STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035189	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Canada Care Center	7970 North LA Canada Drive Tucson, AZ 85704

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 clinical record review, interviews, review of facility documentation and policy and procedures, the facility failed to ensure medications administered to 1 of 3 sampled residents (#20) had physician orders. The census was 101. The deficient practice resulted in resident hospitalization due to a change in resident's condition.Findings include:Resident #20 was admitted [DATE] with diagnoses of metabolic encephalopathy, essential tremor, epilepsy, dementia, spinal stenosis, cognitive communication deficit and syncope and collapse.The history & physical note dated January 12, 2026 included the resident was admitted at the facility for inpatient rehabilitation; and that, all medications were reviewed and reconciled. Assessments included history of TIA (transient ischemic attack); muscle weakness and seizure disorder. Medications included Primidone.A care plan initiated on January 13, 2026, revealed a focus on the resident having hypertension with interventions to give antihypertensive medications as ordered and monitor for side effects such as hypotension and increased heart rate.The eMAR (electronic medication administration record) notes dated January 13, 2026 revealed that prescribed medications for Resident #20 was documented as administered as ordered by a Registered Nurse (RN/Staff #46) on January 13, 2026.The physician order summary report active as of January 16, 2026 included the following medications:Acidophilus (Lactobacillus-probiotics), 1 tablet by mouth one time a day for probioticB-complex w/biotin & folic acid (supplement), 1 tablet by mouth one time a day for supplementClopidogrel bisulfate (antiplatelet) 75 mg (milligrams)1 tablet by mouth one time a day for a history of transient ischemic attackFluconazole (antifungal) 200 mg 1 tablet by mouth one time a day for toe infectionLoratadine (antihistamine) 10 mg 1 tablet by mouth one time a day for allergiesMultivitamin (supplement) 1 tablet by mouth once a day for supplementPolyethylene glycol (laxative)3350 powder 17 grams by mouth daily for bowel regimenPropranolol (beta-blocker) ER (extended release) 120 mg, 1 capsule by mouth one time a day for hypertensionFluticasone propionate (synthetic corticosteroid) nasal suspension, 50 mcg (microgram)/Act (activation) 1 spray in both nostrils every 12 hours for allergiesLamotrigine (anticonvulsant) 100 mg 1 tablet by mouth every 12 hours for seizuresAcetaminophen (analgesic) 1000 mg by mouth every 8 hours for chronic painHeparin (anticoagulant) 5000 unit/ml (milliliter), inject 5000 unit subcutaneously every 8 hours for deep vein thrombosis prophylaxisReview of the clinical record revealed documentation that prescribed medications for Resident #20 were administered as ordered on January 16, 2026A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 05, which indicated severe cognitive impairment. Per the assessment, the resident was taking anticoagulants, antiplatelets and anticoagulants with 4 medications being received through injections.A nursing progress note dated January 16, 2026, at 4:00 p.m. included that the resident's family arrived to visit and found the resident #20 slumped over in her chair. It also included that the nurse assessed the resident and noted that the resident did not respond to verbal cues but did respond to physical stimulation. Per the documentation, the resident (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	was unable to state her birthday, the current year, or her location; and, the only question resident could answer was the name of her family. Further, the documentation included that the resident's eyes rolled back while speaking and that the resident fell asleep immediately afterward. According to the documentation, the resident's BP (blood pressure) was 162/81 and the provider was notified. Further, the note included an instruction to send the resident out due to a change in condition.A nursing progress note dated January 16, 2026 at 10:41 p.m. revealed that the resident's family notified the facility that the resident was being admitted to the hospital for observation related to elevated blood pressure.A review of an undated handwritten document written by the License Practical Nurse (LPN/Staff #7) revealed a list of medications of another resident that were given to Resident #20 included the following:-Amiodarone (antiarrhythmic) 200 mg;-Aripiprazole (antipsychotic) 5 mg;-Aspirin (non-steroidal anti-inflammatory) 325 mg;-Citalopram (antidepressant) 40 mg;-Apixaban (direct-acting anticoagulant) 2.5 mg;-Ferrous sulfate (supplement) 325 mg;-Folic acid (supplement) 1 mg;-Lasix (diuretic) 40 mg;-Midodrine (antihypotensive) 10 mg;-Multivitamin with minerals (supplement);-Potassium (supplement) ER 20 mEq (milliequivalent);-Vitamin B12 (supplement) 1000 mcg; and,-Vitamin D3 (supplement) 1000 IU (international units).The clinical record revealed no evidence that Resident #20 had physician orders for medications listed in the handwritten document and documented as administered to her, including amiodarone, aripiprazole, aspirin, citalopram, apixaban, ferrous sulfate, folic acid, Lasix, midodrine, a multivitamin with minerals, potassium ER, vitamin B12, or vitamin D3.Continued review of an undated handwritten document showed a list of morning vital signs documented as prior to event, including a blood pressure of 140/72, pulse of 73, oxygen saturation of 93, respirations of 18, and a temperature