STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056062	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure three of seven confidential residents who were eligible to vote, were assisted to vote. In addition, the facility did not ensure a resident's rights related to self determination were addressed. This failure had the potential to cause emotional distress to the residents. Findings: 1. A confidential group meeting with the facility residents was conducted on 3/4/20 at 10:07 A.M. Confidential Residents (CR) 1, 2 and 4 stated they were very concerned they would not be able to vote. CR 1 stated, I feel very strongly to vote! I need to vote! CR 2 stated, It is too late, the election was yesterday. CR 4 stated, Voting is important to me too; nobody told me. An interview was conducted with the SSD on 3/5/20 at 8:06 A.M. The SSD stated, I don't vote and didn't realize it was important to the residents. I am not sure of the process to register; it is important to the residents because they want to feel like part of the outside community and what it is going on. A joint interview was conducted with the Admin and DON on 3/6/20 at 9:14 A.M. The Admin stated, It is their right to vote; we should help with that. A review of the facility's policy, dated, 11/1/13, titled, Voting, indicated, Purpose: to assist residents with voting .Policy: the facility will respect and honor the resident's right to vote. The facility will keep residents informed of upcoming elections, and will provide residents with assistance to exercise their right to vote . 2. Resident 35 was admitted to the facility on [DATE], per the facility's Face Sheet. During a review of the resident's History and Physical (H & P) dated [DATE], the H & P indicated, Resident 35 had the capacity to understand and make decisions. On 3/3/20 at 8:56 A.M., a tour of the facility and observation was conducted in a shared bedroom. Inside the shared bedroom, there were three residents. Resident 35's bed was located by the door, an unsampled resident in the middle, and Resident 29's bed was located by the window. Each resident had their own television (TV) and TV remote control. On 3/4/20 at 10:07 A.M., an interview with Resident 35 was conducted. Resident 35 stated his roommate (Resident 29) would usually ask the CNA assigned to him (Resident 29) to either change the volume of his TV or turn it off, or shut the door when he wished to. Resident 35 stated he felt claustrophobic. On 3/4/20 at 3:48 P.M., an interview with CNA 21 was conducted. CNA 21 was the assigned CNA for Resident 29. CNA 21 stated Resident 29 was a bully to Resident 35. CNA 21 stated Resident 29 would either turn off or increase the volume of Resident 35's TV. The TV remote had a universal control for the volume and power. In addition, Resident 29 wanted the door shut opposite to what Resident 35 wanted. On 3/5/20 at 2:40 P.M., an interview with CNA 22 was conducted. CNA 22 was the assigned CNA in the shared room. CNA 22 stated Resident 29 turned off or turned down the volume of Resident 35's TV. Resident 29 also wanted the door of the room closed while Resident 35 wanted the door of the room opened. CNA 22 stated this had been ongoing since Resident 35 was transferred to this room. CNA 22 stated Resident 35 would just leave the room. On 3/6/20 at 8:43 A.M., an interview with LN 21 was conducted. LN 21 stated there had been an issue between Resident 29 and Resident 35 and was aware regarding preferences of keeping the door or window closed or opened. LN 21 stated the issue should have been addressed right away because it was a dignity issue and to ensure the residents were safe and happy. On 3/6/20 at 9:59 A.M., a joint interview with the Admin and the DON was conducted. The DON stated the LNs should have communicated Resident 35's issues so it could have been addressed. A review of the facility's policy titled, Resident Rights, revised 1/2012, indicated, Purpose- to promote and protect the rights of all residents at the facility . Policy . The facility will promote and protect those rights . Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights .
F 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents have reasonable access to and privacy in their use of communication methods.** Based on interview and record review, the facility failed to ensure three of seven Confidential Residents (CR) 2,3,4 received their mail on Saturdays. This failure had the potential to violate Residents' rights. Findings: A group meeting was held with facility residents on 3/4/20 at 10:07 A.M. CR 2, CR 3, and CR 4 each stated that mail was not delivered on Saturdays. An interview was conducted with the AD on 3/5/20 at 11:39 A.M. The AD stated, I am in charge of mail delivery for residents; mail is not always delivered on Saturday. An interview was conducted with the AA on 3/5/20 at 11:56 A.M. The AA stated, I don't always deliver the mail on Saturdays. A joint interview was conducted with the Admin and DON on 3/6/20 at 9:14 A.M. The Admin stated, It (mail delivery) is their right. A review of the facility's policy,dated,1/1/12, titled, Resident Rights-Mail, indicated, Purpose: to ensure that residents have access to mail delivery .Procedure IV: mail is delivered to the resident within twenty-four (24) hours of delivery to the premises or to the facility's post office box (including Saturday deliveries).
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a clean environment for residents related to dust-covered air vents for 10 of 24 resident rooms. This failure had the potential to expose residents to environmental hazards. Findings: During the initial tour on 3/3/20 at 3:24 P.M., Resident 7 in room [ROOM NUMBER]A was observed in bed, with a towel on his head. Resident 7 stated, I had a towel on my head because the air vent blows on me and the air vent is covered with dust. The air vent was noted to be covered in dust and was rusty. In addition, the air vent was not flush with the wall and had dust behind it. On 3/4/20 at 8:37 A.M., the air vent was again observed and was still covered in dust and rust. Additional air vents in other residents' rooms were observed on 3/4/20: 8:52 A.M. room [ROOM NUMBER]: the air vent had stringy dust on it. 8:54 A.M. room [ROOM NUMBER]: the air vent was dusty. 9:03 A.M. room [ROOM NUMBER]: the air vent was dusty. 9:03 A.M. Room17: the air vent was dusty. On 3/4/20 at 3:21 P.M., a concurrent tour/observation of Rooms 10,12,16,17, and an interview was conducted with the Admin and the Hskg Lead. The Admin stated, The vents were dusty and were an infection control issue for residents. Additionally, the Admin stated that the facility currently had no Maintenance Supervisor and borrowed one from another facility when needed. Additional air vents in other residents' rooms were observed on 3/5/20: 9:52 A.M. room [ROOM NUMBER]: the air vent was dusty. 9:54 A.M. room [ROOM NUMBER]: the air vent was dusty. 9:56 A.M. room [ROOM NUMBER]: the air vent was dusty. 9:58 A.M. room [ROOM NUMBER]: the air vent was dusty. On

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

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F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 3/5/20 at 10:33 A.M., a concurrent tour/observation of Rooms 21, 22, 23, 24 and an interview was conducted with the DON. The DON acknowledged the air vents were dirty, dusty and rusty. A review of the facility's policy, dated, 1/1/12, titled, Cleaning and Disinfection of Environmental Surfaces, indicated, .Policy: Environmental surfaces are cleaned and disinfected according to current CDC recommendations for disinfection .
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** Based on interview and record review, the facility failed to notify the resident's representative (RR) when Resident 13 was transferred to general acute care hospital (GACH) due to change of condition for one of three closed record reviews. This failure violated resident's rights and potential to cause anxiety on resident's RR. Findings: On 3/5/20 at 11:37 A.M., a closed record review was conducted. Resident 13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The face sheet indicated Resident 13's RR's contact number. The H & P dated 12/26/19 indicated, Resident 13's RR was informed of the resident's change in medical condition. A review of the nursing progress notes dated 2/17/20 at 8 A.M., Resident 13 was transported to GACH for distress. There was no documentation found in the licensed progress notes related to notifying the RR. In addition, there was no documentation from the social services related to notifying Resident 13's RR upon transfer to GACH. On 3/5/20 at 2:57 P.M., a joint interview and record review with the DON was conducted. The DON stated there was no documentation in Resident 13's medical record. On 3/6/20 at 11:34 A.M., a joint interview with the Admin and the DON was conducted. The DON stated the RR should have been notified regarding Resident 13's transfer to GACH, so the RR would know what happened to their loved ones. A review of the facility's policy titled, Notice of Transfer/Discharge, revised 10/2017, indicated, . III. Before the transfer . the facility must notify the resident and if known, the responsible party . of the transfer and reasons for the transfer, and document in the resident's clinical record .
