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	11/25/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to review and revise a comprehensive care plan (a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for one of three sampled residents (Resident 1) by failing to ensure Residents 1's care plan was revised to reflect Resident 1's skin problems. This deficient practice had the potential to delay provision of person-centered care for Residents 1.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 7/2/2025, with diagnoses including diabetes mellitus type two (DM II-a disorder characterized by difficulty in blood sugar control and poor wound healing), depression (mental health illness causing a persistent feeling of sadness, loss of interest, and can interfere with daily life), and combined systolic and diastolic heart failure (a condition where the heart's ability to both pump blood and fill with blood is impaired). During a review of Resident 1's History and Physical (H&P), dated 7/2/2025, the H&P indicated Resident 1 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 10/8/2025, the MDS indicated Resident 1 had moderately impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 was dependent (helper does all of the effort) on the facility staff for toileting hygiene, personal hygiene, showers, upper and lower body dressing. During a review of Resident 1's Change of Condition (COC -major decline or improvement in a resident's status that will not resolve without intervention) form, dated 10/10/2025, the COC form indicated Resident 1 had right abdominal skin fissure (a narrow, linear crack in the skin, which can be superficial or deep). During a review of Resident 1's Dermatology (the branch of medicine concerned with the diagnoses and treatment of skin disorders) Progress Note, dated 11/18/2025, the Progress Note indicated Resident 1 had pink, erythematous (an abnormal redness of the skin or mucous membranes which is often a sign of inflammation), scaly plaques involving bilateral upper and lower extremities. During a concurrent interview and record review on 11/25/2025 at 1:13p.m. with licensed Vocational Nurse (LVN) 1, Resident 1's Care Plan was reviewed. LVN 1 stated Resident 1's care plan was not updated to reflect Resident 1's skin concerns. LVN 1 stated residents' care plans need to be updated when residents develop new skin issues. LVN 1 stated the failure to update Resident 1's care plan had the potential to care for Resident 1 negatively affecting Resident 1's wound healing. During an interview on 11/25/2025 at 3:46 p.m. with the Director of Nursing (DON), the DON stated residents' Care Plans should reflect long-term and short-term care goals and interventions for the residents. The DON stated Resident 1's Care Plan should have been updated when Resident 1's skin problems were initially identified. The DON stated the failure to update Resident 1's Care Plan had the potential for provision of care that did not meet Resident 1's needs. During a review of the facility-provided policy and procedure (P&P) titled, Care plans, Comprehensive Person-Centered, last revised 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 and functional needs is developed and implemented for each resident. 2. The care plan interventions are derived from a thorough analysis of the information (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gathered as part of the comprehensive assessment.6. The comprehensive, person-centered care plan: .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being 10. Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's conditions change.