

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/09/2026
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)		
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. Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained dignity for one of the three sampled residents (Resident 4) by failing to ensure Resident 4 was provided with silverware (eating utensils such as forks, knives, and spoons) with breakfast tray. On 6/8/2026, Licensed Vocational Nurse (LVN) 1 provided disposable utensils to Resident 4. This failure had the potential to negatively affect Resident 4's self-esteem and self-worth. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 2/27/2026, with diagnoses that included sacral (tailbone) stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), mild protein-calorie malnutrition (a condition where the body receives inadequate protein and/or calories, leading to measurable but generally reversible physical changes) and adult failure to thrive (a syndrome characterized by unintended weight loss, decreased appetite, poor nutrition, and physical or mental decline). During a review of Resident 4'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 3/2/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 4's Order Summary Report, dated 4/30/2026, the Order Summary Report indicated controlled carbohydrate (a meal plan that regulates the amount of carbohydrates resident eats to maintain stable blood sugar levels) regular textured diet (a normal, everyday diet requiring no restrictions or modifications). During an observation on 6/8/2026 at 8:57 a.m., outside of Resident 4's room, Certified Nursing Assistant (CNA) 2 delivered a food tray inside Resident 4's room. Observed the food tray had no utensils. During an observation on 6/8/2026 at 9:23 a.m. inside Resident 4's room, observed the breakfast tray unopened. During an interview on 6/8/2026 at 9:41 a.m. with LVN 1, LVN 1 stated Resident 4's breakfast tray had missing utensils. LVN 1 stated it could delay Resident 4's food intake. During an interview on 6/8/2026 at 9:46 a.m. with the Assistant Director of Nursing (ADON), the ADON stated kitchen staff should check for the completeness of the meal tray. During a concurrent observation and interview on 6/8/2026 at 9:48 a.m. with CNA 2, CNA 2 stated it was the kitchen's staff responsibility to ensure the residents had utensils. CNA 2 observed and stated Resident 4 was eating using a disposable spoon. During a concurrent interview and record review on 6/8/2026 at 10:05 a.m. with the Assistant Dietary Supervisor (ADS), Resident 4's Meal Ticket, was reviewed. The ADS stated the facility provides silverware to residents. The ADS stated if Resident 4 prefers disposable utensils it will be indicated in Resident 4's Meal Ticket under the Alerts. The ADS stated Resident 4's Meal Ticket did not indicate Resident 4's preference for disposable utensils. The ADS stated Resident 4 should have been provided with silverware for dignity purposes. During an interview on 6/8/2026 at 10:56 a.m. with the Director of Nursing (DON), the DON stated Resident 4 should have been provided with regular silverware unless it's Resident 4's preference. The DON stated providing disposable utensils could (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	affect Resident 4's dignity.During a review of facility's policy and procedure (P&P) titled, Meal Service, dated 2023, and last reviewed on 4/27/2026, the P&P indicated, Trays will be delivered as completed to a designated area at a predetermined time for Nursing to pick up.8. Nursing personnel will serve the trays immediately upon checking the tray to be sure nothing is missing from the tray and the diets are correct.During a review of facility's P&P titled, Dignity, dated 4/27/2026, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times.During a review of facility's P&P titled, Resident Rights, dated 4/27/2026, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity.1. 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. be treated with respect, kindness, and dignity; .		

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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. Based on interview and record review, the facility failed to promptly notify one of three sampled residents (Resident 3) Responsible Party (RP) 1 of Resident 3's change in condition on 6/1/2026, before Resident 3 was transferred to the General Acute Care Hospital (GACH). This failure had violated RP's 1's right to be informed and had the potential to increase RP 1's level of anxiety (an intense, persistent, and often overwhelming feeling of worry, dread, or unease). Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 12/27/2023, with diagnoses including unspecified (unconfirmed) Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and unspecified schizophrenia (a mental illness that is characterized by disturbances in thought). The admission Record indicated RP 1 was Resident 3's responsible party. During a review of Resident 3'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 12/5/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 4/6/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. During a review of Resident 3's Change in Condition Evaluation (CIC - a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 6/1/2026, timed at 8:03 p.m., the CIC indicated Resident 3 had behavioral symptoms, nausea and vomiting. The CIC indicated Resident 3 had unmanageable behavior of disturbing other residents and had two episodes of