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** Based on observation, interview and record review, the facility failed to follow a care plan for a cardiac assistive device for one of 13 residents reviewed for care plan. This failure had the potential for inconsistent care provided to the resident. Findings: Per the Face sheet, Resident 24 was admitted on [DATE] with [DIAGNOSES REDACTED]. On 3/3/20 at 9 A.M., Resident 24 was observed sitting on his bed. There was a dressing on his right lower abdomen and a small, long tube coming out from the dressing. The tube was connected to a machine the size of a lap top. Resident 24 said, I have a left ventricular assistive device (LVAD), (a pump that is used for patients who have reached end-stage heart failure, a battery operated, mechanical pump which helps the left ventricle pump blood to the rest of the body.) Resident 24 stated, This machine is keeping me alive. On 3/5/20, a document titled, Left Ventricular Device short term care plan dated 2/21/20 was reviewed, Problem/need: Resident with LVAD for Hemodynamic support. GOAL: Patient will tolerate LVAD: with no complications no systemic or driveline site infection . No signs/symptoms of heart failure while on VAD. GOAL date: 5/21/20 Approach: A. Patient monitor: B/P & Map: Goal MAP (BLANK) A Document titled, (name of hospital) .Blood pressure guidelines for VAD patients .Resident Goal MAPs Hartman 3: 65-105 mmHg. Exercise Goal MAPs +20-30 mmHg. Resting Goal HR<120bpm. On 3/6/20 at 10 A.M., a joint interview with the DON, LN 21, and the DSD was conducted. The DSD stated, I've given in-services on the care of this device. The only instruction given to us by (hospital name) was to do the MAP . During the same interview, LN 21 stated, The MAP (Mean Arterial Pressure) is obtained by calculating the diastolic (bottom number of the blood pressure reading) number of the residents blood pressure x2 then adding the systolic (the top number of the blood pressure reading) number. The total is divided by three. The answer gives you the MAP. We have a flow sheet which we keep in the MAR (Medication Administration Record). On 3/6/20 at 11 A.M., a document titled, Heartware Flow Sheet was reviewed with LN 21. Vital signs which included the systolic and diastolic blood pressure numbers were missing for 7 AM on the following days: 2/19, 2/29, 3/1, 3/2, 3/4, and 3/5/20. LN 21 stated, Vital signs should be done at the beginning of every shift by the licensed nurse. LN 21 further stated, The vital signs show how the resident is doing. It's important to get vital signs every shift especially for this patient who has this heart device and is on antiarrhythmic medication. On 3/6/20 at 2 P.M., an interview with the Admin was conducted. The Admin acknowledged Resident 24's vital signs were missing in the flow sheet. The Admin stated the vital signs were essential assessment for Resident 24's care. A review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised 11/2018, indicated, . Policy: It is the policy of this facility to provide person-centered, comprehensive and interdiscilplinary care that reflects best practice standards for meeting health, safety . needs of residents .
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 label [MEDICATION NAME] test solution (used for testing [MEDICAL CONDITION]) with open date. In addition, the facility failed to ensure medication refrigerator temperature was monitored per the facility's policy for one of one medication refrigerator inspected. This failure had the potential to alter medication efficacy and unsafe storage of the refrigerated medications. Findings: 1. On 3/5/20 at 3:12 P.M., a joint inspection of the medication refrigerator, and an interview with LN 21 was conducted. LN 21 took out an opened [MEDICATION NAME] test solution from the refrigerator, and stated there was no date when the solution was opened. LN 21 stated the [MEDICATION NAME] solution should have been dated so as to know when the solution should have been discarded. A review of the undated medication insert, indicated a vial (small glass or plastic bottle, often used to store medication as liquids) of opened [MEDICATION NAME] solution should be discarded within 30 days. On 3/6/20 at 9:48 A.M., an interview with the DON was conducted. The DON stated the LNs should have labeled and dated the [MEDICATION NAME] solution once it was opened. The DON stated the LNs would not be able to know when to discard the solution when there was no open date. 2. On 3/5/20 at 4:10 P.M., a concurrent interview and record review with the DON was conducted. The DON stated they were using the Refrigerator/ Freezer temperature log form. The form indicated, Refrigerator temperatures should be at 41 degree Fahrenheit (F) or below. The DON stated the range would be 0 to 41 F. The DON stated they were using the form based on their policy. The DON gave their policy indicating Refrigerator/ Freezer temperature log- Operational manual- Dietary services. The DON stated it was not the right form and she did not realize the form/log was for use with food refrigerators. A review of the undated medication insert, under storage, [MEDICATION NAME] test solution should be stored at 35- 46 F. The medication insert also indicated, Discard product if exposed to freezing. On 3/6/20 at 8:25 A.M., a joint interview and record review with LN 21 was conducted. LN 21 took out the medication refrigerator log and stated they were logging the temperature in the Refrigerator/ Freezer temperature log- dietary services. LN 21 stated there should be a temperature range for the medication refrigerator, to maintain the efficacy of the refrigerated medication. LN 21 further stated the temperature of the refrigerator should have been maintained to the temperature range so that we knew when to report if there was an issue with the medication refrigerator and not to alter the potency of the medication. On 3/6/20 at 9:48 A.M., a joint interview with the Admin and the DON was conducted. The DON stated the temperature log form would be changed appropriate for monitoring the temperature range of the refrigerated medication. A review of the facility's policy titled, Temperature of Medications, revised 11/2017, indicated, Drugs shall be stored in appropriate temperatures . B. Drugs requiring refrigeration shall be stored in a refrigerator between 2 degrees Celsius (36 F) and 8 degrees Celsius (46 F) .

F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** Based on observation, interview and record review, the facility failed to serve food at proper temperatures for five out of seven confidential residents. As a result, the improper temperatures did not ensure food safety and palatability. Findings: On 3/4/20 at 10 A.M., during a group meeting with the facility residents, five out of seven confidential residents stated when breakfast was served, hot foods were often not hot and cold drinks were not so cold. The residents stated when this happened, they usually did not eat that food item. On 3/5/20 at 7:04 A.M., breakfast tray line was observed. The last tray prepared was a regular diet which consisted of Baked Spanish Omelet, sausage, hot cereal, milk and juice. The last tray was placed on the last tray cart and brought to the dining room. On 3/5/20 at 8:25 A.M., a concurrent interview with the Cook (C1) and observation of the last tray was conducted in the dining room. C1 placed the tray on the dining table and measured the temperature of each food item. The temperatures of the food items were the following: Eggs-151.2 degrees Fahrenheit Sausage-124 degrees Fahrenheit Hot cereal- 143.2 degrees Fahrenheit Milk- 51.4 degrees Fahrenheit Juice- 53.4 degrees Fahrenheit On 3/5/20 at 8:26 A.M., the test tray was tested for palatability. The egg omelet temperature was warm. The sausage temperature was tepid (only slightly warm). The hot cereal was hot. The Milk was tepid. The juice was tepid. On 3/5/20 at 8:27 A.M., an interview with C1 was conducted. C1 stated, The temperature of hot foods should be 135 degrees Fahrenheit or higher and cold foods should be 41 degrees Fahrenheit or colder. According to the facility's policy titled,

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F 0800 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Food Temperatures, dated July 1, 2014, .II. Acceptable Serving Temperatures .Meats, entrees temperature required >140 degrees Fahrenheit .Milk, juice temperature required <41 degrees Fahrenheit .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, hand washing supplies were not available in the laundry room. In addition, the staff failed to consistently perform hand hygiene during medication administration. This failure had the potential to increase the infection rate among staff, residents, and visitors. Findings: 1. A tour/observation of the facility's laundry area was conducted on 3/5/20 at 2:53 P.M. with the hskg lead. In the room containing the washer and dryer there was a sink, but no hand soap. An interview was conducted on 3/5/20 at 2:55 P.M. with the hskg lead. The hskg lead stated there was no hand soap near the sink. An interview was conducted on 3/6/20 at 8:41 A.M. with the ICN. The ICN stated that the laundry staff should have soap available to wash their hands. A joint interview was conducted on 3/6/20 at 9:14 A.M. with the Admin and the DON. The Admin and DON both stated that laundry staff should have soap available to wash their hands. A review of the facility's policy, dated, 2/1/13, titled, Hand Hygiene, indicated, Purpose: to ensure that all individuals use appropriate hand hygiene while at the facility .Policy . the facility considers hand hygiene the primary means to prevent the spread of infection .III. Hand hygiene products and supplies (sinks, soaps .etc) are readily available and convenient for staff use to encourage compliance with hand hygiene policy . 2a. On 3/5/20 at 7:29 A.M., an observation of LN 22 passing the medication was conducted. LN 22 put a pair of gloves, took out the sanitary wipes, wiped the medication tray, removed the gloves, touched the lid of the trash bin with bare hands, threw the pair of gloves, then touched the surface of the medication cart, without performing hand hygiene and took out the glucometer (used to measure blood sugar) from the cart. On 3/5/20 at 7:37 A.M., LN 22 went back to the medication cart number two, and did the same process without performing hand hygiene after touching the lid of the trash bin with bare hands. LN 22 then opened the drawer where the medications were stored and started popping the medication in the medicine cup. LN 22 was observed touching the lid of the trash bin several times with bare hands, then touched the medication cart and drawers without performing hand hygiene. On 3/5/20 at 1:07 P.M., an interview with LN 22 was conducted. LN 22 stated the sharp container down the trash bin was considered dirty. LN 22 stated she did not consistently perform hand hygiene after touching the lid of the trash can. LN 22 stated hands should be sanitized to prevent the spread of germs. 2b. On 3/5/20 at 9:11 A.M., an observation of LN 23 passing the medication was conducted. LN 23 drew insulin from a vial (small glass or plastic bottle, often used to store medication as liquids, powders), placed the syringe with insulin in the medication tray, touched the lid of the trash bin with bare hands to throw a piece of paper, did not perform hand hygiene. LN 23 then took a spoon and scooped some applesauce and placed in a plastic cup. LN 23 went to the resident's room. On 3/5/20 at 9:19 A.M., LN 23 went back to medication cart number one, touched the lid of the trash bin with bare hands, did not perform hand hygiene. LN 23 then opened the drawer and took out the resident's bubble packs (prepackaged medications in pill pockets) and a liquid medication bottle and placed them on top of the cart. LN 23 gave the medication to the resident touching the lip of the cup. On 3/5/20 at 9:53 A.M., a concurrent observation of the medication cart one and an interview with LN 23 was conducted. The trash bin was observed to have brown streak material on the outside. LN 23 stated he was not sure which of the medication cart was considered clean, but the trash bin was considered dirty. LN 23 stated he did not perform hand hygiene after touching the lid of the trash bin. LN 23 stated he should have sanitized his hands to prevent cross contamination and not to spread infections. On 3/6/20 at 9:39 A.M., a joint interview with the Admin and the DON was conducted. The DON stated the LNs should have observed infection control and should have sanitized their hands to prevent contaminating the medications. A review of the facility's policy titled, Hand Hygiene, revised 2/2013, indicated, The Facility considers hand hygiene the primary means to prevent the spread of infections .IV. Facility staff .must perform hand hygiene . A review of the facility's policy titled, Medication-Administration, revised 1/2012 was conducted. The policy did not provide instructions or guidance related to performing hand hygiene after touching an unclean area while administering medication.