of 98 degrees. The documentation indicated that the onsite provider was notified at 12:14 p.m.; the resident, who did not understand at all and was alert and oriented x2ish, was notified at 12:20 p.m.; and, the resident's family, who was described as very angry and requested a list of medications given to Resident #20, was notified at 1:43 p.m. According to the documentation, the physician instructed staff to hold the resident's heparin and propranolol for 24 hours and to monitor vital signs every hour until midnight, then every four hours; and that the monitoring sheet was provided to the CNAs (certified nursing assistants).An undated typewritten facility investigation revealed that on January 16, at approximately 12:10 p.m., the registered nurse (RN/staff #46) and Physical Therapy Assistant (PTA/Staff #57) informed Licensed Practical Nurse (LPN/Staff#7) that Resident #20 was given several medications that were prescribed for a different resident. Per the documentation, the resident reported that she took her medications when she was informed that the nurse had given her additional medications that were not ordered for her. It also included that the resident was leaning to the side and was not responsive to verbal cues, but was responsive to physical stimuli at 4:00 p.m., when the resident's family arrived; and that vital signs were taken and revealed the resident had elevated BP. The documentation included that the provider was notified and orders were received to send Resident #20 to the emergency room; and that, later that evening, the resident's family informed the facility that Resident #20 was admitted for observation for her elevated blood pressure. Further, the documentation included that a follow-up with the hospital on January 21, 2026, confirmed that Resident #20 was still in the hospital and had an admitting diagnosis of unintentional use of medication and pneumonia.A phone interview with the family of Resident #20 was conducted on January 21, 2026, at 1:00 p.m. The family stated that on January 16, 2026, at around 1:45. p.m., the resident's nurse called and informed her that another nurse had gone into the therapy area and asked which therapist was working with another resident. The family said that she was told that the therapist who was working with Resident #20 told the nurse that he had Resident #20, and that (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the nurse gave the medications to Resident #20 instead of the other resident. The family said the nurse told her the doctor was onsite and staff were monitoring Resident #20, but staff did not immediately inform her which medications were given to Resident #20 or that the resident's vital signs were abnormal. She stated that, eventually, the facility gave her a list of the medications shortly after she arrived at the facility that day. The family stated that when she arrived at the facility, Resident #20 was slumped over in her wheelchair, and there were no staff in the room with the resident. The family said that she immediately left the room to call for help and was able to get the LPN (staff #64) to assess and ask the resident questions. She stated that within a minute, the LPN decided to call the ambulance, and the facility sent Resident #20 to the emergency room by 4:00 p.m. Further, the family said that the blood pressure of Resident #20 skyrocketed, and the resident could not lift her head. The family also said that Resident #20 was given medications to treat schizophrenia.A phone interview was conducted on January 21, 2026, at 1:13 p.m. with an LPN (staff#64) who stated that she was scheduled to start the evening shift at 2:00 p.m. on the day of the incident and learned about the incident during shift change. She said that she was told that a nurse from another hall was going to administer medications to another resident who was not in her room, so the nurse went to the therapy room to locate the resident. The LPN stated she did not know how the nurse identified the resident, but the nurse asked Resident #20 if she was the other resident, and Resident #20 responded yes. The LPN stated that the therapist later informed the nurse that the medication had been given to the wrong resident. She reported that she asked the CNAs for the vital sign monitoring sheet, and that blood pressure and heart rate checks were initiated. According to the LPN, the resident's blood pressure increased slightly with each hourly check. The LPN stated that at approximately 3:30 p.m., while she was administering medications in another room, the family of Resident #20 arrived and asked why the resident was slumped over in her wheelchair. The LPN reported that she went to the resident's room and saw Resident #20 slumped over in her wheelchair and unable to lift her head. She stated that she reassessed the resident's vital signs and noted that the resident was not coherent, stated her birthday as October 25, 2025, and had eyes rolling back. The LPN stated that she contacted the physician, who ordered the resident to be sent to the hospital due to a change in condition and had a BP reading of 162/81.An interview was conducted with another LPN (Staff #7) on January 21, 2026, at 1:35 p.m. The LPN stated that when administering medications, she verifies the resident's name, date of birth , and photo in the electronic medical record and follows the medication rights, including the right medication, right patient, right time, and right route. She stated that she was Resident #20's nurse and that during the Friday day shift, she administered the correct medications to the resident. The LPN reported that later that