coffee ground emesis (vomit that looks like dark brown or black coffee grounds). The CIC indicated the Physician was notified on 6/1/2026, at 8:15 p.m. and ordered to transfer Resident 3 to GACH. The CIC indicated RP 1 was notified on 6/1/2026, at 7 p.m. (one hour before the CIC and before the physician ordered the transfer to GACH). During a review of Resident 3's Progress Notes, dated 6/1/2026, timed at 9:00 p.m., the Progress Notes indicated transportation arrived to pick up Resident 3. During a review of Resident 3's Progress Notes, dated 6/1/2026, timed at 9:50 p.m., the Progress Notes indicated Resident 3's family arrived at the facility and RN 1 informed the family of Resident 3's significant changes. During an interview on 6/4/2026 at 3 p.m. with RP 1, RP 1 stated that on 6/1/2026, at 7:45 p.m., she (RP 1) received a call that Resident 3 had unmanageable behavior and that the Physician had ordered to transfer Resident 3 to GACH. RP 1 stated she (RP 1) was not informed that Resident 3 had vomited. RP 1 stated when she (RP 1) got to the facility, Resident 3 was not there, and RN 1 just notified her (RP 1) that Resident 3 had vomited coffee ground emesis. RP 1 stated nobody had contacted and informed her (RP 1) that Resident 3 had coffee ground emesis before the transfer. During an interview on 6/8/2026 at 1:12 p.m. with RN 1, RN 1 stated Resident 3 had a CIC of unmanageable behavior and she (RN 1) called the Physician who ordered to transfer Resident 3 to GACH. RN 1 stated transport was arranged at 11 p.m. pick up but transport arrived between 9 p.m. to 10 p.m. RN 1 stated before 9 p.m., Resident 3 had coffee ground emesis. RN 1 stated she (RN 1) had called RP 1 for the unmanageable behavior and was about to call RP 1 again for the coffee ground emesis, but transport arrived and picked up Resident 3. RN 1 stated she (RN 1) was not able to call RP 1 before the transfer because she (RN 1) got busy with another resident and did not have enough time to call RP 1. RN 1 stated she (RN 1) should have called RP 1 of Resident 3's coffee ground emesis before the transfer. RN 1 stated she (RN 1) should have called before the transfer to inform RP 1 of what's going on with Resident 3. During an interview on 6/8/2026 at 1:30 p.m. with the Assistant Director of Nursing (ADON), the ADON stated family should be notified of CIC for them to be informed. During a review of facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 4/27/2026, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician and the resident representative of the changes in the (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident medical/mental condition and/or status.4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: . b. there is a significant change in the resident's physical, mental, or psychosocial status; .e. it is necessary to transfer the resident to a hospital/treatment center.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review the facility failed to notify the resident's Responsible Party (RP - when signing admissions paperwork for a hospital, nursing home, or assisted living facility, the responsible party is the person designated to make medical or administrative decisions for the resident) of the transfer and the reasons for the move in writing for one of three sampled residents (Resident 3). This failure had the potential for incomplete information conveyed to residents or RP 1 and could have violated resident and RP 1's rights to appeal (the process in which cases are reviewed by a higher authority) transfer or discharge. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 12/27/2023, with diagnoses that included unspecified (unconfirmed) Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and unspecified schizophrenia (a mental illness that is characterized by disturbances in thought). The admission Record indicated RP 1 was Resident 3's responsible party. During a review of Resident 3'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 12/5/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 4/6/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 3 required maximum assistance from staff for eating, oral hygiene and personal hygiene. During a review of Resident 3's Change in Condition Evaluation (CIC - a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 6/1/2026, at 8:03 p.m., the CIC indicated Resident 3 had unmanageable behavior of disturbing other residents and had two episodes of coffee ground emesis (vomit that looks like dark brown or black coffee grounds). The CIC indicated that the Physician was notified on 6/1/2026, at 8:15 p.m. and ordered to transfer Resident 3 to General Acute Care Hospital (GACH). The CIC indicated RP 1 was notified on 6/1/2026, at 7 p.m. (one hour before the CIC and before the physician order the transfer to GACH). During a review of Resident 3's Notice of Proposed Transfer/Discharge, dated 6/1/2026, timed at 8:36 p.m., the Notice of Proposed Transfer/Discharge indicated the transfer is necessary for the resident's welfare and the residents' needs cannot be met at the facility due to unmanageable behavior and two episodes of coffee ground emesis. The Notice of Proposed Transfer/Discharge indicated RP 1 signed the form as verified by Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 7. During a review of Resident 3's Progress Notes, dated 6/1/2026, timed at 9 p.m., the Progress Notes indicated the transportation arrived to pick up Resident 3. During a review of Resident 3's Skilled Nursing Facility (SNF) to Hospital