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	04/24/2026

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. NOT REVIEWED BY 22 Based on facility documentation, staff interviews, and policy review, the facility failed to ensure that daily staff posting information was accurate for total numbers of direct care staff, actual hours worked by direct care staff, and actual staffing totals worked by licensed and unlicensed direct care nursing staff for 9 out of 9 days reviewed. The census was 92. The deficient practice could result in residents, visitors, and facility staff not being informed of accurate and current staffing information. Findings include: Review of 9 randomly selected days of daily staff postings with corresponding punch details revealed the actual hours worked on the daily staff postings were inaccurate related to the number of actual RN, LPN and CNAs working each shift, the actual number of hours worked each shift, and the total number of actual staff hours worked each day. The daily staff posting dated 10/25/2024, revealed a census of 101 residents with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked:7.28 registered nurse (RN) hours, 97.31 licensed practical nurse/licensed vocational nurse (LPN/LVN) hours, and 194.13 certified nursing assistant (CNA) hours However, review of the punch details requested for that day revealed: 34.82 RN hours, 84.06 LPN/LVN hours, and 196.86 CNA hoursThere was a discrepancy of 27.54 RN hours, 13.25 LPN/LVN hours, and 2.73 CNA hours, between the daily staff postings and punch details. The daily staff posting dated 10/26/2024, revealed a census of 95 with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked:8.00 RN hours,97.81 LPN/LVN hours and, 145.00 CNA hours However, review of the punch details requested for that day revealed: 8.00 RN hours88.08 LPN/LVN hours and 156.42 CNA hours There was a discrepancy of 9.73 LPN/LVN hours and 11.42 CNA hours, between the daily staff postings and punch details. The daily staff posting dated 10/27/2024, revealed a census of 94 with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked: 8.23 RN hours 95.46 LPN/LVN hours and 160.54 CNA hours However, review of the punch details requested for that day revealed: 8.23 RN hours94.80 LPN/LVN hours and 160.72 CNA hours There was a discrepancy of 0.66 LPN/LVN hours and 0.18 CNA hours, between the daily staff postings and punch details. The daily staff posting dated 8/30/2025, revealed a census of 104 with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked:18.63 RN hours 77.77 LPN/LVN hours, and 188.95 CNA hours However, review of the punch details requested for that day revealed 18.41 RN hours, 70.97 LPN/LVN hours, and 167.60 CNA hours There was a discrepancy of 0.22 RN hours, 6.8 LPN/LVN hours, and 21.35 CNA hours , between the daily staff postings and punch details. The daily staff posting dated 8/31/2025, revealed a census of 98 with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked:25.69 RN hours,67.99 LPN/LVN hours, and 186.84 CNA hours However, review of the punch details requested (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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for that day revealed: 25.69 RN hours68.99 LPN/LVN hours and 202.52 CNA hours There was a discrepancy of 1.00 LPN/LVN hours and 15.68 CNA hours , between the daily staff postings and punch details. The daily staff posting dated 9/1/2025, revealed a census of 99 with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked: 9.15 RN hours, 89.25 LPN/LVN hours, and 188.77 CNA hours However, review of the punch details requested for that day revealed 25.15 RN hours, 97.25 LPN/LVN hours and 181.88 CNA hours There was a discrepancy of 16.00 RN hours, 8 LPN/LVN hours, and 6.89 CNA hours, between the daily staff postings and punch details. The daily staff posting dated 11/28/2025, revealed a census of 98 with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked:8.6 RN hours, 84.83 LPN/LVN hours, and 163.76 CNA hours However, review of the punch details requested for that day revealed: 24.60 RN hours, 100.56 LPN/LVN hours, and 167.23 CNA hoursThere was a discrepancy of 16 RN hours, 15.73 LPN/LVN hours, and 3.47 CNA hours, between the daily staff postings and punch details. The daily staff posting dated 11/29/2025, revealed a census of 102 with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked: 28.10 RN hours, 59.45 LPN/LVN hours, and 160.88 CNA hours However, Review of the punch details requested for that day revealed:28.10 RN hours, 66.07 LPN/LVN hours, and 144.62 CNA hours There was a discrepancy of 6.62 LPN/LVN hours and 16.26 CNA hours, between the daily staff postings and punch details. The daily staff posting dated 11/30/2025, revealed a census of 102 with no evidence of the total number of nurses and CNAs that worked each shift or the total number of hours worked by all licnesed staff and CNAs each day. The daily staff posting included the following actual hours worked: 24.83 RN hours, 61.02 LPN/LVN hours, and 166.00 CNA hoursHowever, review of the punch details requested for that day revealed: 23.35 RN hours,61.52 LPN/LVN hours, and 187.08 CNA hours There was a discrepancy of 1.48 RN hours, 0.50 LPN/LVN hours, and 21.08 CNA hours, between the daily staff postings and punch details. An interview was conducted on April 24, 2026 at 10:08 a.m. with the Staffing Coordinator (Staff #94). The Staffing Coordinator stated she is responsible for staffing schedules, recruiting, and patient appointments, with human resources assisting in documenting actual hours worked by