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	05/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the Conservator (a court-appointed individual with the legal authority to make personal, medical, and financial decisions for a resident who is no longer capable of making those decisions themselves) of one of three sampled residents (Resident 1) when Resident 1 died on [DATE].This deficient practice resulted in a violation of Resident 1's rights.Findings: During a review of Resident 1's Order Appointing Probate Conservator, filed on [DATE], the Order Appointing Probate Conservator indicated Resident 1's responsible party (RP) 1 was the Conservator of Resident 1 as of [DATE]. During a review of Resident 1's General Acute Care Hospital (GACH) Hospitalist Progress Note, dated [DATE] timed at 7:29 a.m., the Progress Note indicated, Conservatorship paperwork has been initiated due to impaired decision-making capacity.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on [DATE] with diagnoses including cerebral infarction (when blood vessel carrying blood to the brain is blocked or narrowed resulting in the brain tissue to be starved of oxygen causing cells to die), dementia (a decline in mental abilities severe enough to interfere with daily life), dysphagia (difficulty swallowing), and essential hypertension (high blood pressure). The admission Records indicated Resident 1's responsible party was Bioethics. The admission Record indicated the facility discharged Resident 1 on [DATE] at 1:30 p.m. due to being deceased . During a review of Resident 1's Discharge Summary from the General Acute Care Hospital (GACH), dated [DATE], the Discharge Summary indicated GACH discussed placement at Skilled Nursing Facility (SNF) 1 with the Conservator agreeable with the transfer.During a review of Resident 1's History of Present Illness (H&P-a detailed story behind the resident's medical visit), dated [DATE], the H&P indicated Resident 1 did not have the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had the ability to make self understood and was usually understood.During an interview on [DATE] at 3:47 p.m. with the Conservator, the Conservator stated she is the conservator for Resident 1. The Conservator stated Resident 1's family agreed to have Resident 1 conserved. The Conservator stated that when Resident 1 was admitted to Skilled Nursing Facility (SNF) 1 she (Conservator) never heard from SNF 1 and there was no signing of documents for admission for Resident 1. The Conservator stated she made several attempts to call SNF 1 and when she finally contacted SNF 1 and asked for the Ombudsman (OMB) information, then the Conservator finally got a call back informing her that Resident 1 was processed as a Bioethics client because the facility thought Resident 1 had no family and no next of kin. The Conservator stated she informed SNF 1 staff (did not specify) that Resident 1 was conserved. The Conservator stated that when she spoke to SNF 1 staff (did not specify) on [DATE] she was told Resident 1 had passed away on [DATE]. The Conservator stated this was the first time she heard of Resident 1's passing. During a concurrent interview and record review with the admission Coordinator (AC) on [DATE] at 4:22 p.m. Resident 1's admission Record, dated [DATE], was reviewed. The AC stated she was the one who received Resident 1's referral from GACH. The AC reviewed Resident 1's admission Record dated [DATE] and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was the one who completed the form, and she was the one that determined Resident 1 was a bioethics resident because the GACH Case Manager informed her that Resident 1 had family members, but they were not involved. The AC reviewed Resident 1's admission Record and stated she read Resident 1's family listed as emergency contact. The AC stated she did not contact the family.During a concurrent interview and record review on [DATE] at 1:45 p.m. with Social Service Assistant (SSA) 1 Resident 1's admission Record dated [DATE] was reviewed. SSA 1 stated the facility usually tries to get a hold of a conservator. SSA 1 stated she was aware of the note on [DATE] indicating Resident 1's conservatorship was filed on [DATE]. SSA 1 stated she saw Resident 1 on [DATE] and that was when SSA 1 was aware that Resident 1 was conserved. SSA 1 stated she called LA County Conservatorship left a message and did not get a response back. SSA1 stated she only called LA county once and was expecting a call back on [DATE]. SSA 1 stated she would have kept calling the next day but did not. SSA 1 stated she called LA County again on [DATE] but did not make any notes regarding calling the LA County conservatorship. SSA 1 stated that if it was not documented, she