Transfer Form (Transfer Form), dated 6/1/2026, the Transfer Form indicated the reason for transfer was behavioral symptoms. The Transfer Form indicated RP 1 was notified and aware of clinical symptoms. The Transfer Form did not indicate coffee ground emesis. During a review of Resident 3's Progress Notes, dated 6/1/2026, timed at 9:40 p.m., the Progress Notes indicated Resident 3 left the facility, family and physician informed. During a review of Resident 3's Progress Notes, dated 6/1/2026, timed at 9:50 p.m., the Progress Notes indicated Resident 3's family arrived at the facility, spoke with RN 1 and RN 1 informed and explained Resident 3's significant changes. During an interview on 6/2/2026 at 1:27 p.m. with RP 1, RP 1 stated on 6/1/2026, when she (RP 1) arrived at the facility, Resident 3 was already picked up by transportation to go to GACH. RP1 stated there was no form provided to her (RP 1) that Resident 3 will be transferred to GACH. During an interview on 6/4/2026 at 3 p.m. with RP 1, RP 1 stated on 6/1/2026, at 7:45 p.m., RP 1 received a call from LVN 7 informing her (RP 1) that Resident 3 will be transferred to GACH for unmanageable behavior, not about the coffee ground emesis. During an interview on 6/5/2026 at 2:55 p.m. with LVN 7, LVN 7 stated on 6/1/2026, she (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed the Notice of Proposed Transfer and Discharge (Transfer Form). LVN 7 stated when she (LVN 7) completed the Transfer Form there was no signature from RP 1. LVN 7 stated she (LVN 7) had faxed (to send an exact electronic replica of a page, complete with text, images, and signatures from one machine to another over a telephone line or the internet) a copy to the Long Term Care Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities). LVN 7 stated she (LVN 7) called RP 1 before the transfer and RP 1 agreed. LVN 7 stated Resident 3 left the facility on 6/1/2026, before 9 p.m. During an interview on 6/8/2026 at 1:12 p.m. with RN 1, RN 1 stated on 6/1/2026, Resident 3 was scheduled for 11 p.m. pick up to be transferred to GACH for behavioral management. RN 1 stated on 6/1/2026, she (RN 1) called and informed RP 1 that Resident 3 will be picked up at 11 p.m. to be transferred to GACH. RN 1 stated the transportation was already arranged. RN 1 stated RP 1 and family arrived at the facility, but Resident 3 was already transferred out since transportation arrived earlier than scheduled between 9 p.m. to 10 p.m. RN 1 stated she (RN 1) forgot to ask RP 1 to sign the Notice of Proposed Transfer/Discharge. RN 1 stated she (RN 1) wrote RP 1's name on the Notice of Proposed Transfer/Discharge since she (RN 1) had already called and notified RP 1 of the transfer due to behavior. RN 1 stated the signature in the Notice of Proposed Transfer/Discharge was not RP 1's signature. RN 1 stated she (RN 1) did not provide a copy of the Notice of Proposed Transfer/Discharge when RP 1 came at the facility on 6/1/2026. During an interview on 6/8/2026 at 1:30 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the nurses are in charge of providing a copy of the Notice of Proposed Transfer/Discharge to resident or RP. The ADON stated if it's a planned transfer the Social Service or Case Manager will be in charge. The ADON stated the Notice of Proposed Transfer/Discharge should be provided to RP 1 so RP 1 will be aware of the transfer reason and knows where Resident 3 will be transferred to. During an interview on 6/9/2026 at 10:39 a.m. with the Director of Nursing (DON), the DON stated the facility only provides the Notice of Proposed Transfer/Discharge if the discharge or transfer is planned. The DON stated if residents were transferred due to a change in condition, the facility does not provide a copy of the Notice of Proposed Transfer/Discharge. During a review of facility's policy and procedure (P&P) titled, Transfer or Discharge Notices, dated 4/27/2026, the P&P indicated, Residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Notice of Transfer or Discharge (Anticipated) 1. Under the following circumstances, the notice of transfer is given as soon as it is practicable but before the transfer or discharge: a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; b. The resident's health improves sufficiently to allow a more immediate transfer or discharge; c. An immediate transfer or discharge is required by the resident's urgent medical needs; or 2. The residents and representatives are notified in writing of the following information: a. The specific reason for the transfer or discharge, including the basis. b. The effective date of the transfer or discharge; c. The specific location (such as the name of the new provider, description, and/or address if the location is a residence) to which the resident is being transferred or discharged; d. The name, address, and telephone number of the Office of the State Long-term Care Ombudsman; e. The Notice of Facility Bed-Hold and policies; f. The name, address, email, and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); and g. The name, address, email, and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies). 3. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the residents and representatives. 4. When a resident is sent emergently to an acute care setting, this is considered a transfer, not discharge, because the resident's return is generally expected. 5. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (in a monthly list of residents that includes all notice content requirements).		