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	09/04/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to ensure medications were administered according to physician orders for one of three residents (Resident 2) when Resident 2 missed a dosage of three medications on 8/20/25.This failure had the potential to negatively affect the health and well-being of Resident 2, and the efficacy of the medications being administered.Findings: A review of Resident 2's admission RECORD, indicated that Resident 2 was admitted to the facility in 2025 with diagnoses which included displaced intertrochanteric fracture of right femur (a break in the upper part of the hip in which the bones are out of place), and hypertension (a condition in which the force of the blood pushing against the blood vessel walls is consistently too high. This causes the heart to work harder to pump blood). A review of Resident 2's Physician Order Summary, indicated, .AmLODIPine Beselyte [medication to treat hypertension] Tablet 10MG [milligram, a unit of measure] Give 1 tablet by mouth one time a day for HTN [hypertension]. Order Date.08/19/2025.Start Date.08/20/2025.A review of Resident 2's Physician Order Summary, indicated, .Famotidine Oral Tablet [medication to decrease the amount of acid produced in the stomach] 40 MG Give 1 tablet by mouth in the morning for GERD [Gastroesophageal Reflux Disease, a condition where stomach acid flows back up into the esophagus and causes heartburn].Order Date.08/19/2025.Start Date.08/20/2025. A review of Resident 2's Physician Order Summary, indicated, .Linzess Oral Capsule [medication used to treat chronic constipation] 145 MCG [microgram, a unit of measure].Give 1 capsule by mouth one time a day for Irritable Bowel Syndrome [IBS, a condition that causes abdominal bloating, cramping, constipation, and diarrhea].Order Date.08/19/2025.Start Date.08/20/2025.A review of Resident 2's Care Plan Report, indicated, .Focus.[Resident 2] has altered cardiovascular status r/t [related to] HTN, history of CVA [cerebrovascular accident, a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke].Goal.[Resident 2] will be free from s/sx (signs/symptoms) of complications.Date Initiated.08/20/2025.Interventions/Tasks.Administer medications as ordered.A review of Resident 2's Care Plan Report, indicated, .Focus.Resident 2] has GERD r/t hyperacidity [increased acid in the stomach].Goal.[Resident 2] will remain free from discomfort, complications, or s/sx related to dx [diagnosis] of GERD.Date Initiated.08/20/2025.Interventions/Tasks.Administer medications as ordered.A review of Resident 2's Care Plan Report, indicated, .Focus.[Resident 2] has an alteration in Gastro-Intestinal status r/t IBS [irritable bowel syndrome, a long term condition affecting the large intestine with symptoms of abdominal pain, bloating cramping, gas, and constipation].Goal.[Resident 2] will remain free from discomfort, complications or s/sx.Date Initiated.08/20/2025.Interventions/Tasks.Administer medications as ordered.A review of Resident 2's Medication Administration Record (MAR, a document listing medications and monitoring parameters), dated August 2025, indicated a 13 was documented for the 9 a.m. dose of Amlodipine on 8/20/25. The chart code on the August 2025 MAR indicated that 13 indicated Drug not available.A review of Resident 2's MAR, dated August 2025, indicated a 13 was documented for the 9 a.m. dose of Linzess on 8/20/25.A review of Resident 2's MAR, dated August 2025, indicated a 7 was documented for the 6 a.m. dose of Famotidine on 8/20/25. The chart code on the August 2025 MAR indicated that 7 indicated Sleeping.During an interview on 9/4/25, at 10:07 a.m., with LN 2, LN 2 stated that if a resident's medication was not available to administer during medication administration time, she would check to see if the medication was in the e-kit in the medication storage room. LN 2 stated that there was a list of medications and dosages available in the e-kit, so if the medication was in the e-kit, she would take the medication out of the e-kit and fill out the form indicating which medication she took and fax the form to the pharmacy so that the pharmacy could replace the e-kit. LN 2 stated that if the medication was not in the e-kit, she would call the resident's physician to let the physician know that the medication was not available in the medication cart or the e-kit. LN 2 stated that the physician sometimes gave a one-time order to give the medication when it arrived late, then the regular medication times resumed. LN 2 stated that she would document that the medication was not available and what steps she took to resolve it in the resident's progress notes. During a concurrent interview and record review on 9/4/25, at 12:10 p.m., with the Nurse Supervisor (SUP), Resident 2's electronic medical record (EMR) was reviewed. The SUP confirmed that on Resident 2's MAR on 8/20/25, at 9 a.m., a 13 was entered for the dose of Amlodipine and the dose of Linzess; where the LN would document that the medications were given. The SUP further confirmed the 13 was a code that indicated Drug not available. The SUP confirmed that on 8/20/25, at 6 a.m., a 7 was entered for the dose of Famotidine; where the LN would document that the medication was given. The SUP further