cannot say she called LA county conservatorship. SSA 1 stated if the facility did not establish Resident 1's conservatorship there will be a lack of communication. SSA1 stated the facility violated Resident 1's wishes because conservators are there to establish resident's wishes and advocate for the residents.During a review of the Facility Policy and Procedures (P&P) titled, Resident Representative (Bioethics/[NAME] Bill), last reviewed on [DATE], the P&P indicated the facility treats the decision of the resident representative as the decision of the resident to the extent delegated by the resident or to the extent required by the court, in accordance with applicable law. 6. The IDT is responsible for making reasonable efforts to obtain updates or changes that are made by the resident including resident's revocation of delated rights, to ensure that the resident's preferences are being upheld.During a review of the Facility P&P titled, Change in a Resident's Condition or Status, last reviewed on [DATE], the P&P indicated our facility promptly notifies the resident, his or her attending physical, and the resident representative of changes in the resident's medical and mental condition and or status. 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the attending physician (MD) and responsible party (Conservator - a court-appointed individual with the legal authority to make personal, medical, and financial decisions for a resident who is no longer capable of making those decisions themselves) of two of three sampled residents (Resident 1 and Resident 2). The facility failed to:1.Inform Resident 1's MD and the Conservator, when Resident 1 was found unresponsive and died on [DATE].2.Inform Resident 2's MD when Resident 2 was in pain and medication was unavailable on [DATE].These deficient practices resulted in violation of Resident 1's rights and the potential for Resident 2 to have unmanaged pain.Findings: a. During a review of Resident 1's Order Appointing Probate Conservator filed on [DATE], the Order Appointing Probate Conservator indicated Resident 1's responsible party (RP) as the Conservator of Resident 1 as of [DATE]. During a review of Resident 1's Order Appointing Probate Conservator, filed on [DATE], the Order Appointing Probate Conservator indicated Responsible Party (RP) 1 was the conservator of Resident 1 as of [DATE].During a review of Resident 1's General Acute Care Hospital (GACH) Hospitalist Progress Note, dated [DATE] timed at 7:29 a.m., the Progress Note indicated, Conservatorship paperwork has been initiated due to impaired decision-making capacity.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on [DATE] with diagnoses including cerebral infarction (when blood vessel carrying blood to the brain is blocked or narrowed resulting in the brain tissue to be starved of oxygen causing cells to die), dementia (a decline in mental abilities severe enough to interfere with daily life), dysphagia (difficulty swallowing), and essential hypertension (high blood pressure). The admission Records indicated Resident 1's responsible party was Bioethics. The admission Record indicated the facility discharged Resident 1 on [DATE] at 1:30 p.m. due to being deceased .During a review of Resident 1's History of Present Illness (H&P-a detailed story behind the resident's medical visit), dated [DATE], the H&P indicated Resident 1 did not have the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had the ability to make self understood and was usually understood.During a review of Resident 1's Progress Note titled, Health Status Note, dated [DATE] at 1:31 p.m., the Progress Note indicated that at 1:04 p.m. Resident 1 was unresponsive to verbal, and tactile stimulus, and without a pulse. Immediately, cardiopulmonary resuscitation (CPR- a lifesaving emergency procedure used when someone's heart stops beating or they stop breathing) was initiated, code blue activated, code status verified, and other team members came with the crash cart. The Progress note indicated Resident 1's time of death was 1:30 p.m. ([DATE]). During an interview on [DATE] at 3:47 p.m. with the Conservator, the Conservator stated she is the conservator for Resident 1. The Conservator stated Resident 1's family agreed to have Resident 1 conserved. The Conservator stated that when Resident 1 was admitted to Skilled Nursing Facility (SNF) 1 she (Conservator) never heard from SNF 1 and there was no signing of documents for admission for Resident 1. The Conservator stated she made several attempts to call SNF 1 and when she finally contacted SNF 1 and asked for the Ombudsman (OMB) information, then the Conservator finally got a call back informing her that Resident 1 was processed as a Bioethics client because