

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 03/06/2026
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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>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 General Acute Care Hospital's (GACH) Case Manager (CM) inquiry on Resident 1's discharge back to the facility and reason why the facility did not accept Resident 1 back on 3/5/2026. This failure had the potential to result in confusion in care and the medical records containing incomplete documentation. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/5/2025, with diagnoses that included unspecified (unconfirmed) parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), aphasia (a disorder that makes it difficult to speak), and generalized muscle weakness. 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 11/6/2026, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a concurrent interview and record review on 3/6/2026, at 9:44 a.m., with the Admissions Assistant (AA), Resident 1's Progress Notes, dated 3/5/2026, were reviewed. The AA stated on 3/5/2026, at around 12 noon, AA had spoken to the GACH's CM and informed her (CM) that the facility will accept Resident 1 back at the facility once the facility receives the test result for candida auris (a fungal infection that can cause serious illness) so the facility could make room changes to accommodate Resident 1's isolation (separation of residents with an infection from residents without an infection) room as needed. The AA stated she (AA) was not able to document the conversation with the CM yesterday (3/5/2026). The AA stated she (AA) should have documented. The AA stated she (AA) left the facility yesterday (3/5/2026) at 4 p.m., so she (AA) had four more hours to document. During a concurrent interview and record review on 3/6/2026, at 10:05 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Progress Notes, dated 3/5/2026, were reviewed. The ADON stated she (ADON) had no idea if Resident 1 was coming back to the facility. The ADON stated the AA should have documented her (AA) conversation with the CM. The ADON stated it is important to document timely for communication of all facility department so the facility would know when it happened and for Resident 1's accurate and complete medical record. The ADON stated if it was not documented in Resident 1's medical record, there could be confusion on plan for Resident 1's readmission to the facility. During a concurrent interview and record review on 3/6/2026, at 10:46 a.m., with the Director of Nursing (DON), the 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 (the interaction between a person's internal psychological state [thoughts, emotions, personality] and their external social environment [relationships, work, culture]) condition, shall be documented in the resident's medical record. The medical record should facilitate (continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>communication between the interdisciplinary team (IDT- a coordinated group of experts from several different fields who work together) 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. The DON stated the facility's policy was to have accurate and complete medical records.</p>		