

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Clearwater Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. Based on interview, and record review, the facility failed to ensure medications were administered according to physician orders for one of one sampled resident (Resident 1) when:1. Resident 1's blood pressure medications were administered without following the set parameters for multiple days during June of 2026; and,2. Resident 1's vaginal cream was administered incorrectly for 3 days. These failures had the potential to negatively affect the health and well-being of Resident 1 including hypotension (low blood pressure) and vaginal bleeding. Findings:1a. A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including surgical aftercare following surgery on genitourinary system, abnormal uterine (uterus/womb) and vaginal bleeding, and female genital prolapse (an organ or tissue slips or falls out of its normal place). A review of Resident 1's Care Plan, dated 6/4/26, indicated that Resident 1 had an altered cardiovascular status related to hypertension (increased blood pressure) and hyperlipidemia (high levels of fats in the blood). Interventions included administering medication as ordered, vital signs as indicated, and to notify the physician of any abnormal readings. During an interview on 7/1/26, at 9:38 AM, with Licensed Nurse (LN) 1, LN 1 stated in regard to a resident's medication administration record (MAR); if the document had a check mark, then it meant the medication was administered. LN 1 further stated that if the document showed a number 4; it meant the vital signs (essential, measurable indicators of your body's basic functions) were below normal. During a concurrent interview and record review on 7/1/26, at 10:43 AM, with the Nursing Supervisor (NS), Resident 1's MAR for June 2026 was reviewed. The MAR indicated for Resident 1 to take Amlodipine (medication to treat high blood pressure) tablet daily and to hold the medication if the systolic blood pressure (SBP, top and higher number in a BP reading) was below 140 and the diastolic (DBP, bottom number in a BP reading) was below 80. The NS confirmed Resident 1's June MAR indicated that Amlodipine was administered to Resident 1 on June 6th when the BP was 114/64, on June 7th when the BP was 132/73, on June 8th when the BP was 128/60, on June 9th when the BP was 126/67, on June 12th when the BP was 108/61, on June 13th when the BP was 117/67, on June 14th when the BP was 107/60, and on June 15th when the BP was 107/59. Further review of Resident 1's MAR with the NS indicated, Losartan potassium (medication to treat high blood pressure) tablet daily with parameters to hold off medication if the SBP was less than 140 and the DBP was less than 80. The NS confirmed that Losartan was administered on June 5th when the BP was 122/79, on June 6th when the BP was 118/65, on June 7th when the BP was 112/68, and on June 8th when the BP was 125/84. Further review of the MAR with the NS indicated, Metoprolol (medication to treat high blood pressure) tablet daily with parameters to hold off if the SBP was less than 140, the DBP was less than 80 or the pulse (heart) rate was less than 60. The NS confirmed that the MAR indicated that Metoprolol was administered to Resident 1 on June 6th when the BP was 114/64, on June 7th when the BP was 132/73 and the pulse rate was 56, on June 8th when the BP was 128/60, on June 9th when the BP was 126/67, on June 12th when the BP was 108/61, on June 13th when the BP was 117/67, on June 14th when the BP was 107/60 and on June 15th when the BP was 107/59. The NS stated that the nurse should have held off giving the blood pressure medications when Resident 1's systolic BP was (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	below 140 and the diastolic BP was below 80 and the pulse was below 60. The NS further stated that when providing antihypertensive medicines (helps bring BP back down to a normal range), the nurses needed to check the BP first and if there were no parameters, then they would need to call the doctor. The NS stated it was important to check the BP to make sure they did not give antihypertensive medicines to the resident when the BP was too low. The NS further stated if the BP was not normal, the nurses needed to hold off the medication and inform the doctor. During an interview at 7/1/26, at 1:26 PM, with the Director of Nursing (DON), the DON stated that he expected the nurses to check the parameters before administering blood pressure medications and to follow the set parameters. The DON further stated that if there was no parameter, the nurses needed to call the doctor and ask for parameters. The DON stated there could be adverse effects if the parameters were not followed such as hypotension. 1b. A review of Resident 1's Care Plan, dated 6/4/26, indicated that Resident 1 had genital organ prolapse and interventions included administering medication as ordered. A review of Resident 1's MAR was reviewed for the month of June 2026. The MAR indicated that Estradiol vaginal cream (helps improve the health of vaginal tissue, supports proper healing, and relieves or prevents dryness and thinning in the vaginal area) was administered to Resident 1 from June 5th to June 7th. A review of Resident 1's Progress notes, dated 6/9/26, indicated that Resident 1 was having moderate amount of vaginal bleeding. Urogynecology (doctor that specializes in female pelvic floor disorders) was contacted and the facility was informed that the latest schedule appointment available was on July 8th. A review of Resident 1's Progress notes, dated 6/9/26, indicated that Resident 1's family member (FM) 1 was at the ED (emergency department) with Resident 1 due to the continued vaginal bleeding. A review of Resident 1's Progress notes, dated 6/11/26, indicated, Resident 1 was readmitted back to the facility from the hospital. Further review of the document indicated that Resident 1 was at the hospital for abnormal vaginal bleeding. During an interview on 7/1/26, at 11 AM, with the NS, the NS stated when administering vaginal cream to a resident, they needed to check the order first, check for the indication, check the resident's history and physical (H&P), and to clarify with the doctor. The NS further stated if a resident experienced vaginal bleeding, the nursing staff needed to monitor and if the bleeding persisted then they needed to call the doctor. The NS stated it was important to notify the doctor. During a concurrent interview and record review on 7/1/26, at 1:06 PM, with the DON, Resident 1's MAR for June 2026 was reviewed. The DON confirmed that Resident 1's Estradiol vaginal cream on June 5-7 was administered vaginally. The DON stated when Resident 1 was admitted to the facility there was an order for vaginal cream and it was transcribed in the order that the medication would be a full insertion into the vagina. The DON further stated it was a transcription error from the admission nurse. The DON explained it was a mistake that no one clarified until June 6th when there was a concern for the vaginal bleeding. The DON stated the admission nurse did not clarify with the doctor before inputting the order. The DON further stated that Resident 1's hospital discharge records indicated that the vaginal cream should be dabbed on the vaginal area, and the word dab was not transcribed in the EHR order. A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated, .The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Medications are administered in a safe and timely manner, and as prescribed. The following information is checked/verified for each resident prior to administering medications. Vital signs, if necessary.		