STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A340	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Manor - 104	1130 Monaco Court Stockton, CA 95207

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 - Minimal harm or potential for 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. Based on observation, interview, and record review, the facility failed to protect one of three sampled residents (Resident 1) from physical abuse when Resident 2, who had a known history of assaultive, destructive, and intrusive behaviors entered Resident 1's personal space and smeared feces on Resident 1's face on 11/19/25.This failure resulted in Resident 1 experiencing unwanted physical contact with feces, which placed Resident 1 at risk for loss of dignity, psychosocial (emotional and social well-being including how a person feels, thinks, and interacts with others) harm, and potential exposure to infection, and placed other vulnerable residents in the facility at risk for abuse. Findings:Review of Resident 1's ADMISSON RECORD indicated, Resident 1 was admitted to the facility with diagnoses including schizoaffective disorder (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions, disorganized thinking) with mood disorder symptoms (mania or depression)), bipolar type (a mental health condition that causes mood swings with hallucinations or disorganized thinking), cataract (the clouding of the normally clear lens inside the eye, which obstructs light from reaching the retina and causes blurry, hazy, or less colorful vision), presbyopia (age-related difficulty focusing on close objects), and anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissue).Review of Resident 2's ADMISSON RECORD indicated, Resident 2 was admitted to the facility with diagnoses including schizoaffective disorder bipolar type, violent behavior, mild neurocognitive disorder (involves a slight, noticeable decline in memory, language, or executive function that exceeds normal aging but does not prevent independent daily living) due to known physiological condition with behavioral disturbance (mild decline in thinking or memory caused by a medical condition that also affects behavior).Review of Resident 2s Progress Notes dated 11/19/25 at 5:18 AM, in the section titled SBAR [Situation, Background, Assessment, and Recommendation; a communication tool nurses use to share important resident information with physicians and other providers], indicated that on 11/19/25 at about 4 AM, Resident 2 had a bowel movement in the bathroom when Resident 2 grabbed her feces and smeared feces on Resident 1's face while Resident 1 was sleeping. The Certified Nurse Assistant (CNA) yelled for help. The Licensed Nurse (LN) responded but Resident 2 became more aggressive. LN offered Ativan by mouth but Resident 2 refused, and the LN administered Ativan by injection. The SBAR indicated Resident 2 was currently on one-on-one supervision (1:1, a staff member provides constant, direct observation of a single resident, typically remaining within arm's reach or eyesight, dependent on facility practices) due to sexual and socially inappropriate behavior. The SBAR further indicated that on 11/18/25, Resident 2 went to the nurse's station twice and left a paper towel with feces, and on 11/15/25, Resident 2 grabbed a shower hose and sprayed water at CNAs.During an observation on 1/7/26 at 12:07 PM in Resident 1's room, the room had three beds placed side by side, with Bed A near the entrance, Bed B in the middle, and Bed C near the window and bathroom. The head of Bed C was against the wall away from the bathroom door, and the foot of the bed was visible from the (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathroom exit. During an interview on 1/7/26 at 1:45 PM with the Social Services Director (SSD), the SSD stated Resident 2 had increased sexually inappropriate behavior the day before Resident 2 smeared feces on Resident 1's face and was placed on one-on-one (1:1) supervision.During an interview on 1/8/26 at 7:29 AM with CNA 1, CNA 1 stated she provided 1:1 supervision to Resident 2 on 11/19/25 during the incident when Resident 2 smeared feces on Resident 1's face. CNA 1 stated Resident 2's bed was Bed B and Resident 1's bed was Bed C. CNA 1 stated prior to the incident, Resident 2 was up and down, leaving the room repeatedly, and stated Resident 2 was acting weird. CNA 1 clarified that acting weird meant Resident 2 was restless, agitated, and pacing. CNA 1 stated before the incident, Resident 2's uncontrolled behaviors including restlessness, agitation, and pacing did not respond to redirection (verbal attempts to calm and guide the resident) provided by CNA 1. CNA 1 stated she asked the nurse to give medication (to help with behavior), however Resident 2 refused. CNA 1 stated Resident 2 continued to be restless and that she had advised Resident 2 to calm down and encouraged Resident 2 to go back to sleep, but these interventions were unsuccessful. CNA 1 stated Resident 2 then used the bathroom and when Resident 2 exited the bathroom, Resident 2 walked toward Resident 1, approached the head of Resident 1's bed, and smeared feces on Resident 1's face while Resident 1 was sleeping. During a concurrent interview and record review on 1/8/26 at 12:24 PM with LN 1, Resident 2's Progress Notes dated 11/19/25 at 5:32 AM and Medication Administration Record (MAR) were reviewed. Resident 2's Progress Notes indicated that the incident when Resident 2 smeared feces on Resident 1's face occurred at