

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/24/2025
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe, clean, homelike environment for two of four sampled residents (Residents 7 and 8) by:1. Failing to ensure Resident 7's room was free of leaking ceiling (from rainwater).2. Failing to ensure Resident 8's room had a comfortable room temperature.These failures had the potential for unsafe and unclean environment with the potential to place Residents 7 and 8 at risk for physical discomfort.Findings:a. During a review of Resident 7's admission Record, the admission Record indicated the facility admitted Resident 7 on 11/12/2025, with diagnoses that included left tibia (shin bone. It's the second longest bone in your body, and it is an important part of your ability to stand and move) displaced fracture (the pieces of your bone moved so much that a gap formed around the fracture when your bone broke), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities).During a review of Resident 7'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 11/12/2025, the H&P indicated Resident 7 was confused, with minimal communication but does follow commands.During a review of Resident 7's Care Plan, dated 11/12/2025, regarding the risk of fall and pain, the Care Plan indicated an intervention to modify environment as needed to meet current needs:- Non-slip surface for bath/shower,- Floors that are even and free from spills and clutter,During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 7's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.During an observation on 11/21/2025, at 11:16 a.m., inside Resident 7's room, Resident 7 lying in bed close to the door. Observed an open yellow container with a blanket spread on the floor underneath the yellow container. The yellow container was placed beside the window under an open part of the ceiling with visible drops of rainwater. In the middle of the room a towel was spread on the floor and a light gray trash bin was placed on top of the towel and a bulging ceiling paint was observed on the ceiling directly above the light gray trash bin. During a concurrent observation, and interview on 11/21/2025, at 11:18 a.m., with Licensed Vocational Nurse 2 (LVN 2), inside Resident 7's room. LVN 2 stated there was a leak in the ceiling by the window of Resident 9's bed and by the foot of Resident 10's bed. LVN 2 stated there was a visible drop of water from the ceiling of Resident 7's room. LVN 2 stated both Resident 9 and Resident 10 were moved out of the room.During an interview on 11/21/2025, at 11:55 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 7 was left in a room with a leaking ceiling and had no plan of moving her (Resident 7) out of the room yet. CNA 1 stated Resident 7's room temperature could drop and get cold because of the leaking ceiling especially at night.During an interview on 11/21/2025, at 12:02 p.m., with LVN 2, LVN 2 stated leaking ceiling could potentially affect Resident 7's convenience, and safety because room temperature could be cold.During an interview on 11/21/2025, at 12:18 p.m., with LVN 3, LVN 3 stated leaking ceiling in a resident's room could result to mold (organisms that can grow virtually anywhere, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056039
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	both in homes and outdoors) and if the ceiling gets soft from the water damage, ceiling could fall onto Resident 7. LVN 3 stated all residents including Resident 7 should be moved out of the room with leaking ceiling. During an interview on 11/21/2025, at 12:22 p.m., with the Maintenance Supervisor (MS), the MS stated he (MS) was not aware of a leak in the ceiling of Resident 7's room. The MS stated if he (MS) was informed, he (MS) would have move all residents out of Resident 7's room, open the ceiling, patch it dry, inspect if there were any molds, use a fan and a humidifier (a device for keeping the atmosphere moist in a room to help reduce the spread of viruses and promote other potential health benefits) for half a day or the whole day. During an interview on 11/21/2025, at 12:45 p.m., with Maintenance 2 (M 2), M 2 stated today 11/21/2025, at 6:30 a.m., Registered Nurse 1 (RN 1) reported that Resident 7's room had a leak. M 2 stated all residents should have been moved out of Resident 7's room. During an interview on 11/21/2025, at 1:32 p.m. with the MS, the MS stated the facility did not have a policy for leaking ceiling and comfortable room temperature. b. During a review of Resident 8's admission Record, the admission Record indicated the facility admitted Resident 8 on 5/7/2024, with diagnoses that included metabolic encephalopathy (a change in how your brain works due to an underlying condition), unspecified anxiety disorder (a feeling of unease, worry, or apprehension) and essential hypertension (occurs when you have abnormally high blood pressure that's not the result of a medical condition). During a review of Resident 8's Care Plan, dated 6/11/2025, regarding room temperature preference, the Care Plan indicated an intervention to ensure comfortable and safe environment. During a review of Resident 8's H&P, dated 10/10/2025, the H&P indicated Resident 8 had fluctuating capacity to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognitive skills for daily decisions were intact. The MDS indicated Resident 8 required moderate assistance from staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily). During an observation, and interview on 11/21/2025, at 11:25 a.m., with Resident 8, at Resident 8's doorway. Observed Resident 8 had a white sheet covering her chest, down to her (Resident 8) toes. Resident 8 was calling for assistance and asking for a blanket. Resident 8 asked the Surveyor to come inside her (Resident 8) room. Resident 8 stated the room was too cold and Resident 8 requested a blanket from the Surveyor. During an observation, and