STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555307	A. BUILDING _____ B. WING _____	**03/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their weight loss protocol to inform the family representative of a significant weight loss for one of 3 sampled residents (Resident 1). This failure had the potential for Resident 1's representative not to be aware of the significant weight loss which could adversely impact Resident 1's health. Findings: According to the 'Admission Record', the facility admitted Resident 1 last year with multiple [DIAGNOSES REDACTED]. A review of Resident 1's '. at risk for weight loss .' care plan revised on 11/1/19 indicated he had lost 6 pounds in one week and 10 pounds in 4 weeks. A review of Resident 1's 'Weights and Vitals Summary' reflected his weight on 12/31/20 was 160 pounds, on 1/7/20 the weight was 153.4 pounds., a loss of 6.6 pounds in a week. On 1/15/20 the weight was 147.4 pounds, a loss of 6 pounds in one week. During a review of Resident 1's clinical record, there was no documented evidence the facility notified his family about the weight loss. During an interview and concurrent Resident 1's record review with the Director of Nursing (DON) on [DATE] at 2:15 p.m., he stated Resident 1's family should have been notified of the weight loss. A review of the facility's 'Weight Change Protocol' dated 2018 indicated, Unplanned weight loss trend that has occurred 2 times or more. This can refer to weekly or monthly weights . 3# (pounds) weight loss in 1 week . 5# weight loss in 1 month .GOALS . To be determined with resident or decision maker . Consider possible negative health effects from the weight change and discussion of this with the resident or decision-maker. Consider Residents or decision-makers desire for weight control . allow for food preferences . from home . Food preferences can be obtained from the resident, family .
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a turning and repositioning intervention, to prevent worsening of pressure ulcers (sores), was implemented for one of 3 sampled residents (Resident 1) when there was no documented evidence in the clinical record. This failure had the potential for Resident 1's facility acquired pressure ulcers to worsen. Additionally, this failure potentially hindered the ability of the staff to evaluate the effectiveness of the treatment intervention. Findings: According to the 'Admission Record', the facility admitted Resident 1 last year with multiple [DIAGNOSES REDACTED]. A review of Resident 1's care plan dated 1/12/20 indicated he had developed facility acquired pressure sores ' . actual pressure ulcer to right heel . left heel .right outer ankle . r/t (related to) Immobility.' The care plan listed the interventions which included assisting him to turn and reposition at least every 2 hours and more often as needed and pain medication prior to turning to ensure comfort. During an interview and concurrent Resident 1's record review with the Wound Nurse (WN) on [DATE] at 12:05 p.m., she stated she identified facility acquired pressure sores to bilateral (both sides) heels and right ankle on 1/12/20 and initiated interventions to prevent worsening of the sores. The WN stated Resident 1's mobility had declined due to a recent hospitalization and she included turning and repositioning every 2 hours or more often in his care plan. The WN stated, the turning and repositioning should be documented in Resident 1's clinical record under CNA's tasks. A review of Resident 1's Certified Nursing Assistants (CNA's) documentation task, reflected no documented evidence he was assisted with repositioning every 2 hours or more often as per the care plan. A review of the facility's 'Pressure Ulcer .' policy dated 7/2017 indicated, Develop the resident-centered care plan and interventions . The effects of the interventions must be evaluated. During an interview and concurrent Resident 1's record review with the Director of Nursing (DON) on [DATE] at 2:15 p.m., he stated the CNA's should have documented turning and repositioning every 2 hours under the CNA tasks. The DON stated he was unable to locate the turning and repositioning documentation and stated he would find it and fax it to the Department. The facility was requested for the turning and repositioning documentation on [DATE], 3/17/20 and [DATE] but was not received.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and clinical record review,the facility failed to ensure the clinical record for one of 3 sampled residents (Resident 1) was complete and accurately documented when the consent forms for use of antipsychotic medications (used to treat mental disorders) were incomplete. This failure had the risk potential for Resident 1 to receive medications without information regarding their side effects. Findings: According to the 'Admission Record', the facility admitted Resident 1 last year with multiple [DIAGNOSES REDACTED]. A review of Resident 1's physician's 'Order Summary Report' dated 1/7/20 including the following orders : 10/23/19: [MEDICATION NAME] (antipsychotic medication used for mental conditions) 5 mg (unit of weight) daily for unspecified [MEDICAL CONDITION] manifested by combativeness. 11/1[DATE]9: [MEDICATION NAME] (antipsychotic medication used for mental conditions) 5 mg twice daily for unspecified [MEDICAL CONDITION] manifested by combativeness. A review of Resident 1's 'Informed Consent for Antipsychotic . Medication' consent form dated 10/23/19, the physician did not check the boxes to indicate if he had discussed the risk and benefits for use of [MEDICATION NAME] with the Resident or his designated family member. A review of Resident 1's 'Informed Consent for Antipsychotic . Medication' consent form dated 11/1[DATE]9, the physician did not check the boxes to indicate if he had discussed the risk and benefits for use of [MEDICATION NAME] with the Resident or his designated family member. During an interview and concurrent record review with the Director of Nursing (DON) on [DATE], at 2:15 p.m., he stated the physician should have completed the check boxes on the informed consent forms to validate he had discussed the risks and benefits for use of [MEDICATION NAME] with Resident 1 or his designated representative. A review of the facility's 'Antipsychotic Medication Use' policy dated 12/2016 indicated, Nursing staff shall monitor for any . side effects and adverse consequences of the antipsychotic medications to the attending physician . The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting . why the benefits of the medication outweigh the risks . The policy did not contain information on how the physician would document the discussion of the risks versus benefits with the resident or his representative.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.