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	04/13/2026

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 residents' right to be free from physical abuse (causing bodily harm, pain, or impairment, such as hitting, slapping, or pushing) for 2 of 4 sampled residents (Resident 2, and Resident 3) when:Resident 1 had a physical altercation (a fight between residents) with Resident 2 on 9/6/25, during which Resident 1 hit Resident 2 on the head with a belt; and,Resident 3 had a physical altercation with Resident 4 in Resident 3's bathroom on 9/3/25, after Resident 4 used Resident 3's bathroom without permission and hit Resident 3 in the face with a closed fist.These failures resulted in Resident 2 sustaining a skin tear to the top of his head and resulted in Resident 3 falling to the floor on her left side after being struck resulting in swelling and discoloration to her left eyebrow and left side of her lip as well as Resident 3 stated feelings of being scared of Resident 4.Findings:1. Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including schizophrenia (a mental illness that affects thinking and behavior, and may cause false beliefs or seeing/hearing things that are not real).Review of Resident 1's Progress Notes dated 9/6/26 indicated, .It was reported by licensed nurse that.she heard yelling. When Nurse walked in [Resident 1's] room to see resident, resident was standing next to [Resident 2'] head. [Resident 1] was noted to be putting belt on and stated that.[Resident 2] had kicked him.Background.[Resident 1] has history of assaultive behavior, accusatory statements, and verbal abuse.During a concurrent interview and record review on 4/13/26 at 1:33 PM with Licensed Nurse (LN) 1, Resident 1's care plans and progress notes were reviewed. Resident 1's care plan titled, Care Plan: ASSAULTIVE BEHAVIOR, initiated on 7/25/25, in the section titled Focus, indicated .ASSAULTIVE BEHAVIOR [physical aggression toward others].7/25/25 [Resident 1] kicked peer.9/6/25 [Resident 1] hit [Resident 2] with a belt. Resident 1's Care Plan: DELUSIONAL STATEMENTS, initiated on 6/26/25, in the section titled Focus, indicated Resident 1 had delusional statements (false beliefs), paranoid statements (unfounded fear or suspicion), and inappropriate sexual behavior. LN 1 confirmed Resident 1 had kicked his previous roommate on the buttocks on 7/25/25. LN 1 confirmed Resident 1 exhibited paranoid statements, delusions, hallucinations (seeing or hearing things not present), and inappropriate sexual behaviors, which resulted in aggressive and assaultive behaviors toward others and required staff supervision with every 15-minute checks during the morning and evening shifts, which was initiated on 7/28/25 to prevent aggressive and assaultive behavior. Resident 1's Progress Note dated 8/21/25 at 6:28 AM indicated Resident 1 was placed on line-of-sight checks (continuous visual supervision) on the night shift. LN 1 confirmed to prevent further resident- to-resident altercations, Resident 1 remained on every 15-minute checks during the morning and evening shifts and, due to increased paranoia on night shift, line-of-sight checks were implemented for Resident 1. LN 1 stated Resident 1's first assaultive behavior on 7/25/25 was managed with every 15-minute checks and line-of-sight monitoring to prevent further assaultive behavior and reduce the risk of harm to other residents. LN 1 further stated that according to Resident 1's Progress Note, dated 9/1/25, Resident 1 was taken off every 15-minute checks. LN 1 stated after approximately five days of being off every 15-minute checks, Resident 1 had another episode of assaultive behavior and hit Resident 2 on the head with a belt on (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	9/6/25, which caused harm to Resident 2.Review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with diagnoses including schizophrenia, dementia with psychotic disturbance (memory loss with confusion and false beliefs or seeing/hearing things that are not real), and a wedge compression fracture of first lumbar vertebra (a broken bone in the lower back).During a concurrent interview and record review on 4/13/26 at 1:40 PM, Resident 2's care plan regarding assaultive behavior, initiated on 4/5/21, and Resident 2's SBAR (situation, background, assessment, and recommendation), dated 9/6/25, was reviewed with LN 1. The section titled Focus, indicated .9/26/25 [Resident 2] allegedly kicked [Resident 1] due to being hit by [Resident 1] . Resident 2's SBAR indicated that Resident 2 asked Resident 1 to turn down the television, and Resident 1 hit Resident 2 with a belt causing a skin tear. Resident 2 then kicked Resident 1. LN 1 stated Resident 2's assaultive behavior was triggered after being hit by Resident 1 and because staff could not intervene before the behavior escalated, Resident 2 sustained physical harm.During an interview on 4/13/26 at 4:35 PM with the