interview on 11/21/2025, at 11:32 a.m., with the MS, at Resident 8's doorway. MS checked Resident 8's room temperature using a thermometer scanner (device that measures the temperature) and the thermometer scanner showed 64 degrees Fahrenheit. The MS stated room temperature should be between 72 degrees to 77 degrees Fahrenheit. During an interview on 11/21/2025, at 12:18 p.m., with LVN 3. LVN 3 stated cold room temperature could start Resident 8's cough, colds (an illness affecting your nose and throat) or arthritis (a disease that causes damage in your joints) pain. During an interview on 11/21/2025, at 4:12 p.m., with the Director of Nursing (DON), the DON stated the best room temperature for residents' comfort should be between 71 to 81 degrees Fahrenheit. The DON stated 64 degrees was too cold for Resident 8. The DON stated cold room temperature could affect Resident 8's vital signs (blood pressure, temperature, respiratory rate and heart rate) and could be uncomfortable for Resident 8. During a concurrent interview, and record review on 11/24/2025, at 11:09 a.m., with the DON, facility's policy and procedure (P&P), titled, Homelike Environment, dated 2001, and last reviewed on 7/24/2025, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment; b. comfortable (minimum glare) yet adequate (suitable to the task) lighting; c. inviting colors and decor; d. personalized furniture and room arrangements; e. clean bed and bath linens that are in good condition; f. pleasant, neutral scents; g. plants and flowers, where appropriate; h. comfortable and safe temperatures; [NAME]. comfortable sound levels. The DON stated homelike (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environment means room was clean and organized. The DON stated the facility's P&P indicated to have a safe, clean, and comfortable environment. The DON stated Resident 7's leaking room with containers was not a homelike environment. The DON stated Resident 8's room being too cold was also not a homelike environment. The DON stated the facility P&P was not followed.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 7) by failing to develop a person-centered care plan to address Resident 7's safety secondary to refusal of room change while Resident 7's room had a leaking ceiling from rainwater. This failure had the potential for delays in the delivery of necessary care and services to Resident 7 and placed Resident 7's safety at risk. Findings: During a review of Resident 7's admission Record, the admission Record indicated the facility admitted Resident 7 on 11/12/2025, with diagnoses that included left tibia (shin bone. It's the second longest bone in your body, and it's an important part of your ability to stand and move) displaced fracture (the pieces of your bone moved so much that a gap formed around the fracture when your bone broke), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities). During a review of Resident 7'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 11/12/2025, the H&P indicated Resident 7 was confused, with minimal communication but does follow commands. During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 7's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During an observation on 11/21/2025, at 11:16 a.m., inside Resident 7's room, Resident 7 lying in bed close to the door. Observed an open yellow container with a blanket spread on the floor underneath the yellow container. The yellow container was placed beside the window under an open part of the ceiling with visible drops of water. In the middle of the room a towel was spread on the floor and a light gray trash bin was placed on top of the towel and a bulging ceiling paint was observed on the ceiling directly above the light gray trash bin. During a concurrent observation, and interview on 11/21/2025, at 11:18 a.m., with Licensed Vocational Nurse 2 (LVN 2), inside Resident 7's room. LVN 2 stated there was a leak in the ceiling by the window of Resident 9's bed and by the foot of Resident 10's bed. LVN 2 stated there was a visible drop of water from the ceiling of Resident 7's room. LVN 2 stated both Resident 9 and Resident 10 were moved out of the room. During an interview on 11/21/2025, at 12:02 p.m., with LVN 2, LVN 2 stated leaking ceiling could potentially affect Resident 7's convenience and safety because room temperature could be cold. During an interview on 11/21/2025, at 12:18 p.m., with LVN 3, LVN 3 stated leaking ceiling in a resident's room could result to mold (organisms that can grow virtually anywhere, both in homes and outdoors) and if the ceiling gets soft from the water damage, ceiling could fall onto Resident 7. During an interview on 11/21/2025, at 12:22 p.m., with the Maintenance Supervisor (MS), the MS stated he (MS) was not aware of a leak in the ceiling of Resident 7's room. The MS stated if he (MS) was informed, he (MS) would have move all residents out of Resident 7's room, open the ceiling, patch it dry, inspect if there were any molds, use a fan and a humidifier (a device for keeping the atmosphere moist in a room to help reduce the spread of viruses and promote other potential health benefits) for half a day or the whole day. During an interview on 11/21/2025, at 3:30 p.m., with Registered Nurse 1 (RN 1), RN 1 stated she (RN 1) did not develop a care plan to address Resident 7's safety after refusing room change. RN 1 stated there should be a care plan with intervention like monitoring Resident 7 in her (Resident 7) room every shift to check for her (Resident 7) safety in a room that had a leaking ceiling. RN 1 stated it was still raining outside and leak in the ceiling could still be possible. During a concurrent interview, and record review on 11/21/2025, at 3:43 p.m., with the Minimum Data Set Nurse Assistant (MDSA), Resident 7's Care Plan dated 11/21/2025, regarding refusal of care was reviewed. The Care Plan indicated the following interventions:-encourage active participation of (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care-Inform of risks and ramifications (a consequence of an action or event) of continued noncompliance.