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	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirage Post Acute	44445 15th St W Lancaster, CA 93534

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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	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 (to do something quickly, without delay, or exactly at a scheduled time) notify one of three sampled residents (Resident 2) Responsible Party 1 (RP 1) of Resident 2's change in condition on 4/21/2026.This failure had violated RP 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 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 4/15/2026, with diagnoses that included unspecified (unconfirmed) acute and chronic respiratory failure (a life-threatening medical emergency where a patient with an existing, long-term lung disease experiences a sudden, severe worsening of their breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified dementia (a progressive state of decline in mental abilities).During a review of Resident 2's Change in Condition (CIC) Evaluation, dated 4/21/2026, the CIC on 4/20/2026, from 11 p.m., to 4/21/2026, at 1 a.m., indicated Resident 2 had noticeable crackles (when small airways and air sacs snap open as a person breathes in, signaling that air is passing through fluid, mucus, or narrowed, inflamed tissue) with no shortness of breath and on oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). The CIC indicated at 4:08 a.m. Resident 2 was cyanotic (having blue or purplish skin or lips and fingernails because there is not enough oxygen in the blood) with cold clammy (skin that feels unusually cool to the touch and damp or sticky with sweat, often appearing pale) skin, visibly struggling to breath with oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) at 66 percent (%) on two liters per minute via nasal cannula. The CIC indicated at 4:10 a.m., breathing treatment administered and at 4:12 a.m., 911 (emergency response system) called. The CIC indicated at 4:20 a.m. paramedics arrived and transferred Resident 2 to General Acute Care Hospital (GACH). The CIC indicated the physician was notified at 12 midnight, and RP 1 was notified at 6 a.m.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired.During an interview on 6/26/2026, at 8:48 a.m., with Family Member 1 (FM 1), FM 1 stated RP 1 was notified of Resident 2's change in condition at 6 a.m., when Resident 2 was already in GACH.During a concurrent interview and record review on 6/30/2026, at 10:45 a.m., with the Assistant Director of Nursing (ADON), Resident 2's CIC, dated 4/21/2026, and Progress Notes, dated 4/20/2026, to 4/21/2026, were reviewed. The ADON stated Resident 2 had a CIC from, 4/20/2026, at 11 p.m., to 4/21/2026 at 1 a.m. The ADON stated paramedics picked up Resident 2 on 4/21/2026, at 4:20 a.m. and RP 1 was notified at 6 a.m. The ADON stated there were no documented attempts to call RP 1 from 1 a.m., when Resident 2 had a change in condition. The ADON stated it is important to notify RP 1 timely of Resident 2's change in condition to ensure RP 1 knew what was going on with Resident 2.During an interview on 7/1/2026, at 1:19 p.m., with RP 1, RP 1 stated on 4/21/2026, the facility called him (RP 1) after Resident 2 was already transferred to the GACH.During an interview on 7/1/2026, at 3:21 p.m., with the Director of Nursing (DON), the DON stated attempts should be made (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to call and inform the family before a resident is transferred out to GACH so the family will be informed of Resident 2's status.During a review of the facility's policy and procedure (P&P), titled, Change in a Resident's Condition or Status dated 4/27/2026, was reviewed. The P&P indicated, Our facility promptly (doing something quickly, without delay, or exactly at a specified time) notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (changes in level of care, billing/payments, resident rights).2. A significant change of condition is a major decline or improvement in the residents' status that:a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-limiting);b. Impacts more than one area of the resident's health 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure an accurate assessment was conducted for one of three sampled residents (Resident 1). Resident 1 did not have an accurate assessment on 6/16/2026, when Resident 1 was using a single point cane (a standard, classic walking stick with one rubber tip at the bottom) instead of a walker (provides a wide, stable base of support so that the user can lean their weight on the device while moving forward, offering more stability than canes) and a wheelchair (chair with wheels).This failure had the potential to result in a delay in necessary care and treatment.