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	05/29/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review, the facility failed to follow the Responsible Party's (RPs- the individual legally and financially accountable for paying medical bills) request to be notified prior to any ancillary services (are diagnostic, therapeutic, or custodial support measures that assist primary care providers in treating residents). On 5/18/2026, the Podiatrist (a physician and surgeon who treats the foot, ankle, and related structures of the leg), trimmed one of three sampled residents (Resident 1) toenails without RP's approval.This failure had violated the RPs right to be informed.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 3/14/2012, with diagnoses that included unspecified (unconfirmed) Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and unspecified peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). The admission Record indicated the RP had power of attorney (POA- a legal document that allows someone else to act on a person's behalf).During a review of Resident 1's Physician Order, dated 10/29/2025, the Physician Order indicated no ancillary consults to be performed without prior notice and approval from Resident 1's RP.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 4/19/2026, 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 4/30/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Convalescent Podiatry Care Evaluation and Treatment (Podiatry [a specialized branch of medicine focused on the prevention, diagnosis, and treatment of conditions affecting the feet, ankles, and lower legs] Notes), dated 5/18/2026, the Podiatry Notes indicated Resident 1 had debridement (the medical process of removing dead, damaged, or infected tissue from a wound) and trimming of toenails utilizing nail clipper (a specialized hand tool used to safely trim and maintain fingernails and toenails) and Dreme (power tool features a small, interchangeable tip that spins at incredibly high speeds).During an interview on 5/29/2026, at 9:15 a.m., with the RP, the RP stated on 5/18/2026, she (RP) had noticed that someone had cut Resident 1's toenails. The RP stated that she (RP) had verbalized and had multiple meetings with staff during Interdisciplinary Team meetings (IDT-a coordinated group of experts from several different fields who work together) that she (RP) had to be informed first before Resident 1 can be seen by other outside services like Podiatrist.During an interview on 5/29/2026, at 9:35 a.m. with the Social Service Assistant (SSA), the SSA stated that on 5/17/2026, the nurse had notified her (SSA) that Resident 1 needed to be seen by a podiatrist for the trimming of the long toenails. The SSA stated the facility emailed the Podiatrist for referrals. The SSA stated Resident 1 was not her regular resident and she (SSA) was only covering for another SSA who was out on leave reason why she (SSA) was not familiar with Resident 1. The SSA stated she (SSA) had not noticed that Resident 1's RP had (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
	056039	A. Building B. Wing	05/29/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested Resident 1 not to be seen by any ancillary services unless RP was informed and had agreed. The SSA stated the Podiatrist came on 5/18/2026, and trimmed Resident 1's toenails. The SSA stated she (SSA) only found out about no ancillary services, when the RP spoke to her (SSA) and notified her (SSA) on 5/19/2026. The SSA stated Resident 1's RP was not notified before the Podiatrist came and trimmed Resident 1's toenails. The SSA stated the facility violated Resident 1's RP's right to be informed before the procedure is done. The SSA stated the RP was the one advocating for Resident 1's right. During an interview on 5/29/2026, at 10:54 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 1's RP had POA and was always the one deciding for Resident 1. The ADON stated the facility violated RP's right to be informed prior to a procedure. The ADON stated not informing RP of a procedure could affect RP's trust in the facility.During an interview on 5/29/2026, at 11:17 a.m., with the Director of Nursing (DON), the DON stated Resident 1 had no capacity to decide for herself. The DON stated the RP advocates (a person who represents another person's interests) for Resident 1 and had POA. The DON stated RP had prior requests that no ancillary services unless she (RP) was notified. The DON stated the facility did not follow the part of notifying RP first before Resident 1 can be seen by the Podiatrist. The DON stated the facility notified her (RP) after the Podiatrist had already trimmed Resident 1's toenails. The DON stated because the RP was not notified the RP was not pleased with the facility. The DON stated the RP should have been informed prior to podiatrist visit.During an interview on 5/29/2026, at 12:47 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated RP's right was not followed. LVN 1 stated RP requests to be informed prior to any ancillary services should be followed.During a review of facility's policy and procedure (P&P) titled, Resident Rights, dated 4/27/2026, was reviewed. The P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . a. a dignified existence;b. treated with respect, kindness, and dignity; .h. appoints a legal representative of his or her choice, in accordance with state law.