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) for one of three sampled residents (Resident 4) by failing to ensure the low air loss mattress (LALM-a mattress designed to distribute the patient's body weight over a broad surface area to prevent skin breakdown and treat pressure ulcers) was set according to Resident 4's weight as per physician order and manufacturer's guidelines (the official recommendations and standards set by the company that built a product that outline the proper procedures for installation, operation, maintenance, and troubleshooting, ensuring the product functions safely, efficiently, and within its warranty limits). This failure had the potential for the worsening of Resident 4's pressure ulcers. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 2/27/2026, with diagnoses that included sacral (tailbone) stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), mild protein-calorie malnutrition (a condition where the body receives inadequate protein and/or calories, leading to measurable but generally reversible physical changes) and adult failure to thrive (a syndrome characterized by unintended weight loss, decreased appetite, poor nutrition, and physical or mental decline). During a review of Resident 4's Care Plan, dated 2/28/2026, for LALM for wound management, the Care Plan indicated an intervention to set at resident's weight. During a review of Resident 4's Order Summary Report, dated 3/1/2026, the Order Summary Report indicated LALM for wound management, set to residents' weight. During a review of Resident 4'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 3/2/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 4's weight was 100 pounds (lbs-unit of weight and mass). During an observation on 6/8/2026, at 9:28 a.m., inside Resident 4's room, Resident 4 was on LALM and was set at 180 lbs. The low air loss machine had an arrow pointing close to 90 lbs. During a concurrent interview and record review on 6/8/2026, at 9:34 a.m., with the Assistant Director of Nursing (ADON), Resident 4's weight was reviewed. The ADON stated Resident 4's weight was 103 lbs on 6/2026. During a concurrent observation and interview on 6/8/2026, at 9:35 a.m., with the ADON, inside Resident 4's room. The ADON stated Resident 4's LALM was set at 180 lbs. and should be set close to 90 lbs. The ADON stated the LALM setting should be at Resident 4's weight level. During an interview on 6/8/2026, at 9:40 a.m., with the Treatment Nurse (TN), TN stated LALM setting should be based on resident's weight. The TN stated if the setting was above the resident's weight, the pressure was not circulating properly, and the LALM was not beneficial to Resident 4. During an interview on 6/8/2026, at 10:48 am, with the ADON, the ADON stated LALM setting should be based on weight to prevent skin breakdown. The ADON stated if the setting is higher, the bed is firmer and defeats the purpose of the LALM. During an interview on 6/8/2026, at 10:56 a.m., with the Director of Nursing (DON), the DON stated LALM should be based on Resident 4's weight to prevent pressure ulcer and for Resident 4's comfort. During a review of the facility's LALM Manufacturers' Guidelines, dated 1/31/2024, the Manufacturer's Guidelines indicated, The system is a high quality and affordable mattress system suitable for treatment and prevention of pressure ulcers. This product is intended to help and reduce the incidence of pressure ulcers while optimizing patient comfort. Higher pressure output will support the heavier weight patient. According to the weight and height of the patient, adjust the pressure setting to the most comfortable level without bottoming out, then the pressure in mattress will slowly increase to the intended value after the air mattress is ready to use.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for two of three sampled residents (Residents 1, and 2) by failing:1. To ensure Licensed Vocational Nurse 4 (LVN 4) follow physician order to hold (to temporarily pause or skip a dose as instructed by a healthcare professional) losartan (medication used to treat hypertension [HTN- high blood pressure]) for Resident 1's systolic blood pressure (sbp- the top or first number in a blood pressure reading. It measures the maximum pressure the blood exerts against the artery walls when the heart beats and pumps blood throughout the body) below 110 millimeters mercury (mmHg-standard unit of measurement for pressure) on 5/14/2026, at 9 a.m.2. To ensure LVN 3, LVN 5 and LVN 6 follow physician order to hold clonidine (medication used to treat HTN) and hydralazine (medication used to treat HTN) for Resident 2's sbp below 110 mmHg on 5/14/2026, at 6 a.m., 12 noon, 1 p.m., and on 5/16/2026, at 6 a.m. These failures had the potential to result in medication errors and could result in Resident 1 and 2's hypotension that could possibly cause fall and injury. Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/2/2026, with diagnoses that included essential HTN and cerebral infarction (occurs when a blocked or narrowed blood vessel cuts off the blood supply to part of the brain). During a review of Resident 1's Physician Order, dated 5/2/2026, the Physician Order indicated losartan potassium oral tablet 50 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth daily for HTN, hold if sbp below 110 mmHg. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 5/8/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 5/2/2026, the MAR indicated on 5/14/2026, at 9 a.m., LVN 4 administered losartan to Resident 1 who had a blood pressure of 101/68 mmHg. During a concurrent interview and record review on 6/8/2026, at 10:18 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Physician Order, dated 5/2/2026, and MAR, dated 5/2/2026, were reviewed. The ADON stated on 5/14/2026, at 9 a.m., LVN 4 administered losartan to Resident 1 who had a blood pressure of 101/68 mmHg. The ADON stated the physician order was not followed. The ADON stated LVN 4 should read the physician order and held the losartan. The ADON stated Resident 1 could experience hypotension (low blood pressure). b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 8/7/2024, with diagnoses that included unspecified (unconfirmed) nontraumatic subdural hemorrhage (bleeding in the space between the brain and skull without a history of head injury), and hypertensive chronic kidney disease (kidney damage and impaired function caused by long-term, unmanaged high blood pressure). 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 8/13/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decisions were intact. During a review of Resident 2's Order Recapitulation Report, dated 5/9/2026, the Order Recapitulation Report indicated the following orders:1. Clonidine hydrochloride tablet 0.2 mg, give one tablet by mouth two times a day for HTN, hold for sbp below 110 mmHg.2. Hydralazine hydrochloride oral tablet 50 mg, give one tablet by mouth every six hours for HTN, hold for sbp below 110 mmHg. During a review of Resident 2's MAR, dated 5/2026, the MAR indicated the following:1. LVN 3 administered clonidine on 5/14/2026, at 1 p.m. with blood pressure of 103/64 mmHg.2. LVN 5 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Mirage Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 44445 15th St W Lancaster, CA 93534	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered hydralazine on 5/14/2026, at 6 a.m. with blood pressure of 94/60 mmHg.3. LVN 3 administered hydralazine on 5/14/2026, at 12 noon with blood pressure of 103/64 mmHg.4. LVN 6 administered hydralazine on 5/16/2026, at 6 a.m. with blood pressure of 109/89 mmHg. During a concurrent interview and record review on 6/5/2026, at 3:12 p.m., with the Director of Staff Development (DSD), Resident 2's Physician Order, dated 5/9/2026, and MAR, dated 5/2026, were reviewed. The DSD stated the physician ordered to hold the clonidine and hydralazine for sbp below 110 mmHg. The DSD stated LVN 3 should have held the clonidine on 5/14/2026, at 12 noon, since Resident 2's blood pressure was 103/64 mmHg. The DSD stated on 5/14/2026, at 1 p.m., LVN 3 should have held the hydralazine since Resident 2's blood pressure was still at 103/64 mmHg. The DSD stated LVN 5 should have held the hydralazine on 5/14/2026, at 6 a.m., since Resident 2's blood pressure was 94/60 mmHg. The DSD stated LVN 6 should have held the hydralazine on 5/16/2026, at 6 a.m., since Resident 2's blood pressure was 109/80 mmHg. The DSD stated Resident 2's could develop hypotension. During an interview on 6/5/2026, at 3:31 p.m. with the ADON, the ADON stated Resident 2 could develop orthostatic hypotension (a sudden drop in blood pressure that occurs when you stand up after sitting or lying down) because the LVNs administered the blood pressure medications below the parameter ordered by the physician. During an interview on 6/8/2026, at 10:56 a.m., with the Director of Nursing (DON), the DON stated Residents 1 and 2 could potentially experience hypotension. The DON stated LVNs 3, 4, 5 and 6 should check the blood pressure, compare result with the order and should have held the blood pressure medication as per physician order. During an interview on 6/8/2026, at 1:49 p.m., with LVN 3, LVN 3 stated she (LVN 3) did not have any documented evidence that she (LVN 3) had held the blood pressure medication. LVN 3 stated Resident 2's medical record indicated she (LVN 3) had administered clonidine and hydralazine on 5/14/2026. LVN 3 stated administration of blood pressure medication to a resident with low blood pressure can cause further drop of blood pressure causing hypotension. During an interview on 6/8/2026, at 1:54 p.m., with LVN 5, LVN 5 stated he (LVN 5) might have clicked administered accidentally. LVN 5 stated he (LVN 5) does not have documentary evidence that he (LVN 5) held the blood pressure medication on 5/16/2026, at 6 a.m. LVN 5 stated there were too many things to click in the electronic health record. LVN 5 stated he (LVN 5) honestly does not read everything. LVN 5 stated Resident 2's blood pressure can go down if medicated with blood pressure medication when Resident 2's blood pressure was already low at 94/60 mmHg and could result in fall and injury. During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 4/27/2026, was reviewed. The P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.11. The following information is checked/verified for each resident prior to administering medications: . b. Vital signs, if necessary. During a review of facility's P&P, titled, Adverse Consequences and Medication Errors, dated 4/27/2026, the P&P indicated, A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with provider's orders.