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	03/28/2025

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that Minimum Data Set (MDS) assessments for 1 of 12 sampled residents (#37) accurately reflected their status regarding falls. The deficient practice could result in suboptimal care planning and effect the quality of care provided. Findings include: Resident #37 was admitted on [DATE] with diagnoses that included Parkinson's disease, dementia, repeated falls, muscle weakness, abnormalities of gait/mobility, malignant neoplasm of prostate and skin. An admission summary progress note dated March 6, 2025, revealed that the resident's spouse stated that he was admitted due to frequent falls. A fall risk evaluation progress note dated March 6, 2025, revealed a history of three or more falls within the past three months, and a fall risk of 26, which indicated a moderate fall risk. A clinical admission progress note dated March 6, 2025, revealed safety concerns related to falls. A Care Plan initiated on March 6, 2025, revealed the following areas of focus: -Safety, with interventions to encourage the use of prescribed assistive devices. -Risk for falls -Safety Concerns: Safety measures A physician progress note dated March 7, 2025, revealed that the resident had presented to the emergency room after multiple falls attributed to increasing unsteadiness, dizziness, and altered mental status. The progress note also revealed that the resident had poor safety awareness and was a high fall risk. A Baseline Care Plan Summary dated March 7, 2025, revealed the reason for admission included frequent falls and Parkinson's. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Medicare 5 Day Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. Further review of the assessment revealed that the resident had sustained no falls prior to admission, despite a diagnosis of repeated falls. The assessment also included the digital signature of the MDS Coordinator (staff # 31) as the person completing the fall section of the MDS (Section J) on March 18, 2025, and certifying that the information accurately reflected resident assessment information for the resident. An interview was conducted on March 26, 2025 at 12:02 PM with the MDS Coordinator (staff #31), who stated that the MDS assessment policy indicated that MDS assessments should accurately reflect the resident's status. She reviewed the clinical record and stated that Resident #37 had a diagnosis of previous falls. She reviewed the resident's admission 5 Day Medicare MDS Assessment, dated March 12, 2025, and stated that the fall portion of the assessment, indicated that the resident had no falls at any time in the last 2-6 month's prior to admission, and the code entered was 0, which indicated no. She stated that Section J of the MDS regarding previous falls, should have been coded as 1, indicating yes. She further stated that the fall section of the MDS was inaccurate and that she would need to send a modification MDS to correct the error. The MDS Coordinator stated that a Registered Nurse (RN) would sign off that the MDS was complete, and the MDS Coordinator signs all the MDS assessments that she completed. She reviewed Section Z of the 5-Day Medicare MDS assessment dated [DATE], and stated that there is a statement at the top of the form relaying that the accompanying information accurately represents the resident assessment. She stated that the MDS was not accurate, regarding Section J previous falls, of the admission 5-day MDS Assessment, and that she would not have noticed, if it had not been brought to her attention. She stated that she will send a correction for Section Jof the MDS regarding previous falls. An interview was conducted on March 27, 2025 at 9:44 AM with the Director of Nursing (DON/staff #35), who stated that she expected MDS assessments to be as accurate as possible, including the section regarding previous falls. She also stated that prior to signing the MDS sections, the nurse should review the assessments for accuracy. The DON also stated that she was made aware of the inaccurate 5-Day Medicare Assessment for Resident #37 yesterday after the surveyor brought it to the attention of the MDS Coordinator. The DON stated that the risk of an inaccurate MDS assessment could result in inaccurate data submitted to the Centers for Medicare and Medicaid Services (CMS). A facility titled, MDS 3.0 Completion, revealed that residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections. According to federal regulations, Sun Health conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. The RAI manual for the MDS stated that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The manual also included that the MDS assessment is the basis for the development of an individualized care plan.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure that a baseline care plan regarding urostomy care/treatment was developed for two of two sampled residents (#145, and #146). The deficient practice could result in goals and interventions not being evaluated, and available to the staff providing the care and treatment. Findings include: -Regarding Resident #145: Resident #145 was admitted on [DATE] with diagnoses that included cerebral infarction, history of malignant neoplasm of bladder, and artificial openings of urinary tract. Physician orders dated March 15, 2025, revealed an order for urostomy care two times a day. A weekly skin assessment dated [DATE], revealed the presence of a urostomy on the resident's left abdomen. A clinical admission progress note dated March 15, 2025, revealed the presence of an intact urostomy, and urostomy stoma. The March 2025 Treatment Administration Record (TAR) revealed evidence that urostomy treatments had been provided as ordered from March 15, 2025 through March 26, 2025. A baseline care plan dated March 17, 2025 revealed no evidence in the plan for nursing care regarding urostomy care/treatment. Review of the electronic health record (EHR) care plan revealed no evidence of a focus or interventions regarding urostomy care/treatment. Further review of the clinical record revealed that a Brief Interview for Mental Status (BIMS) assessment had been conducted on March 19, 2025 with a score of 12, which indicated moderate cognitive impairment. An interview was conducted on March 26, 2025 at 11:43 AM with the Director of Quality Management and Infection Preventionist (DQM-IP/staff #77), who stated that she would expect that a care plan would have been developed for urostomy care/treatment for the resident. She reviewed the clinical record and stated that there was no evidence of a care plan focus for urostomy care/treatment. She also reviewed the resident's baseline care plan and stated that there was no evidence that urostomy care/treatment had been included in the plan. She further stated that urostomy care should have been included in the baseline care plan and in the electronic care plan, but was not. The QM-IP (staff #77) stated the risk of not developing a plan regarding urostomy care/treatment on the baseline care plan could result in the resident/representative not being aware of the care/treatment the facility would provide. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephonic interview was conducted on March 27, 2025 at 11:48 AM with a Unit Manager (staff #4), who stated that she completes admission care plans in the EHR, that include activity of daily living, skin, and antibiotics, and the MDS Coordinator would add any devices including urostomy care. She further stated that the baseline care plan should include the basic care that the resident should receive, including urostomy care/treatment. She also stated that medical records personnel develop the baseline care plan, and review it with the resident/family. An interview was conducted on March 27, 2025 at 9:09 AM with the Health Information Manager (HIM/staff #44), who stated that baseline care plans are developed on a form that is called the Baseline Care Plan Summary. The HIM stated that she completes the entire form by reviewing the resident's diagnoses, orders, and records that are received during admission. She further stated that she would review the Baseline Care Plan Summary with the resident/representative to include a breakdown of the care that the resident will be receiving while at the facility. She also stated that if a resident had a urostomy diagnosis she would add that in the other section of the baseline care plan form. She reviewed the resident's medical record and confirmed a diagnosis of 'other urinary tract device'. She also reviewed Resident #145's baseline care plan dated March 17, 2025, and stated that there was no evidence of a plan for urostomy care, and that urostomy care should have been included on the baseline care plan. The HIM also stated that she was not aware of any risk to the resident from not including urostomy care on the baseline care plan. An interview was conducted on March 27, 2025 at 9:44 AM with the Director of Nursing (DON/staff # 35), who stated that the unit manager completes the care plan in the EHR, that included orders and diagnoses. The DON also stated that she would expect that urostomy care/treatment would be included in the EHR care plan and the baseline care plan, if there were diagnoses and orders for urostomy care. She reviewed Resident #145's medical records and stated that there was on order for urostomy care dated March 15, 2025; and that, urostomy care should have been included on the baseline care plan within 48 hours of admission. The DON also stated that the risk of not including urostomy care on the baseline care plan could result in staff not knowing how to care for the resident. -Regarding Resident #146: Resident #146 was admitted on [DATE] with diagnoses that included peritoneal abscess, type 2 diabetes mellitus, depression, colostomy and encounter for surgical aftercare following surgery on the digestive system. Physician orders dated March 21, 2025, revealed an order for ostomy care every 7 days and PRN (as needed), and to monitor output every shift. An additional order, dated March 22, 2025, was located for Foley catheter care every shift. During an initial observation of Resident #146 on March 25, 2025, at 9:43 AM, the resident was observed to have an ileostomy and a Foley catheter in place. An Advanced Skilled Evaluation Progress Note dated March 25, 2025, revealed the presence of an ileostomy and a Foley catheter. A Baseline Care Plan Summary (BCP), dated March 24, 2025, revealed no evidence in the plan for nursing care regarding ileostomy or Foley catheter care/treatment. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An electronic health record (EHR) Care Plan Report initiated March 22, 2025, revealed no evidence for nursing care regarding ileostomy or Foley catheter care/treatment. An interview was conducted on March 26, 2025 at 1:23 PM with the Director of Nursing (DON/staff # 35), who stated she would expect that ileostomy and Foley catheter care/treatment would be included in the BCP and the EHR care plan report, if there were diagnoses and orders for ileostomy and Foley catheter care. The DON reviewed Resident #146's medical record and stated that there was on order for ostomy and Foley catheter care dated March 21, 2025 and March 22, 2025 respectively, and they should have been included on the baseline care plan within 48 hours of admission. The DON also stated that the risk of not including ostomy and Foley catheter care on the baseline care plan could result in staff not knowing how to care for the resident. A policy titled, Baseline Care Plan Policy, revealed that Sun Health will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. A written summary of the baseline care plan shall be provided to the resident/representative, and shall include, at a minimum, any services and treatments to be administered by Sun Health and personnel acting on behalf of Sun Health. A policy titled, Ostomy Care - Colostomy, Urostomy, and Ileostomy, revealed that the resident's goals and preferences for care and treatment of the ostomy will be used to formulate a plan of care for the ostomy. The frequency of pouch changes and the products required for changing ostomy devices will be noted on the resident's person-centered care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews and policy review, the facility failed to provide indwelling (Foley) catheter care in accordance with professional standards of practice for one of one sampled resident (#146). This deficient practice could lead to indwelling foley catheter complications. Findings include: Resident #146 was admitted to the facility on [DATE] with diagnoses that included peritoneal abscess, type 2 diabetes mellitus, depression, colostomy and encounter for surgical aftercare following surgery on the digestive system. An initial observation was conducted on March 25, 2025 at 9:43 AM of Resident #146, who was lying in her bed with a catheter bag hanging on the bed frame. The resident stated she had a Foley catheter. A Nursing Skilled Evaluation Progress Note, dated March 25, 2025 indicated that the resident had a Foley catheter due to urinary retention. A provider order was written on March 21, 2025, for Foley catheter care to be conducted on every shift, by wiping from the proximal end (closest to the body) to the distal end (farthest away from the body) of the Foley catheter. The Treatment Administration Record (TAR), dated March 