the facility thought Resident 1 had no family and no next of kin. The Conservator stated she informed SNF 1 staff (did not specify) that Resident 1 was conserved. The Conservator stated that when she spoke to SNF 1 staff (did not specify) on [DATE] she was told Resident 1 had passed away on [DATE]. The Conservator stated this was the first time she heard of Resident 1's passing.During a concurrent interview and record review with the admission Coordinator (AC) on [DATE] at 4:22 p.m. Resident 1's admission Record, dated [DATE], was reviewed. The AC stated she was the one who received Resident 1's referral from GACH. The AC reviewed Resident 1's admission Record dated [DATE] and (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was the one who completed the form, and she was the one that determined Resident 1 was a bioethics resident because the GACH Case Manager informed her that Resident 1 had family members, but they were not involved. The AC reviewed Resident 1's admission Record and stated she read Resident 1's family listed as emergency contact. The AC stated she did not contact the family.During an interview on [DATE] at 11:55 a.m. with Registered Nurse (RN) 2, RN 2 stated he worked on [DATE] around 1:02 p.m. and was told by Licensed Vocational Nurse (LVN) 4 that Resident 1 was unresponsive. RN 2 stated CPR was provided to Resident 1 and paramedics were called and arrived in SNF 1 around 1:20 p.m. and around 1:30 p.m. paramedics pronounced Resident 1 dead. RN 2 was not able to provide documented evidence that he notified the MD regarding Resident 1's death. RN 2 stated that if it was not documented, he cannot say he notified Resident 1's MD.During a concurrent interview and record review on [DATE] at 1:45 p.m. with Social Service Assistant (SSA) 1 Resident 1's admission Record dated [DATE] was reviewed. SSA 1 stated the facility usually tries to get a hold of a conservator. SSA 1 stated she was aware of the note on [DATE] indicating Resident 1's conservatorship was filed on [DATE]. SSA 1 stated she saw Resident 1 on [DATE] and that was when SSA 1 was aware that Resident 1 was conserved. SSA 1 stated she called LA County Conservatorship left a message and did not get a response back. SSA1 stated she only called LA county once and was expecting a call back on [DATE]. SSA 1 stated she would have kept calling the next day but did not. SSA 1 stated she called LA County again on [DATE] but did not make any notes regarding calling the LA County conservatorship. SSA 1 stated that if it was not documented, she cannot say she called LA county conservatorship. SSA 1 stated if the facility did not establish Resident 1's conservatorship there will be a lack of communication. SSA1 stated the facility violated Resident 1's wishes because conservators are there to establish resident's wishes and advocate for the residents.During an interview on [DATE] at 2:27 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was under Bioethics. The DON stated MD need to be notified of Changes of Conditions (COC) if not then the MD will not be able to release the body (Resident 1's dead body). The DON stated not notifying the MD and RP (Conservator) can be a potential for delay in care and RP's wishes to be not respected.b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on [DATE] with diagnoses including encounter for surgical aftercare following surgery on the circulatory system (cardiovascular system, it uses your heart to pump blood through a network of vessels, delivering oxygen and nutrients to every cell while carrying away waste), presence of aortocoronary bypass graft (CABG- a surgical procedure that creates a detour around blocked or narrowed arteries supplying blood to the heart), and hypertensive heart disease (any heart problem caused by long-term, unmanaged high blood pressure) with heart failure (a condition where the heart muscle becomes too weak or too stiff to pump blood effectively).During a review of Resident 2 Order Summary Report (OSR), dated [DATE], the OSR indicated:-monitor pain level using the following scale 0= no pain, 1-3= mild pain, 4-6= moderate pain, 7-10= severe pain every shift.