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 3/10/2026, with diagnoses that included cerebral infarction (brain tissue death caused by a lack of blood flow), essential hypertension (HTN-high blood pressure) and generalized muscle weakness.During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 3/11/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Rehabilitation-Screening Form, dated 4/21/2026, the Rehabilitation-Screening Form indicated Resident 1 was deemed safe after a Physical Therapy screening (a quick, proactive check-up used to identify potential movement issues, underlying weaknesses, or risks of future injury) to assess safety during ambulation using a single point cane. The Rehabilitation-Screening Form indicated the Restorative Nursing Assistance (RNA) orders were updated.During a review of Resident 1's Order Summary Report, dated 4/21/2026, the Order Summary Report indicated an order for RNA to perform active range of motion (AROM-how far a resident can move a joint like an elbow, knee, or shoulder using their own muscle power, without any outside help) exercises for bilateral lower extremity (legs) and ambulation with single point cane daily five times a week.During a review of Resident 1's Rehabilitation-Screening Form, dated 6/5/2026, the Rehabilitation-Screening Form indicated ambulation with single point cane daily.During a review of Resident 1's Interdisciplinary Team (IDT- the group of healthcare professionals who collaborate to create, manage, and update personalized care plan) Conference Notes, dated 6/16/2026, the IDT Conference Notes indicated ambulation with single point cane daily five times a week as tolerated.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/16/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 used a walker and a wheelchair as mobility devices. The MDS indicated Resident 1 was independent in walking 10 feet to 150 feet.During an interview on 6/26/2026, at 9:37 a.m., with RNA 1, RNA 1 stated Resident 1 is independent and ambulates with the use of single point cane. RNA 1 stated Resident 1 first used a quad cane and the therapist changed it to single point cane.During an interview on 6/26/2026, at 9:48 a.m. with the Rehabilitation Director (RD), the RD stated Resident 1 used a single point cane since 4/21/2026.During a concurrent interview and record review on 6/30/2026, at 9:28 a.m., with Minimum Data Set Nurse 1 (MDSN 1), Resident 1's MDS, dated [DATE], was reviewed. MDSN 1 stated the 6/16/2026, MDS assessment indicated Resident 1 used a walker and a wheelchair. MDSN 1 stated there was no documentation in the MDS, dated [DATE], regarding the use of a single point cane. MDSN 1 stated if Resident 1 used a single point cane, it should reflect in the MDS.During an interview on 6/30/2026, at 10:45 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 was highly functioning (manages daily living tasks independently). The ADON stated the MDS assessment on 6/16/2026, was not accurate. The ADON stated it is important to have an accurate MDS assessment to have an overall view of the status of the residents.During an interview on 7/1/2026, at 3:21 p.m., with the Director of Nursing (DON), the DON stated the MDS assessment should be accurate and if not accurate the right care will not be provided to Resident 1.During a review of the facility's policy and procedure (P&P) titled, MDS Assessment, dated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/27/2026, was reviewed. The P&P indicated, The MDS coordinator is responsible for ensuring appropriate edits are made prior to transmitting MDS data and feedback and validation reports from each transmission are maintained for historical purposes and for tracking.During a review of facility's P&P, titled, Resident Assessment, dated 10/2023, and last reviewed on 4/27/2026, the P&P indicated, 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care, and resident observations/interviews.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for two of three sampled residents (Residents 1 and 2) by failing to:1. Develop a care plan to address Resident 1's fabrication of stories (deliberately inventing or constructing false information, often with the intent to deceive, manipulate, or impress others) as per Change in Condition on 6/18/2026.2. Develop a care plan to address Resident 2's refusal of intravenous (IV- within a vein) IV insertion for hydration (giving the body the fluid and electrolytes it needs).These failures had the potential to result in delays in the delivery of necessary care and services.Findings:a. During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 3/10/2026, with diagnoses that included cerebral infarction (brain tissue death caused by a lack of blood flow), essential hypertension (HTN-high blood pressure) and unspecified depression.