STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055984	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Healthcare Center, LLC	501 South Beach Blvd. Anaheim, CA 92804

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of three sampled residents (Resident 1) attained and maintained the highest practicable physical well-being. * The facility failed to ensure Resident 1's colostomy bag was emptied according to the standards of practice when CNA 1 poured hot water in the colostomy bag. While the hot water was being poured, the colostomy bag touched the resident's skin, resulting in Resident 1 sustaining a burn on the left thigh and requiring pain medication administration and wound treatment. This failure had caused the burn to the resident's skin and the resident to experience pain and need wound treatment. Findings: Review of facility's P&P titled Ostomy Care - Colostomy, Urostomy, and Ileostomy revised 12/19/22, showed it is the policy of the facility to ensure that residents who require colostomy, urostomy, or ileostomy services receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goal and preference. Review of the facility's lesson plan titled Emptying an Ostomy bag (undated) showed 1. When applicable, direct care staff will empty the ostomy bag if bowel or air is noted. Supplies must be gathered prior to performing the task such as: wipes, toilet tissue, disposable bag, 2. Once supplies are obtained, direct care staff will wash hands and apply gloves. Then, place the disposable bag over the clamp at the bottom of the ostomy bag. This will ensure all of the contents in the ostomy bag are captured inside the disposable bag. Direct care staff will then, unclamp the clip and begin pushing the bowel or air down towards the opening with your gloved finger slowly, preventing any potential damage to the bag. Once all air or bowel is removed, wipe the ends of the opening and apply clamp. Ensure the clamp is closed. 4. Dispose of the disposable bag. Remove gloves and wash hands. 5. Direct care staff members will notify direct supervisor if resident asks for changing of the pouch or cleaning the inside of the pouch or any other care that direct care staff is not obligated to perform. (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 0684 Level of Harm - Actual harm Residents Affected - Few	6. It is never appropriate for direct care staff to perform such tasks that are not within their scope. These may include, but are not limited to: a. Changing of the pouch. b. Cleaning of the stoma. c. Putting fluids into the pouch. Medical record review for Resident 1 was initiated on 5/20/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 3/5/25, showed the resident had capacity to understand and make decisions. Review of Resident 1's MDS quarterly assessment dated [DATE], showed a BIMS summary score of 14, indicating the resident was cognitively intact. Review of Resident 1's Order Summary Report as of 5/20/25, showed the following physician's orders: - dated 9/26/24, for colostomy care, wash with soapy water, rinse, and pat dry as needed. - dated 9/27/24, for colostomy care, wash with soapy water, rinse, and pat dry every day shift. - dated 9/26/24, may change the colostomy bag as needed. - dated 9/26/24, may change the colostomy bag every day shift - dated 5/19/25, for the left upper thigh blister, cleanse with NS, pat dry, apply Xeroform and cover with dry dressing every day shift. Review or Resident 1's eINTERACT Change in Condition Evaluation dated 5/16/25, showed at 1455 hours, Resident 1 had a change in condition with symptoms of redness to the left outer hip and left lower abdomen. Review of Resident 1's Wound Progress Note dated 5/19/25, showed the burn was present on the left thigh with blister and wound status open. The wound measurements were as follows: area was 12.5 cm², perimeter was 17.6 cm, length was 6.6 cm, width was 2.1 cm, max depth was 0.1 cm, mean depth was 0.0 cm, and volume was 0.0 cm3. The Body % Burned Total showed 18%. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/20/25 at 1333 hours, an interview was conducted with Resident 1. Resident 1 stated on the afternoon of 5/16/25, CNA 1 emptied Resident 1's colostomy bag. CNA 1 was not able to empty the bag completely because there were feces left in the bag. Resident 1 further stated CNA 1 left the room and returned with a cup of water. CNA 1 poured the cup of water into the colostomy bag. Resident 1 stated suddenly she felt a burning sensation on her left thigh and abdomen. Resident 1 further stated it was burning so bad that she was yelling to CNA 1, it's burning, it's burning. However, CNA 1 did not promptly react to Resident 1's response. Resident 1 stated she swatted CNA 1's arm to remove the bag away from her. Resident 1 further stated CNA 1 was apologetic to her and admitted it was his fault to use hot water in cleaning the colostomy bag. Resident 1 stated CNA 1 verbalized he figured the colostomy bag could only be cleaned with hot water. Resident 1 stated the hot water must have burned the skin in her thigh for at least a minute because CNA 1 did not stop. Resident 1 stated her skin was bright red on her abdomen and thigh. Resident 1 stated LVN 1 told her she would be monitored. Resident 1 stated on Sunday afternoon (5/18/25), the redness on her thigh developed to a blister. Resident 1 further stated the nurses did not start the treatment for the blister until Monday (5/19/15). Resident 1 stated the burn still felt painful and sensitive when