-Oxycodone HCl oral tablet 10 milligrams (mg- a unit of measurement) give one table by mouth every 6 hours as needed for moderate to severe pain (4-10/10). Not to exceed 3 grams in 24 hours provide nonpharmacological interventions before administration 1. Relaxation, 2. Deep breathing, 3. Medication, 4. Distraction, 5. Adjust room temp, 6. Hot/cold, give if ineffective, notify doctor if pain is unrelieved. During a review of Resident 2's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated [DATE], the MAR indicated:-On [DATE] at 7:50 a.m. for oxycodone HCl 10 mg give one table by mouth every 6 hours as needed for moderate to severe pain (4-10/10). Not to exceed 3 grams in 24 hours provide nonpharmacological interventions before administration 1. Relaxation, 2. Deep breathing, 3. Medication, 4. Distraction, 5. Adjust room temp, 6. Hot/cold, give if ineffective, notify doctor if pain is unrelieved. MAR indicated Resident 2 had a pain of 6 out of 10 (moderate to severe pain). -Monitor pain level using the following scale 0= no pain, 1-3= mild pain, 4-6= moderate pain, 7-10= severe pain every shift indicated no pain (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment done for Resident 2 on [DATE] night shift, [DATE] day shift, and [DATE] evening shift. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had the ability to understand and was understood. The MDS indicated Resident 2 required substantial assistance (helper does more than half the effort) with toileting, showering, lower body dressing and putting on and taking off footwear and required partial assistance (helper does less than half the effort) upper body dressing, required supervision (helper provides verbal cues and or touching and steading and or contact guard assistance as resident completes activities) with eating, oral hygiene, and personal hygiene.During a review of Resident 2's Care plan (CP), created on [DATE], the CP titled acute pain recent surgery indicated to administer medication as ordered, assess pain every shift and as indicated and pain consult as ordered.During an interview on [DATE] at 1 p.m. with Resident 2, Resident 2 stated she was admitted to SNF 1 on [DATE] and arrived at the facility around 6 p.m. Resident 2 stated she did not receive any medications until the next morning at around 8 a.m. Resident 2 stated she was in pain, had a pain level of 8 out of 10 on her chest because she (Resident 2) had recent heart surgery. Resident 2 stated when she was admitted to SNF at 6 p.m. was already in pain and asked her (Resident 2) nurse for pain medication and was told by the nurse they were ordering it through the pharmacy. Resident 2 stated her pain was 8 out of 10, she could not sleep, and she cried. During an interview on [DATE] at 2:51p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated worked on [DATE] from 7 a.m. to 3 p.m. shift and was the assigned nurse for Resident 2. LVN 2 stated Resident 2 had a surgery on her chest. LVN 2 stated Resident 2's medication had just arrived at the facility and LVN 2 went into Resident 2's room around 8:45 a.m. to 9 a.m. and gave Resident 2 all her morning medications. LVN 2 stated Resident 2 did not appear in pain or distraught at that time. LVN 2 stated when residents are admitted the nurse will transcribe everything via Point Click Care (PCC-electronic patient charting) and the pharmacy will process the medications and get them delivered, it is based on the pharmacy. LVN 2 stated when she arrived to SNF 1 the medications were already delivered. LVN2 stated if there is a concern with pain, and the medications were not yet delivered we can get approval from the pharmacy to pull the medication from Cubex (a brand of secure, automated medication dispensing cabinet often used in nursing homes). LVN 2 stated we follow up with pharmacy, we keep calling pharmacy every few hours until we get the medication.During an interview on [DATE] at 9 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she worked on [DATE] from 11 p.m. to 7 a.m. with Resident 2. CNA 2 stated Resident 2 was complaining of pain around 11 p.m. to 11:30 p.m. when CNA 2 did her initial round. CNA 2 stated Resident 2 was a new admission, and the facility did not have any pain medications. CNA 2 stated Resident 2 did not say how bad the pain was, but Resident 2 was in pain. CNA 2 stated around 6:30 a.m. to 6:40 a.m. went to change Resident 2 and Resident 2 was complaining of pain. CNA2 stated Resident 2 complained of a lot of pain at that time when we tried to change her. During an interview on [DATE] at 1:08 p.m. with the Director of Nursing (DON), the DON stated upon admission, the nurse will review the discharge medication list with the doctor and will see what medications will be continued then the nurse will fax or input the approved medication orders into PCC to the pharmacy. The DON stated the pharmacy has scheduled delivery times 8 p.m., then 8 a.m. the following day. The DON stated we have a cubex that nurses can use when resident's medication is not available. The DON stated when medications are not available the nurse can call the doctor and get it approved. The DON stated the oxycodone that Resident 2 was prescribed is available in Cubex. The DON stated if the medication is not available then the nurse should have called the doctor right away because there is no point in not giving the medication. The DON stated the nurse should have called the doctor to get authorization to use the cubex. The DON stated if resident is in pain we will not be able to meet the resident needs. During a review of the Facility Policy and Procedures (P&P) titled Pain Assessment and Management, last reviewed on [DATE] the P&P indicated ask the resident if he or she is experiencing pain.Assessing Pain:2. Assess the resident at admission and during ongoing assessments. 