staff. The Staffing Coordinator stated she completes daily staff postings, including scheduled and actual hours worked, and further stated the daily staff postings reflect hours worked per shift rather and does not include the number of staff members. The Staffing Coordinator stated each shift is generally calculated as 8 hours which is why she does not include the number of staff on the daily postings. Regarding hours per patient day (PPD) and staffing numbers for CNA/LPN/RN staff, the Staffing Coordinator stated she knows how to calculate staffing needs; however, PPD is not listed on the daily staffing sheet. The Staffing Coordinator further stated staffing decisions are based on general guidelines from the Director of Nursing (DON), acuity and census of the building, and resident feedback. The Staffing Coordinator stated facility expectations are for postings to be accurate and completed each morning. The Staffing Coordinator reviewed the sampled daily postings and punch details for the following days; 10/26/2024-10/28/2026, 8/30/2025-9/1/2025, and 11/28/2025-11/30/2025. After reviewing the sampled days the Staffing Coordinator stated the numbers did not match, however, further stated the daily staff postings meet facility expectations. The Staffing Coordinator stated she did not know how to prove the accuracy of the daily staff postings. The Staffing Coordinator stated inaccurate postings could affect reporting of care hours PPD and compliance staffing regulations. An interview was conducted on April 24, 2026 at 10:58 a.m. with the Director of Nursing (DON/Staff #134). The DON stated she oversees staffing operations and monitors daily staffing postings. The DON stated that the Staffing Coordinator is responsible for completing daily staffing postings and documenting actual hours worked by direct care staff. The DON (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated that she expected the daily staff postings should be routinely updated; however, staff call-outs and punch-in/punch-out inaccuracies were not always identified until the end of the pay period. The DON stated the facility did not always know staff were not punching in and out correctly until staff turned in punch-in/out correction forms at the end of the pay period. The DON stated corrections to staffing postings after the fact were difficult due to frequent call-outs and delayed identification of attendance discrepancies. The DON stated the purpose of maintaining accurate daily staffing postings was to ensure awareness of staffing coverage levels and assist the facility in determining staffing needs. The DON stated that she expects daily staffing postings to be completed accurately and maintained consistently. The DON stated inaccurate posting of actual hours worked by clinical staff could result in inaccurate staffing schedules and the facility not knowing when additional staff coverage was needed. Review of the Staffing Numbers, Posting policy, last revised October 2025, revealed the facility will post the number of staff working who are directly responsible for resident care and include hours worked by Registered Nurses, Licensed Practical/Vocational Nurses, and Nursing Assistants for each shift.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of facility documents, and review of policies, the facility failed to protect the resident right to be free from chemical restraints by not administering pain medication in accordance with the physician's order for one resident (#1). The deficient practice could result in medications being administered without following the physician's order and could place the resident's health at risk for illnesses.Findings include:Resident #1 was admitted to the facility on [DATE], with diagnoses that included a fracture of her right thigh with subsequent encounter for closed fracture with routine healing, Chronic Obstructive Pulmonary Disease (COPD), muscle weakness, and epilepsy.The admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15.0, indicating that the Resident was cognitively intact. Further, the assessment revealed that the Resident used opioid medications.A review of the physician's orders revealed an order for Acetaminophen oral tablet to give 650 mg (milligram) by mouth every 4 hours as needed for pain level 1-5 and an order for Oxycodone-Acetaminophen 5-325 mg tablet to give 1 tablet by mouth every 4 hours as needed for pain level of 6-10. A review of the April 2026 Medication Administration Record (MAR) revealed a transcribed order dated 03/31/2026, for Oxycodone-Acetaminophen tablet 5-325 MG give 1 tablet by mouth every 4 hours as needed for pain level of 6-10. Further, the MAR revealed that on: -04/4/2026, at 4:53 PM, the Resident's documented pain level was 4, and Oxycodone-Acetaminophen 5-325 mg tablet to give 1 tablet by mouth every 4 hours as needed for pain level of 6-10 was administered, despite an order to give for pain level of 6-10.- 04/4/2026, at 8:58 PM, the Resident's documented pain level was 4, and Oxycodone-Acetaminophen 5-325 mg tablet to give 1 tablet by mouth every 4 hours as needed for pain level of 6-10 was administered, despite an order to give for pain level of 6-10.- 04/21/2026, at 4:38 PM, the Resident's documented pain level was 5, and Oxycodone-Acetaminophen 5-325 mg tablet to give 1 tablet by mouth every 4 hours as needed for pain level of 6-10 was administered, despite an order to give for pain level of 6-10.