- Monitor the effectiveness of safety equipment.MDSA stated the care plan was generalized and did not indicate hourly rounding to check and observe for the progression of leaks if improving or not and to check if Resident 7 was safe and feels safe inside the room. MDSA stated the care plan should be individualized to address resident safety inside a room that had a leaking ceiling.During an interview on 11/21/2025, at 4:12 p.m., with the Director of Nursing (DON), the DON stated Resident 7's Care Plan should be person centered or individualized to address her (Resident 7) safety inside the room that had a leaking ceiling.During a concurrent interview, and record review on 11/24/2025, at 11:09 a.m., with the DON, facility's policy and procedure (P&P), titled, Homelike Environment dated 2001, and last reviewed on 7/24/2025, the P&P indicated, Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The DON stated Resident 7's Care Plan should have an intervention that Resident 7 was being checked hourly to check for her (Resident 7) safety. The DON stated without the person-centered care plan, there might be a delay in room change and placing Resident 7's safety at risk. The DON stated the P&P for person-centered care was not followed.During a record review of facility's P&P, titled, Comprehensive Person-Centered Care Plans, dated 2001, and last reviewed on 3/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.6. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; .9. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident safety for three of six sampled residents (Resident 2, Resident 3, and Resident 4) when the ceiling of the residents' room was leaking with rainwater. The facility did not move the residents from the room with leaking rainwater. This deficient practice had the potential for Residents 2, 3, and 4 to be at risk of sustaining injury related to ceiling leaking with rainwater. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 9/25/2024 with diagnoses including hypertension (the force of your blood pushing against your artery walls is consistently too high) and anemia (a condition where your blood doesn't have healthy red blood cells). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 10/2/2025, the MDS indicated Resident 2's thought process was intact and required supervision 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 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 3/29/2024 with diagnoses including end stage renal failure (kidneys have permanently failed and cannot filter waste and extra fluid from your body) and hypertension. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was moderately impaired with thought process and required substantial assistance from staff to complete ADLs. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 8/3/2025 with diagnoses including cirrhosis (permanent scarring of the liver, a serious condition that can cause a range of symptoms from fatigue and poor appetite to more severe complications like internal bleeding, confusion, and swelling) and seizures (a sudden, uncontrolled electrical disturbance in the brain that causes temporary change in movement, sensation, aware, or behavior). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 was severely impaired with thought process and required substantial assistance from staff to complete ADLs. During an interview on 11/18/2025 at 2:52 p.m. with Resident 4's Public [NAME] (PG) 1, PG 1 stated that she (PG 1) did not receive any call from the facility to ask to do a room change for Resident 4. During an interview on 11/17/2025 at 11:35 a.m. with Resident 2, Resident 2 stated that his room's ceiling had been leaking since Saturday, and the facility was trying to fix it and put the bucket under the leak. Resident 2 stated that he and his other two roommate stayed in their room the whole time because facility staff did not move them (the residents) anywhere. Resident 2 stated that he was very careful when walking to the bathroom because he did not want to fall. During an interview on 11/17/2025 at 11:42 a.m. with License Vocational Nurse (LVN) 1, LVN 1 stated that the previous shift endorsed to her (LVN 1) that the ceiling of Resident 2, Resident 3 and Resident 4's room was leaking with rainwater and needed to be reported to maintenance. LVN 1 stated that Resident 2, Resident 3 and Resident 4 stayed in their room when the ceiling was leaking and did not do a room change. LVN 1 stated that she (LVN 1) should have changed the room for Resident 2, Resident 3 and Resident 4 due to the residents' safety at risk because of the water on the floor from the ceiling. During an interview on 11/17/2025 at 11:46 a.m. with Housekeeper (HK) 1, HK 1 stated she (HK 1) was assigned to Resident 2, Resident 3 and Resident 4's room during the weekend. HK 1 stated that the ceiling was leaking with rainwater and she placed a bucket under the dripping water. During an interview on 11/19/2025 at 9:44 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that residents (Residents 2, 3, and 4) could fall if the floor was wet and it can possibly cause an accident for the residents. During an interview on 11/24/2025 at 1:20 p.m. with the Director of Nursing (DON), the DON stated that the facility did not provide proper care or meet the residents' (Residents 2, 3, and 4) needs by not changing their room when the ceiling was leaking with rainwater. This failure meant residents were not comfortable or safe in their rooms. During a review of the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility policy and procedure titled, Homelike Environment, last review date of 11/6/2025, the policy and procedure indicated, Residents are provided with a safe, clean, comfortable and