STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amaya Springs Health Care Center	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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to provide a written notice of discharge to one of three sampled discharged residents (8). As a result, Resident 8 was not fully informed regarding his discharge. Findings: Per the facility's Admission Record, Resident 8 was admitted to the facility on [DATE] with diagnoses to include osteomyelitis (bone infection). On 9/12/24 a review was conducted of Resident 8's medical record. Per the facility's Progress Note, dated 9/4/24 at 12:42 P.M., Resident 8 was transferred to an acute care hospital for a change in condition and was awake at the time of transfer. There was no documentation on 9/4/24 that Resident 8 was provided with a Notice of Proposed Transfer and Discharge form prior to his transfer. On 9/12/24 at 3:26 P.M., an interview was conducted with Licensed Nurse (LN) 6. LN 6 stated, Resident 8 went to the hospital due to a change in his condition and was awake at the time of discharge. LN 6 further stated, he did not provide any paperwork to Resident 8 at the time of discharge, and he was not familiar with the Notice of Proposed Transfer and Discharge form. On 9/12/24 at 4:02 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, when a resident was sent to an acute care hospital the Social Worker (SW) was responsible for providing the Notice of Proposed Transfer and Discharge form to the resident. On 9/13/24 at 8:28 A.M., an interview was conducted with the SW. The SW stated, the licensed nurses were responsible for providing the Notice of Proposed Transfer and Discharge form to residents when they were transferred to an acute care hospital. Per the facility's policy, titled Discharge and Transfer of Residents, revised February 2018, .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 .

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to provide a written notice of the facility's bed hold policy at the time of discharge to one of three sampled discharged residents (8). As a result, Resident 8 was not fully informed of his bed hold rights. Findings: Per the facility's Admission Record, Resident 8 was admitted to the facility on [DATE] with diagnoses to include osteomyelitis (bone infection). On 9/12/24 a review was conducted of Resident 8's medical record. Per the facility's Progress Note, dated 9/4/24 at 12:42 P.M., Resident 8 was transferred to an acute care hospital for a change in condition and was awake at the time of transfer. There was no documentation on 9/4/24 or 9/5/24 that Resident 8 was provided with a written notice of the facility's bed hold policy. Per the facility's Bed Hold Agreement, signed by Resident 8 on 1/17/24 (at the time of admission), the portion of the form titled, Notification of Bed Hold Option Upon Transfer/Therapeutic Leave was not completed. The form was blank for the sections on which acute care hospital Resident 8 transferred to, what day and time he left, who notified him of the bed hold option, when he was notified, and the location for staff to sign that they completed the form. On 9/12/24 at 3:26 P.M., an interview was conducted with Licensed Nurse (LN) 6. LN 6 stated, Resident 8 went to the hospital due to a change in his condition and was awake at the time of discharge. LN 6 further stated, he transferred Resident 8 to the hospital and did not provide a written notice of bed hold. On 9/12/24 at 3:38 P.M., an interview was conducted with the Admissions Coordinator (AC). The AC stated, when a resident was sent to a hospital, the licensed nurses were responsible for offering the bed hold at the time of discharge if the resident was awake, otherwise she would notify the resident's responsible part by phone the following day. The AC stated that when she called to offer the bed hold, she did not provide a written notice of bed hold to the resident or resident representative. On 9/12/24 at 4:02 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, when a resident was sent to an acute care hospital the facility did not provide a written notice of the facility's bed hold policy. Per the facility's policy, titled Bed Hold, revised July 2017, .The Facility notifies the resident and/or representative, in writing, of the bed hold, option any time the resident is transferred to an acute care hospital .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to notify the physician of a resident's low blood sugar readings, and did not monitor fluid intake and output for two of 12 sampled residents (1, 29). As a result, Resident 1 did not receive treatment for low blood sugar, and the facility could not determine if Resident 29 had proper fluid intake and adequate output, which may have lead to the late detection of fluid abnormalities in the body. Findings: 1. Per the facility's Admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses to include diabetes (disease of abnormal blood sugar). A record review was conducted. Per the facility's Orders, there was an order on 11/29/23 to check Resident 1's blood sugar before giving insulin (a medication to lower blood sugar), and to notify the physician if it was less than 70 milligrams (mg)/deciliter (dl). Per the facility's Weights and Vitals Summary, on 8/9/24 at 4:46 P.M., Resident 1's blood sugar reading was 13 mg/dl, and on 8/17/24 at 12:13 P.M., Resident 1's blood sugar reading was 59 mg/dl. On 9/12/24 a review was conducted of Resident 1's medical record. There was no documentation on 8/9/24 or 8/17/24 to show that staff notified Resident 1's physician of the blood sugar readings less than 70 mg/dl, any attempts to raise Resident 1's blood sugar, or any rechecks of Resident 1's blood sugar. Licensed Nurse (LN) 1 was not available for interview. On 9/12/24 at 3:43 P.M., an interview was conducted with LN 2. LN 2 stated, she should have offered Resident 1 a snack, rechecked the blood sugar, notified the physician, and documented what she did. On 9/12/24 at 3:53 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated, for Resident 1's low blood sugar readings on 8/9/24 and 8/17/24, the nurses should have given Resident 1 a sugary snack, rechecked the blood sugar, notified the physician, and documented what they did. Per the facility's policy, titled Blood Glucose Monitoring, revised 4/27/23, .Notify the healthcare provider of a Blood Sugar Level lower than 70 . 