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on observation, interview, and record review, the facility failed to ensure that resident's was free of unnecessary medication for one of three sampled residents (Resident 3) by failing to ensure Licensed Vocational Nurse (LVN) 8 and LVN 9 adequately monitor and document for the manifested behavior of restlessness for a resident who received antianxiety medications (medications used to treat symptoms of anxiety, such as excessive worry, panic attacks, fear, and physical tension). This failure had the potential to result in Resident 3 receiving unnecessary medications and not receiving the adequate care and treatment necessary for physical, mental and psychosocial well-being. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 12/27/2023, with diagnoses that included unspecified (unconfirmed) Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and unspecified schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 3'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 12/5/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 4/6/2026, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 3 was on antianxiety medications. During a review of Resident 3's Physician Order, dated 5/3/2026, the Physician Order indicated Ativan (medication used to treat anxiety disorders) oral tablet 0.5 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every six hours as needed for anxiety manifested by restlessness as evidenced by yelling and rocking back and forth aggressively for 14 days. During a review of Resident 3's Order Recapitulation Report, dated 5/3/2026, the Order Recapitulation Report indicated monitor behavior episode of antianxiety use manifested by restlessness as evidenced by yelling and rocking back and forth aggressively. During a review of Resident 3's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 5/2026, the MAR indicated Resident 3 had one behavioral episode of restlessness as evidenced by yelling and rocking back and forth aggressively on 5/4/2026, and 5/10/2026, from 3 p.m., to 11 p.m. During a review of Resident 3's MAR, dated 5/2026, the MAR indicated the following: 1. Licensed Vocational Nurse 8 (LVN 8) administered Ativan on 5/5/2026, 5/6/2026, 5/10/2026, 5/11/2026, 5/12/2026, 5/13/2026, 5/14/2026 and 5/17/2026 between 8:03 a.m. to 8:39 a.m. 2. LVN 9 administered Ativan on 5/9/2026, at 7:45 p.m. During an interview on 6/4/2026, at 3 p.m., with Responsible Party 1 (RP 1), RP 1 stated on 6/1/2026, at 7:45 p.m., she (RP 1) received a call that Resident 3 will be transferred to General Acute Care Hospital (GACH) for unmanageable behavior. During a concurrent interview and record review on 6/5/2026, at 3:31 p.m., with the Assistant Director of Nursing (ADON), Resident 3's Physician Order, dated 5/3/2026, and MAR, dated 5/2026, were reviewed. The ADON stated the physician ordered Ativan on 5/3/2026, for anxiety manifested by restlessness as evidenced by yelling. The ADON stated the monitoring for the behavior was documented in the MAR. The ADON stated the MAR indicated two episodes of restlessness, one on 5/4/2026, and one on 5/10/2026, at 3 p.m. to 11 p.m. The ADON stated the MAR did not indicate the behavior on 5/5/2026, 5/6/2026, 5/9/2026, 5/11/2026, 5/12/2026, 5/13/2026, 5/14/2026, and 5/17/2026. The ADON stated the Ativan was ordered to be administered as needed for Resident 3's behavior. The ADON stated the nurses should have documented the behavior in MAR to justify the need for Ativan. The ADON stated it was important to document number of episodes of behavior to inform the physician if the medication needs to be adjusted or not. During a concurrent interview and record review on 6/9/2026, at 9:29 a.m., with ADON, Resident 3's Progress Notes, dated 5/2026, were reviewed. The ADON stated the nurses should document reason why they administer the Ativan since it was ordered as needed. The (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON stated there were no documented episodes of behavior in Resident 3's Progress Notes. The DON stated the Ativan should be given as per physician order. During an interview on 6/9/2026, at 10:39 a.m., with the Director of Nursing (DON), the DON stated the nurses should document in Resident 3's medical record why they administered the Ativan. The DON stated the nurses should document number of Resident 3's behavioral episode of restlessness in the MAR or Progress notes. The DON stated Resident 3 had behavior, but nurses did not document that Resident 3 had behavior and still administered the Ativan. The DON stated since nurses did not document Resident 3's behavior, the nurses did not follow the physician order to medicate resident, only if Resident 3 had a behavior of restlessness. During a review of facility's policy and procedure (P&P) titled, Psychotropic (medication that affects the brain and alters the mood, thoughts, behavior, or perception) Medication Use, dated 4/27/2026, was reviewed. 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. 2. Psychotropic medication management is an interdisciplinary process (when different fields or areas of expertise team up to tackle a problem) that involves the resident, family, and/or the representative and includes: a. determining adequate indications for use; Adequate Indications for Psychotropic Medication Use 1. Adequate indication for use refers to the identified, documented clinical rationale for administering medication that is based on: a. an assessment of the resident's condition and therapeutic goals; .3. The clinical rationale for the use of psychotropic medication, or a change from one type of psychotropic to another, is documented in the medical record. As Needed (PRN) Medication 1. Psychotropic medications are not prescribed or administered on a PRN basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.		

