STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555307	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Healthcare Center	1517 East Knickerbocker Drive Stockton, CA 95210

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(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 Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50716 Based on observation, interview, and record review, the facility failed to implement individualized and effective interventions to protect one of four sampled residents, Resident 6, with known yelling behavior, from verbal threats of violence by her roommate (Resident 5), on 4/18/25. This failure resulted in Resident 6 screaming fearfully with a frightened look on her face, causing potential psychosocial distress. Findings: During an observation on 4/22/23 at 3:04 PM, in Resident 6's room, Resident 6 was heard calling out incoherently (words that are difficult to understand). Resident 6 stopped calling out when asked questions but did not answer any questions verbally or by gesture, including when asked her name. Resident 6 stared with a blank expression when asked questions and did not respond. Resident 6 was observed inside the room quiet and called out incoherent words when observed from outside the room. During an interview on 4/22/25 at 3:08 PM, Resident 7 stated that Resident 6 calls out a lot when she needs something. Resident 7 stated Resident 6 did not really talk. During an observation on 4/22/25 at 3:12 PM, in the hallway near Resident 6's room, Resident 6 could be heard calling out from her room. Nurses observed at the nurse ' s station did not respond to Resident 6 calling out. During an observation on 4/22/25 at 3:16 PM, Certified Nursing Assistant (CNA) 2, was observed going into Resident 6's room. CNA 2 was heard talking to Resident 6 in a language other than English, Resident 6 still did not respond to CNA 2 talking to her and continued to make incoherent sounds. During an interview on 4/22/25 at 5:07 PM, in the hallway outside of Resident 6's room, CNA 2 confirmed he went into Resident 6's room because she was calling out. CNA 2 stated Resident 6 called out all the time for assistance since Resident 6 did not understand how to use the call light. CNA 2 stated Resident 6 was mostly non-verbal (does not talk) but she used to say some words in English and another language. CNA 2 stated since Resident 6 could not express her needs, they tried to anticipate her needs, by making sure she was not soiled, and offered food/drinks. (continued on next page)

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 Note: The nursing home is disputing this citation.	During an interview on 4/22/25 at 5:15 PM, Licensed Nurse (LN) 3 stated she was familiar with Resident 6. LN 3 further stated, it was normal for Resident 6 to call out and stated it was Resident 6's baseline (normal behavior). LN 3 further explained Resident 6 was lonely and called out to have someone around her. LN 3 further stated calling out was Resident 6's way of talking because Resident 6 did not speak or get out of bed. During a telephone interview on 4/23/25 at 2:11 PM, CNA 3 stated on the evening shift of 4/18/25 at approximately 6:35 PM she was taking a dinner cart back to the cafeteria and on her way back she heard Resident 6 screaming. CNA 3 explained she was familiar with Resident 6, and stated the screaming was a frightened scream, very loud, and different from how she normally called out. CNA 3 further explained she quickly went into Resident 6's room and observed Resident 5 standing over Resident 6 on the side of Resident 6's bed. CNA 3 continued to explain Resident 5 had one of her fists up to Resident 6's face, and her other hand, holding Resident 6 down by the shoulder. CNA 3 stated she heard Resident 5 threaten Resident 6, .shut up, shut up, or else I'm going to give you this . to Resident 6. CNA 3 further stated Resident 5 was threatening to hit Resident 5 with her fist. CNA 3 explained Resident 6 looked surprised when CNA 3 entered the room and stopped screaming soon after. CNA 3 further explained she told Resident 5 to step away from Resident 6, and Resident 5 stated, shut up to CNA 3, but backed away from Resident 6, walked to her bed and laid down. CNA 3 stated Resident 5 was upset, agitated, and stated she was upset because she was tired from all the yelling and could not rest. Resident 5 further stated to CNA 3, she was there for hospice (end of life care) and could not have peace in a room with a resident who was loud. CNA 3 stated she acknowledged Resident 5's feelings and told her they would get another room for her. CNA 3 further stated she checked Resident 6 for physical injuries, there were none. CNA 3 stated Resident 6 still had a surprised look on her face and was quiet, she did not speak or answer questions but stated that was normal for