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	12/17/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 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 observation, interview, and record review, the facility failed to maintain complete and accurate medical records for one of three sampled residents (Resident 1), when Licensed Vocational Nurse (LVN) 1 failed to document Resident 1's apixaban (an anticoagulant-medication used to prevent and treat blood clots) administration accurately when the medication was documented as administered instead of not administered on 12/15/2025 at 9 a.m. This deficient practice had the potential for facility staff to not know if the medication was administered or not.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 12/14/2025 with diagnoses including sepsis (a life-threatening blood infection), end stage renal disease (ESRD - irreversible kidney failure), and diabetes mellitus type II (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Order Summary Report (OSR), dated 12/14/2025, the OSR indicated apixaban oral tablet five (5) milligrams (mg - a unit of measurement), give 5 mg by mouth two times a day for deep vein thrombosis (DVT - when a blood clot forms in a deep vein, usually in the leg or thigh, blocking blood flow and causing pain, swelling, redness, and warmth) prophylaxis (prevention). During a concurrent observation, interview, and record review on 12/16/2025 at 10:38 a.m. with LVN 1, LVN 1 stated she was assigned to Resident 1 today, 12/16/2025, and yesterday, 12/15/2025. Resident 1's Medication Administration Record (MAR), for 12/2025, was reviewed and LVN 1 stated she has not given Resident 1's 9 a.m. scheduled medications yet, but she will after. LVN 1 stated the check mark on the MAR means that the medication was administered. LVN 1 stated she signed the apixaban yesterday, scheduled 12/15/2025 at 9 a.m. LVN 1 stated yesterday, 12/15/2025, Resident 1's 9 a.m. medications arrived during the 11 p.m. to 7 a.m. shift before her shift started. Inside the medication cart, observed Eliquis (apixaban) in bubble packs (packaging that have a preformed plastic pocket or shell where a product sits securely in place) for morning shift. LVN 1 stated she has not given the apixaban yet and will give today. When LVN 1 was asked, how come the Eliquis (apixaban) was marked as administered but the apixaban tablet is still inside the bubble pack?, LVN 1 did not provide an answer. Resident 1's Eliquis bubble pack was observed and indicated the filled date as 12/14/2025 with quantity seven (7) of 7 tablets in the bubble pack. During a concurrent interview and record review on 12/17/2025 at 10:22 a.m. with Assistant Director of Nursing (ADON), Resident 1's [DATE]/2025, nursing progress notes and pharmacy delivery receipt, dated 12/14/2025, were reviewed and the ADON stated code 10 on the MAR means the resident was unavailable and there is documentation the reason it was not given. The ADON stated the nursing progress notes indicated on 12/15/2025 the resident went out to dialysis and metoprolol (medication for high blood pressure), and amiodarone (heart rhythm medication) were documented as not given on the MAR. The ADON stated she could not find any nursing notes on 12/15/2025 when the apixaban was marked as given when Resident 1 was in dialysis at that time. During an interview on 12/17/2025 at 11:16 a.m. with the Director of Nursing (DON), the DON stated the licensed nurses need to make sure medications are given and to sign after they have administered the medication to the residents. The DON stated Resident 1's apixaban medication was signed as administered but was held. The DON stated she does not know if MAR documentation was a typographical error. The DON stated when the licensed nurse signed the electronic MAR and the medication was not given, it creates a discrepancy and gives a different message to the reader. The DON stated it is important that residents' information and summary of care is complete and accurate and should be corrected when there is inaccurate charting in order to minimize errors or issues. The DON stated when the information is not accurate it would give incomplete information. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/24/2025, the P&P indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.