homelike environment The facility staff and management maximize to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: A. Follow its policy and procedure titled, Infection Prevention and Control Program, last reviewed on 11/6/2025, for one of three sampled residents (Resident 1) by failing to: 1. Ensure that the third-party's (an external company or individual specializing in air and water safety to the facility) recommendations indicated in the Annual Analytical Validation Viable Legionella Bacteria Report (a document that confirms the effectiveness of a facility's Water Management Program [ongoing plan to control and minimize hazards in building water systems primarily to prevent growth of harmful bacteria such as Legionella bacteria {naturally found in [NAME], but becomes a health risk when they grow in man-made water systems and the contaminated water is aerosolized - tiny particles suspended in the air, leading to inhalation and causing lung illness}, ensure water safety by identifying risks, assess water systems and implement control measures] in controlling Legionella growth), dated 2/26/2024, 12/9/2024, 1/24/2025, 2/19/2025, and 3/17/2025 were reviewed and followed. These reports indicated that Legionella bacteria were found in the facility's water system since 2/26/2024; however, the facility failed to act on the findings and failed to implement the recommendations outlined in the report. 2. Ensure the facility's Water Management Program Water Safety Plan (a comprehensive risk assessment and risk management approach that encompasses all steps in a drinking-water supply chain to identify hazardous conditions and outline steps to minimize the health impact of waterborne pathogens [some bodies of water have microorganisms called pathogens that can cause residents to get sick]) was reviewed and followed when Legionella bacteria were detected (identify the presence or existence of) at the facility since 2/26/2024. 3. Ensure the Infection Preventionist Nurse (IP Nurse) carried out her (IP Nurse) duties and responsibilities by coordinating and overseeing the facility's Infection Prevention and Control Program (IPCP - refers to evidence-based practices and procedures that, when applied consistently in health care settings, can prevent or reduce the risk of transmission of microorganisms to residents and health workers) in relation to the Legionella bacteria detected at the facility since 2/26/2024. 4. Ensure the facility identified the areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria (caused by pathogenic microbes {microorganisms that can cause disease in humans} spread via contaminated water). 5. Ensure a communication process was in place for the previous Administrator (Administrator 2) to inform the current Administrator (Administrator 1) of the Legionella bacteria detected at the facility since 2/26/2024 when Administrator 1 took over and started working at the facility on 4/2025. B. Report to the California Department of Public Health (CDPH) that the facility's water system was positive for Legionella bacteria since 2/26/2024. These deficient practices resulted in Resident 1 having a Change in Condition (a major decline in a resident's health status) on 10/25/2025 at 7:37 a.m., including altered mental status (a change in mental function), fever (abnormally high body temperature), shortness of breath, and was found unresponsive (does not respond to activity, touch, sound, or other stimulation). The paramedics (individuals trained to provide emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) arrived at the facility on 10/25/2025 at 7:45 a.m. and transferred Resident 1 to the General Acute Care Hospital (GACH) where Resident 1 underwent a Legionella pneumoniae sputum procedure (a diagnostic test in which a sample of sputum [thick, sticky substance from the lungs] is collected and analyze in a laboratory for the presence of Legionella bacteria) on 10/25/2025 at 10:46 a.m., which detected Legionella bacteria. Resident 1 subsequently died at the GACH on 10/31/2025 (specific time not indicated). Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 2/12/2025 and readmitted in the facility on 10/2/2025 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease that causes air to become trapped in the lungs, making it hard to breathe) and type two (2) diabetes (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	mellitus (DM - a condition where the body does not use insulin [a hormone that regulates blood sugar by helping sugar from food move from the bloodstream into the body's cells for energy] properly to get energy from the food eaten). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/8/2025, the MDS indicated that Resident 1 was severely impaired (having significant limitations) in thought processes and required dependent assistance (resident requires total physical or mechanical help) 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 Change in Condition (CIC - major decline in a resident's health status that will not resolve without interventions) Form, dated 10/25/2025, the CIC indicated that Resident 1 was noted with altered mental status (change in mental function), fever, shortness of breath, and was unresponsive. The CIC further indicated that the paramedics arrived on 10/25/2025 at 7:45 a.m. and transferred Resident 1 to the GACH. During a review of Resident 1's Physician's Order, dated 10/25/2025, timed at 7:59 a.m., the Physician's Order indicated to transfer Resident 1 to GACH for further evaluation. During a review of Resident 1's Care Plan Report (a structured and individualized approach that helps clinicians provide effective care for the resident), dated 10/25/2025, the Care Plan Report indicated that Resident 1 was transferred to GACH for further evaluation due to abnormal vital signs (basic measurements of the body's essential functions), altered mental status, labored breathing (breathing feels