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	01/30/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from chemical restraint (use of medication to manage a patient's behavior or restrict their freedom of movement, primarily to control agitation [a feeling of irritability, mental distress or severe restlessness] or aggression [any behavior, word, or action that is intended to harm another person, animal, or object]) by:Failing to monitor Resident 1 for the side effect (secondary, usually unwanted, effects of a medication or treatment that occur alongside the intended therapeutic result) of orthostatic blood pressure (a sudden drop in blood pressure occurring within three minutes of standing, that causes symptoms like dizziness, lightheadedness, blurred vision, or fainting) changes on 1/18/2026, and 1/25/2026, while on quetiapine (medication used to treat various mental health conditions) use.Failing to obtain a new Informed Consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) when Resident 1's quetiapine was increased from 100 milligram (mg-metric unit of measurement, used for medication dosage and/or amount) to 150 mg on 12/28/2025.Failing to ensure Informed Consent was obtained from Resident 1's Responsible Party (RP) on 12/19/2025.These failures had the potential for unnecessary chemical restraint and placed Resident 1 at risk for decline, isolation (being physically or emotionally separated from others, leading to feelings of loneliness or being alone) and injury.Findings:a. During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 12/19/2025, with diagnoses that included orthopedic aftercare (medical care and precautions a person needs to take after a bone or joints procedure to ensure proper healing), unspecified (unconfirmed) psychosis ((a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and history of fall.During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 12/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Order Summary Report, dated 12/22/2025, the Order Summary Report indicated the physician ordered quetiapine fumarate oral tablet 100 mg, give one tablet by mouth at bedtime for psychosis manifested by delusion (a strong, fixed, false belief that is not based in reality).During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for hygiene, toileting, and showering. The MDS indicated Resident 1 was on antipsychotic (medication used to treat psychosis) medication.During a review of Resident 1's Order Summary Report, dated 1/15/2026, the Order Summary Report indicated orthostatic blood pressure (on lying and sitting position) every Sunday for quetiapine use. Monitor blood pressure on lying position then sitting (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	position within three-minute intervals. Call the Physician if systolic blood pressure (sbp- measures the maximum pressure in your arteries when the heart contracts and pumps blood) is greater than 20-millimeter mercury (mmHg- a unit of measurement for pressure) and diastolic blood pressure (dbp-measuring the pressure in the arteries when the heart muscle rests between beats and refills with blood) greater than 10 mmHg.During a review of Resident 1's Medication Administration Record (MAR-flowsheet that indicates medications given to a resident), dated 1/2026, the MAR indicated on 1/18/2026, and 1/25/2026, Licensed Vocational Nurse 5 (LVN 5) documented orthostatic blood pressure was not applicable on both lying and sitting position.During a concurrent interview, and record review on 1/29/2026, at 10:33 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Order Summary Report, dated 1/15/2026, and MAR, dated 1/2026 were reviewed. The ADON stated the physician ordered monitoring of orthostatic blood pressure once a week on Sunday on a lying and sitting position due to quetiapine use. The ADON stated quetiapine had a side effect of orthostatic hypotension (a drop in blood pressure upon standing, which can lead to dizziness, lightheadedness, and an increased risk of fall). The ADON stated the MAR indicated LVN 5 documented orthostatic blood pressure check was not applicable on 1/18/2026, and 1/25/2026. The ADON stated nurses would not know if Resident 1 had orthostatic blood pressure changes because it was not monitored and documented and could delay physician notification and delay Resident 1's care.During an interview on 1/29/2026, at 11:22 a.m., with the Director of Nursing (DON), the DON stated quetiapine is a psychotropic medication (a class of drugs that affect brain activity, resulting in changes to mood, perception, consciousness, thoughts, or behavior) that affects the blood pressure. The DON stated Resident 1 should be monitored for orthostatic hypotension. The DON stated LVN 5 did not follow the physician order. The DON stated there was incomplete assessment that could potentially delay physician notification. The DON stated nurses should follow the physician order and document orthostatic blood pressure and notify the physician if there was any blood pressure change. The DON stated incomplete assessment affects the evaluation of resident conditions.During a review of facility's policy and procedure (P&P), titled, Adverse Consequences and Medication Errors, dated 11/2025, the P&P indicated, 1. An adverse consequence refers to an unwanted, uncomfortable, or dangerous effect a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include:a. adverse drug/medication reaction;b. side effect;c. medication-medication interaction; ord. medication-food interaction.3. Residents receiving medication are monitored for adverse consequences.4. Adverse consequences are promptly identified and reported.During a review of facility's P&P, titled, Psychotropic Medication Use, dated 11/2025, the P&P indicated, Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications:a. Anti-psychotics;b. Anti-depressants (medications that treat mental health conditions like depression [a common, serious mood disorder characterized by persistent feelings of sadness, emptiness, or a loss of interest in activities for at least two weeks]);c. Anti-anxiety medications (medication used to treat anxiety [excessive, persistent fear or worry that interferes with daily life]); andd. Hypnotics (medication used to reduce anxiety)/ sedative (medications used to induce sleep).2. Psychotropic medication management is an interdisciplinary (IDT- a coordinated group of experts from several different fields who work together) process that involves the resident, family, and/or the representative and includes:a. determining adequate indications for use;b. adequate monitoring for efficacy and adverse consequences;c. determining appropriateness of gradual dose reduction (GDR-the stepwise (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tapering of a medication dose to determine if symptoms can be managed on a lower dose or discontinued); andd. preventing, identifying, and responding to adverse consequences.Monitoring and Adverse Consequences: .Residents receiving psychotropic medication are monitored and the response to treatment is documented.Monitoring may include laboratory results, vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions), progress notes, behavior flow sheets, medication administration records, and the drug regimen review from the consultant pharmacist.b. During a review of Resident 1's Informed Consent, dated 12/19/2025, the Informed Consent indicated Resident 1 was on 50 mg of quetiapine twice a day.During a record review of Resident 1's Order Summary Report dated 12/22/2025, the Order Summary Report indicated quetiapine fumarate oral tablet 100 mg, give one tablet by mouth at bedtime for psychosis manifested by delusion thinking that he can still do everything he wanted.During a record review of Resident 1's Order Summary Report dated 12/28/2025, the Order Summary Report indicated quetiapine fumarate oral tablet 50 mg, give one tablet by mouth in the evening for psychosis manifested by delusion.During a review of Resident 1's MAR dated 12/2025, and 1/2025, the MAR indicated Resident 1 received a total of 150 mg of quetiapine from 12/28/2025, to 1/4/2026.During a concurrent interview, and record review on 1/30/2026, at 11:30 a.m., with the ADON, Resident 1's Order Summary Report, dated 12/22/2025, and 12/28/2025, MAR, dated 12/2025, and 1/2026, were reviewed. The ADON stated on initial admission Resident 1 was on quetiapine 50 mg twice a day, then order was clarified and medication was changed to 100 mg at bedtime. The ADON stated on 12/28/2025, the physician added additional quetiapine 50 mg in the evening for a total of 150 mg a day. The ADON stated from 12/28/2025, to 1/4/2026, Resident 1 had 150 mg total of quetiapine. The ADON stated if the medication dose increase, the facility needs to obtain a new Informed Consent.During an interview on 1/30/2026, at 12:13 p.m., with the Director of Nursing (DON), the DON stated Informed Consent is obtained for any use of psychotropic medications, if there is a change in the psychotropic medication or if there is an increase in the dose of the psychotropic medication. The DON stated the nurse should have obtained a new Informed Consent on 12/28/2025, when the physician added 50 mg more of quetiapine for a total of 150 mg. The DON stated quetiapine affects the brain, residents thinking and movement and use of quetiapine without consent can become a chemical restraint.During a concurrent interview, and record review on 1/30/2026, at 12:29 p.m., with the DON, facility's policy and procedure (P&P), titled, Psychotropic Medication Use, dated 11/2025 was reviewed. The P&P indicated, Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review with the resident/representative prior to obtaining documented consent or refusal. The DON stated the P&P was not followed. The DON stated the nurses should have obtained a new consent.c. During a review of Resident 1's Informed Consent, dated 12/19/2025, the Informed Consent indicated Resident 1 provided verbal consent for the use of quetiapine 50 mg twice a day for agitation and aggression. The Informed Consent indicated Registered Nurse 2 (RN 2) verified the Informed Consent on 12/19/2025, at 9 p.m.During a concurrent interview, and record review on 1/30/2026, at 11:30 a.m., with the ADON, Resident 1's H&P, dated 12/19/2025, and MDS, dated [DATE], were reviewed. The H&P indicated Resident 1 did not have the capacity to understand and make decisions. The MDS indicated Resident 1 cognitive skills for daily decisions were intact. The ADON stated the facility should have followed the H&P from the physician. The ADON stated nurses should have clarified the order with the physician and informed the Responsible Party (RP).During an interview on 1/30/2026, at 12:29 p.m., with the DON, the DON stated Resident 1 did not have the capacity and the RP should be the one who should sign the Informed Consent for use of quetiapine. The DON stated without valid (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Informed Consent, RPs rights were violated. The DON stated the P&P was not followed.During a concurrent interview and record review on 1/30/2026, at 12:29 p.m. with the DON, facility's P&P, titled, Antipsychotic Medication Use, dated 11/2025, was reviewed. The P&P indicated, Residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use. Residents (and/or representatives) may refuse medications of any kind. The DON stated the facility do not have a specific P&P for chemical restraint but uses the Antipsychotic Medication Use P&P.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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 two of three sampled residents (Residents 1 and 2) by:Failing to develop a care plan on Resident 1's noncompliance with oxygen use.Failing to implement care plan on Resident 2's risk for fall to keep bed in low position. These failures had the potential for delays in the delivery of necessary care and services to Resident 1 causing hypoxia (low levels of oxygen in your body tissues) and could result in Resident 2's fall and injury.Findings:a. During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 12/19/2025, with diagnoses that included orthopedic aftercare (medical care and precautions a person needs to take after a bone or joints procedure to ensure proper healing), unspecified (unconfirmed) COPD, and acute (sudden in onset) and chronic (a health condition or disease that persists for an extended period, typically lasting three months to one year or longer) respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood) with hypoxia (a medical emergency where tissues and organs do not receive enough oxygen to function properly, potentially causing rapid damage to the brain and heart).During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 12/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for hygiene, toileting, and showering.During a review of Resident 1's Order Summary Report, dated 1/14/2025, the Order Summary Report indicated the physician ordered for oxygen at two liters per minute via nasal cannula continuously every shift.During an observation on 1/29/2026, at 9:19 a.m., at Resident 1's bedside, observed Resident 1 asleep, with oxygen concentrator (a medical device that filters surrounding room air, compresses it, and removes nitrogen to deliver concentrated, high-purity oxygen typically 90-95 percent (%) to individuals with breathing disorders) at five liters per minute via nasal cannula. Observed the nasal cannula not connected to Resident 1 and was hanging on the portable emergency light on top of Resident 1's rolling table.During a concurrent observation, and interview on 1/29/2026, at 9:24 a.m., with Registered Nurse 1 (RN 1), at Resident 1's bedside. RN 1 moved Resident 1's rolling table and checked the oxygen concentrator. RN 1 stated oxygen was ongoing at five liters per minute, but nasal cannula was not connected to Resident 1.During an interview on 1/29/2026, at 9:31 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated if oxygen cannula was not connected to Resident 1, Resident 1 had removed it.During a concurrent interview, and record review on 1/29/2026, at 9:34 a.m., with Licensed Vocational Nurse 6 (LVN 6) Resident 1's Care Plans were reviewed. LVN 6 stated there was no Care Plan developed for Resident 1's refusal of oxygen use.During a concurrent interview, and record review on 1/29/2026, at 9:42 a.m., with Assistant Director of Nursing (ADON), the ADON stated there was no care plan developed for Resident 1's removal of oxygen cannula. During an interview on 1/29/2026, at 11:22 a.m., with the Director of Nursing (DON), the DON stated care plan is designed for resident person-centered care. The DON stated without care plan for Resident 1's removal of oxygen cannula, facility would not be able to provide resident care and address Resident 1's refusal. The DON stated Resident 1 could have hypoxia for not using oxygen.b. During a review of Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2‘s admission Record, the admission Record indicated the facility admitted Resident 2 on 6/8/2024, with diagnoses that included left shoulder primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), morbid obesity (a serious, chronic disease involving an excessive accumulation of body fat that severely impairs health and limits mobility) and right knee pain.During a review of Resident 2's H&P, dated 6/10/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions.During a review of Resident 2's Care Plan, dated 6/10/2024, about risk for fall, the Care Plan indicated an intervention to keep bed in low position with brakes locked.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 2 required moderate assistance from staff for toileting and lower body dressing.During a review of Resident 2's Fall Risk Observation/Assessment, dated 12/16/2025, the Fall Risk Observation/Assessment indicated Resident 2 was a high risk for fall.During an observation on 1/29/2026, at 9:18 a.m., outside of Resident 2's room, Resident 2 was asleep with the bed on a high position.During a concurrent interview, and record review on 1/29/2026, at 9:42 a.m., with the Assistant Director of Nursing (ADON), Resident 2's Care Plans were reviewed. The ADON stated there were no care plans on Resident 2's bed in a high position. The ADON stated Resident 2 can possibly fall and cause injury if bed were high. The ADON stated if Resident 2 would have preferred to have a bed with a high position the facility should have developed a care plan.During an interview on 1/29/2026, at 10:54 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated it was the first time she observed Resident 2's bed on high position. CNA 1 stated Resident 2 could fall off the bed if left too high.During an interview on 1/29/2026, at 11:11 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated he (LVN 1) just found out today 1/29/2026, that Resident 2 prefers her (Resident 2) bed high. LVN 1 stated care plan for Resident 2's preference to have a high bed should have been developed to prevent fall.During a concurrent interview, and record review on 1/29/2026, at 11:22 a.m., with the Director of Nursing (DON), Resident 2's Fall Risk Observation/Assessment, dated 12/16/2025, was reviewed. The DON stated Fall Risk Observation/Assessment, dated 12/16/2025, indicated Resident 2 was a high risk for fall. The DON stated Resident 2 did not have a care plan developed for high position bed. The DON stated Resident 2 put her bed up high and the facility should have care planned it as resident preference. The DON stated Resident 2 was at a high risk for fall and could potentially fall and cause injury if bed was in a high position.During a review of facility's policy and procedure (P&P), titled, Comprehensive Person-Centered Care Plans', dated 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.10. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.11. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.During a review of facility's policy and procedure (P&P) titled, Falls/Accident/Fall Management Prevention, dated 7/24/2025 was reviewed. The P&P (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.

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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 one of three sampled residents (Resident 2), who was assessed as high risk (a person is significantly more likely to fall due to factors like weak muscles, poor balance, dizziness from medication, or vision problems) for fall, was asleep on a bed in high position.This deficient practice had the potential to place Resident 2's at risk of fall and injury.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 6/8/2024, with diagnoses that included left shoulder primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), morbid obesity (a serious, chronic disease involving an excessive accumulation of body fat that severely impairs health and limits mobility) and right knee pain.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 6/10/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions.During a review of Resident 2's Care Plan, dated 6/10/2024, about risk for fall, the Care Plan indicated an intervention to keep bed in low position with brakes locked.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 12/16/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 2 required moderate assistance from staff for toileting and lower body dressing.During a review of Resident 2's Fall Risk Observation/Assessment, dated 12/16/2025, the Fall Risk Observation/Assessment indicated Resident 2 was at a high risk for fall.During an observation on 1/29/2026, at 9:18 a.m., outside of Resident 2's room, Resident 2 was asleep with the bed on a high position.During a concurrent interview, and record review on 1/29/2026, at 9:42 a.m., with the Assistant Director of Nursing (ADON), Resident 2's Care Plans were reviewed. The ADON stated there were no care plans on Resident 2's bed in a high position. The ADON stated Resident 2 can possibly fall and cause injury if bed were high. The ADON stated if Resident 2 would have preferred to have a bed with a high position the facility should have developed a care plan.During an interview on 1/29/2026, at 10:54 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated it was the first time she (CNA 1) observed Resident 2's bed was too high. CNA 1 stated Resident 2 can fall off the bed if left too high.During a concurrent interview, and record review on 1/29/2026, at 11:22 a.m., with the Director of Nursing (DON), Resident 2's Fall Risk Observation/Assessment, dated 12/16/2025, was reviewed. The DON stated Fall Risk Observation/Assessment, dated 12/16/2025, indicated Resident 2 was a high risk for fall. The DON stated Resident 2 did not have a care plan developed for high position bed. The DON stated Resident 2 put her bed up high and the facility should have care planned it as resident preference. The DON stated Resident 2 was at a high risk for fall and could potentially fall and cause injury if bed was in a high position.During a review of facility's policy and procedure (P&P) titled, Falls/Accident/Fall Management Prevention, dated 7/24/2025 was reviewed. The P&P indicated, Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) were provided with respiratory care consistent with professional standards of practice by:Failing to ensure oxygen nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was connected to Resident 1.Failing to follow a physician order for oxygen administration of two liters per minute via nasal cannula.These failures can negatively impact on Resident 1's health and well-being and can potentially result in excessive oxygen, suppressing (the act of stopping) Resident 1's ability to breathe. Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 12/19/2025, with diagnoses that included orthopedic aftercare (medical care and precautions a person needs to take after a bone or joints procedure to ensure proper healing), unspecified (unconfirmed) COPD, and acute (sudden in onset) and chronic (a health condition or disease that persists for an extended period, typically lasting three months to one year or longer) respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood) with hypoxia (a medical emergency where tissues and organs do not receive enough oxygen to function properly, potentially causing rapid damage to the brain and heart).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 12/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Order Summary Report, dated 12/19/2025, the Order Summary Report indicated an order for oxygen at four liters per minute via nasal cannula, continuous inhalation with humification (involves moistening the air or gases breathed in) for COPD, shortness of breath (sob) every shift.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for hygiene, toileting, and showering.During a review of Resident 1's Order Summary Report, dated 1/14/2025, the Order Summary Report indicated the physician ordered for oxygen at two liters per minute via nasal cannula continuously every shift.During an observation on 1/29/2026, at 9:19 a.m., at Resident 1's bedside, observed Resident 1 asleep, with oxygen concentrator (a medical device that filters surrounding room air, compresses it, and removes nitrogen to deliver concentrated, high-purity oxygen typically 90-95 percent [%] to individuals with breathing disorders) at five liters per minute via nasal cannula. Observed the nasal cannula not connected to Resident 1 and was hanging on the portable emergency light on top of Resident 1's rolling table.During a concurrent observation, and interview on 1/29/2026, at 9:24 a.m., with Registered Nurse 1 (RN 1), at Resident 1's bedside. RN 1 moved Resident 1's rolling table and checked the oxygen concentrator. RN 1 stated oxygen was ongoing at five liters per minute, but nasal cannula was not connected to Resident 1. RN 1 observed calling Licensed Vocational Nurse 1 (LVN 1) to bring a pulse oximeter (a small, noninvasive device typically clipped onto a fingertip, earlobe, or toe that measures the percentage of oxygen saturation in the blood).During an observation on 1/29/2026, at 9:25 a.m., at Resident 1's bedside, observed LVN 1 went inside Resident 1's room and placed the pulse oximeter on Resident 1's left index finger and the pulse oximeter indicated 92%. Observed LVN 1 reconnected the oxygen nasal cannula to Resident 1. LVN 1 stated Resident 1's oxygen saturation (blood oxygen level) fluctuated between 80% to 90% while on five liters per minute. Observed Resident 1 woke up and coughed out white phlegm and oxygen increased to 91%.During a concurrent (continued on next page)

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	056039	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirage Post Acute	44445 15th St W Lancaster, CA 93534

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview, and record review on 1/29/2026, at 9:42 a.m. with the Assistant Director of Nursing (ADON), Resident 1's Order Summary Report, dated 1/14/2026, was reviewed. The ADON stated the physician order for Resident 1's oxygen on 1/14/2026, was at two liters per minute. The ADON stated a physician order is needed to increase the oxygen and there was no order to titrate (the process of adjusting the amount of oxygen a resident receives to keep their blood oxygen levels within a specific, healthy range) the oxygen. The ADON stated Resident 1 who was not connected to oxygen could experience sob.During an interview on 1/29/2026, at 11:11 a.m., with LVN 1, LVN 1 stated he (LVN 1) had observed Resident 1's oxygen was set at five liters per minute. LVN 1 stated Resident 1 had history of COPD and giving high oxygen can cause sob.During an interview on 1/29/2026, at 11:22 a.m., with the Director of Nursing (DON), the DON stated nurses should follow the physician order for continuous oxygen administration of only two liters per minute. The DON stated higher oxygen administration could result in Resident 1's hyperventilation (rapid and deep breathing).During a concurrent interview, and record review on 1/30/2026, at 12:29 p.m., with the DON, facility's policy and procedure (P&P), titled, Administering Medications, dated 7/24/2025, was reviewed. The P&P indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The DON stated with the use of oxygen the facility follows the P&P for medication administration since oxygen is considered a medication and should be administered according to the physician order.During a review of facility's policy and procedure (P&P) titled, Oxygen Administration, dated 7/24/2025, was reviewed. The P&P indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. 5. Adjust the oxygen delivery device so that it is comfortable for the residents and the proper flow of oxygen is being administered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was medicated for pain as per physician's order. On 1/21/2026, 1/25/2026, 1/26/2026, and 1/29/2026, nurses administered hydrocodone (medication used to treat pain) 5/325 milligram (mg-metric unit of measurement, used for medication dosage and/or amount) to Resident 1 despite a physician order to administer oxycodone (medication used to treat pain) for pain level between seven to ten (zero- no pain and ten- worst pain).These failures had the potential to result in Resident 1's uncontrolled pain.Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 12/19/2025, with diagnoses that included orthopedic aftercare (medical care and precautions a person needs to take after a bone or joints procedure to ensure proper healing), unspecified (unconfirmed) chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and acute (sudden in onset) and chronic (a health condition or disease that persists for an extended period, typically lasting three months to one year or longer) respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood) with hypoxia (a medical emergency where tissues and organs do not receive enough oxygen to function properly, potentially causing rapid damage to the brain and heart).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 12/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for hygiene, toileting, and showering. The MDS indicated Resident 1 had occasionally moderate pain.During a review of Resident 1's Physician Order, dated 1/15/2026, the Physician Order indicated the physician ordered hydrocodone-acetaminophen oral tablet 5-325 mg, give one tablet by mouth every four hours as needed for moderate pain level of four to six.During a review of Resident 1's Physician Order, dated 1/15/2026, the Physician Order indicated the physician ordered oxycodone-acetaminophen oral tablet 7.5-300 mg, give one tablet by mouth every six hours as needed for severe pain level of seven to ten.During a review of Resident 1's Medication Administration Record (MAR-flowsheet that indicates medications given to a resident), dated 1/2026, the MAR indicated Licensed Vocational Nurse 2 (LVN 2), LVN 3 and LVN 4 administered hydrocodone to Resident 1 on the following dates and times.1/21/2026 at 2:27 a.m., with pain level of seven.1/25/2026, at 6:28 a.m., with pain level of eight.1/26/2026, at 1:10 a.m., with pain level of eight1/29/2026, at 3:10 a.m., with pain level of eight.During an interview on 1/29/2026, at 10:33 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Physician Order, dated 1/15/2026, and MAR, dated 1/2026, were reviewed. The ADON stated LVN 2 administered hydrocodone to Resident 1 on 1/21/2026, at 2:27 a.m., for pain level of seven. The ADON stated LVN 3 administered hydrocodone to Resident 1 on 1/25/2026, at 6:28 a.m., and on 1/29/2026, at 3:10 a.m. The ADON stated LVN 4 administered hydrocodone to Resident 1 on 1/26/2026, at 1:10 a.m., with pain level of eight out of ten. The ADON stated the physician order was to administer hydrocodone only for pain level between four to six and to administer oxycodone for pain level between seven to ten. The ADON stated LVN 2, LVN 3 and LVN 4 should have administered oxycodone instead of hydrocodone as per physician order. The ADON stated Resident 1 could have uncontrolled pain because nurses did not follow the physician order.During an interview on 1/29/2026, at 11:22 a.m., with the Director of Nursing (DON), the DON stated nurses should follow the physician's order. The DON stated Resident 1's (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pain could not be completely relieved because nurses did not follow the physician order.During a concurrent interview, and record review on 1/30/2026, at 12:29 p.m., with the DON, facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated 4/2025, was reviewed. The P&P indicated, The medication regimen is implemented as ordered.During a review of facility's P&P, titled, Administering Medications, dated 7/24/2025, was reviewed. The P&P indicated, Medications are administered in accordance with prescriber's order, including any required time frame.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 1) by failing to document the conversation of Family Member 1 (FM 1) with Social Service Assistant 1 (SSA 1) about Resident 1's medication.This failure had the potential to cause confusion in care and the medical records containing inaccurate documentation.Findings: During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 12/19/2025, with diagnoses that included orthopedic aftercare (medical care and precautions a person needs to take after a bone or joints procedure to ensure proper healing), unspecified (unconfirmed) psychosis ((a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and history of fall.During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 12/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for hygiene, toileting, and showering. The MDS indicated Resident 1 was on antipsychotic (medication used to treat psychosis) medication.During an interview on 1/29/2026, at 9:01 a.m., with FM 1, FM 1 stated on the second day of admission [DATE]) he (FM 1) had found pills in a clear plastic bag, and he (FM 1) took a picture and texted (an electronic written message) to SSA 1. FM 1 stated nothing was done about it.During an interview on 1/29/2026, at 10:59 a.m., with SSA 1, SSA 1 stated on 12/29/2025, FM 1 spoke to her (SSA 1) to discuss Resident 1's medications. SSA 1 stated Resident 1 approved FM 1's visit but refused to share medical status with FM 1. SSA 1 stated FM 1 showed a picture of a clear plastic bag with pills that was found in the General Acute Care Hospital (GACH). SSA 1 stated FM 1 reported that Resident 1 was caught with pills in the GACH. SSA 1 stated she (SSA 1) did not document conversation with FM 1 on 12/29/2025.During an interview on 1/30/2026, at 10 a.m., with SSA 1, SSA 1 stated she (SSA 1) did not document in Resident 1's medical record that FM 1 showed a picture of a clear plastic bag with pills.During a concurrent interview, and record review on 1/30/2026, at 12:29 p.m. with the Director of Nursing (DON), facility's policy and procedure (P&P), titled, Charting and Documentation, dated 7/24/2025, was reviewed. 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. The following information is to be documented in the resident medical record: a. Objective observations; . e. Events, incidents or accidents involving the resident; . 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The DON stated SSA 1 should have document concerns and conversation with FM 1. The DON stated if it was not documented, Resident 1's medical record was incomplete. The DON stated it is the facility policy to have a complete and accurate medical record.

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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. Based on observation, interview, and record review, the facility failed to implement infection control measures for one of three sampled residents (Resident 1) by failing to ensure oxygen tubing was not touching the floor. This failure had the potential for Resident 1 to get infection.Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 12/19/2025, with diagnoses that included orthopedic aftercare (medical care and precautions a person needs to take after a bone or joints procedure to ensure proper healing), unspecified (unconfirmed) COPD, and acute (sudden in onset) and chronic (a health condition or disease that persists for an extended period, typically lasting three months to one year or longer) respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood) with hypoxia (a medical emergency where tissues and organs do not receive enough oxygen to function properly, potentially causing rapid damage to the brain and heart).During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 12/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 12/25/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for hygiene, toileting, and showering.During an observation on 1/29/2026, at 9:19 a.m., at Resident 1's bedside, observed Resident 1 asleep, with oxygen concentrator (a medical device that filters surrounding room air, compresses it, and removes nitrogen to deliver concentrated, high-purity oxygen typically 90-95 percent (%) to individuals with breathing disorders) at five liters per minute via nasal cannula. Observed the nasal cannula not connected to Resident 1 and was hanging on the portable emergency light on top of Resident 1's rolling table. Observed oxygen tubing touching the floor.During an interview on 1/29/2026, at 9:42 a.m., with the Assistant Director of Nursing (ADON), the ADON stated oxygen tubing should not be touching the floor for infection control.During an interview on 1/29/2026, at 11:22 a.m., with the Director of Nursing (DON), the DON stated Resident 1 could get infection if oxygen tubing was touching the floor.During an interview on 1/30/2026, at 12:29 p.m., with the DON, the DON stated the facility does not have a specific policy that oxygen tubing should not touch the floor. The DON stated the facility practices that oxygen tubing should be kept off the floor for infection control.