

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035264	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2025
NAME OF PROVIDER OR SUPPLIER Sun Health LA Loma Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and caregiver interviews, and policy and procedures, the facility failed to ensure advance directives was followed for one resident (#10). Findings include: Resident #10 was admitted on [DATE], with diagnoses of muscle weakness, bacteremia, methicillin resistant staphylococcus aureus (MRSA), acute abscess of female pelvis, acute delirium, atrial-fibrillation, unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. The facesheet of the clinical record revealed no code status documented. The hospital history and physical dated [DATE] revealed that the resident had a code status of Do Not Resuscitate (DNR) and Do Not Intubate (DNI). An undated admission report sheet included that the resident had a code status of DNR. An admission progress note dated [DATE] revealed that resident #10 was alert and oriented with some confusion. The advance medical directive statement signed by the POA (power of attorney) and dated [DATE] included that the resident would receive cardio-pulmonary resuscitation (CPR), hospital transfer, feeding tube, pain medication, and hydration. The NP (nurse practitioner) note dated [DATE] included that the resident had a full code status. The physician's order dated [DATE] revealed that the resident had a full code. A brief interview for mental status (BIMS) assessment was completed on [DATE] included a score of 5 indicating the resident had severe cognitive impairment. Review of the care plan dated [DATE] revealed no code status was identified for resident #10. The provider note dated [DATE] included that the resident had a full code status. The provider note dated [DATE] included that the resident had a full code status. There was also no evidence found in the clinical record that the physician order for the full code status was changed or discontinued. However, review of the shift report sheet for [DATE] documented that the resident's code status was DNR. There was no evidence found in the clinical record that the code status of the resident was clarified with the resident and/or the resident's POA and/or the physician. The progress note dated [DATE] revealed that at 7:15 am, resident was in bed sleeping and had no acute respiratory distress noted. It also included that at 8:05 a.m., the resident was found unresponsive; and that, two nurses assessed the resident and noted that all vital signs ceased. The documentation did not include whether or not CPR was initiated for resident #10. There was no evidence found in the clinical record that CPR was initiated for resident #10. The facility's self report dated [DATE] included that the director of quality management notified the administrator and the DON (director of nursing) that on [DATE] CPR (cardiopulmonary resuscitation) was not performed when resident #10 was found unresponsive with no signs of life; and that, the resident passed away. During an interview conducted with registered nurse (RN/staff#11) on [DATE] at approximately 2:05 p.m., the RN stated that if a resident was found unresponsive she would check the physical chart for the resident's code status and honor the resident's wishes if they were DNR or Full Code. She said that if the resident was a full code then CPR would be started and CPR would continue until paramedics arrived and assumed care. An interview on [DATE] at approximately 2:15 p.m. with a certified nursing assistant (CNA/staff # 5) who stated that if he finds a resident unresponsive, he would call for the nurse and wait for the nurse to instruct him if CPR should be started. In an interview with another CNA (staff #7) conducted on [DATE] at approximately 2:30 p.m., the CNA (staff # 7) stated that if she found a resident unresponsive she would call for the nurse, would get the emergency cart and call 911 if the nurse told her to, and would wait for the nurse to instruct her if CPR should be started. Regarding resident #10, the CNA stated that she was working that day when resident #10 was found unresponsive; and that, she was assigned to provide care to resident #10. She stated that resident #10 did not want to get up after her vital signs were taken and had asked to be covered with her blanket which she did. The CNA stated that she was passing ice water when a student nurse requested her assistance because the resident (#10) was not waking up. The CNA said that she then went and checked the resident who did not seem to be breathing so she called the nurse. She stated that two nurses came: One nurse checked the resident's vitals; and, another nurse who was a licensed practical nurse (LPN) went to check the chart for the resident's code status. The CNA stated that the LPN came back and told her and the other nurse that the resident was a DNR. Further, the CNA stated that at that time, the LPN said the resident was gone. During an interview with another RN (staff #9) conducted on [DATE] at approximately 2:25 p.m., the RN stated that if a resident was found unresponsive she would call for assistance, call code blue and get the code cart. Additionally, she stated that she would check in the paper chart for the resident's code status and follow the direction. The RN stated staff response would depend on what was going on with the resident and the level of the resident's</p>		