difficult, requiring extra effort), desaturation (a drop in blood oxygen levels below normal) and lethargy (a condition marked by drowsiness and an unusual lack of energy and mental alertness). During a review of Resident 1's GACH record, dated 10/25/2025, the GACH record indicated the GACH Emergency Department (a medical unit for severe, life-threatening conditions and serious injuries needed immediate care) admitted Resident 1 on 10/25/2025 at 8:05 a.m. presenting with altered mental status and being found unresponsive. The GACH record indicated that on 10/25/2025 at 10:46 a.m., Resident 1 underwent a Legionella pneumoniae sputum procedure, which indicated that Legionella bacteria were detected. During an interview on 11/13/2025 at 11:04 a.m., with Maintenance Supervisor 1 (MS 1), in the facility's water room, MS 1 stated that the facility's most recent report titled, Annual Analytical Validation Viable Legionella Bacteria, which indicated that Legionella bacteria were present in the facility's water, was dated 3/2025. MS 1 stated he (MS 1) did not have a copy of the report in his (MS 1) office, but that a copy was kept by the IP Nurse. MS 1 stated that maintenance staff (depending on who was on duty each day) had been performing daily water flushing (the process of running water through the pipes in the water system) in room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], Nurse Station 1, Nurse Station 2, Bathtub 1, and Bathtub 2 since 1/2024, based on instructions from the previous Maintenance Supervisor 2 (MS 2). MS 1 stated he (MS 1) did not change or rotate any rooms included in the water flushing routine. MS 1 stated there was no documented evidence that the facility implemented additional interventions (other than water flushing) to prevent Legionella bacteria growth, such as replacing the angle stop valves (small valves installed at the corner where a water line meets a fixture like under the sink, behind the toilet, or near the water heater), faucets, water supply hoses (used to connect faucets to the water pipes under the sink), or filters (devices that remove impurities by lowering contamination of water using a fine physical barrier). MS 1 further stated he (MS 1) did not have a copy of the facility's water flow diagram (a visual tool that shows all the water sources and system flow) and was therefore unable to determine where Legionella bacteria or other opportunistic pathogens (is an organism that normally does not harm its host but can cause disease especially when the host's resistance is low) could potentially grow. During an interview on 11/13/2025 at 11:31 a.m., with the IP Nurse, the IP Nurse stated that on 11/12/2025, Public Health Nurse 1 (PHN 1) e-mailed her (IP Nurse) indicating that the Los Angeles County Department of Public Health's Acute Communicable Disease Control Program (LACDPH-ACDC) had identified a presumptive healthcare-associated (when a resident had a continuous stay at the skilled nursing facility during the 14 days before onset of symptoms) Legionella disease case in the facility (Resident 1). During a (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Mirage Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 44445 15th St W Lancaster, CA 93534	
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F 0880 Level of Harm - Actual harm Residents Affected - Few	concurrent interview and record review on 11/13/2025 at 2:02 p.m., with the IP Nurse, the recommended actions from the Annual Analytical Validation Viable Legionella Bacteria Reports dated 2/26/2024, 12/9/2024, 1/24/2025, 2/19/2025, and 3/17/2025, and the facility's Domestic Water Flushing Log since 1/2024, were reviewed. The IP stated that all the results indicated Legionella bacteria had been found in the facility's water since 2/26/2024. The IP stated that maintenance staff handled the interventions by performing daily flushing in room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], Nurse Station 1, Nurse Station 2, Bathtub 1, and Bathtub 2 and by conducting annual (every year) water testing for Legionella bacteria. During a concurrent interview and record review on 11/13/2025 at 2:31 p.m., with the Director of Nursing (DON), IP Nurse, and MS 1, the recommended actions from the Annual Analytical Validation Viable Legionella Bacteria Reports dated 2/26/2024, 12/9/2024, 1/24/2025, 2/19/2025, and 3/17/2025, the facility's Domestic Water Flushing Log since 1/2024, and the facility's Water Management Program Water Safety Plan, dated 2025 (specific month and day not indicated) were reviewed. The IP Nurse stated that the Water Management Program Water Safety Plan indicated to Isolate the system to minimize exposure of water to patients (residents) as directed by Infection Prevention. The Water Management Program Water Safety Plan indicated to Isolate means Disabling the water supply to the fixture until remediation (act of correcting an error or a fault) has been conducted. The IP Nurse further stated that the Water Management Program Water Safety Plan indicated to resample the water for Legionella bacteria within five to 10 days after corrective actions were implemented. The DON, IP Nurse, and MS 1 stated that the facility did not follow or act on the recommendations outlined in the Annual Analytical Validation Viable Legionella Bacteria Reports dated 2/26/2024, 12/9/2024, 1/24/2025, 2/19/2025, and 3/17/2025, or in the Water Management Program Water Safety Plan, dated 2025 and that there was no documented evidence indicating these actions were implemented. During an interview on 11/13/2025 at 3:13 p.m. with Administrator 1, Administrator 1 stated that he (Administrator 1) began working at the facility at the end of 4/2025. Administrator 1 stated that MS 1 was responsible for the facility's Water Management Program. Administrator 1 stated that the water testing company (third party) had been reporting the water test results to the previous administrator (Administrator 2), which was why he (Administrator 1) was not aware of the water test results. Administrator 1 further stated that he (Administrator 1) did not contact the water testing company to inform them that he (Administrator 1) was the new administrator of the facility because no issues had been reported to him (Administrator 1). During a concurrent observation and interview on 11/19/2025 at 10:55 a.m., the facility's water system in randomly selected residents rooms (room [ROOM NUMBER] and room [ROOM NUMBER]), shower tubs (Bathtubs 3, 4, 5, and 6), Station 1 utility faucet, Station 2 utility faucet, kitchen ice machine, and the beauty shops (Beauty Shop 1 and Beauty Shop 2), was observed with LACDPH-ACDC team (ACDC MD 2, ACDC MD 3, ACDC Team Member 1, ACDC Team Member 2, ACDC Team Member 3, and ACDC Team Member 4) together with the facility's DON, IP Nurse, and Nurse Consultant. ACDC MD 2 stated that the facility's water system had a lot of faucets (number of faucets not specified) that were not in use. During an interview with ACDC MD 2 on 11/19/2025 at 12:12 p.m., ACDC MD 2 stated that he (ACDC MD 2) was concerned that the facility's water system had a lot of dead leg (a section of potable {safe to drink} water pipe which contains water that has no flow or does not circulate). During an interview on 11/19/2025 at 3:14 p.m., with the IP Nurse, the IP Nurse stated that her (IP Nurse) responsibility as an IP Nurse regarding monitoring Legionella was to assist the administration and maintenance management with any potential or suspected exposure to Legionella bacteria. The IP nurse stated that she (IP Nurse) reviews the Annual Analytical Validation Viable Legionella Bacteria reports with the team, along with the accompanying recommendations. The IP Nurse stated that she (IP Nurse) did not carry out her role in managing Legionella, and that there was no documented evidence that the facility developed or implemented a plan to address facility-specific infection control needs and requirements identified in the facility assessment and infection control risk (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	assessment. During an interview on 11/20/2025 at 11:13 a.m., with the IP Nurse, the IP Nurse stated that the facility should follow the water management recommendations until no Legionella bacteria were detected in the water. The IP Nurse stated that she (IP Nurse) was not aware that the facility's water tested positive for Legionella on 2/26/2024 and only became aware of the water test results conducted on 11/26/2024 (results and recommendations were reported by the third-party testing company to the facility on [DATE]) when Administrator 2 informed her (IP Nurse). The IP Nurse stated that she was not made aware of any water testing results after 12/9/2024. The IP Nurse stated that she (IP Nurse) did not maintain any logs indicating whether residents were being monitored for potential Legionella exposure. The IP Nurse stated that without monitoring residents and maintaining logs, the facility could not determine if residents were affected or potentially exposed to Legionella bacteria. The IP Nurse stated that monitoring residents was essential because they (residents) could develop worsening respiratory (refers to the lungs and breathing) issues, require hospitalization or die as a result of Legionella exposure. The IP Nurse stated that the facility failed to monitor residents for Legionella-related illness, failed to implement and follow the water management plan recommendations, and did not isolate residents with pneumonia (an infection in the lungs that inflames the air sacs, causing them to fill with fluid or pus [a thick, opaque (not transparent), usually yellowish-white, fluid matter that is formed as part of an inflammatory response typically associated with an infection]). The IP Nurse stated the facility did not report to CDPH that Legionella bacteria was detected at the facility's water system since 2/26/2024 to 3/17/2025. The IP Nurse stated the presence of Legionella bacteria in the facility's water system should be reported to CDPH within 24 hours due to unusual occurrence in the facility. During an interview on 11/20/2025 at 12:20 p.m., with the DON, the DON stated that the IP Nurse manages the monthly surveillance log for Legionella. The DON stated that the IP Nurse should notify the DON when the facility's water tests positive for Legionella bacteria. The DON stated that she (DON) was not aware that the 3/17/2025 water test was positive for Legionella. The DON stated that had she (DON) been aware, she (DON) would have ensured the facility implemented the recommended actions outlined in the Water Management Plan. The DON further stated that there was no documented evidence that the facility monitored the residents for Legionella exposure. The DON stated that the facility failed to ensure effective communication between incoming and outgoing administrators regarding the presence of Legionella bacteria in the water. The DON stated that this situation was preventable. The DON stated that monitoring and communication should have been the responsibility of the IP Nurse, but the IP Nurse did not carry out these duties, and proper communication did not occur. The DON stated the presence of Legionella bacteria in the facility's water system was an unusual occurrence and was not reported to CDPH. The DON stated the presence of Legionella bacteria in the facility's water system must be reported to CDPH within 24 to 48 hours as unusual occurrence according to facility's policy and procedure. During a review of the Infection Control Nurse - Job Description, undated, the job description indicated the primary purpose of the Infection Control Nurse is to plan, organize, develop, coordinate, and direct our infection control program and its activities in accordance with current federal, state, and local standards, guidelines, and regulations that govern such program, and as may be directed by the Administrator and the Infection Control Committee to ensure that an effective infection control program is maintained at all time. During a review of the facility's Domestic Water Flushing Log from 1/2024 to 3/31/2025, the log indicated that the facility performed water flushing in the following rooms:1. 1/1/2024 to 1/31/2024 - Rooms 1, 2, 3, and 4; Nurse Stations 1, and 2; Bathtubs 1 and 2. 2. 2/1/2024 to 2/28/2024 - Rooms 1, 2, 3, and 4; Nurse Stations 1, and 2; Bathtubs 1 and 2. 3. 11/1/2024 to 11/30/2024 - Rooms 1, 2, 3, and 4; Nurse Stations 1, and 2; Bathtubs 1 and 2. 4. 12/1/2024 to 12/31/2024 - Rooms 1, 2, 3, and 4; Nurse Stations 1, and 2; Bathtubs 1 and 2. 5. 1/1/2025 to 1/31/2025 - Rooms 1, 2, 3, and 4; Nurse Stations 1, and 2; Bathtubs 1 and 2. 6. 2/1/2025 to 2/28/2025 - Rooms 1, 2, 3, and 4; Nurse Stations 1, and 2; Bathtubs 1 and 2. 7. 3/1/2025 to 3/31/2025 - Rooms 1, 2, 3, and 4; Nurse Stations 1, and 2; Bathtubs 1 and 2. During a review of the (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	facility's Annual Analytical Validation Viable Legionella Bacteria Reports dated 2/26/2024, 12/9/2024, 1/24/2025, 2/19/2025, and 3/17/2025 indicated the following results: 1. First water sample: Collected on 2/14/2024; result was reported to the facility on 2/26/2024. Result: For domestic water, one (1) sample showed the presence of Legionella bacteria (room [ROOM NUMBER]). 2. Second water sample: Collected on 11/26/2024; result was reported to the facility on [DATE].Result: For domestic water, two (2) water samples showed detectable Legionella bacteria (room [ROOM NUMBER] and room [ROOM NUMBER]). 3. Third water sample: Collected on 1/15/2025; result was reported to the facility on 1/24/2025. Result: For domestic water, three (3) water samples showed detectable Legionella bacteria (room [ROOM NUMBER], Bathtub 1, and room [ROOM NUMBER]). 4. Fourth water sample: Collected on 2/11/2025; result was reported to the facility on 2/19/2025. Result: For domestic water, three (3) water samples showed detectable Legionella bacteria (room [ROOM NUMBER], Bathtub 1, and room [ROOM NUMBER]). 5. Fifth and last water sample: Collected on 3/7/2025; result was reported to the facility on 3/17/2025. Result: For domestic water, two of three water samples showed detectable Legionella bacteria (Bathtub 1 and room [ROOM NUMBER]). Further review of the facility's Annual Analytical Validation Viable Legionella Bacteria Reports dated 2/26/2024, 12/9/2024, 1/24/2025, 2/19/2025, and 3/17/2025 indicated the following Recommended Actions for water samples reported on 2/26/2024, 12/9/2024, 1/24/2025, 2/19/2025, and 3/17/2025: - It is recommended that positive fixtures (general category of devices that are installed for the intentional supply and usage of water within a building) and adjacent taps be thoroughly flushed for five minutes a day for a period of five to seven days. It is important to verify the hot water temperature reaches the target temperature. It is also recommended that the affected showerheads and associated hose lines be replaced. - It is also recommended to either replace or descale (remove built-up or incrustation {formation of a hard, thick layer or crust of deposited material on the surfaces of pipes, pumps and other system components}) and disinfect the fixtures in the affected rooms per your Management Plan Standard Operating Procedures (SOP) in Section 4. - All positive locations should be re-tested following completion of corrective actions in order to re-establish acceptable control. If additional testing continues to show the presence of Legionella bacteria, alternate control measures should be considered, including the use of permanent secondary disinfection system or routine remediation procedures. - Continue to follow all the preventative actions as part of your Water Safety Plan, including routine testing of the water systems. Additional recommended action is advised for water sample report on 11/26/2025: - Since a majority of the samples were positive, it is recommended that a chlorination process (process of adding chlorine or chlorine compounds to water to kill harmful bacteria) be implemented in conjunction with flushing of the domestic water supply, as outlined in your Water Safety Program in Section 4. Additional recommended action is advised for water sample report on 1/24/2025: - It is recommended to sample from the angle stop at next visit to rule out detection in the line. - Localized treatments such as fixture disinfections, riser disinfections refers to the practice of using disinfectants within riser pipes, which are vertical sections of plumbing that carry water between floors in a building or from the ground into a storage tank or irrigation line, and drop-leg (synonymous with a dead leg or blind end, which is a section of piping with little or no water flow where water becomes stagnant) plumbing disinfections can be very effective if the source of the contamination is indeed local. Additional recommended action is advised for water sample report on 2/19/2025: - The samples with Legionella detections may be associated with low-use areas where stagnant conditions can occur. All affected fixtures should be temporarily isolated if directed by Infection Prevention. Examples of System Isolation may consist of 1) Disabling the water supply to the fixture until remediation has been conducted, 2) Isolating the room where the fixture is located from normal use, and 3) Installation of microbiological filters (physically remove harmful microorganisms such as bacteria and particles from water using fine pore membranes (like 0.1-10 micron {or micrometer - unit of measure, symbolized as um, refers to the use of highly precise filtration systems that measure and (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	remove contaminants from water based on their extremely small size) to prevent exposure to Legionella. - Since a majority of the samples were positive, it is recommended that a chlorination process be implemented in conjunction with flushing of the domestic water supply, as outlined in your Water Safety Program in Section 4. Additional recommended action is advised for water sample report on 3/17/2025: - The samples with Legionella detections may be associated with low-use areas where stagnant conditions can occur. All affected fixtures should be temporarily isolated if directed by Infection Prevention. Examples of System Isolation may consist of 1) Disabling the water supply to the fixture until remediation has been conducted, 2) Isolating the room where the fixture is located from normal use, and 3) Installation of microbiological filters to prevent exposure to Legionella.