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	01/29/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications had proper storage and labeling when:1. An injectable medication (heparin, anticoagulant) comingled with oral medications.2. Discontinued medications of residents were not disposed of accordingly.3. A resident's medication was left at bedside (Resident 38). These failures had the potential for medications to be incorrectly administered, decrease medication potency (medication strength) that could compromise the therapeutic effectiveness of stored medications and prevent misappropriation of the medications. Findings: 1.A medication cart storage observation was conducted on [DATE] at 9:06 A.M. with Licensed Nurse (LN) 11. LN 11 opened the first drawer of the medication cart # 2 which contained over the counter (OTC) oral medications. A box of heparin injectable medications comingled with the oral OTC medications. LN 11 stated the injectable medications should not be included in the oral medications for safety and infection control. An interview with the Director of Nursing (DON) on [DATE] at 5:12 P.M., the DON stated the injectable medications should not be co-mingling with the oral medications for safety and infection control. A review of the facility's policy titled Medication Storage in the Facility, dated 4/2008, indicated, Medications and biologicals are stored safely.and properly.C. Orally administered medications are kept separate. 2. A medication storage room observation was conducted on [DATE] at 4:21 P.M. with LN 12. There was combination of patch, injectable pens, oral inhalation medications and medicated shampoo that belonged to eight residents. LN 12 stated two of the eight residents expired on [DATE] and [DATE] (one of the two expired residents was discharged to comfort care on [DATE] and later died on [DATE]), three of the eight residents had medications that were discontinued by the attending physician, and another three of the eight residents were discharged from the facility. LN 12 stated the discontinued medications of the residents should have been disposed of according to the facility's policy to prevent misappropriation of the medicines. LN 12 stated the medications should have been marked as discontinued. An interview with the DON on [DATE] at 5:12 P.M., the DON stated discontinued medications should have been disposed of properly to prevent misappropriation of medications. A review of the facility's policy titled Disposal of Medications and Medication-Related Supplies, dated (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/2018, indicated, When medications are.discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/ her, or in the event of a resident's death, the medications are marked as discontinued or stored in a separate location and later destroyed. 3.Resident 38 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (breathing problem) and polyneuropathy (malfunction of many peripheral nerves throughout the body), per the facility's admission record. On [DATE] at 4:25 P.M., an observation was conducted with Resident 38 in her room. Resident 38 sat in her wheelchair by the bedside table. Resident 38 was alert and verbally responsive. Resident 38 had two pills in the medicine container, which she identified as gabapentin (treat for nerve pain), Senokot (stool softener), an inhaler (for breathing), and an eye drop were left at the bedside. A review of Resident 38's Medication Administration Record (MAR) indicated the gabapentin, Senokot, eye drop, and the inhaler were scheduled to be administered at 5 P.M. On [DATE] at 4:40 P.M., an interview was conducted with Licensed Nurse (LN)1. LN 1 stated medications should have not been left at the bedside. On [DATE] at 4:45 P.M., an interview was conducted with LN 2. LN 2 stated she left the gabapentin, Senokot, inhaler and the eye drops on Resident 38 bedside table. LN 2 stated she was in the room to administer the medications but left and forgot to come back. LN 2 stated she should not have left the medications unattended in Resident 38's bedside table for resident's safety. On [DATE] at 5 P.M., an interview was conducted with the Director of Nursing (DON). The Director of Nursing stated that medications should never be left unattended at the bedside for the safety of the residents. A review of the facility's policy titled Medication Storage in the Facility, dated 4/2008, indicated, Medications and biologicals are stored safely.and properly.