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 3/11/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/16/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 used walkers and wheelchairs as mobility devices. The MDS indicated Resident 1 was independent in walking 10 feet to 150 feet.During a review of Resident 1's Change in Condition (CIC) Evaluation, dated 6/18/2026, the CIC indicated fabrication of stories.During a concurrent interview and record review on 6/30/2026, at 10:45 a.m., with the Assistant Director of Nursing (ADON), Resident 1's CIC dated 6/18/2026, and Care Plans were reviewed. The ADON stated there was no care plan developed for the fabrication of stories as per Resident 1's CIC on 6/18/2026. The ADON stated the care plan should have been developed. The ADON stated care plans are interventions provided to residents and provide communication between providers. The ADON stated that without a care plan, no appropriate intervention could be provided to Resident 1.During an interview on 7/1/2026, at 3:21 p.m., with the Director of Nursing (DON), the DON stated the care plan should have been developed for Resident 1's fabrication of stories to provide the right care and services. The DON stated if a care plan was not developed, the facility will not be able to meet Resident 1's needs.b. During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 4/15/2026, with diagnoses that included unspecified (unconfirmed) acute and chronic respiratory failure (a life-threatening medical emergency where a patient with an existing, long-term lung disease experiences a sudden, severe worsening of their breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified dementia (a progressive state of decline in mental abilities).During a review of Resident 2's Order Summary Report, dated 4/16/2026, the Order Summary Report indicated the following orders:1. Insert peripheral IV catheter (a short, flexible tube inserted into a vein [usually in the hand or arm] to administer fluids, medications, or blood) every 72 hours and as needed if signs and symptoms of complication are noted.2. Lactated Ringers IV solution (a balanced fluid that contains a mixture of water and critical electrolytes the body needs to function), use 75 milliliters (ml- a metric unit of volume equal to one-thousandth of a liter) per hour IV every shift for hydration for three days.During a review of Resident 2's Progress Notes, dated 4/17/2026, timed at 6:42 a.m., the Progress Notes indicated Registered Nurse 4 (RN 4) documented that Resident 2 refused the new peripheral IV insertion three times.During a review of Resident 2's Progress Notes, dated 4/17/2026, timed at 11:43 a.m., the Progress Notes indicated RN 5 documented that Resident 2 refused IV insertion three times.During a review of Resident 2's Progress Notes, dated 4/17/2026, timed at 4:12 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m., the Progress Notes indicated RN 6 documented that Resident 2 refused IV insertion three times.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 had peripheral IV access. During a concurrent interview and record review on 6/26/2026, at 10:04 a.m., with RN 1, Resident 2's Progress Notes, dated 4/17/2026, were reviewed. RN 1 stated on 4/17/2026, Resident 2 refused IV insertion.During a concurrent interview and record review on 6/30/2026, at 10:45 a.m., with the ADON, Resident 2's Care Plans were reviewed. The ADON stated there was no care plan developed for Resident 2's refusal of IV insertion. The ADON stated the care plan should have been developed for Resident 2's refusal of IV insertion.During an interview on 7/1/2026, at 3:21 p.m., with the DON, the DON stated the care plan should have been developed for Resident 2's refusal of IV to provide appropriate care and services to the resident. The DON stated that without a care plan, Resident 2's needs could not be provided.During a review of the facility's policy and procedure (P&P), titled, Comprehensive Person-Centered Care Plans, dated 4/27/2026, the P&P indicated, The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure the residents received care consistent with professional standards of practice for one of three sampled residents (Resident 2) by failing to ensure Resident 2 had a diagnosis of dehydration (when the body uses or loses more fluid than it takes in) and was not drinking before providing intravenous (IV- within the vein) fluid hydration (giving the body the water it needs to function).This failure had the potential to place Resident 1 at risk for fluid overload (excess fluid). Findings:During a review of Resident 2's General Acute care Hospital (GACH) History and Physical (H&P), dated 3/31/2026, the H&P indicated the following:1. Blood Urea Nitrogen (BUN- test measures how much urea nitrogen is in your blood. BUN levels vary. High levels may indicate kidney damage) at normal range of 17 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) per/deciliter (dl- a metric unit of volume equal to one-tenth of a liter).2. Creatinine (a waste product created by your muscles as they move and break down) at normal range of 0.7 mg/dl.During a review of Resident 2's General Acute care Hospital (GACH) Progress Notes, dated 4/13/2026, the Progress Notes