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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. Based on interview and record review, the facility failed to maintain accurate and complete medical records for one of three sampled residents (Resident 2) by failing to ensure dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) forms were completed prior to transferring Resident 2 to the dialysis center and upon return to the facility. This failure had the potential to cause confusion in the care and the medical records containing inaccurate documentation. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 8/7/2024, with diagnoses that included unspecified (unconfirmed) nontraumatic subdural hemorrhage (bleeding in the space between the brain and skull without a history of head injury), sacral (tailbone) stage four pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and dependent on renal dialysis (a life-sustaining treatment that performs the filtering functions of the kidneys). 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 8/13/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 3/4/2026, 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 was on dialysis. During a review of Resident 2's Order Recapitulation Report, dated 5/11/2026, the Order Recapitulation Report indicated three times a week, dialysis schedules on Tuesdays, Thursdays and Saturdays. During a review of Resident 2's Nursing: Hemodialysis (one specific type of renal dialysis that uses an external machine and a synthetic filter [dialyzer] to clean the blood) Communication Observation/Assessment (HD form), dated 5/14/2026, the HD form indicated prior to dialysis treatment, the pain level, pain location and time of last meal were left blank. During a review of Resident 2's HD form, dated 5/23/2026, the HD form indicated prior to dialysis treatment, the pain level, pain location, time of last meal, diet and sack meal were left blank. The HD form indicated post (after) dialysis treatment pain level and pain location were left blank. During an interview on 6/8/2026, at 10:56 a.m., with the Director of Nursing (DON), the DON stated HD forms should be complete. During an interview on 6/9/2026, at 10:39 a.m., with the DON, the DON stated HD forms should be completed as part of communication between the facility and the dialysis center. During a review of facility's policy and procedure (P&P), titled, Charting and Documentation, dated 4/27/2026, 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 (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.		

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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 its infection control measures for one of three sampled residents (Resident 4), by failing to ensure Licensed Vocational Nurse 1 (LVN 1) wear a gown when assisting Resident 4 who was on enhanced barrier precaution (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO- a germ that is resistant to many antibiotics] in nursing homes) to turn and sit on the edge of the bed. This failure had the potential to spread and expose other residents, staff, and visitors to infection. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 2/27/2026, with diagnoses that included stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 4'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 3/2/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 4 was dependent on staff for rolling from left to right position. The MDS indicated from lying to sitting on the side of the bed was not attempted. During a review of Resident 4's Order Summary Report, dated 3/4/2026, the Order Summary Report indicated EBP for high contact resident care activities (direct, hands-on interactions with patients that involve personal hygiene, mobility assistance, or medical device management) secondary to wound and gastrostomy tube (GT- a flexible tube surgically inserted through abdomen into the stomach for feeding, fluid and medication administration), management every shift. During a concurrent observation and interview on 6/8/2026, at 9:23 am, with the Assistant Director of Nursing (ADON), inside Resident 4's room, an EBP signage posted by Resident 4's door. Resident 4 was on oxygen, and the nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) tubing was touching the floor. ADON stated nasal cannula tubing should not be touching the floor. ADON stated she (ADON) will change the nasal cannula. During an observation on 6/8/2026, at 9:26 a.m., inside Resident 4's room, ADON went inside Resident 4's room wearing a gown and gloves and changed Resident 4's nasal cannula. During an observation on 6/8/2026, at 9:38 a.m., inside Resident 4's room, Resident 4 was lying on the left side of the bed and facing the left side, observed LVN 1 stood on the right side of the bed wearing gloves and no gown. LVN 1 reached out from the right side of the bed and held Resident 4's forearms and assisted Resident 4 to turn on her (Resident 4) back. Observed LVN 1 held Resident 4's lower legs and slid it down on the edge of the bed. LVN 1 assisted Resident 4 to sit on the edge of the right side of the bed. During an interview on 6/8/2026, at 9:41 a.m., with LVN 1 inside Resident 4's room. LVN 1 stated Resident 4 was on EBP, and she (LVN 1) should have worn a gown to help Resident 4 get up and sit on the edge of the bed to eat her (Resident 4) breakfast. LVN 1 stated not wearing a gown on EBP residents can potentially cause a spread of infection. During an interview on 6/8/2026, at 9:55 a.m. with Director of Staff Development (DSD) who was also the Infection Preventionist 2 (IP 2), the DSD stated staff who will provide direct high contact care will need to use personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) like gown and gloves. During a concurrent interview and record review on 6/8/2026, at 10:33 a.m., with the DSD, facility's EBP signage was reviewed. The EBP signage indicated Everyone must: a. clean hands on room entry and when exiting. b. wear gloves and a gown for the high contact resident care activities below: . 