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to provide documentation to verify performance evaluation had been completed for two certified nursing assistants (CNAs).These failures had the potential to affect clients' well-being, should the staff be unable to perform duties effectively, efficiently, and competently.Findings: On 1/29/26 at 11 A.M., a concurrent review of the personnel files and interview was conducted with the Director of Staff Development (DSD). CNA 1 was hired on 10/29/18. The DSD could not find performance evaluations in CNA 1's personnel file. On 1/29/26 at 11:15 A.M., a concurrent review of personnel files and interview was conducted with the DSD. CNA 2 was hired on 9/17/24. The DSD could not find performance evaluation in CNA 2's personnel file.On 1/29/26 at 4:50 P.M., an interview was conducted with the Director of Nursing (DON). The Director of Nursing stated that staff should undergo performance evaluations annually to ensure they have the necessary skills to provide quality care and maintain compliance.On 1/29/26 at 4:55 P.M., an interview was conducted with the Administrator (ADM). The ADM acknowledged that performance evaluations were not completed for CNA 1 and CNA 2. The ADM stated performance evaluation should have been completed yearly. A review of the facility's provided documentation titled, Performance Evaluations, dated 1/24, indicated .performance evaluations maybe conducted annually, on or around their anniversary 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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's behavior was managed effectively, for one of one sampled resident (Resident 39). As a result, Resident 39's yelling and screaming was constant and disruptive to other residents.Findings: Resident 39 was admitted to the facility on [DATE] with diagnoses which included brain disorders (progressive loss of structure and function of the brain as a consequence of progressive degeneration and/or death of nerve cells), per the facility's admission record. A review of Resident 39's Brief Interview for Mental Status (BIMS, cognitive assessment), dated 11/19/25, indicated a score of 9, which meant Resident 39 had a moderate cognitive impairment. A review of the psychiatric assessment dated [DATE], indicated diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), adjustment disorder (the reaction to a stressful change or event) and anxiety disorder (persistent and excessive worry that interferes with daily activities). On 1/26/26 at 9 A.M., an initial screening was conducted in the facility's hallway. A yelling was heard coming from Resident's 39's room. On 1/26/26 at 3:50 P.M., an observation and an interview was conducted with Resident 39 in her room. Resident 39 was lying in her bed, spoke Spanish. Resident 39 yelled out loudly in Spanish. On 1/28/26 at 8:30 A.M., an observation was conducted of Resident 39 in her room. Resident 39 yelled out loudly in Spanish, constantly screaming Ya and hey. There were times Resident 39 yelled comprehensible words and there were times Resident 39 yelled out incomprehensible words. On 1/28/26 at 12:39 P.M., an observation was conducted of Resident 39 in her room. Resident 39 yelled out loudly in Spanish. Staff went into Resident 39's room and after exiting, Resident 39 started yelling out again. On 1/28/26 at 2:47 P.M., an observation was conducted in Resident 39's room. Resident 39 continued to yell out loudly even when the staff was in the room. On 1/26/26 at 9 A.M., an interview was conducted with Resident 39's roommate. Resident 39's roommate stated Resident 39 was Noisy all the time and it bothered her. Resident 39's roommate stated she was unable to get enough sleep because of Resident 39's constant yelling. On 1/28/26 at 8:34 A.M., an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated Resident 39 was alert but confused at times. CNA 3 stated Resident 39 yelled out intermittently throughout the day. CNA 3 stated Resident yelled out his brother's name and wanted to go home. CNA 3 stated he was unable to redirect Resident 39's behavior at times. On 1/28/26 at 3:06 P.M., an interview was conducted with CNA 4. CNA 4 stated Resident 39 was confused and disoriented. CNA 4 stated Resident 39 yelled out all day. CNA 4 stated Resident 39's roommate had voiced her complaints related to Resident 39's constant yelling. On 1/29/26 at 10:13 A.M., an interview was conducted with CNA 5. CNA 5 stated Resident 39 was alert but confused, yelled all the time when she was awake. CNA 5 stated Resident 39 yelled for a brief change even after care had been provided. CNA 5 stated Resident 39's roommate voiced her concerns about not being able to sleep due to Resident 39's constant yelling. On 1/28/26 at 3:24 P.M., an interview was conducted with Licensed Nurse (LN) 4. LN 4 stated Resident 39 frequently yelled during the afternoon and early evening. LN 4 stated she felt sorry for Resident 39's roommate. On 1/28/26 at 3:29 P.M., an interview was conducted with the Director of Social Services (DSS). The DSS stated Resident 39 was alert and confused. The DSS stated Resident 39 yelled while staff were in the room. The DSS stated Resident 39 could communicate her needs and requested things repetitively. The DSS stated It might be an attention seeking behavior. On 1/28/26 at 5:22 P.M., an interview was conducted with LN 12. LN 12 stated Resident 39 was agitated and yelled throughout the morning and afternoon shifts. LN 12 stated the staff could not consistently redirect Resident 39's behavior. LN 12 stated Resident 39 received medications but were ineffective. LN 12 stated she was not aware of Resident 39's roommate's concerns about Resident 39's yelling. On 1/29/26 at 10:23 A.M. an interview was conducted with LN 11. LN 11 stated Resident 39 was confused and yelled (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequently. LN 11 stated Resident 39 screamed that she would like to go home. LN 11 stated Resident 39 received medications but was ineffective. On 1/29/26 at 5 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 39 had an increased disruptive behavioral symptom. The staff were no longer able to redirect Resident 39 and the medication for her behavior was ineffective. The DON stated a psychiatric referral was made for Resident 39. A review of the facility's undated policy titled Behavior Management, indicated, .The facility will ensure that when a resident displays a mental disorder, psychosocial adjustment difficulties (e.g. crying, yelling, hitting, etc.).will receive appropriate treatment to address the problem or attain the highest practical mental and psychosocial well-being. ˆ