36471 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Per the facility's Admission Record, Resident 30 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease (kidney problem). A review of Resident 30's medical record was conducted. Per the Order Summary, dated 5/15/24, Resident 30's fluid intake and output were to be monitored. Per the same document, dated 7/26/24, Resident 30 was to restrict fluid intake to one liter daily. There was no evidence that Resident 30's fluid intake and output were being monitored and assessed. On 9/13/24 at 8:09 A.M., an interview and record review was conducted with LN 6. LN 6 stated he could not show evidence that the fluid restriction was consistently followed or if the assessments were done. On 9/13/24 at 9:19 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated fluid intake and output should have been monitored and evaluated after seven days. Per the facility's policy and procedure, dated 4/15/21, titled Intake and Output Recording, .Fluid Restriction after seven days of the initial order will be reevaluated .Intake and output will be monitored and recorded per the physician's order.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36471 Based on observation, interview, and record review, the facility failed to ensure that opened dressings in the refrigerator were labeled with an open date and that the freezer's foods were stored per the facility's policy and procedure. These failures placed residents at risk of acquiring foodborne illness and may have caused the texture of the food in the freezer to become less palatable. Findings: On 9/10/24 at 7:42 A.M., an initial tour of the kitchen was conducted with the Dietary Manager (DM). It was observed in the reach-in refrigerator that two large jars of dressings were opened, and there was no date. In addition, inside the reach-in freezer, there was a large sealable bag full of air, containing chicken thighs that had icicles built up on the meat. There was also an opened clear bag of diced chicken which was manually tied to close the item. On 9/10/24 at 8:07 A.M., an interview was conducted with the DM. The DM stated that opened items should be labeled and dated. Items in the freezer should have been stored appropriately. Per the facility's policy and procedure, dated 6/4/24, titled Dietary Services: Food Storage and Handling, . Refreezing of defrosted food is not recommended .Foods to be frozen should be stored in airtight containers or wrapped in heavy-duty aluminum foil or special laminated papers .label and date all food items .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed when: (1) The nebulizer (a small machine that turns liquid medicine into a mist that gets inhaled into the lungs), mask, and cup (contains liquid medicine for the nebulizer) were not cleaned and bagged after each use, per the facility's policy, and (2) The water waste management program was not implemented. These deficient practices placed residents at risk for infections. Findings: 1. Resident 29 was readmitted to the facility on [DATE] with diagnoses which included Respiratory Failure (breathing problem), per the Admission Record. On 9/11/24 at 10:09 A.M., Resident 29's nebulizer machine was observed on top of the dresser with a long clear tubing attached to the machine. The clear tubing was hung on the privacy curtain and down tuck inside the drawer. Inside the drawer were opaque-colored nebulizer cup and masks attached to the tubing. On 9/11/24 at 10:12 A.M., Resident 29 stated the licensed nurse (LN) administered his nebulizer treatment this morning. On 9/11/24 at 2:18 P.M., a joint observation and interview was conducted with LN 5. LN 5 stated he administered the nebulizer treatment to Resident 29 at 9 A.M. and 1 P.M. LN 5 further stated he did not clean the nebulizer mask and cup after administering the medication to Resident 29, but he should have. On 9/13/24 at 9:50 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated that the nebulizer mask and cup should be rinsed with water, dried, and placed in the bag after use. Per the facility's policy and procedure, dated 10/15/20, titled Nebulizer (small volume), .Drain any condensate from the nebulizer, rinse nebulizer cup with sterile normal saline or water and empty. Dry the nebulizer cup by placing the nebulizer in the Resident's equipment bag and leaving the compressor on for approximately ten minutes . 2. On 9/13/24 at 8:45 A.M., an interview and record review of the waste management program was conducted with the Maintenance Director (MAIN). The MAIN stated he was testing the water monthly and quarterly but ran out of the testing kit two months ago. In addition, the MAIN could not provide documented evidence of monitoring and tracking the water system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per the facility's policy and procedure, dated 5/25/23, titled Water Management, .Quarterly measurement of the water quality throughout the system to ensure changes that may lead to Legionella growth are not occurring .Monthly monitoring of chlorine levels .

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 36471 Based on interview and record review, the facility failed to ensure the Infection Control Preventionist (ICP) completed the specialized infection and prevention training. This failure could result in the ICP not being knowledgeable or qualified to perform the duties to prevent the spread of infection. Findings: On 9/13/24 at 9:37 A.M., an interview and record review was conducted with the Infection Preventionist Nurse (IPN). The IPN stated she was helping with the infection control prevention program, and the designated IPN quit, leaving her to do the job. IPN further stated she did not have the chance to do the required specialized training. On 9/13/24 at 11:38 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the designated ICP should have had the required training. Per the facility's policy and procedure, dated 2/19/21, titled Infection Preventionist, .[The Infection Preventionist] Have education, training, expertise or certification in specialized infection control and prevention practices .