5. mobility assistance and preparing to leave the room. The DSD stated LVN 1 should have worn a gown (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when assisting Resident 4 to turn and sit on the edge of the bed since it is part of the mobility assistance. During an interview on 6/8/2026, at 10:56 a.m., with the Director of Nursing (DON), the DON stated LVN 1 should have worn a gown when providing mobility assistance to Resident 4 who was on EBP to prevent spread of infection. During a review of facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, dated 1/2026, and last reviewed on 4/27/2026, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). 8. Example of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . e. Transferring; f. Providing bed mobility.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement its policy for antibiotic (medication used to treat infection) stewardship (efforts in doctor's offices, hospitals, long-term care facilities and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) for one of three sampled residents (Resident 2) by failing to monitor Resident 2 for the adverse effects (undesired or harmful effects) of levofloxacin (medication used to treat bacterial infections) on 5/10/2026, and 5/11/2026, from 3 pm to 7 a.m. These failures had the potential for antibiotic resistance (do not respond to a drug) and had the potential for Resident 2 to experience an adverse reaction. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 8/7/2024, with diagnoses that included unspecified (unconfirmed) nontraumatic subdural hemorrhage (bleeding in the space between the brain and skull without a history of head injury), sacral (tailbone) stage four pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). 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 8/13/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 3/4/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. During a review of Resident 2's Order Recapitulation Report, dated 5/9/2026, the Order Recapitulation Report indicated levofloxacin oral tablet 250 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth daily for wound infection for seven days. During a review of Resident 2's Order Recapitulation Report, dated 5/10/2026, the Order Recapitulation Report indicated monitoring for antibiotic therapy, use of levofloxacin for adverse reactions: 1. Rash, 2. Itching, 3. Swelling, 4. Shortness of breath, 5. Nausea, 6. Vomiting, 7. Diarrhea and 0. No adverse reaction. Inform the physician of adverse effects every shift until 5/20/2026, 11:59 p.m. During a review of Resident 2's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 5/2026, the MAR indicated the following: 1. Licensed Vocational Nurse 2 (LVN 2) started and administered levofloxacin on 5/10/2026, and 5/11/2026, at 9 a.m. 2. LVN 3 administered levofloxacin on 5/12/2026, at 9 a.m. During a review of Resident 2's Progress Notes, dated 5/10/2026, timed at 3:37 p.m., the Progress Notes, indicated a late entry (late documentation) by LVN 2 that indicated Resident 2 had no adverse effects on 5/10/2026 from 7 a.m. to 3 p.m. During a review of Resident 2's Progress Notes, dated 5/11/2026, timed at 2:41 p.m., the Progress Notes, indicated a late entry by LVN 2 that indicated Resident 2 had no adverse effects on 5/11/2026 from 7 a.m. to 3 p.m. During a review of Resident 2's Progress Notes, dated 5/12/2026, timed at 2:29 p.m., the Progress Notes indicated LVN 2 documented that Resident 2 had no adverse effects on 5/12/2026 from 7 a.m. to 3 p.m. During a review of Resident 2's MAR, dated 5/2026, the MAR indicated the nurses started every shift monitoring of antibiotic therapy on 5/12/2026, at 3 p.m. - 11 p.m. During a review of facility's Lesson Plan (detailed guide for what students need to learn, how the lesson will be taught, and how learning will be measured) for in-service on Antibiotic Stewardship Program, completed on 5/13/2026, the Lesson Plan indicated licensed nurses were reeducated on: 1. Antibiotic stewardship. 2. Adverse side effects monitoring every shift. During a concurrent interview and record review on 6/5/2026, at 3:12 p.m., with Infection Preventionist 2 (IP 2), Resident 2's Physician Order, dated 5/9/2026, MAR, dated 5/2026, and Progress Notes, dated 5/10/2026 to 5/12/2026, were reviewed. IP 2 stated the physician ordered levofloxacin on 5/9/2026, and LVN 2 administered the first dose of levofloxacin on 5/10/2026, at 9 a.m., IP 2 stated residents on antibiotic are monitored every shift for the adverse reaction and (continued on next page)		

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 06/09/2026
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)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented in the MAR. IP 2 stated the documented monitoring for adverse reaction was started in the MAR on 5/12/2026, at 3 p.m. to 11 p.m. shift. IP 2 stated there was no documented monitoring in MAR, dated 5/10/2026, 3 p.m. to 5/11/2026, at 7 a.m. and no documented monitoring in MAR, on 5/11/2026, from 3 p.m., to 5/12/2026, at 7 a.m. IP 2 stated there was no documented monitoring for adverse reaction in Resident 2's Progress Notes on 5/10/2026, and 5/11/2026, from 3 p.m. to 11 p.m., and 11 p.m., to 7 a.m. IP 2 stated monitoring should be started as soon as the first dose of the antibiotic medication was started. IP 2 stated the importance of monitoring residents every shift for the adverse effects was to ensure residents do not have adverse reactions. IP 2 stated if Resident 2 were not monitored she (Resident 4) could have developed an adverse reaction. During an interview on 6/9/2026, at 10:39 a.m., with the Director of Nursing (DON), residents are monitored for the adverse reaction every shift from when antibiotics are started. The DON stated if residents were not monitored for adverse effects every shift, the nurses would not be able to find out the clinical condition of the residents. During a review of facility's policy and procedure (P&P) titled, Antibiotic Stewardship, dated 4/27/2026, was reviewed. The P&P indicated, The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. During a review of facility's P&P, titled, Adverse Consequences and Medication Errors, dated 4/27/2026, the P&P indicated, Residents receiving medication are monitored for adverse consequences.		