Administrator (ADM), the ADM stated staff were expected to ensure resident safety. The ADM stated that although behaviors could not always be anticipated, staff could implement line-of-sight monitoring to prevent resident-to-resident altercations. The ADM acknowledged that when Resident 1 hit Resident 2 with a belt on the head, there were not every 15-minute checks or line-of-sight monitoring in place.2. Review of Resident 3's admission RECORD, indicated Resident 3 was admitted to the facility with diagnoses including schizoaffective disorder (mental illness with mood problems and altered thinking), parkinsonism (movement disorders causing tremors and stiffness), and presbyopia (age-related difficulty seeing up close).Review of Resident 3's Progress Note dated 9/3/25, indicated .At approximately 1350 [1:50 PM] [Resident 3] was heard screaming in her room, upon entering [Resident 3] was found on her left side near the bathroom door. When asked what happened initially [Resident 3] stated that [Resident 4] pulled her off the toilet and then hit her and pushed her down. [Resident 3 and Resident 4] her [sic] separated immediately and assessed. [Resident 3] was noted with swelling/discoloration to her left upper eyebrow. First aid rendered and ice applied and given PRN [as needed] Ibuprofen [mild pain medication].When interviewed about incident [Resident 3] then said that she was washing her hands and then [Resident 4] pushed her, then hit her, then pushed her to the ground.During a concurrent observation and interview on 4/13/26 at 12:10 PM with Certified Nurse Assistant (CNA) 1, Resident 3's room was observed to be occupied by three residents who shared the bathroom with the adjoining room. CNA 1 stated Resident 3 did not want anyone other than her roommates to use the bathroom in her room. CNA 1 further stated residents who needed to use the bathroom when their own bathroom was occupied would be assisted to use the shower room (a large room with a shower and toilet).During an interview on 4/13/26 at 12:15 PM with Resident 3, Resident 3 stated Resident 4 was not her roommate and entered her room and used her bathroom, then hit her in the face, causing her to fall to the floor. Resident 3 stated she was scared of Resident 4.Review of Resident 4's admission RECORD, indicated Resident 4 was admitted to the facility with diagnoses including schizoaffective disorder.Review of Resident 4's Progress Notes, dated 9/3/25, indicated, .When asked why [Resident 4] had hit [Resident 3], [Resident 4] stated, she was raising a fist at me, so I hit her first.When interviewed, [Resident 4] stated her bathroom was full, so she went to the other bathroom. When [Resident 3] was using the bathroom, [Resident 4] entered. [Resident 3] raised a closed fist to [Resident 4]. Before [Resident 3] made contact, [Resident 4] then hit [Resident 3] with a closed fist to her face causing [Resident 3] to fall to her left side. [Resident 4] noted with discoloration and swelling to right middle finger.During an interview on 4/13/26 at 4:30 PM with CNA 2, CNA 2 stated the facility was the residents' home and the residents' rooms were their personal space, including the bathroom. During an interview on 4/13/25 at 4:35 PM with the ADM, the ADM stated if a resident needed to use a bathroom and the bathroom in their room was not available, staff were expected to assist the residents to use other bathrooms. The ADM stated that before anyone entered a resident's room, they had to knock at the resident's door and wait to be given permission to enter the room by (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident who occupied the room. The ADM acknowledged that Resident 4 entering Resident 3's room and using the bathroom without permission and without staff supervision placed both residents at risk for physical harm. 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, .[Facility Name] believes every person served , client, or resident has the right to be free of: a) Physical abuse.Each resident and person served has the right to be free from verbal, sexual, physical, and mental abuse.Review of facility's P&P, titled Resident Rights, revised on 11/15/16, the P&P indicated, .The facility respects each resident's autonomy.Review of facility's P&P, titled Management/Prevention of Assaultive Behavior, dated on 5/28/24, the P&P indicated, .Prevention of assault is the focus for safety of all.Supervisory staff rounding and observation is also key in recognizing early signs of aggression such as yelling, cursing, verbal threats, attempts to touch others, racial slurs and wandering into peer's spaces.