her. CNA 3 stated she had another staff member stay with the residents so she could notify the supervisor of the incident. During an interview on 4/22/25 at 5:29 PM, LN 4 confirmed she was working on 4/18/25 during the evening shift. LN 4 stated she was notified of the incident and went into Resident 5 and Resident 6's room to investigate further. LN 4 further stated upon entering the room, Resident 5 was still very agitated. LN 4 explained Resident 5, and Resident 6 were separated but still in the same room, which was occupied by both residents. LN 4 stated Resident 6 had a frightened and fearful look on her face and laid in bed quietly, she did not answer any questions or say anything. LN 4 further explained Resident 5 was now calm and quiet. LN 4 stated Resident 5 had been known to previously get agitated at times, but had not had any incidents involving other residents that she could recall. LN 4 stated she was familiar with Resident 6 yelling out when someone passed her room, or when she needed something. LN 4 further stated calling out was Resident 6's way of communicating her needs. LN 4 stated after the incident, a room change was initiated for Resident 5. During a concurrent interview and record review on 4/22/25 at 5:38 PM, Resident 5's Plan of Care Note (a written record of events related to resident care) dated 4/19/25, was reviewed with LN 4. LN 4 confirmed she wrote the note which indicated, .Informed by CNA that patient [Resident 5] pushed down her roommate [Resident 6] by her shoulder with her fist up while the roommate [Resident 6] was lying in the bed in her room .and [Resident 5] said to stop or else I am going to hit you and when CNA tried to stop the patient [Resident 5] said to the CNA shut up .patient [Resident 5] appears a little aggressive and stated that she will hit the roommate [Resident 6] if she does not stop. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent observation and interview on 4/22/25 at 6:45 PM in Resident 5's room, Resident 5 was observed sitting on the edge of her bed. When asked if Resident 5 could recall her previous roommate and the incident on 4/18/25, Resident 5 stated she moved to a new room because her old roommate .yelled and yelled and yelled all the time Resident 5 further stated, .I was so mad at her I was going to punch her. I did punch her . Resident 5 further explained she was on hospice (a form of end-of-life care that provides comfort, support, and medical assistance to people) and deserved to have peace and quiet. Resident 5 could not recall if Resident 6 said or did anything but stated .it sure did make her shut up . During a concurrent interview and record review on 4/23/25 at 2:57 PM, the Director of Nursing (DON) stated he was informed about the incident between Resident 5 and Resident 6 by the ADM on 4/18/25 after it occurred. The DON reviewed Resident 6's, Care Plan, (a detailed individualized resident document outlining specific needs, goals and interventions to meet the goals), date initiated 5/13/21, which indicated, .Recurring behaviors: spitting on the floor, constant yelling out for staff throughout the day/night .Interventions/Tasks: Explain all procedures to resident before starting .If reasonable, discuss the residents, behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to resident When asked if the interventions were individualized to meet Resident 6's needs of calling out, the DON stated, yes, they were. The DON further explained if the facility talked to Resident 6 in another language, she would respond. When explained to the DON, staff were observed trying to talk to Resident 6 in another language she still did not respond. The DON then stated it would be beneficial to create new behavior monitoring with interventions that they were already doing and update Resident 6's care plan and monitoring to meet Resident 6's needs. The DON explained the importance of care plan interventions was to ensure the resident's care plan was followed, to see what was working for the resident, and what interventions needed to be revised to better fit their individualized needs. During a concurrent interview and record review on 4/23/25 at 2:57 PM, with the DON, the DON stated Resident 5 had never had any previous incidents of yelling or hurting other residents or staff. The DON reviewed Resident 5's orders and confirmed an order (a directive from a healthcare provider, such as a doctor, specifying instructions for patient care and treatment) dated 12/2/24, which indicated, .Behavior Monitoring for use of [medication name]; as m/b [manifested by] 1. Yelling out. Document Number of Episodes per shift . The DON reviewed Resident 5's Medication Administration Record, MAR - record used to document medications, treatments, or behaviors of a resident) dated 4/2025 and confirmed there were zero documented behaviors for 4/18/25. The DON could not explain an order to monitor a behavior of yelling out, but stated due to being on a behavioral medication something must have happened previously with Resident 5's behavior. The DON further stated the behaviors should have been documented on Resident 5's MAR on 4/18/25. The DON explained the importance of documentation was so the care team can monitor the behaviors of the residents to see if their medications were effective. The DON reviewed the room changes over the last 3 months for Resident 5 and confirmed Resident 5 had switched rooms for various reasons 6 times since January 2025. The DON stated Resident 5 was placed in the room with Resident 6 on 4/11/2025. During a telephone interview on 4/29/25 at 4:16 PM, the Social Services Director (SSD) confirmed Resident 5 had changed rooms 6 times on the following dates: 1/9/25 -for .Room consolidation 2/9/25 -for .Room consolidation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	3/7/25 -for .unknown type of roommate issue . 4/11/25 -for .a private room possibly due to a cough . 4/14/25 -for .Room consolidation . 4/18/25 .Due to incident with roommate . The SSD further stated room consolidation could be for several reasons including needing the room for a different gender. The SSD stated the room change for a roommate issue could be anything and was unable to find documentation of what occurred on 3/7/25. During an interview on 4/23/25 at 5:00 PM, the ADM stated he was alerted about the Resident-Resident incident on 4/18/25 shortly after it occurred. The ADM stated on 4/21/25 he checked in with Resident 6, who did not respond to him or answer questions. The ADM further stated he checked on Resident 5 and she confirmed to him that she just wanted Resident 6 to be quiet since she yelled so much. The ADM confirmed Resident 5 was on hospice care and room placement would be looked at moving forward, for hospice residents to help prevent future incidents. The ADM further stated creating specific interventions and monitoring for Resident 6 ' s behaviors of calling out should be addressed and documented. A review of Resident 5's clinical record titled, Order Details, dated 11/29/25, indicated, .Admit [Resident 5] to National Hospice . A review of Resident 5's clinical record titled, Order Details, dated, 12/2/24, indicated, .Behavior Monitoring for use of [medication]; as m/b [manifested by] 1. Yelling out. Document number of episodes . A review of Resident 5's clinical record titled, Order Details, initiated 5/13/21, indicated, .Behavior Monitoring for use of [medication]; as m/b 1. Yelling out 2. Physical aggression 3. Threathening [sic] behavior . A review of Resident 5's clinical record titled, Care Plan Report, dated 4/22/25, indicated, . [Resident 5] demonstrate physical aggression and threatening behavior towards roommate r/t [related to] Alzheimer ' s disease (a progressive disease that destroys memory and other important mental functions) . A review of Resident 6's clinical record titled, Care Plan Report, revised 2/14/22 under the section Focus, indicated, . [Resident 6] Recurring behaviors: spitting on floor, constant yelling out for staff throughout the day/night .Interventions/Tasks: Explain all procedures to resident before starting and allowing [Resident 6] to adjust to changes .If reasonable, discuss the resident ' s behavior. Explain/reinforce why behavior is inappropriate and/or unactable to [Resident 6] . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident .reflects currently recognized standards of practice for problem areas and conditions .Care plan interventions are chosen only after data gathering .careful consideration of the relationship between the residents problem areas and their causes .interventions address the underlying source(s) of the problem area(s), not just symptoms . A review of the facility P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, indicated, .Residents have the right to be free from abuse, neglect .This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse . Protect residents from abuse .by anyone including .other residents .Establish and maintain a culture of compassion and caring for all resident and particularly those with behavioral, cognitive or emotional problems .