3. Monitor the resident for the presence of pain and the need for further assessment (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when there is a change of condition. 4. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognition level.The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.During a review of the facility provided Service Agreement with OWL Western Pharmacy, the Service Agreement titled Appendix H: General CUBEX Mediation List, indicated the CUBEX stocked oxycodone HCl 10 mg tablet. During a review of the Facility P&P titled, Change in a Resident's Condition or Status, last reviewed on [DATE] the P&P indicated our facility promptly notifies the resident, his or her attending physical, and the resident representative of changes in the resident's medical and mental condition and or status. 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source.During a review of the Facility P&P titled, Resident Representative, last reviewed on [DATE] the P&P indicated the facility treats the decision of the resident representative as the decision of the resident to the extent delegated by the resident or to the extent required by the court, in accordance with applicable law. 6. The IDT is responsible for making reasonable efforts to obtain updates or changes that are made by the resident including resident's revocation of delated rights, to ensure that the resident's preferences are being upheld.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 2) who complained of pain received medication according to the physician orders. This failure resulted in Resident 2's pain management to be ineffective resulting in Resident 2 being in pain.Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 5/6/2026 with diagnoses including encounter for surgical aftercare following surgery on the circulatory system (cardiovascular system, it uses your heart to pump blood through a network of vessels, delivering oxygen and nutrients to every cell while carrying away waste), presence of aortocoronary bypass graft (CABG- a surgical procedure that creates a detour around blocked or narrowed arteries supplying blood to the heart), and hypertensive heart disease (any heart problem caused by long-term, unmanaged high blood pressure) with heart failure (a condition where the heart muscle becomes too weak or too stiff to pump blood effectively). During a review of Resident 2 Order Summary Report (OSR), dated 5/6/2026, the OSR indicated: -Monitor pain level using the following scale 0= no pain, 1-3= mild pain, 4-6= moderate pain, 7-10= severe pain every shift. -Oxycodone HCl oral tablet 10 milligrams (mg- a unit of measurement) give one table by mouth every 6 hours as needed for moderate to severe pain (4-10/10). Not to exceed 3 grams in 24 hours provide nonpharmacological interventions before administration 1. Relaxation, 2. Deep breathing, 3. Medication, 4. Distraction, 5. Adjust room temp, 6. Hot/cold, give if ineffective, notify doctor if pain is unrelieved. During a review of Resident 2's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated May 2026, the MAR indicated: -On 5/7/2026 at 7:50 a.m. for oxycodone HCl 10 mg give one table by mouth every 6 hours as needed for moderate to severe pain (4-10/10). Not to exceed 3 grams in 24 hours provide nonpharmacological interventions before administration 1. Relaxation, 2. Deep breathing, 3. Medication, 4. Distraction, 5. Adjust room temp, 6. Hot/cold, give if ineffective, notify doctor if pain is unrelieved. MAR indicated Resident 2 had a pain of 6 out of 10 (moderate to severe pain). -Monitor pain level using the following scale 0= no pain, 1-3= mild pain, 4-6= moderate pain, 7-10= severe pain every shift indicated no pain assessment done for Resident 2 on 5/6/26 night shift, 5/7/26 day shift, and 5/7/26 evening shift. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 5/12/2026, the MDS indicated Resident 2 had the ability to understand and was understood. The MDS indicated Resident 2 required substantial assistance (helper does more than half the effort) with toileting, showering, lower body dressing and putting on and taking off footwear and required partial assistance (helper does less than half the effort) upper body dressing, required supervision (helper provides verbal cues and or touching and steading and or contact guard assistance as resident completes activities) with eating, oral hygiene and personal hygiene. During a review of Resident 2's Care plan (CP) created on 5/12/2026, the CP titled acute pain recent surgery indicated to administer Resident 2's medication as ordered, assess pain every shift and as indicated and pain consult as ordered. During an interview on 5/20/2026 at 1 p.m. with Resident 2, Resident 2 stated she was admitted to Skilled Nursing Facility (SNF 1) on 5/6/2026 and arrived at the facility around 6 p.m. Resident 2 stated she did not receive any medications until the next morning at around 8 a.m. Resident 2 stated she was in pain, had a pain level of 8 out of 10 on her chest because she (Resident 2) had a recent heart surgery. Resident 2 stated when she was admitted to SNF at 6 p.m. she was already in pain and asked her (Resident 2) nurse for pain medication and was told by the nurse they were ordering it through the pharmacy. Resident 2 stated her pain was 8 out of 10, she could not sleep, and she cried. During an interview on 5/20/2026 at 2:51 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she worked on 5/7/2026 from 7 a.m. to 3 p.m. shift and was the assigned nurse for Resident 2. LVN 2 stated Resident 2 had a surgery on her chest. LVN 2 stated Resident 2's medication had just arrived at the facility and LVN 2 went into Resident 2's room around 8:45 a.m. to 9 a.m. and gave Resident 2 all her morning medications. LVN 2 stated (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2 did not appear in pain or distraught at that time. LVN 2 stated when residents are admitted the nurse will transcribe everything via Point Click Care (PCC-electronic patient charting) and the pharmacy will process the medications and get them delivered, it is based on the pharmacy. LVN 2 stated when she arrived to SNF 1 the medications were already delivered. LVN2 stated if there is a concern with pain, and the medications are not yet delivered we can get approval from the pharmacy to pull the medication from Cubex (a brand of secure, automated medication dispensing cabinet often used in nursing homes). LVN 2 stated we follow up with pharmacy we keep calling pharmacy every few hours until we get the medication.During an interview on 5/21/2026 at 9 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she worked on 5/6/2026 from 11 p.m. to 7 a.m. with Resident 2. CNA 2 stated Resident 2 was complaining of pain around 11 p.m. to 11:30 p.m. when CNA 2 did her initial round. CNA 2 stated Resident 2 was a new admission, and the facility did not have any pain medications. CNA 2 stated Resident 2 did not say how bad the pain was, but Resident 2 was in pain. CNA 2 stated around 6:30 a.m. to 6:40 a.m. went to change Resident 2 and Resident 2 was complaining of pain. CNA 2 stated Resident 2 complained of a lot of pain at that time when we tried to change her. During an interview on 5/21/2026 at 1:08 p.m. with the Director of Nursing (DON), the DON stated upon admission, the nurse will review the discharge medication list with the doctor and will see what medications will be continued then the nurse will fax or input the approved medication orders into PCC to the pharmacy. The DON stated the pharmacy has scheduled delivery times 8 p.m., then 8 a.m. the following day. The DON stated we have a cubex that nurses can use when residents' medication is not available. The DON stated when medications are not available the nurse can call the doctor and get it approved. The DON stated the oxycodone that Resident 2 was prescribed is available in Cubex. The DON stated if the medication is not available then nurse should have called the doctor right away, because there is no point in not giving the medication. The DON stated nurse should have called the doctor to get authorization to use the cubex. The DON stated if resident is in pain we will not be able to meet the resident needs. During a review of the Facility Policy and Procedures (P&P) titled, Pain Assessment and Management, last reviewed on 4/27/2026, the P&P indicated to ask the resident if he or she is experiencing pain.Assessing Pain:2. Assess the resident at admission and during ongoing assessments. 3. Monitor the resident for the presence of pain and the need for further assessment when there is a change of condition. 4. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognition level.The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications. During a review of the facility provided Service Agreement with OWL Western Pharmacy, the Service Agreement titled Appendix H: General CUBEX Mediation List, indicated the CUBEX stocked oxycodone HCl 10 mg tablet.