indicated the following:1. BUN at normal range of 9 mg/dl.2. Creatinine at low level (low level may indicate low muscle mass, malnutrition, or underlying health conditions like liver disease) of 0.4 mg/dl.During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 4/15/2026, with diagnoses that included unspecified (unconfirmed) acute and chronic respiratory failure (a life-threatening medical emergency where a patient with an existing, long-term lung disease experiences a sudden, severe worsening of their breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified pulmonary hypertension (high blood pressure specifically in the arteries of the lungs).During a review of Resident 2's Progress Notes, dated 4/15/2026, the Progress Notes indicated the facility admitted Resident 2 on 4/15/2026, at 7:25 p.m.During a review of Resident 2's Intake and Output (I&O) Record, dated 4/15/2026, the I&O Record indicated Resident 2 had 240 milliliters (ml- a metric unit used to measure small amounts of liquid volume) of fluid intake on the night shift.During a review of Resident 2's Laboratory Results Report, dated 4/16/2026, the Laboratory Results Report indicated the following:1. BUN at normal range of 12 mg/dl.2. Creatinine low at 0.5 mg/dl.During a review of Resident 2's I&O Record, dated 4/16/2026, the I&O Record indicated Resident 2 had 1,630 ml of fluid intake.During a review of Resident 2's Order Summary Report, dated 4/16/2026, the Order Summary Report indicated to infuse Lactated Ringers IV solution (a balanced fluid that contains a mixture of water and critical electrolytes the body needs to function), at 75 ml per hour IV every shift for hydration for three days.During a review of Resident 2's I&O Record, dated 4/17/2026, the I&O Record indicated Resident 2 had 1,580 ml of fluid intake.During a review of Resident 2's I&O Record, dated 4/18/2026, the I&O Record indicated Resident 2 had 1,400 ml of fluid intake.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 had peripheral IV access and had an average fluid intake of 501 ml per day or more.During an interview on 6/26/2026, at 8:48 a.m., with Family Member 1 (FM 1), FM 1 stated the facility gave Resident 2 IV fluids, even if she (Resident 2) did not need it, because she (Resident 2) drinks on her (Resident 2) own. FM 1 stated Resident 2 just needed encouragement to drink.During an interview on 6/26/2026, at 10:01 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 2 received IV fluids.During an interview on 6/26/2026, at 10:04 a.m., with Registered Nurse 1 (RN 1), RN 1 stated Resident 2 received Lactated Ringers IV for hydration on 4/16/2026 and 4/18/2026, RN 1 stated on 4/17/2026, Resident 2 refused IV insertion.During a concurrent interview and record review on 7/1/2026, at 1:34 p.m., with Minimum Data Set Nurse 2 (MDSN 2), Resident 2's GACH records and H&P, dated 3/31/2026, were reviewed. The H&P indicated normal BUN and creatinine. The GACH records and H&P did not indicate diagnosis (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of dehydration. MDSN 2 stated upon Resident 2's admission, she (MDSN 2) reviewed Resident 2's GACH records and noted Resident 2 had a diagnosis of dehydration and the laboratory results indicated elevated BUN and creatinine. MDSN 2 stated she (MDSN 2) called the Primary Medical Doctor (PMD) and recommended IV fluids for hydration. MDSN 2 stated when she (MDSN 2) obtained the order, the PMD had not seen Resident 2 at the facility yet. MDSN 2 stated looking into the GACH records, right now there were no documented dehydration diagnoses and BUN and creatinine were both within normal limits.During a concurrent interview and record review on 7/1/2026, at 3:21 p.m. with the Director of Nursing (DON), Resident 2's I&O, dated 4/15/2026, to 4/18/2026, were reviewed. The DON stated if laboratory results were normal and Resident 2 drinks, there is no need for IV hydration. The DON stated it is unnecessary to administer IV fluids when Resident 2 drinks and Resident 2's laboratory results were normal. The DON stated administering IV fluids could cause fluid overload.During a review of facility's policy and procedure (P&P), titled, Nutrition and Hydration to Maintain Skin Integrity, dated 4/2026, was reviewed. The P&P indicated, Hydration Assessment1. Assessment of hydration status involves monitoring the resident for clinical signs of fluid balance, including:a. Vital signs, .b. First morning urine color-pale yellow color generally indicates proper hydration.c. Body mass changes -monitoring and tracking daily morning body weight to measure fluid loss or gain.d. Urine specific gravity (USG-measures how concentrated or diluted your urine is compared to pure water)/Osmolality (a measure of how concentrated a fluid is) less than 1.020.e. Assessment of mucous membrane (the body's internal skin), skin turgor (skins elasticity), and thirst.f. Measuring total intake -total output to calculate fluid balance.Hydration Interventions:1. Encourage