around 4 AM on 11/19/26. Resident 2's MAR indicated that on 11/19/25, Resident 2 refused Ativan oral tablet at 4:07 AM and received Ativan injection at 4:13 AM. LN 1 stated the Ativan oral medication was offered to Resident 2 after the incident, and the Ativan injection was administered to Resident 2 after the incident. LN 1 stated if nonpharmacological interventions (non-medication methods used to calm behaviors) were not effective, medication could be given following the physician's order. LN 1 further stated if a medication ordered to manage behavior was not administered in a timely manner, the resident's behavior could escalate and place the resident and others at risk for safety concerns.During interview on 1/21/26 at 8:43 AM with LN 2, LN 2 stated that on 11/19/25, before the incident where Resident 2 smeared feces on Resident 1's face, Resident 2 was restless, agitated, and walked in and out of the room. LN 2 stated CNA 1, who provided 1:1 supervision attempted redirection, but it was ineffective. LN 2 stated when CNA 1 reported the incident, LN 2 went to the room and assisted another nurse in administering Ativan by injection while Resident 2 was sitting on Bed B. LN 2 stated the Ativan injection was administered to Resident 2 after the incident. LN 2 further stated 1:1 supervision required staff to maintain close observation, redirect behaviors, and prevent Resident 2 from entering another resident's personal space.During a concurrent interview and record review on 1/21/26 at 10:06 AM with LN 3, Resident 2's care plan was reviewed. In the section titled Focus indicated that on 4/29/25, intrusive behavior describing Resident 2 as anxious, pacing the halls, entering other resident's rooms, and becoming aggressive when redirection was provided. An assaultive behavior care plan was created on 4/29/25. On 6/30/25, a combative behavior care plan was created, describing Resident 2 as attempting to strike staff during oral medication administration. On 10/16/25, a socially inappropriate behavior care plan was created. LN 3 stated Resident 2 had a history of intrusive, anxious, pacing, aggressive, assaultive, and combative behaviors that placed Resident 2 at risk for resident-to-resident altercations. LN 3 stated Resident 2 was on 1:1 supervision before and at the time of incident. LN 3 stated 1:1 supervision required staff to closely monitor Resident 2, anticipate behavioral escalation, and intervene to prevent Resident 2 from entering another resident's space. LN 3 further stated that if uncontrolled behaviors did not respond to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	redirection, staff were expected to administer prescribed medication promptly, as delays could increase escalation and risk for resident-to-resident abuse. During interview on 1/21/26 at 5:25 PM with LN 4, LN 4 stated that he was on break, and upon returning, the CNA providing 1:1 supervision to Resident 1 reported that Resident 1 was restless, was acting out, and had smeared feces on the wall. LN 4 stated he went to the resident's room and observed that Resident 1 had a bowel movement and had smeared feces on the bathroom wall and curtain. LN 4 stated Ativan by mouth was offered at the bedside, however Resident 1 refused the medication and attempted to slap his hand away. LN 4 stated that prior to the incident Resident 1 required 1:1 supervision due to ongoing behaviors but was not fully aware of the specific behaviors that prompted the 1:1 supervision. LN 4 stated the focus of the 1:1 supervision was for resident safety. LN 4 stated that when a resident was on 1:1 supervision, staff were expected to always remain in close proximity, like elbow to elbow. LN 4 stated Ativan by injection was administered to Resident 2 after the incident. LN 4 stated that if medications ordered to manage behaviors were not given in a timely manner, behaviors could escalate and increase safety risks for residents and staff. LN 4 further stated Resident 1 could have experienced distress related to the incident. During an interview on 2/1/26 at 10:23 AM with the Director of Nursing (DON), the DON stated that when a resident is on a line-of-sight supervision and an increase in behaviors is observed during the shift, nursing staff have the option to increase supervision to 1:1 if behaviors escalate. The DON stated line-of -sight supervision requires continuous visual observation while 1:1 supervision requires staff to always remain within arm's length of the resident. The DON stated that when a resident showed behaviors such as severe anxiety and non-pharmacological interventions were not effective, staff were expected to notify the nurse so medication could be initiated promptly. Review of facility's policy and procedure (P&P), titled Management/Prevention of Assaultive Behavior dated 5/8/24, the P&P indicated .In the event that licensed staff assess that the individual is not responding to nonpharmacological interventions.then prn (as needed) medication may be offered per Dr. order.Review of facility's policy and procedure (P&P), titled Elder and Dependent Adult Abuse/Suspicion of a Crime revised on 1/9/19, the P&P indicated .Crestwood Behavioral Health, Inc. Believes every person served, client, or resident has the right to be free of: a) Physical abuse.with resulting physical harm, or pain or mental suffering.Each resident and person served had the right to be free from verbal, sexual, physical and mental abuse.Persons served must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents.