

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER Amaya Springs Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8625 Lamar Street Spring Valley, CA 91977	

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)
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46980</p> <p>Based on interview and record review the facility failed to fully prepare three of four sampled residents, (1, 2, 4) for discharge in accordance with the facility discharge policy.</p> <p>Findings:</p> <p>A review of the facility policy entitled Discharge and Transfer of Residents revised February 2018 indicated, . When a resident is admitted to the Facility, Facility Staff will initiate a discharge plan. The resident/ resident representative will be provided with a Notice of Proposed Transfer and Discharge 30 days prior to discharge or as soon as practicable. When the resident is near a planned discharge, the Interdisciplinary Team (IDT) will complete a Discharge Summary/ Post Discharge Plan of Care. Nursing Staff will complete a Discharge Summary/ Post Discharge Plan of Care for each resident, which will include a recapitulation of the resident ' s stay and final summary of the resident ' s status .</p> <p>1. Resident 1 was admitted to the facility on [DATE] with diagnoses that included bilateral lower extremity lymphedema (a condition in which fluid that comes from the liquid part of the blood builds up in tissues causing swelling) with cellulitis (an infection of the skin) and maggot infestation and homelessness. Resident 1 was discharged from the facility on 4/6/24. Resident 1 was not provided with a Notice of Proposed Discharge.</p> <p>2. Resident 2 was admitted to the facility on [DATE] with diagnoses that included rhabdomyolysis (breakdown of muscle tissue that releases chemicals into the blood that can cause kidney damage), difficulty in walking, and need for assistance with personal care. Resident 2 was discharged from the facility on 4/1/24. Resident 2 received a Notice of Proposed Discharge on 4/1/24, the same date as her discharge.</p> <p>3. Resident 4 was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit (difficulty communicating because of injury to the brain), toxic encephalopathy (brain dysfunction caused by exposure to a toxin), acute systolic heart failure (failure of the bottom left chamber of the heart), obstructive sleep apnea (a disorder in which a person frequently stops breathing during sleep), acquired absence of right leg below knee (removal of the leg below the knee), unsteadiness on feet, and need for assistance with personal care. Resident 4 was discharged from the facility on 4/23/24. Resident 4 received a Notice of Proposed Discharge one day prior to discharge.</p> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Direct care staff for Residents 1, 2 and 4 were not available for interview during the on-site investigation.</p> <p>On 5/6/23 at 1:25 P.M., an interview and concurrent record review were conducted with the Director of Nursing (DON) and Social Worker (SW). The SW stated her role in the discharge process was to assist with resources, find placements, create referrals for Home Health/ ILF/ ALF. The SW stated, I find out where they live during the first interview with the resident. I ask if they have income. I ask where they want to go, and invite them to CP/ IDT meetings, talk with them about their plans. The DON stated Resident 1 ' s discharge care plan was template interventions (a software generated selection that is not specialized to a patient), not resident centered and specific, and there were no interventions for adjustment to living in a shelter or car with new medical needs. The SW stated the facility did not provide Resident 1 with a Notice of Proposed Discharge. A concurrent record review of a nursing discharge note dated 4/6/24 at 11 A.M. indicated, Discharge: friend ' s business (address). A record review of the IDT Discharge Planning Review note dated 4/5/24 signed by the SW indicated the review was done one day prior to Resident 1 ' s discharge.</p> <p>On 5/6/23 at 2:30 P.M., an interview and concurrent record review were conducted with the DON and SW regarding Resident 2. The DON stated Resident 2 ' s discharge care plan did not have specific interventions regarding her goals. A concurrent review of the Notice of Proposed Transfer and discharge date d 4/1/24 was conducted. The SW stated Resident 2 had been in the facility for several months but was not given the notice 30 days prior to discharge. The SW stated, There was no notice given in advance, she got it the same day she discharged . A review of the IDT Discharge Planning Review note dated 3/31/24 signed by the SW indicated the review was done one day prior to Resident 2 ' s discharge. No nursing discharge note was produced during or after the onsite investigation.</p> <p>On 5/6/24 at 3:20 P.M., an interview and concurrent record review were conducted with the DON and SW regarding Resident 4. The DON stated Resident 4 did not have a discharge care plan. The SW stated the first discharge planning note was on 4/19/24, one month after Resident 4 was admitted . The SW stated, Patient was aware of discharge to shelter, he has no home. No one at a shelter can be relied on to provide needed assistance. I didn ' t document his last covered day. We could have still skilled him (changed billing status within the facility), I don ' t know what happened. Everyone at IDT knew he needed assistance. He wanted to try ALF/ ILF. I don ' t know why we discharged this resident. The SW stated no 30-day notice of discharge was given though Resident 4 was at the facility for more than 30 days. The DON stated, We do not have a discharge note.</p> <p>The DON and SW acknowledged the facility did not implement all steps of the facility discharge process as indicated in the facility policy.</p>		