fluids for the resident at risk of fluid volume deficit. Oral intake is the preferred method for fluid administration. Administer IV fluids as ordered.2. Monitor and report symptoms of fluid loss including fatigue, thirst, decreased urine output, and dizziness or confusion.3. Monitor and report changes in clinical signs/symptoms of fluid volume imbalance including urine SG, vital signs, and body mass.Steps in the Procedure1. Explain and ask for residents' permission to conduct nutritional screening or hydration assessment.2. Complete nutritional screening or hydration assessment using nutrition screening tools, interview, observation, and record review.3. Review ancillary documentation including, but not limited to, food and fluid intake records, vital signs, weight and height records, laboratory results, and nursing notes.4. Document the results of the screening. Notify the provider of clinical indicators of malnutrition or dehydration.DocumentationRecord in the resident's medical record:1. The results of nutritional screening and assessment.2. Clinical signs or symptoms of fluid volume imbalance.3. Changes in the residents' clinical status.4. Problems or complaints reported by the residents related to intake of food or fluids.5. If the resident refuses nutrition or hydration, the reason(s) and explanation of risk, benefits, and alternatives.

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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 interview, and record review, the facility failed to ensure the resident received care consistent with professional standards of practice to prevent pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) for one of three sampled residents (Resident 2) by failing to administer pressure ulcer treatment on 4/16/2026.This failure had the potential to result in the development and worsening of pressure ulcers.Findings:During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 4/15/2026, with diagnoses that included unspecified (unconfirmed) acute and chronic respiratory failure (a life-threatening medical emergency where a patient with an existing, long-term lung disease experiences a sudden, severe worsening of their breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified dementia (a progressive state of decline in mental abilities).During a review of Resident 2's Nursing-Comprehensive Skin Evaluation/Assessment (Skin Assessment), dated 4/15/2026, the Skin Assessment indicated a stage 2 pressure ulcer (partial-thickness loss of skin, presenting as a shallow open sore or wound) on the sacrococcyx (tailbone).During a review of Resident 2's Order Summary Report, dated 4/16/2026, the Order Summary Report indicated to clean sacral (tailbone) deep tissue injury (DTI-damage to underlying tissues, including muscles, bones, and subcutaneous layer) with normal saline (saline water), pat dry, apply zinc oxide (medication used to create a protective, breathable barrier, offering anti-inflammatory, soothing, and antibacterial properties) and leave open to air daily and as needed for 30 days.During a review of Resident 2's Treatment Administration Record (TAR- flowsheet that indicates treatment given to a resident), dated 4/16/2026, the TAR did not indicate treatment was provided to Resident 2's DTI.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 required supervision from staff for toileting and transfer. The MDS further indicated Resident 2 had one unstageable (a severe wound where the true depth and tissue damage are hidden by dead tissue) pressure ulcer present upon admission.During a concurrent interview and record review on 6/30/2026, at 9:47 a.m., with Treatment Nurse 1 (TN 1), Resident 2's Physician Order, and TAR, dated 4/16/2026, were reviewed. TN 1 stated there was no documented wound treatment provided on 4/16/2026. TN 1 stated Resident 2 could have further skin integrity issues and worsening of Resident 2's wound.During an interview on 7/1/2026, at 3:21 p.m. with the Director of Nursing (DON), the DON stated treatment should be started right away after obtaining a physician order. The DON stated delay in treatment could potentially result in worsening pressure ulcers. During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated 4/27/2026, the P&P indicated, The physician will order pertinent wound treatments.During a review of facility's P&P, titled, Administering Medications, dated 4/27/2026, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. Topical medications used in treatments are recorded on the residents treatment record (TAR).

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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. 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 one of three sampled residents (Resident 2) by failing to:1. Ensure the residents respiratory rate (the number of breaths taken per minute) was counted and documented before administering Ativan (medication used to quickly calm the brain and nerves, primarily for severe anxiety, panic attacks, and insomnia).2. Ensure the physician order was followed to hold (temporarily stop) Ativan for a respiratory rate over 12 breathes per minute.These failures had the potential to result in medication errors and could potentially result in respiratory depression (a person is breathing too slowly or too shallowly).Findings:During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 4/15/2026, with diagnoses that included unspecified (unconfirmed) acute and chronic respiratory failure (a life-threatening medical emergency where a patient with an existing, long-term lung disease experiences a sudden, severe worsening of their breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and generalized anxiety disorder (a chronic mental health condition characterized by excessive, uncontrollable worry about everyday issues like health, money, work, and family).During a review of Resident 2's Order Summary Report, dated 4/18/2026, the Order Summary Report indicated to administer Ativan oral tablet 0.5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), give 0.5 mg by mouth every six hours as needed for anxiety manifested by verbalization of nervousness for 14 days, Hold if respiratory rate is above 12.During a review of Resident 2's Medication Administration Record (MAR), dated 4/2026, the MAR indicated Resident 2 was administered Ativan on the following dates and times:1. 4/18/2026, at 6:20 p.m.2. 4/20/2026, at 8:44 a.m.3. 4/20/2026, at 4:33 p.m.4. 4/21/2026, at 12:30 a.m.During a review of Resident 2's Weights and Vital Summary, dated 4/18/2026, to 4/21/2026, the Weights and Vital Summary indicated the following documented respiratory rate before Ativan administration:1. 4/18/2026, at 12:28 a.m.- 18 breaths per minute2. 4/20/2026, at 3:39 a.m.-17 breaths per minute3. 4/20/2026, at 11:40 a.m.-18 breaths per minuteDuring a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 had anxiety and depression disorder (a common, serious mood disorder that causes persistent feelings of sadness, hopelessness, and a loss of interest in activities you once enjoyed).During a concurrent interview and record review on 6/30/2026, at 10:45 a.m., with the Assistant Director of Nursing (ADON), Resident 2's Physician Order, dated 4/18/2026, and MAR, dated 4/2026, were reviewed. The ADON stated the Physician Order was to hold Ativan for a respiratory rate above 12 breaths per minute. The ADON stated Licensed Vocational Nurse 4 (LVN 4) received the physician order and she (LVN 4) should have clarified with the Physician since the Ativan is usually held if respiratory rate is below 12 breaths per minute not above 12 breaths per minute. The ADON stated because the order was incorrectly transcribed (written), nurses should have held the Ativan. The ADON stated nurses should have checked and documented the respiratory rate, and call the Physician for clarification before Ativan administration.During an interview on 7/1/2026, at 8:06 a.m., with LVN 5, LVN 5 stated Ativan order indicated to hold it if the respiratory rate was below 12. LVN 5 stated on 4/21/2026, at 12: 30 a.m., Resident 2 was agitated (a state of anxiety, worry, or restless excitement) and the respiratory rate was above 12 breaths per minute, so she (LVN 5) administered Ativan. LVN 5 stated she (LVN 5) did not notice the order to hold Ativan for respiratory rate over 12 breaths per minute. LVN 5 stated she (LVN 5) had checked Resident 2's respiratory rate and it was above 12 and she (LVN 5) might have forgotten to document the respiratory rate in Resident 2's medical record.During an interview on (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/1/2026, at 1:10 p.m., with LVN 4, LVN 4 stated if she (LVN 4) had wrongly transcribed the order, nurses who administered the Ativan should have called and clarified the order with the Physician before Ativan administration.During an interview on 7/1/2026, at 3:21 p.m., with the Director of Nursing (DON), the DON stated nurses should have clarified the order before Ativan administration. The DON stated based on the physician order, Ativan should have been held for a respiratory rate above 12 breathes per minute. The DON stated the respiratory rate should be checked and documented in Resident 2's medical record before Ativan administration.During a review of facility's policy and procedure (P&P), titled, Administering Medications, dated 4/27/2026, the P&P indicated, 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 (clinical measurements used to assess the body's basic functions. The four standard vital signs monitored by healthcare providers include body temperature, pulse (heart) rate, respiration (breathing) rate, and blood pressure), if necessary.