- Since a majority of the samples were positive, it is recommended that a chlorination process be implemented in conjunction with flushing of the domestic water supply, as outlined in your Water Safety Program in Section 4. During a review of the facility-provided policy and procedure titled, Legionella Water Management Program, last reviewed on 11/6/2025, the policy indicated, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation Section: 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 5. The water management program includes the following elements: .c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: (1) Storage tanks; (2) Water heaters; (3) Filters; (4) Aerators (process by which air is circulated through, mixed with or dissolved in a liquid or other substances that act as a fluid); (5) Showerheads and hoses; (6) Misters (a device, such as a bottle, with a nozzle for spraying a mist of water), atomizers (a device for emitting water as a fine spray), air washers (recirculating water systems to force air through a spray of water to remove impurities and humidity) and humidifiers (a device for keeping the atmosphere moist in a room); (7) Hot tubs; .(9) Medical devices such as continuous positive airway pressure (CPAP) machines (machines that uses mild air pressure to keep breathing airways open while you sleep), hydrotherapy equipment (assists in creating a safe water environment in which to exercise) . d. The identification of situations that can lead to Legionella growth, such as: (1) construction; (2) water main breaks; (7) water stagnation; and(8) inadequate disinfection. e. Specific measures used to control the introduction and/or spread or Legionella (e.g. [for example], temperature, disinfectants). f. The control limits or parameters that are acceptable and that are monitored. g. A system to monitor control limits and the effectiveness of control measures. h. Documentation of the program. 6. The water management program is reviewed at least once a year, or sooner if any of the following occur: a. The control limits are consistently not met.c. There are any disease cases associated with the water system. During a review of the facility-provided policy and procedure titled, Legionella Surveillance and Detection, last reviewed on 11/6/2025, the policy and procedure indicated, Our facility is committed to the prevention, detection and control of water-borne contaminants (any physical, chemical, biological (relating to living organisms), or radiological (relating to or involving high-energy radiation) substances or matter in water, other than water molecules themselves, that can degrade water quality and pose risk to human health and environment), including Legionella. Legionnaire's disease is included as part of our infection surveillance activities. As part of the infection prevention and control program, all cases of pneumonia that are diagnosed in residents > [greater than] 48 hours after admission are investigated for possible Legionnaire's disease. Risk factors for developing Legionnaire's Disease include: c. Chronic lung disease, such as emphysema (progressive lung disease that causes shortness of breath) or COPD; . f. Underlying illness, such as diabetes, renal failure (kidney failure a condition which one or both kidneys no longer work on their own), or hepatic failure (liver is no longer to function adequately for body needs). Residents who have signs and symptoms of pneumonia may be placed on transmission-based (droplet [used to prevent transmission of infectious agents spread through respiratory]) precautions, although person-to person transmission is rare. During a review of the (continued on next page)		

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F 0880 Level of Harm - Actual harm Residents Affected - Few	facility-provided policy and procedure titled, Infection Prevention and Control Program, last reviewed on 11/6/2025, the policy and procedure indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The IPCP is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The IPCP provides a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents. Elements of the IPCP 1. Coordination and Oversight a. The IPCP is coordinated and overseen by an infection prevention specialist (infection preventionist). 2. Policies and Proceduresb. The infection prevention and control committee, medical director, director of nursing services, and other key clinical and administrative staff review the infection control policies at least annually. 3. Surveillance and reportingb. Surveillance tools are used for identifying the occurrence of infections, recording their number and frequency, .monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. During a review of the facility-provided policy and procedure titled, Unusual Occurrence Reporting, last reviewed on 11/6/2025, the policy and procedure indicated, As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as requires by current law and/or regulations such incident or as otherwise required by federal and state regulations. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.		