2025, revealed no evidence that Foley catheter care had been performed on March 24, 2025 during the day shift. A provider order was written on March 25, 2025 to remove the catheter at bedtime, and to perform PVR checks (bladder scans) every 8 hours for 24 hours. The order further revealed to notify the provider if Resident #146 was retaining urine (not able to urinate). The March 2025 TAR indicated that the Foley catheter had been removed on March 25, 2025, per order. Further review of the March 2025 TAR revealed no evidence that the scheduled 6:00 AM bladder scan had been performed per provider order. A provider order was written on March 26, 2025 to re-insert the Foley catheter that night. An additional review of the March 2025 TAR revealed that the Foley catheter was not documented as being re-inserted until March 27, 2025 at 5:37 AM, despite the order to re-insert the Foley catheter the night of March 26, 2025. An interview was conducted on March 26, 2025 at 10:37 AM with Resident #146, who stated that the Foley catheter had been removed at bedtime, on March 25, 2025. The resident stated she had not urinated since the Foley catheter was removed, and that nobody had performed a bladder scan or asked her if she had urinated. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 26, 2025 at 10:56 AM, with a Registered Nurse (RN/staff #41), who stated that she knew Resident 146's Foley catheter had been removed, but she did not know if the resident had urinated since the removal of the catheter. The RN confirmed a bladder scan should have been performed on March 26, 2025 at 6:00 AM. The RN reviewed the March 2025 TAR and stated there was no evidence that scan had been performed. An interview was conducted on March 26, 2025 at 12:07 PM, with a Certified Nurse Assistant (CNA/staff #42), who confirmed that Resident #146 had still not urinated; and that, a Licensed Practical Nurse (LPN/staff #39) had recently performed a bladder scan on the resident. An interview was conducted on March 26, 2025, at 12:12 PM with the LPN (staff #39) who stated she scanned the resident's bladder and found 69 milliliters of urine (small amount) in the bladder. The LPN confirmed that the resident was unable to urinate and had not urinated since the Foley had been removed the previous night. An interview was conducted on March 27, 2025 at 9:43 AM, with a Licensed Practical Nurse (LPN/staff #100), who stated Resident #146 had a Foley catheter re-inserted due to urine retention. She stated that the order was received from the provider on March 26, 2025 at approximately 5:00 PM, but the catheter was not re-inserted until the morning of March 27, 2025. An interview was conducted on March 27, 2025 at 10:49 AM, with the Director of Nursing (DON/staff #35), who reviewed the provider's orders and stated that the provider ordered the Foley catheter to be re-inserted the night of March 26, 2025. The DON then reviewed the March 2025 TAR and stated there was no evidence that the scheduled bladder scan had been performed at 6:00 AM on March 26, 2025. She also stated there was no evidence that the catheter had been re-inserted on March 26, 2025, per provider order. However, the DON stated the catheter may have been re-inserted on March 26, 2025, but it was not documented as being inserted until the morning of March 27, 2025. The DON stated that the risk of not performing the bladder scans, and not re-inserting the catheter per provider orders, could lead to urine retention and the need to send the resident to the emergency room. Review of a policy titled, Indwelling Catheter Use and Removal, indicated that the facility would: conduct ongoing assessments for residents with indwelling catheters, provide timely and appropriate assessments, adhere to professional standards of practice, recognize and assess for complications and their causes, maintaining a record of any catheter-related problems and monitor for excessive post void residual after removing a catheter. Review of a policy titled, Catheter Care Policy, indicated the facility was to ensure that residents with indwelling catheters received appropriate catheter care. The policy further specifies that catheter care will be performed on every shift and as needed. Review of a policy titled, Incontinence, indicated that residents who are incontinent of bladder will receive appropriate treatment to prevent infections and to restore continence to the extent possible. Review of a policy titled, Documentation in Medical Record Policy, indicated that all assessments, observations and services provided by licensed staff will be meticulously documented in the resident's medical record.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews and policy review, the facility failed to provide ileostomy care in accordance with professional standards of practice for one of two sampled residents (#146). This deficient practice could lead to ileostomy skin complications. Findings include: Resident #146 was admitted to the facility on [DATE] with diagnoses that included peritoneal abscess, Type 2 diabetes mellitus, depression, colostomy and encounter for surgical aftercare following surgery on the digestive system. A skilled nursing note dated March 21, 2025, revealed the resident had an ileostomy, rather than a colostomy. A provider order was written on March 21, 2025, for ileostomy care to be conducted every seven days and PRN (as needed): cleanse gently the skin and stoma with a wet washcloth or wipe, pat dry, apply wafer and pouch. The Treatment Administration Record (TAR) revealed no evidence that ileostomy care had been performed on March 24, 2025, on the day shift. A progress note dated March 26, 2025 at 5:45 PM written by RN (staff #41) revealed Resident #146's ileostomy was always leaking with liquid stool and the bag had to be changed eight times on her shift. On March 27, 2025 at 9:48 AM, an observation was conducted of the resident's ileostomy site with the Licensed Practical Nurse (LPN/staff #100) present. A light green fluid was observed leaking from the bottom of the ileostomy wafer onto the resident's skin. The skin was observed to be pink in color with no open areas. The LPN (staff #100) reviewed the resident's clinical record who stated there was no evidence that the provider had been notified regarding the ileostomy leaking or received further orders regarding the ongoing care of the ileostomy. An interview was conducted on March 26, 2025 at 10:10 AM, with a Registered Nurse (RN/staff #41), who stated that she had changed Resident 146's ileostomy bag at approximately 10:00 AM due to leakage. She further stated, it had to be changed; it had been waiting too long. An interview was conducted with Resident #146 and her daughter on March 26, 2025 at 10:30 AM. Resident #146 stated her ileostomy bag was leaking this morning when the aide helped me get dressed, around 5:30 AM. The resident's daughter stated she arrived at the facility at approximately 10:00 AM and observed the nurse leaving the resident's room with an armful of very dirty towels, and stated the ileostomay bag should have been changed sooner. An interview was conducted on March 26, 2025 at 12:05 PM, with a Certified Nurse Assistant (CNA/staff #42), who stated she observed the ileostomy bag leaking between 6:30 AM and 7:00 AM and that she notified the nurse at that time. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional interview was conducted with the RN (staff #41) on March 26, 2025 at 12:50 PM, who confirmed that the CNA informed her about the ileostomy leakin, but that she waited to change the ileostomy until approximately 10:00 AM. An interview was conducted on March 27, 2025 at 9:43 AM with an LPN (staff #100), who stated she was not informed about Resident #146's ileostomy bag leaking during the morning shift report. An interview was conducted on March 27, 2025 at 10:49 AM, with the Director of Nursing (DON/staff #35) who reviewed the clinical record and stated there was no evidence of the provider being notified of the leaking ileostomy. She further stated that she expected the ileostomy would be changed as soon as leakage was observed, and that the provider be notified of the ileostomy requiring multiple changes due to leakage. The DON reviewed the March 2025 TAR and stated there was no evidence that ileostomy care had been provided as ordered on the day shift of March 24, 2025. She stated that treatments should be charted when completed; and that, if they were not charted, it was not done. She stated the risk of not providing ileostomy care promptly and as scheduled could lead to, several issues. Review of a policy titled, Ostomy Care-Colostomy, Urostomy and Ileostomy, revealed that direct care staff will observe and respond to any signs of resident's discomfort about the ostomy or its care. Review of a policy titled, Documentation in Medical Record Policy, indicated that all assessments, observations and services provided by licensed staff will be meticulously documented in the resident's medical record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure that anti-hypertensives were administered within parameters for two residents (Residents #14 and #27); and that, pain management medication were administered within parameters for one resident (Resident #27). The deficient practice could result in further instances of inaccurate pain management with opioid medication; and, inaccurate administration of blood pressure medication. Findings include: -Resident #14 was initially admitted on [DATE] and re-admitted on [DATE], with diagnoses that included parkinsonism, unspecified; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; unspecified atrial fibrillation; and essential (primary) hypertension. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident did not have a BIMS (Brief Interview for Mental Status) completed and a staff assessment of the resident's mental status was completed, indicating that the resident rarely/never understood the assessor. A physician's order dated February 27, 2024 revealed an order for Amlodipine 10 milligram, one tab a day for hypertension. The order also revealed that the medication is to be held if the pulse is less than 60 and/or if the systolic blood pressure is less than 110. A physician's order dated February 27, 2024 revealed an order for Metoprolol Succinate Extended Release 25 milligram, one tab a day for hypertension. The order also revealed that the medication is to be held if the pulse is less than 60 and/or if the systolic blood pressure is less than 110. The review of the care plan revealed no evidence of an initiated care intervention regarding the resident's usage of anti-hypertensives. The care plan review did reveal pain management interventions due to the resident having acute and chronic pain. A review of the Medication Administration Record (MAR) for the month of March 2025 revealed that Amplodipine 10 milligram had been administered out of ordered parameters for the dates of March 2; March 8; and, March 12. Metoprolol Succinate Extended Release 25 mlligram had been administered out of ordered parameters for the dates of March 2; March 6; March 12. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on March 27, 2025 at 9:05AM with a Licensed Practical Nurse (LPN/Staff #61) who stated that the facility expectation is that the staff to follow the medication orders as they're ordered by the provider. Staff #61 stated that ordered anti-hypertensive medications will require the completion of vitals, evidenced by the documentation of the blood pressure and pulse records in the MAR, and as well as the confirmation of the administration, evidenced by a signature of the administering nurse. Staff #61 also stated that if the order requires administration within parameters, that the ordered parameters are to be followed; and that, if the order states to hold the medication, that a note can be made by the administering nurse, and to state the reasoning for the medication being held to ensure communication continuity. Staff #61 stated that this is the facility's expectations and that the risk of inaccurate documentation has the potential to for inaccurate administration of medications and inaccurate assessment completion of any changes in condition. When reviewing the medications administered out of parameters of Resident #14, Staff #61 stated that the lack of accurate documentation and administering of medications out of the ordered parameters do not meet the expectations of the facility. An interview was conducted the Director of Nursing/Administrator (Staff #35) who stated the facility expects accurate documentation in the MAR; and that, medications are documented according to what the provider has ordered. Staff #61 stated that if the order states to hold the medication, that a note can be made by the administering nurse, and to state the reasoning for the medication being held to ensure communication continuity. Staff #35 stated that this is the facility's expectations and that the risk of inaccurate documentation has the potential to for inaccurate administration of medications and inaccurate assessment of the resident's condition. When reviewing the medications administered out of parameters of Resident #14, Staff #35 stated that the lack of accurate documentation and administering of medications out of the ordered parameters do not meet the expectations of the facility. - Resident #27 was initially admitted on [DATE] and re-admitted on [DATE] with the diagnosis that include