

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: 056062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/22/2026
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)		
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a baseline care plan (detailed plan with information about a resident's treatment, goal, and interventions) related to a resident's nail care for one of two residents (Resident 2), reviewed for care plan. As a result, the lack of a resident centered care plan with specific interventions had the potential to result in delayed care, miscommunication among caregivers, and a decreased physical well-being of the residents. Cross Reference: F 677 Findings: Resident 2 was admitted to the facility on [DATE], with diagnoses which included osteoarthritis (a degenerative joint disease) and needed assistance for personal care, per the facility's admission Record. A review of Resident 2's clinical record was conducted. According to the initial MDS dated [DATE], Resident 2 had a BIMS (ability to recall) score of 15/15 which indicated Resident 2's cognition was intact. The functional status indicated Resident 2 was dependent on a staff member for personal hygiene. On 6/22/26 at 10:40 A.M., an observation and an interview were conducted of Resident 2 as he laid in bed. Resident 2's feet were exposed, and toenails appeared long, and curved. Resident 2 stated he needed someone to cut his left toenails because they were long and uncomfortable. On 6/22/26 at 11:45 A.M., a joint observation of Resident 2's left toenails, an interview and record review was conducted Licensed Nurse (LN) 2. LN 2 stated Resident 2's toenails were long. LN 2 stated there was no documentation related to Resident 2's long toenails. LN 2 stated the documents did not indicate Resident 2's long toenails were assessed, identified and noted during Resident 2's admission, and during the LN's weekly summary notes (a document that summarizes key information regarding the health condition of a person in relation to nursing care). LN 2 stated if identified, LNs should have developed a care plan related to Resident 2's long toenails and should have been referred to the podiatrist (a doctor who specializes in caring for your feet and ankles) timely and followed thoroughly. On 6/22/26 at 1:28 P.M., a joint observation of Resident 2's toenails and an interview with the Administrator (ADM) and the Director of Staff Development (DSD) was conducted. The ADM and the DSD stated Resident 2's toenails were long. The DSD the expectation was for the LNS to conduct head-to-toe assessments for the resident upon admission and the LNs should have noted and documented in the resident's clinical record and the LNs should have developed a care plan related to Resident 2's long nails and should have been referred to the podiatrist timely. A review of the facility's policy and procedure, titled, Person-Centered Care Planning, revised 4/24/25, indicated, .2. Baseline Care Plan, a. The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs and assistance for activities of daily living.		

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)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide routine nail care to one of two residents (Resident 2), reviewed for Activities of Daily Living (ADL, activities related to personal care/ hygiene) for dependent residents. As a result, Resident 2's toenails were long and curved and Resident 2 was at risk for skin injury and infection. Cross Reference: F 655 Findings: Resident 2 was admitted to the facility on [DATE], with diagnoses which included osteoarthritis (a degenerative joint disease) and needed assistance for personal care, per the facility's admission Record. A review of Resident 2's clinical record was conducted. According to the initial MDS dated [DATE], Resident 2 had a BIMS (ability to recall) score of 15/15 which indicated Resident 2's cognition was intact. The functional status indicated Resident 2 was dependent on a staff member for personal hygiene. On 6/22/26 at 10:40 A.M., an observation and an interview were conducted of Resident 2 as he laid in bed. Resident 2's feet were exposed, and toenails appeared long, and curved. Resident 2 stated he needed someone to cut his left toenails because they were long and uncomfortable. On 6/22/26 at 11:36 A.M., a joint interview and record review of Resident 2's shower sheet was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated Resident 2 needed assistance with ADLs. On 6/22/26 at 11:45 A.M., a joint observation of Resident 2's left toenails, an interview and record review was conducted Licensed Nurse (LN) 2. LN 2 stated Resident 2's toenails were long. LN 2 stated the process upon a resident's admission to the facility; the admitting LN was to conduct skin check on the resident and the treatment nurse would do the follow up skin check the following day. LN 2 stated she did not see any documentation regarding Resident 2's left toenails which were long and curved. LN 2 stated there was no documentation in Resident 2's minimum data set (MDS, a clinical assessment tool), the LN admission progress notes, and in the treatment nurse notes that talked about Resident 2's long toenails. LN 2 stated the documents did not indicate Resident 2's long toenails were assessed, identified and noted during Resident 2's admission, and during the LN's weekly summary notes (a document that summarizes key information regarding the health condition of a person in relation to nursing care). LN 2 stated Resident 2's long toenails should have been assessed and referred to the podiatrist (a doctor who specializes in caring for your feet and ankles) timely and followed thoroughly. On 6/22/26 at 1:28 P.M., a joint observation of Resident 2's toenails and an interview with the Administrator (ADM) and the Director of Staff Development (DSD) was conducted. The ADM and the DSD stated Resident 2's toenails were long. The DSD the expectation was for the LNs to conduct head-to-toe assessments for the resident upon admission and the LNs should have noted and documented in the resident's clinical record for any skin and nail issues. The DSD stated the staff could have notified the Nurse Practitioner (NP, is a nurse who has advanced clinical education and training. NPs share many of the same duties as doctors) and the NPs could have cut Resident 2's toenails when the NPs came to visit him. A review of the facility's policy and procedure, titled, Grooming Care of the Fingernails and Toenails, revised 10/21/21, indicated, Nail care is given to clean the nail bed and keep the nails trimmed.		