morning, a nurse from another hall informed her that medications intended for Resident #61 had been administered to Resident #20. She stated that she then contacted the physician who was onsite, reviewed all medications the resident had received with the physician, and obtained the resident's vital signs before notifying the resident, the family, and the Director of Nursing (Staff #27). The LPN stated that the medication error occurred at approximately 12:10 p.m. while the resident was in therapy. She said the nurse who administered the incorrect medications reported verifying the resident's name with both resident #20 and the therapist present in the therapy room. The LPN stated that the physician instructed staff to hold Resident #20's heparin and propranolol the following day so the resident could be monitored.An interview with the Director of Nursing (DON/Staff #7) was conducted on January 21, 2026, at 2:28 p.m. The DON stated that nursing staff were expected to prepare and verify medications according to the physician's orders, confirm the correct resident, and sign the electronic medication administration record (eMAR) after (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	administering medications. She stated that resident identification may be verified by asking the resident their name and date of birth , checking the door tag, and using the resident's photo in the electronic medical record. The DON stated that when medications were administered in error, nurses were expected to immediately observe the resident, notify the provider with a list of the medications given in error, obtain monitoring orders, and notify the resident and the responsible party. She also said that receiving incorrect medications could result in various health outcomes, including hospitalization or the resident receiving medications for conditions they do not have. Regarding Resident #20, the DON stated that the resident received medications prescribed for Resident #61 while participating in a group therapy session. She said that the RN (staff #46) entered the therapy gym looking for the other resident, and the therapist working with Resident #20 told the RN (staff #46) that he had the other resident. The DON stated that Resident #20 also identified herself as the other resident, and the RN (staff #46) administered the medications to Resident #20. The DON said that after the therapy session, the therapist realized the error and informed the RN (staff #46) that he had been working with Resident #20, not the other resident. The DON stated that a nurse then took Resident #20's vital signs, contacted the provider, and notified Resident #20's assigned nurse. She reported that the resident's vital signs were stable for the first few hours; however, later the resident's blood pressure increased, and the resident became slumped over in her chair, requiring staff to support her head to obtain a response. The DON stated that although the blood pressure was not critically high, the decision was made to send Resident #20 to the hospital due to the medication error.A phone interview was conducted on January 21, 2026, at 2:46 p.m. with a registered nurse (RN, Staff #46) who administered medications of another resident to Resident #20. The RN stated that when administering medications, she checks the medications due and verifies the correct medication, dose, time, and resident. She said that she was the nurse for another resident on the day of the incident when the medication error occurred involving Resident #20. The RN stated that she had never worked on the other resident's hall before and had only seen Resident #20 once previously. She reported that she reviewed the other resident's chart, prepared the other resident's medications, and went to administer them, but the other resident was not in her room. The RN stated that she then went to the therapy gym and asked therapists to locate the other resident. According to the RN, a therapist stated that he had the other resident, and Resident #20 also told the RN that she was the other resident. The RN then administered the medications to Resident #20. The RN stated that approximately 20 to 40 minutes later, the therapist informed her that the medications had been given to the wrong resident and apologized, explaining that he was assigned to both Resident #20 and the other resident. The RN stated that she immediately reported the error to the Director of Nursing, the LPN (Staff #7), and the provider (Staff #15). She further stated that she stayed after her shift to complete documentation and heard the ambulance arrive to transport Resident #20 to the hospital. The RN stated that the potential risks of administering medications to the wrong resident range from medication side effects to death.A phone interview was conducted on January 21, 2026, at 2:56 p.m. with a physical therapist assistant (PTA/Staff #57) who stated that he had not met Resident #20 or the other resident prior to the day of the incident. He reported that on the day of the incident, Resident #20 was brought to the therapy gym for scheduled services. The PTA stated that he introduced himself to the resident and reviewed the resident's level of functioning through a chart review. The PTA stated that the RN (Staff #46) entered the therapy gym looking for the other resident, and he told the RN that he had the other resident. He stated that he should have taken more time to verify the resident's identity, but believed the resident he was working with was the other resident. The PTA reported that the RN then (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	administered the