- 04/21/2026, at 8:41 PM, the Resident's documented pain level was 5, and Oxycodone-Acetaminophen 5-325 mg tablet to give 1 tablet by mouth every 4 hours as needed for pain level of 6-10 was administered, despite an order to give for pain level of 6-10.The care plan review revealed that on 03/31/2026, the Resident was currently prescribed an Opioid for pain, and had the potential for adverse outcomes from opioid use related to status post right femur fracture and right hip pain. The interventions included to use non-pharmalogical interventions; administer opioids as prescribed; assess the Resident for risk of substance abuse and refer as needed; and monitor, document, and report to the provider as needed signs and symptoms of opioid adverse drug reaction such as drowsiness, sedation, dizziness, nausea and vomiting, constipation, or respiratory depression. An interview was conducted on 04/24/2026, at 10:12 AM with a Licensed Practical Nurse (LPN/Staff #96). The LPN stated that when she is administering a pain medication, and the pain medication has a parameter of pain level 1-10, that she would ask the resident their pain level, and then would administer the medication. She said that if the pain level order parameter was 6-10 for a controlled medication, and the Resident's pain level was 4 or 5, she would not administer the controlled pain medication to the Resident because it is not within the ordered pain level parameter of 6-10. She said that if the pain level was below the ordered pain level parameter, she would administer another pain medication that was ordered for a lower pain level or she would reach out to the Resident's provider or the pain specialist.On 04/24/2026, at 10:40 AM an interview was conducted with the Director of Nursing (DON/Staff #134). The DON stated that medication administration is performed based on the physician's order, right medication, right dose, right frequency, right route, right time, and right resident. She said that regarding administering pain medication, she expects her staff to adhere to the order, the right medication, right dose, right frequency, right route, right time, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and right resident. The DON stated that if there was a pain level of 6-10 parameter ordered for a medication such as an oxycodone, and the reported pain of the Resident was within pain level of 6-10, she expects her staff to administer the medication. The DON stated that if the ordered pain medication was given outside the pain level of 6-10 parameter, with Resident's reported pain level was 4 or 5, she said that it does not meet her expectation because her expectation was that the staff adheres to the physician's order. She said that when the staff fail to follow the physician's order, the impact could include that the resident could receive the medication outside the physician's order, and the potential risk for the resident was that the resident could receive more medication than what was ordered for that level of pain. Regarding Resident #1's pain medication order of oxycodone 1 tablet every 4 hours as needed for pain level of 6-10, the DON stated that on 04/4/2026 and 04/21/2026, the pain medication was administered outside the ordered parameter and it did not meet her expectation.An interview was conducted on 4/24/26, at 10:55 AM with LPN staff (Staff #18). The LPN stated that regarding pain medications, that different residents have different pain levels. She stated that she would ask the Resident's pain level before administering the medication. She further stated that if she administers the medication outside the ordered parameter, it could lead to over sedation or it could be ineffective if the resident had a different pain level. A review of the facility policy titled Physician Orders, which was revised on 05/2021, revealed that the drugs shall be administered only upon the order of a person duly licensed and authorized to prescribe such drugs, and for the facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care.A review of the facility policy titled Pain Management, which was reviewed on 10/2025, revealed that the Resident pain is assessed and managed by the interdisciplinary team who work together to achieve the highest practicable outcome. For monitoring, the policy revealed to consult the physician for additional interventions if pain is not relieved by currently ordered treatment modalities and comfort measures.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of facility documents, and review of policies, the facility failed to ensure that a blood pressure medication order was followed in compliance with a physician order according to accepted standards of clinical practice for one resident (#44). The deficient practice could result in medications being administered without following the physician's order and could place the resident's health at risk for illnesses.Findings include:Resident #44 was admitted to the facility on [DATE] with diagnoses of high blood pressure (hypertension), chronic pain syndrome, and urinary tract infection.A review of the Quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15.0, indicating that the Resident cognition was intact.The Resident's care plan initiated on 10/10/2024, revealed that the Resident had hypertension. The interventions included for the staff to administer antihypertensive medications as ordered and monitor for side effects such as orthostatic hypotension and increased heart rate.On 04/24/2026, at 8:03 AM, a medication administration observation was conducted with a Licensed Practical Nurse (LPN/Staff #18) for Resident #44. One of the medications that Staff #18 prepared for Resident #44 was an order for Lisinopril oral tablet 2.5 mg (miligram) give 2.5 mg by mouth one time a day for high blood pressure and hold the lisinopril for a systolic blood pressure below 120. At 04/24/2026, at 8:13 AM, the Resident took her lisinopril medication.A review of the physician orders revealed an order dated 11/30/2025, for Lisinopril oral tablet 2.5 mg, give 2.5 mg by mouth one time a day for high blood pressure and hold the lisinopril for a systolic blood pressure below 120.A review of the December 2025, Medication Administration Record (MAR) revealed a transcribed order dated 11/30/2025, for Lisinopril oral tablet 2.5 mg give 2.5 mg by mouth one time a day for hypertension and hold the lisinopril for a systolic blood pressure below 120.The MAR revealed that on 12/3/2025, the blood pressure documented in the MAR was 118/47 and the MAR revealed that the medication was administered outside the parameter order which was to hold if the Resident's systolic blood pressure was below 120. Further, the December MAR revealed that from 12/4/2025, there were no blood pressure documented when Lisinopril medication was administered.A review of the February 2026 MAR revealed a transcribed order dated 11/30/2025, for Lisinopril oral tablet 2.5 mg give 2.5 mg by mouth one time a day for high blood pressure and to hold lisinopril for systolic blood pressure below 120. Further, the MAR revealed no blood pressure was documented during the administration of Lisinopril.A review of the March 2026 MAR revealed a transcribed order dated 11/30/2025, for Lisinopril oral tablet 2.5 mg give 2.5 mg by mouth one time a day for high blood pressure and to hold lisinopril for systolic blood pressure below 120. Further, the MAR revealed no blood pressure was documented during the administration of Lisinopril. Review of the April 2026 MAR revealed a transcribed order dated 11/30/2025, for Lisinopril oral tablet 2.5 mg give 2.5 mg by mouth one time a day for high blood pressure and to hold lisinopril for systolic blood pressure below 120. Further, the MAR revealed no blood pressure was documented during the administration of Lisinopril. On 04/24/2026, at 10:12 AM an interview was conducted with a Licensed Practical Nurse (LPN/Staff #96). She said that some blood pressure medications have parameter orders. For example, a Lisinopril order could have a parameter to hold for systolic blood pressure of 120. She stated that if there was a parameter order, she would have the vital signs taken early in the morning, and if the systolic blood pressure was 115, she would hold the medication because it was less than the ordered parameter. She also said that if she did not follow the ordered blood pressure parameter and administered the blood pressure medication while the systolic blood pressure was less than 120, the blood pressure of the Resident would tank. An interview was conducted on 04/24/2026, at 10:40 AM with the Director of Nursing (DON/Staff #134). The DON stated that medication administration is performed based on the physician's order, right medication, right dose, right frequency, right route, right time, and right resident. Regarding blood pressure medications, the DON stated that a blood pressure medication (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such as a lisinopril with a hold order for systolic blood pressure less than 120, requires staff to adhere to the physician's order, the right medication, right dose, right frequency, right route, right time, and the right resident. She stated that the risk to the Resident if the blood pressure was administered below 120 was that their blood pressure could be reduced lower than what is expected. The DON stated that she expects the nurse to check the Resident's blood pressure before administering the medication, the Resident's blood pressure would be recorded in the medical record, and in the vital signs section tab in the electronic medical record. She further stated that if the blood pressure was not documented, she would not know if the Resident's blood pressure was checked or not. Regarding Resident #44's lisinopril order, the DON stated that the lisinopril order in the electronic medical record for the Resident was lisinopril 2.5 mg po one time a day and hold for a systolic blood pressure below 120 was ordered on 12/1/2025. Further, the DON looked at the Resident's April 2026 MAR and stated that there was no blood pressure recorded on the MAR. She said that she did not know why there was no blood pressure recorded in the MAR. She also said that she would take the Resident's blood pressure prior to medication administration, and she said that she would not want a vital sign taken hours or using the night shift vital signs before administering a blood pressure medication scheduled in the morning. She said that it does not meet her expectation if the staff used a night shift vital sign.An interview was conducted on 4/24/26, at 10:55 AM with LPN staff (Staff #18). The LPN stated that regarding administering blood pressure medications, she said that if the blood pressure was below the ordered parameter, she would hold the medication. She said that the risk could make the Resident's blood pressure drop lower. She also said that the side effects could include feeling dizzy and lightheaded, and the Resident could become unresponsive if the blood pressure drops too low.A review of the facility policy titled Physician Orders, which was revised on 5/2021, revealed that the drugs shall be administered only upon the order of a person duly licensed and authorized to prescribe such drugs, and for the facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care.