STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555307	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Healthcare Center	1517 East Knickerbocker Drive Stockton, CA 95210

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 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** 40903 Based on interview, and record review, the facility failed to ensure safe medication use and practices when one of the three sampled residents (Resident 1) received duplicate blood thinner medications concurrently (drugs with potential to cause significant internal bleeding) for 3.5 days after admission to the facility, and failed to seek clarification before continuing with the blood thinning therapy after identified the error on [DATE]. These failures resulted in Resident 1 having a critically high Prothrombin Time/International Normalized Ratio (PT/INR: blood tests used to measure bleeding and clotting times- high levels indicate blood takes longer to clot) and Resident 1 was transferred to the Emergency Department (ED) at Hospital B on [DATE], suffered complications that included dropped hemoglobin, two episodes of melena (black tarry stool caused by internal bleeding), cardiogenic shock (severe heart dysfunction), which led to Resident 1's death on [DATE]. Findings: Review of facility clinical record ADMISSION RECORD, with a printed date of [DATE], indicated Resident 1 was admitted to the facility on [DATE]. During a review of Resident 1's electronic medical record (from Hospital A) titled, History and Physical, dated [DATE], the record indicated Resident 1 was transferred to the facility after gallbladder rupture and subsequent surgical complications including infection, blood clot in the lung, abnormal heart rhythm, kidney failure and breathing issues. During a review of Resident 1's electronic medical record titled, Discharge Summary from Hospital A, dated [DATE], the record indicated the following blood thinner drugs to be given in the facility: (Start) Rivaroxaban . [Brand name Xarelto, a blood thinner drug] 2.5 mg (milligram, a unit of measure); Take 6 tablets by mouth 2 times a day with meals for 20 days, and Dabigatran .150 mg [Brand name Pradaxa; a blood thinner drug;] Start taking on [DATE]; Take 1 capsule by mouth 2 times a day . During a review of Resident 1's facility electronic medical record titled, Medication Administration Record, (or MAR- this document lists medication given by the nursing staff) dated [DATE], the record indicated the same start date for the two blood thinners, and they were given concurrently as follows: (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 0760 Level of Harm - Actual harm Residents Affected - Few	a. Rivaroxaban .Tablet 2.5 mg .Give 6 tablet by mouth two times a day .for 20 Days -Start Date-[DATE] 0900 [9 AM]. Rivaroxaban was administered to Resident 1 twice daily [DATE]-[DATE]. b. Dabigatran .Capsule 150 mg .Give 1 capsule by mouth two times a day .Start Date-[DATE] 1700 [5 PM] -D/C Date- [DATE] 1614 [4:14 PM] . Dabigatran was administered to Resident 1 twice daily, on [DATE]-[DATE] and at 9 AM on [DATE]. During a review of Resident 1's electronic medical record titled, Progress Notes, with a date range of [DATE] to [DATE], the record did not indicate any communication with the medical doctor for the concurrent use of the two blood thinners. Review of Resident 1's electronic medical record titled, Change of Condition (COC) Alert, dated [DATE], at 4:15 PM, indicated laboratory test results were critically high, .Resident's PT [prothrombin time: a blood test that measures how long it takes for blood to clot] greater than 100 [normal is ,d+[DATE]] and INR [International Normalized Ratio: a blood test that measures how long it takes for blood to clot] greater than 8 [therapeutic, or the level which is used to treat disorders, is 2XXX,d+[DATE].5] . The COC record under, Immediate & New Interventions indicated, .Called doctor [MD 1] office immediately and informed of lab results [laboratory blood test]. MD 1 requested resident be sent to ER [emergency room]. Review of Resident 1's medical record from Hospital B titled, History and Physical, dated [DATE], indicated, . Anticoagulation [use of blood thinning medication to prevent clotting] was started during a recent hospitalization at [Hospital A] .such that Xarelto was to be given for 20 days, after which Pradaxa was to be substituted for Xarelto. Today, the nursing staff noted a prolonged anticoagulation profile after the nursing staff had inadvertently administered both Xarelto and Pradaxa during the past 3 days .The patient will be given 2 units of PRBC [packed red blood cells-a blood transfusion] . Review of Resident 1's medical record from Hospital B titled, Consultation, dated [DATE], indicated, .Initially No signs of bleeding .Patient subsequently had 2 episodes of [NAME] . Review of Resident 1's medical record from Hospital B titled, Discharge Summary, dated [DATE], indicated once in the ED on [DATE], Resident 1 had a very low blood pressure, irregular heartbeat, lower hemoglobin level of 7.1 gm/dL (or Hgb, A normal hemoglobin level for adult is between 12 and 16 grams per deciliter gm/dL; a protein in red blood cells that carries oxygen throughout the body) than a week earlier on [DATE] when the hemoglobin level was 7.3 gm/dL. The record further indicated, The patient was managed in the Intensive Care Unit from [DATE] to [DATE]. The patient expired on [DATE] from complications of cardiogenic shock [when the heart is unable to pump enough blood to meet the body's needs, resulting in severely low blood pressure and inadequate oxygen delivery to vital organs], acute hypoxemic respiratory failure [unable to breath when the body is not getting enough oxygen in the blood due to a sudden impairment in lung function], Atrial Fibrillation with rapid ventricular response [or A-Fib, rapid and irregular heart beat], acute kidney injury Superimposed on chronic kidney disease [sudden worsening of kidney function], and supratherapeutic anticoagulation [when a drug is given at levels greater than would normally be used to treat a medical condition and results in too much anticoagulation which increases the risk of bleeding] . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview with Licensed Nurse (LN) 1, at Nursing Station 1, on [DATE], at 5:06 PM, LN 1 described the admission process and stated the information packet from the hospital for new resident admission were processed by the admission nurse. The admission nurse entered the signed hospital orders in the electronic health record. The orders, including medication orders, were double checked by the nursing supervisor, and activated in the computer system for the nurse to see the orders in the MAR. LN 1 stated the Order Summary Report then printed out for the facility's doctor to sign. During an interview with the Assistant Director of Nursing (ADON), in her office, on [DATE], at 10:37 AM, the ADON stated Resident 1's medication orders from the hospital were sent to the provider pharmacy for timely medication delivery. The ADON stated the Order Summary Report was reviewed and signed by MD 1. The ADON stated Resident 1's orders were additionally reviewed for nursing care plan, monitoring needs, and other required documentation after admission. The ADON stated when the indication for Resident 1's blood thinner was updated to include a blood clot diagnosis, the computer system reset the order's start date and that was how the dabigatran (Pradaxa) start date was changed from [DATE] to [DATE]. The ADON stated this error was not realized until [DATE] after morning doses were administered. During a telephone interview with MD 1, on [DATE], at 2:43 PM, MD 1 stated his office received a fax communication (electronically transmitting scanned printed documents) from the facility's ADON at the end of day on [DATE] and he saw the fax note late the next day on [DATE] when he ordered to hold both blood thinners. MD 1 stated for urgent issues the facility should have made a phone call rather than sending a fax note. During a concurrent phone interview with the ADON on [DATE] at 12:10 PM, and review of the Provider Pharmacy's (Pharmacy A) medication dispensing record for Resident 1 (an email communication provided by Pharmacy A on [DATE]), the record indicated Pharmacy A delivered rivaroxaban (Xarelto) to the facility on [DATE] and sent dabigatran (Pradaxa) to the facility on [DATE] (the day the duplication error was discovered). The ADON stated she did not know if the nursing staff used another resident's dabigatran to give to Resident 1. During an interview with LN 2, on [DATE], at 12:46 PM, LN 2 stated her workflow on medication administration followed their computer system prompts for giving the medications when it was due. LN 2 stated she marked the medication administration when she verified accuracy of the MAR and medications to be given. LN 2 could not recall Resident 1, for whom she documented giving two blood thinners at the same time. LN 2 stated she looked at the medication or duplication alerts if the computer alerted her. LN 2 stated she found the medications either in a bubble pack format (a card that individually packaged pills) or in a bottle from the top drawer of the medication cart. During a concurrent inspection of the medication cart and interview with LN 3, on [DATE], at 1 PM, LN 3 stated she could not recall Resident 1, for whom she documented giving two blood thinners at the same time. LN 3 stated she followed doctor's orders in the computer and tried to give the medications on time. LN 3 stated the medications for each resident were placed in the cart based on the room number and some were on the top drawer in a bottle. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview with the facility's Director of Nursing (DON) and Administrator (Admin), on [DATE], at 2:17 PM, the DON stated the duplicate use of blood thinner was a result of a clerical error in the system and the computer's response to an order clarification. The Admin stated there was a delay in contacting the MD 1 for addressing the clinical aspect of the error and they had to call the Medical Director (MD 2) to get orders to transfer Resident 1 to the hospital ED. During a telephone interview with MD 2, on [DATE], at 3:39 PM, MD 2 stated he recalled Resident 1 was over-anticoagulated (too much blood thinner medications given) and was sent to the hospital. MD 2 stated he recalled Resident 1 did not have any obvious bleeding while in the facility. MD 2 stated once the error was recognized, both medications should have been stopped until full assessment was completed by medical providers. Review of the facility policy titled, Administering Medications, dated ,d+[DATE], indicated, Medications are administered in a safe and timely manner and as prescribed. The policy on Section 4 indicated, Medications administered in accordance with prescriber's order, including any required time frame. The policy on Section 10 indicated, The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method or route of administration before giving the medication. The policy on Section 26 indicated, Medications ordered for a particular resident may not be administered to another resident . Review of the facility's policy titled, Medical Director, dated ,d+[DATE], indicated, .Medical director function also includes, but are not limited to .acting as a liaison between administration and attending physicians . Acting as a consultant to the Director of Nursing Services in matters relating to resident care services . Assuring that physician services comply with current rules, regulation, and guidelines concerning long term care .