metabolic encephalopathy. A physician's order dated January 20, 2025 revealed an order for Oxycodone HCl 5 mlliram tablet, one tab every four hours as needed for pain levels 4 to 10. The order also revealed that it was discontinued after the first stay. A physician's order dated January 20, 2024 revealed an order for Metoprolol Succinate Extended Release 25 mlligram, one tab two times a day for hypertension. The order also revealed that the medication is to be held if the pulse is less than 60 and/or if the systolic blood pressure is less than 110.The order also revealed that it was discontinued after the first stay. A review of the Medication Administration Record (MAR) for the month of January 2025 revealed that Oxycodone HCl 5 milligram tablet had been administered out of ordered parameters for the dates of January 24; January 25; for one entry on January 26 and for January 27. A review of the Medication Administration Record (MAR) for the month of February 2025 revealed that Metoprolol Succinate Extended Release 25 milligram had been administered out of parameters for the 6:00AM administration for February 3. Oxycodone HCl 5 milligram tablet had been administered out of ordered parameters for the dates of February 13, 2025. (continued on next page)

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	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a BIMS (Brief Interview for Mental Status) of 15, which indicated that the Resident #27's cognitive function is considered intact. An interview was conducted on March 27, 2025 at 9:05AM with a Licensed Practical Nurse (LPN/Staff #61) who stated that the facility expects the staff to follow the medication orders as they're ordered by the provider. Staff #61 stated that ordered anti-hypertensive medications will require the completion of vitals, evidenced by the documentation of the blood pressure and pulse records in the MAR, and as well as the confirmation of the administration, evidenced by a signature of the administering nurse. Staff #61 also stated that if the order states parameters, that the ordered parameters are to be followed. That if the order states to hold the medication, that a note can be made by the administering nurse, and to state the reasoning for the medication being held to ensure communication continuity. Staff #61 stated that this is the facility's expectations and that the risk of inaccurate documentation has the potential to for inaccurate administration of medications and inaccurate assessment completion of any changes in condition. When reviewing the medications administered out of parameters of Resident #27, Staff #61 stated that administering of medications out of the ordered parameters do not meet the expectations of the facility. An interview was conducted the Director of Nursing/Administrator (Staff #35) who stated the facility expects accurate documentation in the MAR and that medications are documented according to what the provider has ordered. Staff #61 also stated that if the order states to hold the medication, that a note can be made by the administering nurse, and to state the reasoning for the medication being held to ensure communication continuity. Staff #35 stated that this is the facility's expectations and that the risk of inaccurate documentation has the potential to for inaccurate administration of medications and inaccurate assessment of the resident's condition. When reviewing the medications administered out of parameters of Resident #27, Staff #35 stated that administering of medications out of the ordered parameters do not meet the expectations of the facility. A facility policy titled, Physician Orders revealed that once an order has been processed and verified, the execution of the order is required to be documented and to notify the Medical Director with any reactions or concerns. A facility policy titled, Medication Administration Policy revealed that staff is to obtain and record vital signs and hold medications per orders. This policy also revealed that medications that require vitals to be taken prior to the administration include anti-hypertensives. This policy also revealed that the vital signs should be recorded on the MAR if they require it or has ordered for it.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, staff interviews and policy review, the facility failed to ensure that prepared food were distributed to residents at a safe and appetizing temperature. The deficient practice could result in the potential of bacterial growth in susceptible conditions. Findings include: On March 26, 2025 at 11:03AM, the tray line was observed, and the initial temperatures of the meat was at 180°F, vegetables were tempted at 169°F, starch tempted at 175°F, and a sandwich to which Staff #103 (Interim Dietary Manager) stated is a cheese steak sandwich tempted at 172°F. No cold components were included in the tray line for this observation due to no cold components on the menu for that day. During this tray line, meal service and tray distribution to all units were observed. On March 26, 2025 at 12:23PM a test tray was provided by Staff #103, the final temperatures of the food were obtained by Staff #103, which revealed meat was tempted at 152°F, vegetables were tempted at 140°F, starch tempted at 157°F, and a cheese steak sandwich tempted at 123°F. An interview on March 27, 2025 was conducted at 8:04AM with Staff #102 (Interim Director of Dining Services) and Staff #104 (Part-Time Registered Dietician) revealed that the facility's food temperatures upon arrival to the resident following the food service is to be referred and followed in accordance to FDA recommendations. Staff #102 also stated that cold holding foods should be kept at 41°F or lower, and that hot holding food should be kept at 135°F or higher, when being provided to residents during food services; and that, the risk of not providing residents with food within safe temperatures can create the opportunity for food borne illnesses. When discussing the temperatures of the test tray, Staff #102 stated that hot holding food to atleast 135°F or higher, such as the cheese steak sandwich that tempted at 123°F, is not the facility's meal service expectations. Review of the kitchen policy titled, 'Food Safety Requirements', revealed that food should be prepared as directed by the recommendations of the current FDA temperature guidelines until recommended temperature for the specific foods are reached. Review of a detailed breakdown of FDA temperature guidelines, revealed for kitchens state keeping hot food at 135°F (57°C) or above, and cold food at 41°F (5°C) or below, while also emphasizing the importance of cooling food properly to prevent bacterial growth within the danger zone (41°F to 135°F).