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record for one of three sampled residents (Resident 2) by failing to:1. Ensure Resident 2's medical records indicated the correct last name of Responsible Party 1 (RP 1).2. Ensure Registered Nurse 1 (RN 1) documented that RP 1 was notified of the purpose of the intravenous (IV-within the vein) hydration (the process of providing or maintaining the adequate fluid levels needed for the body).3. Ensure Licensed Vocational Nurse 6 (LVN 6) documented the accurate date of the Physician and RP 1 notification on the Change in Condition, dated 4/20/2026.These failures had the potential to cause confusion in care and the medical records containing inaccurate documentation.Findings:a. During a review of Resident 2's General Acute Care Hospital (GACH) Inpatient Registration Form, the Inpatient Registration Form indicated the person to notify was RP 1.During a review of Resident 2's Resident Administration Record, dated 4/14/2026, the Resident Administration Record indicated emergency contact was RP 1.During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 4/15/2026, with diagnoses that included unspecified (unconfirmed) acute and chronic respiratory failure (a life-threatening medical emergency where a patient with an existing, long-term lung disease experiences a sudden, severe worsening of their breathing), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified dementia (a progressive state of decline in mental abilities). The admission Record indicated RP 1's name but the last name was different.During a review of Resident 2's Informed Consents, dated 4/15/2026, the Informed Consents indicated RP 1's name but the last name was different.During a review of Resident 2's Consent to Treat, dated 4/16/2026, and 4/21/2026, the Consent to Treat indicated verbal consent obtained from RP 1 whose last name was different.During a review of Resident 2's Change in Condition (CIC) Evaluation, dated 4/16/2026, 4/20/2026, and 4/21/2026, indicated RP 1's last name was different.During a review of Resident 2's Interdisciplinary Team (IDT-group of healthcare professionals who collaborate to plan, deliver, and evaluate coordinated care for a resident) Conference Notes, dated 4/17/21026, the IDT Conference Notes indicated RP 1's first name but had a different last name.During a review of Resident 2's Hospital Transfer Form, dated 4/21/2026, the Hospital Transfer Form indicated RP 1's name but had a different last name.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired.During an interview on 6/26/2026, at 8:48 a.m., with Family Member 1 (FM 1), FM 1 stated she (FM 1) had reviewed Resident 2's medical records and noticed the facility had notified and documented a different person not related to her (FM 1). FM 1 stated RP 1 had the Power of Attorney (POA-a legal document that authorizes a trusted person to make decisions or act on behalf of another person), and the facility had documented RP 1's name but with a different last name. FM 1 stated the admission Director (AD), recommended the facility and she (AD) just assumed his (RP 1) last name was the same as Resident 2.During an interview on 6/30/2026, at 10:32 a.m., with the admission Director (AD), the AD stated she (AD) was familiar with RP 1's last name and during admission she (AD) did fill up the contact list of Resident 2 documenting RP 1's last name. The AD stated she (AD) should have looked at the GACH records and called RP 1 to verify if the same last name as Resident 2 or not. The AD stated the wrong name documented in Resident 2's medical records indicated a different person. The AD stated the right person who is RP 1 will not be informed.During an interview on 6/30/2026, at 10:45 a.m., with the Assistant Director of Nursing (ADON), the ADON stated admission staff should accurately document names especially for residents and responsible party.During a concurrent interview and record review on 6/30/2026, at 10:53 a.m., with the AD, the GACH Inpatient Registration Form and the facility's Resident Administration Record, dated 4/14/2026 were reviewed. The GACH (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inpatient Registration Form and the facility's Resident Administration Record indicated RP 1's name. The AD stated she (AD) added RP 1's first name and last name based on what she (AD) knows him (RP 1) for in the facility admission Record.During an interview on 7/1/2026, at 1:19 p.m., with RP 1, RP 1 stated his (RP 1) last name was different from Resident 2, and he (RP 1) was Resident 2's POA. RP 1 stated nobody from the facility had called and verified his (RP 1) full name. RP 1 stated nobody from the facility had called and notified him of any change in condition, any IDT, any care plans or any consents.During an interview on 7/1/2026, at 2:20 p.m., with the Assistant Director of Nursing (ADON), the ADON stated if the facility had requested a copy of RP 1's POA, it would have been uploaded in Resident 2's medical record. The ADON stated there were no POA uploaded in Resident 2's electronic medical record.During an interview on 7/1/2026, at 3:21 p.m., with the Director of Nursing (DON), the DON stated the admission Staff should have called and verified RP 1's last name before completing Resident 2's admission Record (Face Sheet). The DON stated it should match the exact name listed in the GACH record. The DON stated if the facility documented a different last name that could cause confusion and could be two different people. The DON stated Resident 2's medical record should be accurate since it is a legal paper, and it helps with communication between providers.b. During a review of Resident 2's Order Summary Report, dated 4/16/2026, the Order Summary Report indicated Lactated Ringers IV solution (a balanced fluid that contains a mixture of water and critical electrolytes the body needs to function), use 75 milliliter (ml-a metric unit of volume equal to one-thousandth of a liter) per hour, IV every shift for hydration for three days.During a review of Resident 2's Progress Notes, dated 4/16/2026, the Progress Notes indicated Minimum Data Set Nurse 2 (MDSN 2) obtained an order for Lactated Ringers 75 ml per hour for three days with 10 ml of infuvite multivitamin (a commercially prepared, multi-vitamin formulation administered intravenously) infused to one bag of IV fluids for hydration program. During an interview on 6/26/2026, at 8:48 a.m., FM 1, FM 1 stated they were not informed about the purpose of the IV. FM 1 stated she (FM 1) is a License Vocational Nurse (LVN) and knows Resident 2's laboratory results were normal.During a concurrent interview and record review on 6/26/2026, at 10:04 a.m., with RN 1, Resident 2's Progress Notes, dated 4/16/2026, were reviewed. RN 1 stated there was no documented evidence that RP 1 was informed of the purpose of the IV fluids. RN 1 stated IV insertion is an invasive procedure and RP 1 should have been notified.During an interview on 6/26/2026, at 10:26 a.m., with RN 1, RN 1 stated she (RN 1) had remembered that she (RN 1) had called RP 1 to notify him of the plan for IV fluids.During an interview on 6/30/2026, at 10:45 a.m., with the ADON, the ADON stated there was no documented evidence that RP 1 was notified of the purpose of IV fluids. The ADON stated the nurse should have notified RP 1 and documented in Resident 2's medical record that RP 1 was notified.During an interview on 7/1/2026, at 1:19 p.m. with RP 1, RP 1 stated he (RP 1) was not informed why there was an order for IV fluids. RP 1 stated Resident 2 eats and drinks, and just needs reminders and encouragement to drink.During an interview on 7/1/2026, at 1:34 p.m., with MDSN 2, MDSN 2 stated RN 1 initiated the IV insertion and had spoken to RP 1 at the bedside about the reason for IV fluids. MDSN 2 stated she (MDSN 2) did not hear RN 1 explain to RP 1 the reason for the IV fluids.During an interview on 7/1/2026, at 3:21 p.m., with the DON, the DON stated the nurses should document if they notify the family of any resident procedure and treatment.c. During a review of Resident 2's CIC, dated 4/20/2026, the CIC indicated Resident 2 had abnormal lung sounds, complained of chest pain and used her accessory muscle when breathing (occurs when the body uses muscles in the neck, chest, and abdomen to breathe because the primary muscle [the diaphragm] is struggling), with rales (clicking, bubbling, or rattling lung sounds heard during inhalation that indicates fluid accumulation, inflammation, or scarring in the small airways) right lung sound, diminished on the left lung, respiratory rate of 20 breathes per minute with oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) of 93 percent (%-out of 100) and was on two liters of oxygen per minute. The CIC indicated the Physician was notified on 4/16/2026, (four days before the CIC happened) at 11:50 a.m. and RP 1 was notified on 4/16/2026, (four days before the CIC (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	happen) at 12:10 p.m.During a concurrent interview and record review on 6/30/2026, at 10:45 a.m. with the ADON, Resident 2's CIC, dated 4/20/2026, was reviewed. The ADON stated LVN 6 documented the Physician and RP 1 was notified on 4/16/2026, four days before the CIC happen, when the CIC happened on 4/20/2026. The ADON stated the date was an inaccurately documented. The ADON stated it is important to document accurately the exact date and time of notification to avoid confusion in care.During an interview on 7/1/2026, at 3:21 p.m., with the DON, the DON stated the CIC on 4/20/2026, should be accurate. The DON stated when staff opens the CIC, the date and time of the Physician and RP notification from the last CIC automatically gets uploaded in the new CIC. The DON stated the nurses should have updated the new and current CIC with the correct date and time of when they called and notified the Physician and RP. The DON stated inaccurate documentation could result in confusion in care.During a review of facility's policy and procedure (P&P), titled Charting and Documentation, dated 4/27/2026, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.