

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055917	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/29/2025
NAME OF PROVIDER OR SUPPLIER  Harvest Crossing Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  469 East North Street Manteca, CA 95336	

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 0600  Level of Harm - Actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to protect one of five sampled residents (Resident 4) from physical abuse when, Resident 3 with a history of aggressive behavior, hit Resident 4 in the face with a water pitcher on 10/9/25. This deficient practice resulted in Resident 4 being sent to the emergency room with a facial contusion (bruise), facial lacerations (a torn, ragged wound or cut through the skin, typically caused by blunt force trauma or a sharp object) to the upper lip and right eyebrow which required stitches (threads used to sew up wounds to hold the skin together for healing), and pain. This deficient practice had the potential to affect Resident 4's psychosocial well-being. Findings: A review of Resident 3's admission Record indicated Resident 3 was admitted to the facility in 2021 with diagnoses which included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with other behavioral disturbances and anxiety disorder (more than occasional worry or fear). A review of Resident 4's admission Record indicated Resident 4 was admitted to the facility in 2024 with diagnoses which included dementia and anxiety disorder. During an interview on 11/10/25 at 1:10 p.m., Licensed Nurse (LN) 3 stated, on 10/9/25 around 2:30 p.m. she heard a sound and went inside Resident 4's room. LN 3 stated, upon entering the room she saw Resident 3 leaning over Resident 4's bed. LN 3 stated Resident 4 was lying in her bed and crying. LN 3 stated Resident 4 stated, Why would [Resident 3] do that. why did [Resident 3] hit me with that thing? LN 3 further stated Resident 4 had a cut and was bleeding a lot from her upper lip and right side of the face near the temple area. LN 3 stated Resident 4 was sent to the hospital and Resident 4 returned from the hospital with stitches (a medical device used to hold body tissues together) on her right eyebrow and upper lip. During an interview on 11/10/25 at 1:34 p.m., LN 4 stated, before the incident on 10/9/25, Resident 3 had yelled and had aggressive behavior towards staff and other residents. LN 4 stated on 10/9/25 when LN 4 went inside Resident 4's room, she saw Resident 3 leaning next to Resident 4 and yelling at Resident 4. LN 4 stated she saw a water pitcher was on the floor inside Resident 4's room. LN 4 further stated Resident 4 looked scared and Resident 4's facial grimacing made LN 4 think that Resident 4 was in pain. LN 4 stated Resident 4 was bleeding from her upper lip and above her right eyebrow. During an interview on 11/10/25 at 2:02 p.m., Certified Nursing Assistant (CNA) 3 stated Resident 3 had yelled at staff in the past. During an interview on 11/10/25 at 2:05 p.m., with Resident 4, Resident 4 stated Resident 3 hit her. Resident 4 stated her lips hurt and she was scared when Resident 3 hit her. During an interview on 11/10/25 at 4:15 p.m., the Director of Nursing (DON), the DON stated Resident 3 had a behavioral history of being aggressive. The DON stated, Resident 4 received stitches to the laceration (cut) on her lip and eyebrow. The DON stated the incident may have caused Resident 4 emotional distress. During an interview and concurrent record review, on 12/29/25 at 3:26 p.m., Resident 3's MAR (Medication Administration Record, it serves as a central communication tool among various healthcare providers, ensuring continuity of care, especially during shift changes in place), dated 7/25 through 10/25, and Resident 3's MD [Medical Doctor]/NP [Nurse Practitioner] Progress Note, dated 8/4/25, was reviewed with LN 5. LN 5 stated Resident 3 had a history of behavioral disturbance (when someone acts out in ways that disrupt their own life and relationships, like having frequent angry outbursts, defying rules, being impulsive, or having trouble focusing). LN 5 confirmed Resident 3's MAR, dated 7/25 through 10/25, did not contain behavior monitoring (the behavior monitoring process involves thorough assessment, identifying specific triggers (antecedents), tracking behavior and responses, developing an individualized care plan, implementing person-centered interventions, and continuous evaluation). LN 5 confirmed Resident 3's MAR, dated 10/25, indicated behavior monitoring was not started until 10/9/25. LN 5 further stated Resident 3's behavior monitoring was not done daily after Resident 3 had an altercation with staff on 7/25/25. Resident 3's MD/NP Progress Note, dated 8/4/25, indicated, .continue to provide supportive care. Diagnosis. Unspecified dementia, unspecified severity, with agitation. Restlessness and agitation. Agitation and violent behavior: [Resident 3] gets agitated at times, continue with supportive care and close monitoring. Monitor neuro [Neurological; the overall condition and function of your brain, spinal cord, and nerves, assessed through tests checking alertness, memory, movement, sensation, reflexes, and coordination to identify any issues affecting how you think, feel, and move]/mental status [how someone was thinking, feeling, and behaving]. LN 5 stated a behavior monitoring log on Resident 3's MAR should have been implemented following the doctors progress note which indicated to monitor Resident 3's mental status on 8/3/25 in order to track Resident 3's behavior changes daily. During an interview on 12/29/25 at 3:40 p.m. LN 6 stated that when a doctor ordered behavior</p>		