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	035264	A. Building B. Wing	03/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and policy review, the facility failed to that ensure that policies regarding storing opened food and leftovers were followed. The deficient practice could result in the potential of bacterial growth in susceptible conditions. Findings include: On March 25, 2025 at 8:20AM, an observation was conducted of the facility's kitchen with the Interim Director of Dining Services (Staff #102) providing guidance during this initial observation. At the end of the initial observation of the kitchen and dining services, an observation of the nourishment refrigerator revealed food items including canned beverages and a wrapped item within the freezer, with no labeled dates. An interview was conducted with Staff #102 during the observation above, where Staff #102 reported that they were unsure on whether or not closed items, such as canned beverages and yogurts, require a written date on the item itself due to the best by date on each individual item, however, stated that any leftovers or any items that are opened and then put back into the refrigerators, are to be dated and labeled according to the facility's policy. On March 26, 2025 at 9:02AM, a second observation of the nourishment refrigerators in both the second floor and the first floor were completed. A container with a thick and pink substance was observed with no evidence of a label or a date on the container in the 1st floor nourishment refrigerator. Following this observation, an interview was conducted with Staff #103 (Interim Dietary Manager) and Staff #104 (Part-Time Registered Dietician) at 9:11AM, where Staff #103 and #104 who stated that any leftovers or any items that are opened and then put back into the refrigerators, are to be dated and labeled according to the facility's policy. Further stating that the undated and unlabeled item in the nourishment refrigerator does not meet the facility's expectation. Staff #104 further stated that the expectation of staff is to go through the nourishment fridges at the end of each shift and to dispose of any items that are not properly labeled, and proceeded to dispose the unlabeled items in the nourishment refrigerator. An interview on March 27, 2025 was conducted at 8:04AM with Staff #102 who stated that any leftovers or any items that are opened and then put back into the refrigerators, are to be dated and labeled according to the facility's policy. Staff #102 stated that the undated and unlabeled items in the nourishment refrigerator do not meet the facility's expectation, due to the risk of food borne illness, and for the potential of servicing expired food. A policy titled, 'Monitoring of Cooler/Freezer Temperature', revealed that any refrigerated food should be labeled, dated and monitored so that it is used by the use by date. A policy titled, 'Food Safety Requirements', revealed that to the facility is expected to be labeled and be dated to ensure proper food storage. (continued on next page)

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	035264	A. Building B. Wing	03/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled, 'Resident Refrigerators', revealed that to the facility is expected provide weekly deep cleans of the resident's personal refrigerators to ensure items that are expired and past the used by date are disposed of properly. A policy titled, 'Kitchen Sanitization', revealed the facility's daily expectation for food service staff to inspect refrigerators, coolers, freezers and storage areas on a daily basis.

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	035264	A. Building B. Wing	03/28/2025

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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 observations, interviews and policy, the facility failed to ensure proper infection control practices were implemented to prevent development and transmission of communicable disease/infection for two of two sampled residents related to urostomy care for one resident (#145), and foley catheter care for one resident (#146). The deficient practice could result in transmission of infection. Findings Include: -Regarding Resident #145, PPE Donning/Doffing and hand hygiene: Resident #145 was admitted on [DATE] with diagnoses that included cerebral infarction, history of malignant neoplasm of bladder, and artificial openings of the urinary tract. Physician orders dated March 15, 2025, revealed an order for urostomy care two times a day. Further review of the clinical record revealed that a Brief Interview for Mental Status (BIMS) assessment had been conducted on March 19, 2025 with a score of 12, which indicated moderate cognitive impairment. An observation of Resident #145's urostomy care was conducted on March 26, 2025 at 10:11 AM with a Registered Nurse (RN/staff #41). The RN was observed to exit another resident's room, walk down the hall to gather supplies required for Resident #145's urostomy care. There was an enhanced barrier precautions (EBP) sign posted outside of the resident's room. Prior to entering the resident's room, the RN donned a gown, without tying the neck or waist, and then donned gloves without sanitizing her hands prior to entering the resident's room. As the RN placed a clean towel under the urostomy bag, her gown was observed to fall off of one shoulder, and the RN pulled the gown up onto her shoulder with her gloved hand. The RN opened an alcohol wipe and wiped down the tubing from the stoma. As the RN proceeded to open a second alcohol wipe, her gown was observed to fall off her shoulder, and the RN pulled the gown back up onto her shoulder with her gloved hands. As the observation continued, the RN turned around from the resident's urostomy toward the closet door, and opened the resident's closet door, without removing the gloves that she had used for the ostomy treatment. The RN was observed to check the ostomy stock in the resident's closet, touching a 4x4 gauze package, stoma wafers, and stoma adhesive packages without changing or removing her gloves. The RN was observed to close the closet door, and as she turned, the RN's gown was observed to have fallen off both of her shoulders, down to chest level and was not tied at the neck. The RN removed the towel from under the urostomy pouch and placed a clean wash cloth under the urostomy pouch. The RN was observed to remove the gloves, and as she was removing the gloves the gown fell from her shoulders across her chest. The RN then removed the gown and placed it in a laundry bin. The RN was observed to entere the resident's bathroom and wash her hands with soap and water in the sink. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately after the observation an interview was conducted with the RN (staff # 41) on March, 26, 2025 at 10:34 AM, regarding PPE donning and doffing. The RN stated that the facility policy regarding EBP included that staff donn PPE prior to entering a resident's room to perform urostomy care. The RN stated that she had received training on infection prevention related to donning and doffing PPE, and part of that training included securing the gown at the neck and waist, to prevent the gown from falling, and to protect the resident and staff from infection. The RN stated that she did not secure the gown at the neck or waist when she donned if for the resident's urostomy care. She also stated that the gown did fall off her shoulders and across her chest during the urostomy treatment. The RN stated that this did not meet the facility infection control policy regarding PPE donning/doffing, and she admitted that she was in a hurry when she donned the gown. The RN stated that the risk of not securing the gown could result in the gown falling from her shoulders and exposing the resident and staff to infection. The interview with the RN (staff #41) continued regarding hand hygiene. The RN stated that when donning gloves, she usually does not sanitize her hands prior to treatments, stating that she just puts the gloves on and does the treatment. She stated that she sanitized her hands as she exited a resident's room, before entering Resident #145's room. However, the RN stated that she did not immediately enter Resident #145's room, that she went down the hall to get supplies, and was in other areas prior to entering the resident's room. The RN stated that she did not sanitize her hands prior to entering the resident's room and placing on gloves, and she should have. The RN also stated that she should have removed the gloves she was wearing during the urostomy treatment, prior to checking the supplies in the resident's closet, due to the risk of infection, or contamination of the supplies. She stated that during the treatment some infection control concerns had occurred that did not meet the infection control policy. An interview was conducted on March 26, 2023 at 10:53 AM with the Infection Preventionist/ Director of Quality Management (IP/DQM, staff #77), who stated that she expected staff to use a hand sanitizer or wash hands upon entrance/exit to every resident's room. She also stated that she would not expect staff to sanitize their hands again before entering another resident's room, if the staff member was immediately entering another room, unless they touch something in between rooms. The IP/DQM also stated that staff should sanitize hands prior to donning gloves before entering a room that is placed on EBP. She further stated when staff donn gowns for treatments, that she did not expect the gowns to be tied at both the neck and waist, but did expect the gown to be tied at one or the other, but she would definitely want staff protected. She stated that it did not meet her expectations for a gown to fall off a staff member's shoulders to the chest level, due to the risk of possible contamination and infection. She further stated that opening a closet door without first removing soiled gloves used for urostomy treatment, and touching the clean supplies stored in the closet with the gloves, could result in contamination of the supplies. An interview was conducted on March 27, 2025 with the Director of Nursing (DON/staff #35), who stated that when staff donn a gown she would expect the gown to be tied at the neck or waist, so that the gown does not fall off during treatment/care. She also stated the risk of a gown falling off staff's shoulders during care/treatment could result in exposure to infection, and that there is a reason for those precautions. The DON further stated that she expected staff to sanitize their hands prior to donning gloves and entering a resident's room. She also stated that opening a closet door and touching clean supplies without changing gloves that had been worn during urostomy care/treatment did not meet her expectations, and could result in the risk of contamination of the supplies. (continued on next page)

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	035264	A. Building B. Wing	03/28/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Personal Protective Equipment, revealed that Sun Health promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Perform hand hygiene before donning gloves and after removal. Change gloves and perform hand hygiene between clean and dirty tasks. Gowns should fully cover torso from neck to knees, arms to end of wrist, and wrap around the back, fasten in back at neck and waist. A facility policy titled, Hand Hygiene, revealed that all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, known as alcohol-based hand rub (ABHR). The use of gloves does not replace hand hygiene. If a task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. -Regarding Resident #146, Foley catheter: During an initial observation of Resident #146's room, conducted on March 25, 2025 at 9:30 AM, a foley catheter bag was observed without a privacy bag, and the catheter bag outlet spout was observed unclipped/open, laying on the floor. There was no urine observed to be on the floor by the outlet spout, and a small amount of urine was observed in the catheter bag. Resident #146 was admitted to facility on March 21, 2025 with diagnoses that included peritoneal abscess, type 2 diabetes mellitus, depression, colostomy and encounter for surgical aftercare following surgery on the digestive system. Review of physician orders dated March 15, 2025 through March 25, 2025, revealed no evidence of a PRN (as needed) order to change the foley catheter bag. Further review of Physician orders were written for the following: -Indwelling foley catheter 16 fr (French scale/gauge), 10 ml (millimeter) for urinary retention, dated March 22, 2025. -Catheter care every shift, wipe from proximal to distal end of foley. Maintain dignity cover for drain bag, dated March 22, 2025. -Change foley drain bag every 30 days every night shift for foley care, dated 3/22/2025. -Enhanced Barrier Precautions due to IV access, foley care, wound care: wear increased PPE when working with these items every shift, dated March 23, 2025. Review of the March 2025 Treatment Administration Record (TAR), revealed no evidence that the resident's catheter bag had been changed, despite nursing being informed by a surveyor that the catheter bag outlet spout had been observed open and laying on the floor of the resident's room, on March 25, 2025. Further observations were conducted on March 25, 2025: (continued on next page)

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	035264	A. Building B. Wing	03/28/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11:56 AM, the catheter bag outlet spout was observed to be clipped to the catheter bag, and was not touching the floor. -3:00 PM, the catheter bag was observed to have been be placed in a privacy bag. An interview was conducted on March 25, 2025 at 12:02 PM with a Registered Nurse (RN/staff #65), who stated that she would change the catheter drainage bag, if the catheter bag outlet was found to be unclipped, open and touching the floor. The RN stated that she had not been notified by a Certified Nursing Assistant (CNA) that the resident's catheter bag outlet spout had been left unclipped, open and was lying on the floor. An interview was conducted on March 25, 2025 at 12:05 PM with a CNA (staff #42), who stated that the facility policy regarding catheter care included keeping the catheter bag from touching the floor. She further stated that the catheter bag outlet spout is used to empty urine in the catheter bag, and should be folded up and clipped to the catheter bag when the outlet spout is not in use. She also stated that if the outlet spout would touch the floor it should be cleansed with an alcohol wipe. The CNA stated that the nurse would not need to be notified if the catheter bag outlet spout was left unclipped, open and touching the floor. The CNA stated that she had emptied the resident's catheter bag about a half hour ago, and had observed that the outlet spout was touching/laying on the floor. The CNA further stated that she cleaned the outlet spout with peri-care wipes, because she did not have a chance to use an alcohol wipe. The CNA stated that the peri-wipes are not antibacterial. She stated that when urine is emptied from the catheter bag, a paper towel is placed on the floor under the catheter bag for infection purposes. The CNA stated that she was not sure if there was a risk of infection related to the catheter bag outlet spout lying on the floor. Further interview was conducted on March 25, 2025 at 12:15 PM with RN (staff #65), who stated that the outlet spout on catheter bags should not touch the floor and be clipped closed, due to contamination and risk of infection, as she did not know what could be on the floor. She further stated that the catheter bag would need to be changed if that occurred. The RN stated that she had not changed the catheter bag because she had not been notified by the CNA (staff #41) that the outlet spout had been found lying on the floor. She stated that the spout should have been cleaned with an alcohol wipe or sani-wipe (something with antibacterial properties) by the CNA, and that the CNA should have notified her. The RN stated that the risk of the catheter bag outlet spout laying on the floor could result in contamination. An interview was conducted on March 26, 2023 at 10:53 AM with the IP/DQM (staff #77), who stated that she expected that the catheter bag outlet spout would be kept secured/clipped to the catheter bag, and not be left open and laying on the floor. She also stated that the risk of the outlet spout laying on the floor could result in the spread of infection. She further stated that when a catheter outlet spout is left open and touches the floor, the CNA should clean the outlet spout with an alcohol wipe before re-clipping the spout onto the catheter bag, and then inform the nurse, then nursing should change the catheter bag and document in nursing notes or on the TAR. She further stated that cleaning the outlet with a personal care wipe would be acceptable if the CNA told the nurse, however best practice would be to cleanse the outlet spout with an alcohol swab. The IP/DQM stated that it did not meet her expectations for the catheter bag outlet spout to be left open and laying on the floor. She also stated that the risk of the catheter bag outlet spout unclipped, open and touching the floor could result in contamination. (continued on next page)

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	035264	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 27, 2025 at 1:01 PM with the DON, who stated that foley catheter bags should be kept off the floor, with the outlet spout clipped in the closed position, and that the catheter bag should be covered with a privacy bag. The DON further stated that once a catheter bag outlet spout had been found open and laying on the floor, she would expect staff to follow the policy and clean the spout with a antiseptic wipe, and inform the nurse so that the catheter bag would be changed as soon as possible. The DON stated that it would not meet her expectation for the outlet spout to touch the floor, or for the catheter bag to not be covered with a privacy bag. She also stated that cleaning the outlet spout with an alcohol wipe would be acceptable, but it did not meet her expectation for the outlet spout to be cleansed with a personal wipe, and it did not meet her expectations that the incident was not reported to a nurse. The DON reviewed the March 25, 2025 progress notes and TAR, and stated that there was no evidence that the catheter bag had been changed by nursing. The DON further stated that this did not meet her expectations. A facility policy titled, Catheter Care, revealed that if a foley catheter drainage bag or tubing touches the floor, it is considered contaminated and should be replaced as soon as possible. If immediate replacement is not feasible, the contaminated external surface should be disinfected with a facility-approved disinfectant wipe and allowed to air dry. Staff must change the system as soon as possible.