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to implement care planned interventions (a written plan that guides staff on the resident's care, needs, and services) to provide continued psychosocial support (emotional and mental well-being care) for one of three residents (Resident 3) when Resident 3 was assaulted by another resident on 9/3/25 and the care plan indicated Social Services would follow up with Resident 3 once a week for ninety days, but the follow up was not implemented.This failure resulted in Resident 3 expressing fear of the resident who assaulted her and placed Resident 3 at risk for unmet psychosocial needs (the interaction between an individual's thoughts, emotions, behavior, and their social environment), increased anxiety, and delayed identification of emotional distress following the assault.Findings:Review of Resident 3's admission RECORD, indicated Resident 3 was admitted to the facility with diagnoses including schizoaffective disorder (mental illness with mood problems and altered thinking), parkinsonism (movement disorders causing tremors and stiffness), and presbyopia (age-related difficulty seeing up close).Review of Resident 3's Progress Note dated 9/3/25, indicated that Resident 3 was heard screaming around 1:50 PM in her room and staff found Resident 3 on her left side near the bathroom door in her room on the floor. Resident 3 stated that she was in the bathroom when another resident pulled her off the toilet, hit her, and pushed her down. Resident 3 was noted to have swelling and discoloration to her left eyebrow and left side of her lip.During an interview on 4/13/26 at 12:15 PM with Resident 3, Resident 3 stated another resident who was not her roommate entered her room, used her bathroom, then hit her on the face, causing her to fall to the floor. Resident 3 stated she was scared of the other resident.During a concurrent interview and record review on 4/13/26 at 12:57 PM, Resident 3's Progress Notes were reviewed with Licensed Nurse (LN) 1. Resident 3's Progress Note dated 9/3/25 at 3:29 PM, indicated that the Social Services Designee (SSD) followed up with Resident 3 following the assaultive incident on 9/3/25 at 1:05 PM. The SSD wrote that Resident 3 would be monitored one time a week for 90 days to observe for any psychosocial decline. LN 1 confirmed that there were no documented follow up notes in Resident 3's Progress Notes from the SSD through 12/2/25 to meet the weekly follow up for 90 days. Resident 3's care plan titled, Care Plan: WELLNESS CONSIDERATION initiated 9/3/25 was also reviewed with LN 1. In the section titled Focus indicated .9/3/25 Resident [Resident 3] hit by peer in the face. In the section titled Interventions/Tasks indicated .Social Services will follow up with [Resident 3] 1x [one time] a week for 90 days to observe any signs and symptoms of psychosocial decline. LN 1 stated that the care planned intervention to follow up one time a week for 90 days for Resident 3 was not implemented.During an interview on 4/13/26 at 3:35 PM with the SSD, the SSD stated that they (social services) failed to continue to follow up with Resident 3 after Resident 3 was assaulted by another resident on 9/3/25. The SSD stated that Resident 3's care plan requiring Social Services follow up one time a week for 90 days was not followed, which could place Resident 3 at risk for psychosocial decline by not recognizing early signs and symptoms of psychosocial decline and not providing timely support. During an interview on 4/13/26 at 3:42 PM with the Lead Social Services (LSS), the LSS stated that it was expected for the SSD to meet with residents involved in resident-to-resident altercations and follow up weekly, especially with a resident who was assaulted, to ensure psychosocial needs were met, safety was maintained, and psychosocial decline was prevented. During an interview on 4/13/26 at 3:50 PM with the Director of Nursing (DON), the DON stated when Social Services failed to follow up with residents who were involved in resident-to-resident altercations, psychosocial needs were not addressed.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 .Social Service staff is involved in the direct provision of psychosocial care and support of the involved residents.Social Service staff act as a resident advocate ensuring all rights (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are protected and their safety is ensured.Review of facility's policy and procedure (P&P), titled Management/Prevention of Assaultive Behavior dated 5/28/24, the P&P indicated .Social Service staff should meet with both residents to provide support.Review of facility's policy and procedure (P&P), titled CARE PLANNING revised on 10/28/17, the P&P indicated .A person-centered care plan to meet the individual needs of residents/clients is prepared by an Interdisciplinary Team [IDT - a team of different staff working together on the resident's care].IDT members include:.Other appropriate staff or professionals in disciplines as determined by the resident's needs.Care Planning shall include.mental and psychosocial needs.Develop care plan to be consistent with resident rights.or maintain the resident's highest practicable physical, mental, and psychosocial well-being