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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** Based on observation, interview, and record review the facility failed to ensure infection control procedures were followed when a Licensed Nurse (LN)13 did not wear a gown for Resident 6 with enhanced barrier precautions (EBP - involves gown and glove use during high-contact resident care activities for residents [example: residents with medical devices]), while passing medication (med/s) during med pass observation. This failure had the potential for cross contamination and spread of infection.Findings: A review of Resident 6's admission Record indicated Resident 6 was admitted to the facility on [DATE], with diagnoses which included urinary tract infections and with a gastrostomy tube (g-tube, a surgical opening fitted with a device to allow feedings/ meds to be administered directly to the stomach common for people with swallowing problems). On 1/28/26 at 8:26 A.M., an observation and an interview were conducted of LN 13 prepared medications for Resident 6. There was an EBP sign attached to Resident 6's door. LN 13 assembled Resident 6's medications in a medication tray. LN 13 went in to Resident 6's room and checked Resident 6's g-tube placement and gave the medications to Resident 6 via the g-tube. LN 13 stated, I have to correct myself, I forgot to put a gown on. On 1/28/26 at 8:37 A.M., an interview of LN 13 was conducted. LN 13 stated she should have worn a gown while passing medications to Resident 6 via the g-tube for infection control. On 1/29/26 at 5:10 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was for the staff to follow the procedures on EBP for protection of the staff and the residents to prevent spread of infection. A review of the facility's policy titled, Enhanced Barrier Precautions revised 10/15/24, indicated, .Process.2. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities.g. Device care or use.feeding tube.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide influenza vaccines (prevents the seasonal flu, a contagious respiratory illness) and pneumococcal (an immunization protecting against streptococcus pneumoniae bacteria, which causes severe infections) for two of five residents (Resident 6 and 39), reviewed for vaccinations. As a result, Residents 6 and 39 were at risks of acquiring flu and pneumonia.Findings: 1.Resident 6 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) per the admission Record. Resident 6's history and physical dated 11/1/25 indicated Resident 6's family member (FM) was the responsible party (RP) to sign consents for Resident 6. On 1/28/26 at 3:09 P.M., Resident 6's clinical record was reviewed for immunizations. There was no documented evidence the facility offered influenza vaccination to Resident 6 or the RP consented or declined to influenza vaccination for Resident 6 for 2025 - 2026 Influenza season. On 1/28/26 at 3:10 P.M., a joint review of Resident 6's immunization record and an interview was conducted with the Infection Preventionist Nurse (IPN). The IPN stated there was no influenza vaccination offered to Resident 6. The IPN stated it was important to offer influenza vaccines to Resident 6 for protection and prevention of Resident 6 from acquiring influenza. On 1/29/26 at 5:08 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the expectation was for the licensed nurses to administer the vaccinations to the residents especially when they consented as part of the primary care prevention of illness to the residents. According to the facility's policy, titled Influenza Prevention and Control, revised 9/10/20, .Policy: The facility will follow infection prevention and control policies and procedures to minimize the risk of residents acquiring, transmitting or experiencing complications from influenza.Procedure: ii. Vaccinating Residents against Influenza .B. Residents are offered an influenza immunization every year during flu season. 2. Resident 39 was admitted to the facility on [DATE], with diagnoses which included sepsis (a life-threatening blood infection), per the admission Record. Resident 39's FM was the RP. On 1/28/26 at 3:09 P.M., Resident 39's clinical record was reviewed for immunizations. According to the immunization consent form dated 11/12/25, Resident 39's RP consented the facility to provide pneumococcal vaccination to Resident 39. There was no documented evidence the facility offered and administered pneumococcal vaccination to Resident 39. On 1/28/26 at 3:10 P.M., a joint review of Resident 39's immunization record and an interview was conducted with the IPN. The IPN stated there was no pneumococcal vaccination offered to Resident 39. The IPN stated it was important to offer pneumococcal vaccines to Resident 39 for protection and prevention of Resident 39 from acquiring pneumonia. On 1/29/26 at 5:08 P.M., an interview was conducted with the DON. The DON stated the expectation was for the licensed nurses to administer the vaccinations to the residents especially when they consented as part of the primary care prevention of illness to the residents. According to the facility's policy, titled Pneumococcal Disease Prevention, revised 2/18/21, .Policy: The facility will offer pneumococcal immunization to each resident.