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50716 Based on observation, interview, and record review, the facility failed to implement the repositioning (turning) intervention to prevent pressure ulcer/injury (PU - areas of damaged skin typically caused by staying in one position for too long), for 4 of 5 sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4) who were assessed at risk for PU development. This failure had the potential for pressure ulcers to develop for Resident 1, Resident 2, Resident 3, and Resident 4. Findings: 1. Review of Resident 1 ' s clinical record titled, ADMISSION RECORD, indicated, Resident 1 was admitted with a diagnosis including, but not limited to, .HEMIPLEGIA AND HEMIPARESIS .AFFECTING RIGHT DOMINANT SIDE [weakness or total loss of movement on one side of the body] . During a concurrent observation and interview on 4/23/25 at 1:24 PM, in Resident 1 ' s room, Certified Nursing Assistant (CNA) 1, confirmed Resident 1 was dependent on staff for turning and repositioning in bed since Resident 1 was unable to move. CNA 1 further stated when the residents were turned and repositioned, they chart in the electronic health record (EHR -a digital collection of medication information that is stored and accessed electronically) to document the task was completed. Review of Resident 1 ' s clinical record titled Care Plan Report, initiated on 3/23/25, in the section Focus, indicated, . [Resident 1] is at risk for pressure injury development and skin breakdown r/t [related to] bony prominences [areas where bones are close to the skin ' s surface and have less cushioning from muscle and fat], weakness, impaired mobility, assistance from staff for bed mobility . The section Interventions/Tasks, initiated 3/25/25, indicated, .Turn and reposition q2h [every 2 hours] and PRN [as needed] . [Resident 1] is at risk for fall related to: weakness and being bed bound .ASSESSED FOR NEEDS: TOILETING, REPOSITIONING .Q2H [every two hours] . 2. Review of Resident 2 ' s clinical record titled, ADMISSION RECORD, indicated Resident 2 was admitted with a diagnosis including, but not limited to, .ANOXIC BRAIN DAMAGE [a brain injury from a complete lack of oxygen supply leading to brain cell death and potential impairment or disability] . During an interview on 4/23/25 at 2:05 PM, at Station 2, Licensed Nurse (LN) 1, Resident 2 was bed bound, non-verbal, and dependent on staff for all care including turning and repositioning every two hours. LN 1 explained the importance of a care plan was when something happens, for example, redness on the skin, they needed to care plan it. LN 1 stated the care plan was the plans for the residents care. LN 1 further stated the importance of doing the interventions on the care plans was to prevent a problem from occurring or reoccurring. LN 1 further explained the risk to the resident for not turning or repositioning a resident every two hours was: pressure ulcers, skin tears, moisture associated skin damage (MASD - a condition where the skin becomes inflamed and eroded due to prolonged exposure to various types of moisture, such as urine, feces, wound drainage, or sweating) and infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2 ' s clinical record titled, Care Plan Report, undated, in the section Focus, indicated, . [Resident 2] is at high risk for pressure injury development and skin breakdown r/t [related to] weakness, impaired mobility, assistance from staff for bed mobility .Interventions/Tasks .Reposition and turn Q2H [every two hours] and PRN [as needed] . 3. Review of Resident 3 ' s clinical record titled, ADMISSION RECORD, indicated Resident 3 was admitted with a diagnosis including, but not limited to, .PARAPLEGIA (inability to move the legs or lower part of the body) . During an interview on 4/23/25 at 2:40 PM, at Station 1, LN 2 confirmed Resident 3 was dependent on staff for turning/repositioning in bed, bathing, and dressing. Review of Resident 3 ' s clinical record titled, Care Plan Report, revised 2/25/25 indicated, .[Resident 3] admitted with pressure injury and is at risk for worsening of pressure injury due to compromised tissue damage r/t [related to] history of ulcers, decreased mobility, incontinence of bowel, muscle weakness, paraplegia [sic -paraplegia], Hx [history] of MVA [motor vehicle accident] .Interventions/tasks .Reposition and turn Q2H [every two hours] and PRN [as needed] . Review of Resident 3 ' s clinical record titled, SBAR [Situation, Background, Assessment, and Recommendation; a communication tool used to structure conversations] and INITIAL COC/ALERT [change of condition] CHARTING AND SKILLED DOCUMENTATION, dated 4/12/25, indicated, .During wound care, blanching redness [a temporary loss of color when pressure is applied to a red area, typically due to reduced blood flow to the area] to left hip noted . Review of Resident 3 ' s clinical record titled, SKIN ASSESSMENT (PRESSURE INJURY) dated 4/12/25, indicated, .Left trochanter (hip) Blanching Redness .Skin intact, blanching redness noted. Surrounded with small blisters . 4. Review of Resident 4 ' s facility provided, ADMISSION RECORD, indicated Resident 4 was admitted with diagnosis including, but not limited to, .OTHER ABNORMALITIES OF GAIT [walking] AND MOBILITY . During an interview on 4/23/25 at 2:40 PM, at Station 1, LN 2 confirmed Resident 4 was dependent on staff for all activities including turning/repositioning in bed, bathing, and dressing. LN 2 further stated Resident 4 required a two-person mechanical lift (a device used to assist with the movement and transfer of individuals who need help with mobility). Review of Resident 4 ' s clinical record titled, Care Plan Report, in the section Focus, revised 11/19/21, indicated, [Resident 4] .potential for impairment to skin integrity r/t [related to] decreased mobility, assist needed with bed mobility, Ischemic CVA [Cerebrovascular Accident - stroke, loss of blood flow to a part of the brain] with left sided weakness and left upper extremity contractures [loss of joint movement in the arm, wrist, or hand due to changes in non-bony tissues] .Blindness [the complete or severely reduced ability to see] .Always incontinent [lack of voluntary control over urination or defecation] of B [bladder] and B [bowel] . Intervention/Tasks .TURNING [and] REPOSITIONING EVERY 2 HOURS [and] PRN [as needed] . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4 ' s clinical record titled, Care Plan Report, in the section Focus, revised 10/03/23, indicated, Resident 4 is at risk for fall related injury r/t hx [history] of falls, impaired balance, readmitted with Dx [diagnosis]: L AKA [left above the knee amputation -a surgical procedure where a leg is removed above the knee] .Hx of ischemic stroke [when a blood vessel supplying blood to the brain is blocked, reducing or stopping blood flow] with left sided weakness .Poor trunk control .Interventions/tasks .Assess for needs: Toileting, repositioning .q2hours [every two hours] . During a concurrent interview and record review on 4/23/25 at 2:57 PM, the Director of Nursing (DON) reviewed the care plans for Resident 1, Resident 2, Resident 3, and Resident 4. The DON confirmed each resident had a care plan with an Intervention/Task of Turning and repositioning q2h. The DON reviewed the document titled, POC [point of care] Response History, for the date 4/15/25, which indicated, Task: TURNING [and] REPOSITIONING EVERY 2 HOURS [and] PRN. The times documented and reviewed with the DON for turning and repositioning Resident 1 on 4/15/25 were: 13:18 [1:18 PM], 20:11 [8:11 PM], and 22:00 [10 PM]. The DON confirmed there was no documented evidence that Resident 1 was turned and repositioned every two hours per Resident 1 ' s care plan. The times documented and reviewed with the DON for turning and repositioning Resident 2 on 4/15/25 were: 00:59 [12:59 AM], 01:02 AM, 03:28 AM, 05:13 AM, 13:39 [1:39 PM], 20:25 [8:25 PM], and 21:33 [9:33 PM]. The DON confirmed there was no documented evidence that Resident 2 was turned and repositioned every two hours per Resident 2 ' s care plan. The times documented and reviewed with the DON for turning and repositioning Resident 3 on 4/15/25 were: 02:10 AM, 06:24 AM, 19:09 [7:09 PM], 19:11 [7:11 PM], and 22:47 [10:47 PM]. The DON confirmed there was no documented evidence that Resident 3 was turned and repositioned every two hours per Resident 3 ' s care plan. The times documented and reviewed with the DON for turning and repositioning Resident 4 on 4/15/25 were: 02:11 AM, 6:24 AM, 19:11 [7:11 PM], 19:12 [7:12 PM], and 22:50 [10:50 PM]. The DON confirmed there was no documented evidence that Resident 4 was turned and repositioned every two hours per Resident 4 ' s care plan. The DON explained the documentation of the interventions was important because it gave an overview of what was happening with the residents during that time. The DON further stated care planned interventions were important because they ensured the residents problem area or concerns were being addressed to prevent worsening of conditions and not creating new problems. The DON confirmed the residents not being turned and repositioned every two hours per the care plan did not meet his expectations. Review of the facility policy and procedure (P&P) titled, Prevention of Pressure Ulcers/Injuries, revised 7/2017, indicated, .The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors .Review the residents care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable .Choose a frequency for repositioning based on the resident ' s mobility .skin condition and tolerance .At least every hour, reposition residents who are chair-bound or bed-bound .At least every two hours, reposition residents who are reclining and dependent on staff for repositioning .Reposition more frequently as needed . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility P&P titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident . reflects currently recognized standards of practice for problem areas and conditions .Care plan interventions are chosen only after data gathering .careful consideration of the relationship between the residents problem areas and their causes .interventions address the underlying source(s) of the problem area(s), not just symptoms .