other resident's medications to Resident #20. The PTA stated that it was not until he was escorting Resident #20 back to her room that he realized the medications had been given to the wrong resident. He reported that he immediately informed the RN (Staff #46) and the Director of Nursing (Staff #7) of the error.Review of a policy titled, Medication Administration - Oral, with a review date of April 2025, revealed that it was their policy to accurately prepare, administer, and document oral medications. Essential points of the policy included that no medication was to be administered without a physician's order, and the resident must be identified before administering any medications.Review of a policy titled, Quality of Care, with a review date of May 2025, included that it is their policy that residents would be given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, review of facility documentation and policy and procedures, the facility failed to ensure 1 of 3 sampled residents (#20) was free from a significant medication error. The deficient practice could result in harm to the resident.Findings include:Resident #20 was admitted [DATE] with diagnoses of metabolic encephalopathy, essential tremor, epilepsy, dementia, spinal stenosis, cognitive communication deficit and syncope and collapse.The physician order summary report active as of January 16, 2026 included the following medications:Acidophilus (Lactobacillus-probiotics), 1 tablet by mouth one time a day for probioticB-complex w/biotin & folic acid (supplement), 1 tablet by mouth one time a day for supplementClopidogrel bisulfate (antiplatelet) 75 mg (milligrams)1 tablet by mouth one time a day for a history of transient ischemic attackFluconazole (antifungal) 200 mg 1 tablet by mouth one time a day for toe infectionLoratadine (antihistamine) 10 mg 1 tablet by mouth one time a day for allergiesMultivitamin (supplement) 1 tablet by mouth once a day for supplementPolyethylene glycol (laxative)3350 powder 17 grams by mouth daily for bowel regimenPropranolol (beta-blocker) ER (extended release) 120 mg, 1 capsule by mouth one time a day for hypertensionFluticasone propionate (synthetic corticosteroid) nasal suspension, 50 mcg (microgram)/Act (activation) 1 spray in both nostrils every 12 hours for allergiesLamotrigine (anticonvulsant) 100 mg 1 tablet by mouth every 12 hours for seizuresAcetaminophen (analgesic) 1000 mg by mouth every 8 hours for chronic painHeparin (anticoagulant) 5000 unit/ml (milliliter), inject 5000 unit subcutaneously every 8 hours for deep vein thrombosis prophylaxisThese medications were transcribed onto the MAR (medication administration record) for January 2026. Review of the MAR revealed documentation that these medications were administered as ordered.A nursing progress note dated January 16, 2026, at 4:00 p.m. included that the resident's family arrived to visit and found the resident #20 slumped over in her chair. It also included that the nurse assessed the resident and noted that the resident did not respond to verbal cues but did respond to physical stimulation. Per the documentation, the resident was unable to state her birthday, the current year, or her location; and, the only question resident could answer was the name of her family. Further, the documentation included that the resident's eyes rolled back while speaking and that the resident fell asleep immediately afterward. According to the documentation, the resident's BP (blood pressure) was 162/81 and the provider was notified. Further, the note included an instruction to send the resident out due to a change in condition.A nursing progress note dated January 16, 2026 at 10:41 p.m. revealed that the resident's family notified the facility that the resident was being admitted to the hospital for observation related to elevated blood pressure.A review of an undated handwritten document written by the License Practical Nurse (LPN/Staff #7) revealed a list of medications of another resident that was given to Resident #20 included the following:Amiodarone (antiarrhythmic) 200 mg;Aripiprazole (antipsychotic) 5 mg;Aspirin (non-steroidal anti-inflammatory) 325 mg;Citalopram (antidepressant) 40 mg;Apixaban (direct acting anticoagulant) 2.5 mg;Ferrous sulfate (supplement) 325 mg;Folic acid (supplement) 1 mg;Lasix (diuretic) 40 mg;Midodrine (antihypotensive) 10 mg;Multivitamin with minerals (supplement);Potassium (supplement) ER 20 mEq (milliequivalent);Vitamin B12 (supplement) 1000 mcg; and,Vitamin D3 (supplement) 1000 IU (international units).However, review of the clinical record revealed no evidence that Resident #20 had physician orders for the following medications administered to Resident #20 and listed in the handwritten document: amiodarone, aripiprazole, aspirin, citalopram, apixaban, ferrous sulfate, folic acid, Lasix, midodrine, a multivitamin with minerals, potassium ER, vitamin B12, or vitamin D3.Continued review of an undated handwritten document showed a list of morning vital signs documented as prior to event, including a blood pressure of (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	140/72, pulse of 73, oxygen saturation of 93, respirations of 18, and a temperature of 98 degrees. The documentation indicated that the resident did not understand at all and was alert and oriented x2ish, when she was notified of the error at 12:20 p.m. An undated typewritten facility investigation revealed that on January 16, at approximately 12:10 p.m., the registered nurse (RN/staff #46) and Physical Therapy Assistant (PTA/Staff #57), informed Licensed Practical Nurse (LPN/Staff#7), that Resident #20 was given several medications that were prescribed for a different resident. Per the documentation, the resident reported that she took her medications when she was informed that the nurse gave her additional medications that were not ordered for her. It also included that the resident was leaning to the side and was not responsive to verbal cues, but was responsive to physical stimuli at 4:00 p.m., when the resident's family arrived; and that, vital signs were taken and revealed resident had elevated BP. The documentation included that the provider was notified and orders were received to send Resident #20 to the emergency room; and that, later that evening, the resident's family informed the facility that Resident #20 was admitted for observation for her elevated blood pressure. Further, the documentation included that a follow-up with the hospital on January 21, 2026 confirmed that Resident #20 was still in the hospital; and, had an admitting diagnosis of unintentional use of medication and pneumonia.A phone interview with the family of Resident #20 was conducted on January 21, 2026 at 1:00 p.m. The family stated that on January 16, 2026 at around 1:45. p.m., the resident's nurse called and informed her that another nurse went into the therapy area and asked which therapist was working with another resident. The family said that she was told that the therapist who was working with Resident #20 told the nurse that he had Resident #20; and that, the nurse gave the medications to Resident #20 instead of the other resident. The family said the nurse told her the doctor was onsite and staff were monitoring Resident #20; but, staff did not immediately inform her which medications were given to Resident #20 or that the resident's vital signs were abnormal. She stated that eventually the facility gave her a list of the medications shortly after she arrived at the facility that day. The family stated that when she arrived at the facility, Resident #20 was slumped over in her wheelchair and there were no staff in the room with the resident. The family said that she immediately left the room to call for help and was able to get the LPN (staff #64) to assess and ask the resident questions. She stated that within a minute, the LPN decided to call the ambulance; and the facility sent Resident #20 to the emergency room by 4:00 p.m. Further, the family said that the blood pressure of Resident #20 skyrocketed; and the resident could not lift her head. The family also said that Resident #20 was given medications to treat schizophrenia.A phone interview was conducted on January 21, 2026 at 1:13 p.m. with a LPN (staff#64) who stated that she was scheduled to start the evening shift at 2:00 p.m. on the day of the incident and learned about the incident during shift change. She said that she was told that a nurse from another hall was going to administer medications to another resident who was not in her room, so the nurse went to the therapy room to locate the resident. The LPN stated she did not know how the nurse identified the resident, but the nurse asked Resident #20 if she was the other resident and Resident #20 responded yes. The LPN stated that the therapist later informed the nurse that the medication had been given to the wrong resident. She reported that she asked the CNAs for the vital sign monitoring sheet, and that blood pressure and heart rate checks were initiated. According to the LPN, the resident's blood pressure increased slightly with each hourly check. The LPN stated that at approximately 3:30 p.m., while she was administering medications in another room, the family of Resident #20 arrived and asked why the resident was slumped over in her wheelchair. The LPN reported that she went to the resident's room and saw Resident #20 slumped over in her wheelchair and unable to lift her head. She stated that she (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	reassessed the resident's vital signs and noted that the resident was not coherent, stated her birthday as October 25, 2025, and had eyes rolling back. The LPN stated that she contacted the physician, who ordered the resident to be sent to the hospital due to a change in condition and had a BP reading of 162/81.An interview was conducted with another LPN (Staff #7) on January 21, 2026, at 1:35 p.m. The LPN stated that when administering medications, she verifies the resident's name, date of birth , and photo in the electronic medical record and follows the medication rights, including the right medication, right patient, right time, and right route. She stated that she was Resident #20's nurse and that during the Friday day shift she administered the correct medications to the resident. The LPN reported that later that morning, a nurse from another hall informed her that medications intended for another resident had been administered to Resident #20. She stated that she then contacted the physician who was onsite, reviewed all medications the resident had received with the physician, and obtained the resident's vital signs before notifying the resident, the family, and the Director of Nursing (Staff #27). The LPN stated that the medication error occurred at approximately 12:10 p.m. while the resident was in therapy. She said the nurse who administered the incorrect medications reported verifying the resident's name with both resident #20 and the therapist present in the therapy room. The LPN stated that the physician instructed staff to hold Resident #20's heparin and propranolol the following day so the resident could be monitored.An interview with the Director of Nursing (DON/Staff #7) was conducted on January 21, 2026, at 2:28 p.m. The DON stated that nursing staff were expected to prepare and verify medications according to the physician's orders, confirm the correct resident, and sign the electronic medication administration record (eMAR) after administering medications. She stated that resident identification may be verified by asking the resident their name and date of birth , checking the door tag, and using the resident's photo in the electronic medical record. The DON stated that when medications are administered in error, nurses were expected to immediately observe the resident, notify the provider with a list of the medications given in error, obtain monitoring orders, and notify the resident and the responsible party. She also said that receiving incorrect medications could result in various health outcomes, including hospitalization or the resident receiving medications for conditions they do not have. Regarding Resident #20, the DON stated that the resident received medications prescribed for Resident #61 while participating in a group therapy session. She said that the RN (staff #46) entered the therapy gym looking for the other resident, and the therapist working with Resident #20 told the RN (staff #46) that he had the other resident. The DON stated that Resident #20 also identified herself as the other resident, and the RN (staff #46) administered the medications to Resident #20. The DON said that after the therapy session, the therapist realized the error and informed the RN (staff #46) that he had been working with Resident #20, not the other resident. The DON stated that a nurse then took Resident #20's vital signs, contacted the provider, and notified Resident #20's assigned nurse. She reported that the resident's vital signs were stable for the first few hours; however, later the resident's blood pressure increased, and the resident became slumped over in her chair, requiring staff to support her head to obtain a response. The DON stated that although the blood pressure was not critically high, the decision was made to send Resident #20 to the hospital due to the medication error.A phone interview was conducted on January 21, 2026, at 2:46 p.m. with a registered nurse (RN, Staff #46) who administered medications of another resident to Resident #20. The RN stated that when administering medications, she checks the medications due and verifies the correct medication, dose, time, and resident. She said that she was the nurse for another resident on the day of the incident when the medication error occurred involving Resident #20. The RN stated that she had never worked on the other resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035189	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Canada Care Center	7970 North LA Canada Drive Tucson, AZ 85704

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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 0760 Level of Harm - Actual harm Residents Affected - Few	hall before and had only seen Resident #20 once previously. She reported that she reviewed the other resident's chart, prepared the other resident's medications, and went to administer them, but the other resident was not in her room. The RN stated that she then went to the therapy gym and asked therapists to locate the other resident. According to the RN, a therapist stated that he had the other resident, and Resident #20 also told the RN that she was the other resident. The RN then administered the medications to Resident #20. The RN stated that approximately 20 to 40 minutes later, the therapist informed her that the medications had been given to the wrong resident and apologized, explaining that he was assigned to both Resident #20 and the other resident. The RN stated that she immediately reported the error to the Director of Nursing, the LPN (Staff #7), and the provider (Staff #15). She further stated that she stayed after her shift to complete documentation and heard the ambulance arrive to transport Resident #20 to the hospital. The RN stated that the potential risks of administering medications to the wrong resident range from medication side effects to death.A phone interview was conducted on January 21, 2026, at 2:56 p.m. with a physical therapist assistant (PTA/Staff #57). The PTA stated that he had not met Resident #20 or the other resident prior to the day of the incident. He reported that on the day of the incident, Resident #20 was brought to the therapy gym for scheduled services. The PTA stated that he introduced himself to the resident and reviewed the resident's level of functioning through a chart review. The PTA stated that the RN (Staff #46) entered the therapy gym looking for the other resident, and he told the RN that he had the other resident. He stated that he should have taken more time to verify the resident's identity but believed the resident he was working with was the other resident. The PTA reported that the RN then administered the other resident's medications to Resident #20. The PTA stated that it was not until he was escorting Resident #20 back to her room that he realized the medications had been given to the wrong resident. He reported that he immediately informed the RN (Staff #46) and the Director of Nursing (Staff #7) of the error.Review of a policy titled, Medication Administration - Oral, with a review date of April 2025 revealed that it was their policy to accurately prepare, administer, and document oral medications. Essential points of the policy included that no medication was to be administered without a physician's order, and the resident must be identified before administering any medications.