touched. On 5/20/25 at 1453 hours, an interview was conducted with LVN 1. LVN 1 stated CNA 1 asked him to check Resident 1 on 5/16/25, towards the end of his shift because CNA 1 reported in the process of emptying the colostomy bag, there was a hard feces residue. LVN 1 stated CNA 1 stated he put hot water in the bag which had contact with the resident's skin and caused it to be reddened on the abdomen and left hip area. LVN 1 stated the resident complained of pain and was medicated with acetaminophen 325 mg two tablets orally for the pain scale of 3 (using the pain scale of 0 to 10 with 0 = no pain and 10 = worst pain). On 5/20/25 at 1600 hours, an interview was conducted with the DSD. The DSD stated the CNAs were allowed to empty the ostomy bag in the facility. The DSD stated the CNAs should not put any fluid in the colostomy bag. On 5/21/25 at 1106 hours, a telephone interview was conducted with CNA 1. CNA 1 stated he emptied Resident 1's colostomy bag; however, there were some feces left in the bag. CNA 1 stated he got the water from the water dispenser right by the nursing station and filled the cup halfway. CNA 1 stated he was not paying attention to the temperature of the water because he was in a rush to empty the colostomy bag. CNA 1 stated he put a trash bag against the resident's thigh, however, did not put a towel on top of the resident's thigh. CNA 1 stated the trash bag was placed next to the resident's skin and colostomy bag. CNA 1 stated he poured all the water in the colostomy bag, then Resident 1 started saying, Hot! Hot! Hot! CNA 1 further stated there was redness on the resident's thigh which he reported to LVN 1. On 5/22/25 at 1053 hours, an interview was conducted with the DON. The DON verified CNA 1 emptied the colostomy bag and there were feces remained inside the bag. CNA 1 got hot water, poured it inside the colostomy, rinsed the colostomy bag, in the process, the bag touched the skin and caused the resident to have redness to the left lower abdomen and left hip, and a blister to the left thigh. The blister was observed and treated on 5/19/25. The DON stated the CNAs were not allowed to pour hot water inside the colostomy bag. CNA 1 should have called the charge nurse or treatment nurse. The DON was informed and acknowledged the above findings. Cross reference to F726.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the nurse aide was able to demonstrate competency in skills and techniques necessary to care for the residents' needs as identified through resident assessments and described in the plan of care. * The facility failed to ensure the nursing staff' competency on how to empty Resident 1's colostomy bag. This failure caused Resident 1 to sustain a burn on the left thigh and had the potential for adverse outcomes to the resident. Review of facility's P&P titled Ostomy Care - Colostomy, Urostomy, and Ileostomy revised 12/19/22, showed it is the policy of the facility to ensure that residents who require colostomy, urostomy, or ileostomy services receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goal and preference. Review of the facility's lesson plan titled Emptying an Ostomy bag not dated showed, 1. When applicable, direct care staff will empty the ostomy bag if bowel or air is noted. Supplies must be gathered prior to performing the task such as: wipes, toilet tissue, disposable bag, 2. Once supplies are obtained, direct care staff will wash hands and apply gloves. Then, place the disposable bag over the clamp at the bottom of the ostomy bag. This will ensure all the contents in the ostomy bag are captured inside the disposable bag. Direct care staff will then, unclamp the clip and begin pushing the bowel or air down towards the opening with your gloved finger slowly, preventing any potential damage to the bag. Once all air or bowel is removed, wipe the ends of the opening and apply clamp. Ensure the clamp is closed. 4. Dispose of the disposable bag. Remove gloves and wash hands. 5. Direct care staff members will notify direct supervisor if resident asks for changing of the pouch or cleaning the inside of the pouch or any other care that direct care staff is not obligated to perform. 6. It is never appropriate for direct care staff to perform such tasks that are not within their scope. These may include, but are not limited to: a. Changing of the pouch. b. Cleaning of the stoma. c. Putting fluids into the pouch. Medical record review for Resident 1 was initiated on 5/20/25. Resident 1 was admitted to the facility on [DATE]. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's H&P examination dated 3/5/25, showed the resident had capacity to understand and make decisions. Review of Resident 1's MDS quarterly assessment dated [DATE] showed a BIMS summary score of 14, indicating the resident was cognitively intact. Review of Resident 1's Order Summary Report as of 5/20/25, showed the following physician's orders: - dated 9/26/24, for colostomy care, wash with soapy water, rinse, and pat dry as needed. - dated 9/27/24, for colostomy care, wash with soapy water, rinse, and pat dry every day shift. - dated 9/26/24, may change the colostomy bag as needed. - dated 9/26/24, may change the colostomy bag every day shift - dated 5/19/25, for the left upper thigh blister, cleanse with NS, pat dry, apply Xeroform and cover with dry dressing every day shift. Review or Resident 1's eINTERACT Change in Condition Evaluation dated 5/16/25, showed at 1455 hours, Resident 1 had a change in condition with symptoms of redness to the left outer hip and left lower abdomen. Review of Resident 1's Wound Progress Note dated 5/19/25, showed burn present on left thigh with blister and wound status open. The wound measurements were as follows: area was 12.5 cm², perimeter was 17.6 cm, length was 6.6 cm, width was 2.1 cm, max depth was 0.1 cm, mean depth was 0.0 cm and volume was 0.0 cm3. The Body % Burned Total showed 18%. Review of CNA 1's Nurse Aide Competency form, undated, showed CNA 1 was hired on 2/26/25, and showed the competency of emptying an ostomy bag was completed on 2/26/25. On 5/20/25 at 1333 hours, an interview was conducted with Resident 1. Resident 1 stated on the afternoon of 5/16/25, CNA 1 emptied her colostomy bag. CNA 1 was not able to empty the bag completely because there were feces left in the bag. Resident 1 further stated CNA 1 left the room and returned with a cup of water. CNA 1 poured the cup of water into the colostomy bag. Resident 1 stated suddenly she felt a burning sensation on her left thigh and abdomen. Resident 1 further stated it was burning so bad that she was yelling to CNA 1, it's burning, it's burning. However, CNA 1 did not promptly react to Resident 1's response. Resident 1 stated she swatted CNA 1's arm to remove the bag away from her. Resident 1 further stated CNA 1 was apologetic to her and admitted it was his fault to use hot water in cleaning the colostomy bag. Resident 1 stated CNA 1 verbalized he figured the bag could only be cleaned with hot water. Resident 1 stated the hot water must have burned the skin in her thigh for at least a minute because CNA 1 did not stop. Resident 1 stated her skin was bright red on her abdomen and thigh. Resident 1 stated LVN 1 told her she would be monitored. Resident 1 stated on Sunday afternoon (5/18/25), the redness on her thigh developed to a blister. Resident 1 further stated the nurses did not start the treatment for the blister until Monday (5/19/15). Resident 1 stated the burn still felt painful and sensitive when touched. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/25 at 1434 hours, an interview was conducted with the ADON. The ADON stated the CNAs may empty the colostomy bag by draining the stool or gas to pass from the opening of the colostomy bag and should not put hot water in the colostomy bag. The CNA should have called the charge nurse or treatment nurse if they had any questions in emptying the colostomy bag. On 5/20/25 at 1453 hours, an interview was conducted with LVN 1. LVN 1 stated CNA 1 asked him to check Resident 1 on 5/16/25, towards the end of his shift because CNA 1 reported in the process of emptying the colostomy bag, there was a hard feces residue. LVN 1 stated CNA 1 stated he put hot water in the bag which had contact with the resident's skin and caused it to be reddened on the abdomen and left hip area. LVN 1 stated the resident complained of pain and was medicated with acetaminophen 325 mg two tablets orally for pain scale of 3/10. On 5/20/25 at 1600 hours, an interview and concurrent employee file review was conducted with the DSD. The DSD stated the CNAs were allowed to empty the ostomy bag in the facility. The DSD stated CNA 1 had completed the skills competency. The DSD verified CNA 1's Nurse Aide Competency form showed CNA 1 was hired on 2/26/25, and the competency of emptying ostomy bag was completed on 2/26/25. The DSD stated the CNAs should not put any fluid in the colostomy bag. On 5/21/25 at 1106 hours, a phone interview was conducted with CNA 1. CNA 1 stated he had worked as a CNA for less than three months. CNA 1 stated he was not educated on emptying a colostomy bag in school and was not taught how to empty a colostomy bag during the orientation in the facility. CNA 1 stated two CNAs showed him how to empty a colostomy bag in the facility. CNA 1 stated a CNA showed him by removing the feces from the colostomy bag and the other CNA showed him by pouring water in the colostomy bag to empty it. CNA 1 further stated it was his first time to take care of Resident 1. CNA 1 stated he emptied Resident 1's colostomy bag; however, there were some feces left in the bag. CNA 1 stated he got water from the water dispenser right by the nursing station and filled the cup halfway. CNA 1 stated he was not paying attention to the temperature of the water because he was in a rush to empty the colostomy bag. CNA 1 stated he put a trash bag against the resident's thigh, however, did not put a towel on top of the resident's thigh. CNA 1 stated the trash bag was placed next to the resident's skin and the colostomy bag. CNA 1 stated he poured all the water in the colostomy bag, then Resident 1 started saying, Hot! Hot! Hot!. CNA 1 stated he apologized and told Resident 1 it was his fault. CNA 1 verified there was redness on the resident's thigh, and he called LVN 1 to check the resident. On 5/22/25 at 1053 hours, an interview was conducted with the DON. The DON verified CNA 1 emptied the colostomy bag and there were feces remained inside the bag. CNA 1 got hot water, poured it inside the colostomy, rinsed the colostomy bag, in the process, the bag touched the skin and caused the resident to have redness to the left lower abdomen and left hip, and a blister to the left thigh. The blister was observed and treated on 5/19/25. The DON stated the CNAs were not allowed to pour hot water inside the colostomy bag. CNA 1 should have called the charge nurse or treatment nurse. The DON was informed and acknowledged the findings as above. Cross reference to F684.