STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035264	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Health LA Loma Care Center	14260 South Denny Boulevard Litchfield Park, AZ 85340

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, documentation, staff interviews, and policy and procedures, the facility failed to ensure that one resident (#1) did not elope. The sample was 3. The deficient practice could result in resident harm. Findings include:Resident #1 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture of third lumbar vertebra, cerebral amyloid angiopathy and dementia.The admission minimum data set (MDS) dated [DATE] revealed a brief interview of mental status (BIMS) score of 03. Which indicates that the resident has severe cognition impairment.The elopement risk assessment was completed on admission with a date of June 3, 2025 and revealed that Resident #1 was a low risk with a score of 0.0.A care plan was initiated on June 17, 2025 with a focus for Resident #1 being at risk for elopement. Interventions included to engage resident in purposeful activity, provide clear, simple instructions, provide reorientation to surroundings/environment, schedule time for regular walks/appropriate activity, staff to do 15 minute checks on resident.An Incident Note documented by Administrator (Staff #3) that was dated June 18, 2025 at 10:02 a.m. (late entry) revealed an Interdisciplinary team (IDT) follow up from elopement on June 16 at approximately 6 p.m was held; and that, Community VPO (Staff #7) notified nurse that Resident #1 was observed outside on a bench behind the independent living facility. It was reported that resident #1 had been sitting there for approximately 1 hour and was holding a TV remote and a napkin. Care plan was updated and new intervention for 1:1 sitter at this time until discharge. Discharge is set for June 18, 2025.Review of an updated elopement risk dated June 18, 2025 revealed that Resident #1 had a history of elopement risk while at home, wonders aimlessly. Elopement score is 6.0, indicating the resident is at risk of elopement.An interview was conducted with the Spouse of Resident #1 on June 25, 2025 at 10:35 a.m. and revealed that she was notified when her husband had eloped. An attempt to interview Licensed Practical Nurse (LPN) Staff #4 was conducted on June 25, 2025 at 11:00 a.m. by telephone. Staff #4 did not pick up the phone call, a message was left with a request to return the call. An attempt to conduct an interview with LPN Staff #5 was done on June 25, 2025 at 11:06 a.m. A message was left to return the call. LPN Staff #5 returned the call on June 25, 2025 at 11:08 a.m. and revealed that she was the nurse that did the skin assessment on Resident #1 after he was examined by the local fire department; and that, the police and fire department assisted the resident by giving him water, down in the lobby of the facility. Staff # 5 stated that the resident was hot and sweaty; and that, he was tired and fell asleep in his chair in his room, after he returned. Staff #5 stated that 15-minute checks were done and was on a continuous watch. Staff #5 stated that if residents elope, they could get hit by a car and are not aware of what is around.An interview was conducted with certified nursing assistant (CNA) Staff #8 who revealed that when residents are wandering or an elopement risk, you keep an eye on them by doing 15-minute checks to make sure they are observed. Redirect and show them the way back.An interview was conducted with provisionary Administrator Staff #6 on June 25, 2025 at 12:35 p.m. who revealed that the independent living building is next door to the care center building and was unable to give the approximate distance to the location as to where Resident #1 was found. Staff #6 then called Staff #7 to find out the distance to the building. Staff #7 stated he would show where the resident was located and arrived to the care center in a golf type cart to transport to the location where Resident #1 was found. Resident #1 was found on a bench on a path that goes through the community and was to the left side of the independent living building. That location was not visible from in front of the care center. Approximately 700 feet from the entrance of the facility to the bench where the resident was found.An interview was conducted on June 25, 2025 at 1:47 p.m. with Staff #6 who revealed that (BIMS) score can have an impact on the elopement assessment, depending on if they are exhibiting behaviors. A nurse to nurse report is done prior to arrival and sometimes there is not a clear indication status when the resident arrives to the building on admission. Anything can happen to a resident once they are out there. Review of the policy Hazardous Wandering and Elopements Policy with revision date of March 2024 revealed that Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.