advisory. During an interview on 9/4/2025 at 2:57 p.m., the Administrator stated that around 12 p.m. he contacted HCAI and spoke to HCAI Staff 1 who informed him (Administrator) that if the HVAC was only in a temporary use the facility does not need a HVAC permit from HCAI. The Administrator stated there was no documented evidence that HCAI stated that the facility does not permit HVAC use due to temporary use only of the HVAC.During a review of a facility-provided policy and procedure titled, Use of Portable HVACS, last revised on 4/24/2025, indicated potable HVAC systems should only be considered during power outages as outlined in the emergency preparedness plan or extreme weather conditions.During a review of a facility-provided policy and procedure titled, Maintenance Service, last revised on 4/24/2025, indicated maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned.