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	04/28/2026

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 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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (is a form that summarizes a person's health conditions and current treatments for their care) for one of three sample residents (Resident 1), regarding Resident 1's use of aspirin (a medication used as a blood thinner that prevents blood cells called platelets from sticking together) and Resident 1's behavior of hitting herself. These deficient practices had the potential to negatively affect Resident 1's physical and psychosocial wellbeing.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 12/8/2025 and readmitted the resident on 4/2/2026 with diagnoses that included cerebral ischemia (a critical condition where the brain does not receive enough oxygen-rich blood, often caused by a blocked or narrowed artery, leading to tissue damage or death), muscle weakness, and history of falling. During a review of Resident 1's Order Summary Report (ORS) dated 3/1/2026, the ORS indicated aspirin 81 oral tablet chewable give one tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/16/2026, the MDS indicated Resident 1 had the ability to understand and be understood. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with lower body dressing and putting on and taking off footwear, required supervision (helper provides verbal cues and or touching steadying, contact guard assistance as resident completes activity) with toileting, showering, upper body dressing and personal hygiene and required set up or clean up assistance (helper sets up or cleans up resident completes activity) eating, and oral hygiene. During a review of Resident 1's Situational Background Appearance and Review and Notify (SBAR- a structured communication tool used in healthcare to share important patient information quickly and accurately) Communication Form, dated 3/30/2026, the SBAR Communication Form indicated Resident 1 was noted with discoloration to chin and forehead.During an interview on 4/28/2026 at 3 p.m. with the Registered Nurse (RN 1), RN 1 stated she recalled Resident 1 having the discoloration but not the date of the incident. RN 1 stated she was made aware of Resident 1's discoloration to her chin and forehead by Licensed Vocational Nurse (LVN 1), within a few hours from the start of the shift. RN 1 stated she did an SBAR for Resident 1 because we did not know what happened. RN 1 stated it did not look like Resident 1 was hit. RN 1 stated she (RN 1) felt like the discoloration occurred during repositioning and/or when resident becomes combative. During a concurrent interview and record review on 4/28/2026 at 3:44 p.m., Resident 1's SBAR dated 3/30/2026 and Resident 1's Care Plans were reviewed with the Assistant Director of Nursing (ADON). The ADON stated it was noted that Resident 1 had discoloration on her forehead and chin with no falls that they were aware of. The ADON stated she (ADON) was notified on 3/30/2026. The ADON stated Resident 1 was on anticoagulant medication, and discoloration was a possible side effect. The ADON stated the discoloration of Resident 1's forehead and chin may have occurred from resident leaning forward. The ADON stated Resident 1 had a history of being agitated. The ADON reviewed Resident 1's Care plans and stated there were no care plans related to agitation or restlessness and regarding Resident 1 having behaviors. The ADON stated Resident 1 had a history (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of behaviors but there was no documentation of this. The ADON reviewed Resident 1's care plans and stated there was no care plan for the use of aspirin. The ADON stated there must be care plans for Resident 1's use of aspirin and for her behaviors so staff will know how to care the resident or what precautions to take. During an interview on 4/28/2026 at 4:15 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had a tendency to hurt herself and was on anticoagulant medication. The DON stated there were no care plans for Resident 1's behavior and for the use of anticoagulants. The DON stated Resident 1 should have care plans for both, if there are no care plans, the facility staff will not be able to implement the plan of care for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Care Plan, Comprehensive Person-Centered, last reviewed on 1/27/2026, the P&P indicated 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.

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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	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 medical records in accordance with accepted professional standards and practices for two of three sampled residents (Resident 1 and Resident 3) when:1. The facility failed to ensure Resident 1's Progress Note, dated 4/2/2026, accurately document Resident 1's condition.2. The facility failed to accurately document Resident 3's physician's recommendation on Resident 3's Situational Background Appearance and Review and Notify (SBAR- a structured communication tool used in healthcare to share important patient information quickly and accurately) Communication Form, dated 4/2/2026.3. The facility failed to accurately document Resident 3's care plan (is a form that summarizes a person's health conditions and current treatments for their care) for a witnessed fall.These deficient practices result in inaccurate documentation in Resident 1 and Resident 3's records.Findings:a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 12/8/2025 and readmitted the resident on 4/2/2026 with diagnoses that included cerebral ischemia (a critical condition where the brain does not receive enough oxygen-rich blood, often caused by a blocked or narrowed artery, leading to tissue damage or death), muscle weakness, and history of falling. During a review of Resident 1's Order Summary Report (ORS), dated 3/1/2026, the ORS indicated aspirin 81 oral tablet chewable give one tablet by mouth one time a day for Cerebrovascular Accident (CVA-stroke, loss of blood flow to a part of the brain).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/16/2026, indicated Resident 1 had the ability to understand and be understood. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with lower body dressing and putting on and taking off footwear, required supervision (helper provides verbal cues and or touching steadying, contact guard assistance as resident completes activity) with toileting, showering, upper body dressing and personal hygiene and required set up or clean up assistance (helper sets up or cleans up resident completes activity) eating, and oral hygiene. During a review of Resident 1's SBAR Communication Form, dated 3/30/2026, the SBAR Communication Form indicated Resident 1 was noted with discoloration on her chin and forehead.During a review of Resident 1's Progress Note titled, Medical Practitioner Narrative Note, dated 4/2/2026 at 8:15 a.m. the Progress Note indicated Resident 1 was noted to have a fall recently which she (Resident 1) suffered a left shoulder dislocation, bruising to her chin, and a bump on her forehead. During an interview on 4/28/2026 at 3:44 p.m. with the Assistant Director of Nursing (ADON), the ADON stated she (ADON) spoke with the Nurse Practitioner (NP 1) regarding her (NP 1) note, dated 4/2/2026, about Resident 1's fall and NP 1 stated she (NP 1) assumed Resident 1 had a fall and that no one told her (NP 1) that Resident 1 had a fall. The ADON stated NP 1 did a correction on her note today (4/28/2026). The ADON stated this is inaccurate information and may be confusing if not corrected.During an interview on 4/28/2026 at 4:15 p.m. with Director of Nursing (DON), the DON stated NP 1's note, dated 4/2/2026, was inaccurate because Resident 1 did not have a fall. The DON stated this inaccurate information can cause confusion. b. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities)), difficulty walking, and severe protein-calorie malnutrition (a life-threatening condition caused by long-term, extreme lack of protein and energy intake, resulting in dramatic weight loss, significant muscle and fat wasting, and potential swelling [edema]).During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had the ability to understand and be understood. The MDS indicated Resident 3 required supervision or touching assistance with toileting, showering, lower body dressing, and putting on and taking off footwear, and setup or clean up assistance with upper body dressing and personal hygiene, and was independent with eating, and oral hygiene.During a review of Resident 3's SBAR Communication Form, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 4/2/2026, the SBAR Communication Form indicated Resident 3 had a fall. The SBAR Communication Form indicated Resident 3 was last seen by Certified Nursing Assistant (CNA) 1 at 1:38 p.m. sleeping in bed and at 1:40 p.m. discovered Resident 3 on the floor while doing rounds. The SBAR Communication Form indicated physician was notified on 4/2/2026 at 1:45 p.m. with a recommendation to perform X-ray (a quick, painless test that uses invisible electromagnetic energy beams to produce images of the bones, organs, and tissues inside the body) to Resident 3's right arm and right elbow.During a review of Resident 3's Care plan for Resident 3's witnessed fall initiated on 4/2/2026, the Care plan indicated to keep bed in low position with brakes locked, and to keep call light within reach. During a concurrent interview and record review on 4/28/2026 at 2:24 p.m., Resident 3's SBAR Communication form, dated 4/2/2026, was reviewed with Licensed Vocational Nurse (LVN) 3. LVN 3 stated that on 4/2/2026 CNA 1 notified her (LVN 3) that Resident 3 was found on the floor. LVN 3 reviewed SBAR Communication form, dated 4/2/2026, and stated she (LVN 3) was the one who did the SBAR. LVN 3 stated the physician's recommendations were to have an X-ray. LVN 3 stated she cannot recall if the X-ray was ordered. LVN 3 reviewed Resident 3's physician orders and stated there was no order for the X-ray for Resident 3. LVN 3 stated she should have placed the order. LVN 3 stated if X-ray is not ordered, there can be a potential risk for a fracture the facility would not which would result in a delay in Resident 3's care.During an interview on 4/28/2026 at 3:22 p.m. with LVN 3, LVN 3 stated she went back and found a text message from the physician and stated she (LVN 3) documented on the SBAR the recommendation of an X-ray prior to communicating with the physician. LVN 3 stated it was her (LVN 3) recommendation and assumed the physician would order an X-ray, but the physician did not order an X-ray. LVN 3 stated the physician only ordered for wound care treatment. LVN 3 stated she should have gone back and made a note indicating her SBAR was inaccurate to ensure there was no inaccurate information.During a concurrent interview and record review on 4/28/2026 at 3:44 p.m., Resident 3's SBAR Communication Form, dated 4/2/2026, physician orders and care plans were reviewed with the ADON. The ADON stated the SBAR indicated the physician ordered X-ray to Resident 3's right arm and elbow. The ADON reviewed Resident 3's physician orders and stated there was no order for Resident 3 regarding physician's recommendations. The ADON stated that if this was an error by the nurse then there should have been a progress note indicating this was an error. The ADON reviewed Resident 3's progress notes and stated there was no notes regarding the X-ray. The ADON stated there was a potential for delay in care and the facility staff would not know if Resident 3 had an injury. The ADON stated there was a potential for Resident 3 to have continued pain if he had an unidentified fracture. The ADON reviewed Resident 3's care plan for witnessed falls, initiated on 4/2/2026, and stated the care plan indicated it was a witnessed fall. The ADON stated the SBAR, dated 4/2/2026, indicated CNA 1 found Resident 3 on the floor. The ADON stated the care plan was not accurate, and there was a potential for misinformation.During an interview on 4/28/2026 at 4:15 p.m. with the DON, the DON stated for the SBAR dated 4/2/2026 LVN 3 stated it was recommended by the staff and not by the physician to get an X-ray. The DON stated there should have been documentation that the physician did not order the X-ray. The DON stated this is considered inaccurate documentation. The DON stated there is a potential for communication to not be accurate and would appear the order was not done and there was a delay in care. The DON stated that Resident 3's SBAR, dated 4/2/2026, was also inaccurate. The DON stated CNA 1 witnessed the fall. The DON stated the SBAR and care plan do not coincide with each other and they should. The DON stated there is a potential that the plan of care and the documentation will be inaccurate. During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, last reviewed on 1/27/2026, the P&P indicated the documentation in the medical record will be objective, complete and accurate.