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	06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to ensure Resident 1 who resided at the facility and was transferred to General Acute Care Hospital (GACH) was readmitted to the facility after Resident 1 was cleared by the GACH to return to the facility on 6/15/2025. This deficient practice resulted in Resident 1 remaining at the GACH after Resident 1 was deemed appropriate for discharge back to the facility but was denied readmission by the facility. Resident 1 did not return to the facility resulting in Resident 1's temporary loss of residence and had negative psychosocial outcome, as evidenced by vocalizations of emotional distress. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included generalized muscle weakness and paraplegia. Resident 1 was discharged from the facility on 6/14/2025. During an interview on 6/17/25 at 12:52 PM, License Nurse (LN) 1 stated Resident 1 went out of the facility without notifying a staff member and returned to the facility the same day on 6/14/25 at approximately 5:45 PM. LN 1 stated Resident 1 was sent to the hospital on 6/14/2025 after returning to the facility due to alcohol intoxication. During an interview on 6/17/25 at 1:37 PM, the Director of admission (DOA) stated when the facility sends the resident out for observation and the resident did not have a significant change, they can let them back in the facility, but if there is a significant change, it is up to the Director of Nursing (DON) and Administrator (ADM) if they can be readmitted to the facility. The DOA stated Resident 1 came back with an altered mental status (a change in a person's level of awareness, thinking, or behavior) and was not allowed to come back to the facility. The DOA stated they do not accept residents to be readmitted after signing the AMA (Against Medical Advice - leaving a healthcare facility against medical advice means a patient chooses to discontinue their treatment or leave the healthcare facility before their doctor recommends discharge) form but sometimes it is also a case-by-case basis. During an interview on 6/17/25 at 3 PM, the Director of Nursing (DON) stated when an alert and oriented resident goes out and does not come back before 12 midnight that is considered AMA. The DON stated he considers Resident 1 as AMA although he came back on the same day when he left. The DON stated if the resident wants to go home or leave the facility, the resident needs to sign the AMA form. The DON confirmed Resident 1 did not sign the AMA form. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/25 at 4:19 PM, the ADM stated AMA is for alert and oriented residents voluntarily leaving the facility against medical advice. The ADM stated if the resident refuse to sign the AMA form, they get two witnesses signatures. The ADM stated Resident 1 was not allowed to come back because he was AMA. The ADM stated Resident 1 did not sign the AMA. The ADM stated Resident 1 left the facility without staff ' s knowledge and they considered it AMA, but Resident 1 returned to the facility intoxicated and they sent him to the hospital for evaluation. The ADM stated Resident 1 was too intoxicated to make the decision to go to the hospital, the facility initiated sending Resident 1 to the emergency room, making it a facility-initiated discharge. During an interview on 6/19/25 at 12:31 PM, Resident 1 stated the facility kicked him out and he is still at the emergency room of the hospital. Resident 1 stated he left the facility about 1:30 PM on 6/14/25. Resident 1 stated all the nurses saw him leaving by the nursing station and when he came back, the next shift staff did not know that he left, and the facility sent him to the hospital. Resident 1 stated he has nowhere to go, and his family could not help him. Resident 1 stated the incident caused him a lot of emotional distress. A review of Resident 1's physician orders dated 6/14/25, indicated Resident 1 had an order Send out to [name of hospital] ER [emergency room] for further evaluation. A review of Resident 1's medical record titled, SBAR & INITIAL COC [change of condition]/ALERT CHARTING & SKILLED DOCUMENTATION, the record indicated .Patient was out of facility during AM shift and arrived back to facility PM shift at approx. [approximately] 1745 [5:45 PM]. Was accompanied by friend. Observed resident to be flushed in face, slurred speech, and exhibits slow movements. Speaking nonsense. Seen to be drinking from a cup covered by a paper bag. Refused VS [vital signs] to be taken. DON notified and said to send to ER for intoxication. Sent to [name of hospital] Hospital via [name of ambulance company]. MD [medical doctor] notified 6/14/2025 .Patient is own RP [responsible party] . A review of Resident 1 ' s medical records from the hospital, Nurses Notes, dated 5/15/25, indicated .Pt [patient] transferred to WC [wheelchair] per [emergency medical services], pt still refused to be seen in the ER. Pt states he wants to go back to his facility .Nursing Facility administrator called back regarding plan of care, per administrator, pt broke the rules by being drunk. Pt is apparently not welcome back to the facility at this time . A review of the facility ' s policy and procedure (P & P) titled, Transfer or Discharge, Facility-Initiated, dated 10/22, the P & P indicated .Residents who are sent emergently to an acute care setting, such as hospital, are permitted to return to the facility . If discharge is initiated by the facility after an emergency transfer to the hospital, the reason for discharge is based on the resident ' s status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care) .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure Resident 1 who resided at the facility and was transferred to a General Acute Care Hospital (GACH) was provided a notice of transfer or discharge and a notice of a bed hold during transfer to a GACH when: 1. The facility did not provide a written notice of bed hold (holding or reserving a resident ' s bed while the resident is absent from the facility for therapeutic leave or hospitalization) to Resident 1 at the time of transfer to acute care hospital; 2. Resident 1 was not notified of the discharge in writing and in a manner he/she understood; and, 3. The facility did not notify or send Resident 1's Notice of Transfer or Discharge form to the Ombudsman's office (a government appointed person who actively supports the rights of residents). These failures resulted in Resident 1 not being fully informed of their right to request a bed hold and to return to the facility after hospitalization, Resident 1 not having the opportunity to have had an advocate to inform him of his right to appeal a facility-initiated discharge, and Resident 1 ' s prolonged stay at the GACH emergency room and a temporary loss of residence resulting in emotional distress. Findings: 1. During a concurrent interview and record review on 6/17/25 at 1 PM, Resident 1 ' s medical record was reviewed with the Director of Nursing (DON). The DON stated Resident 1 did not have a bed hold and did not sign a bed hold prior to the hospital transfer on 6/14/25. The DON stated Resident 1 had chosen the option not to put a bed hold during admission and signed the Notice of Bed Hold Policy dated 8/16/23. The DON stated the Notice of Bed-hold is only signed one time during admission. The DON stated the resident was considered AMA (Against Medical Advice - leaving a healthcare facility against medical advice means a patient chooses to discontinue their treatment or leave the healthcare facility before their doctor recommends discharge) and that was why Resident 1 did not have a bed-hold. The DON confirmed Resident 1 did not sign the AMA form. During a concurrent interview and record review on 6/17/25 at 4:19 PM, Resident 1 ' s medical record was reviewed with the Administrator (ADM). The ADM stated they elected not to hold Resident 1 ' s bed because he signed do not hold my bed during admission. The ADM stated Resident 1 ' s Notice of Bed Hold Policy form was signed during his admission and was dated 8/16/23. The ADM stated residents signed the bed-hold notice form during admission or if they need to readmit a resident. A review of the facility ' s policy and procedure (P&P) titled, Bed-Holds and Returns, dated 10/22, the P&P indicated .Residents and/or representatives are informed (in writing) of the facility and stated (if applicable) bed-hold policies .1. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident ' s bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: 1. notice 1: well advance of any transfer (e.g., in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) . (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an online article published by the California Advocates for Nursing Home Reform (CANHR) titled, Nursing home residents have the right to a 7-day bed hold when hospitalized , dated 10/17, indicated, .In addition to including information about bed-hold policies in the admissions agreement, the facility must give a written bed-hold notice to the resident and/or the resident ' s family upon being transferred to the hospital, as is required by both federal law and state regulations . (https://canhr.org/nursing-home-residents-have-the-right-to-a7-day-bed-hold-when-hospitalized /) 2. During an interview on 6/17/25 at 3 PM, the DON stated they have not sent the notice of transfer and discharge because the resident was not in their building. During an interview on 6/17/25 at 4:19 PM the ADM stated resident left the facility without staff ' s knowledge and they considered it AMA, but the resident returned to the facility intoxicated and they sent him to the hospital for evaluation. The ADM stated Resident 1 was too intoxicated to make the decision to go to the hospital, so the facility initiated it for him making it a facility-initiated discharge. The ADM stated Resident 1 was not issued a notice of transfer or discharge when he was transferred to the hospital. 3. During a concurrent interview and record review on 6/17/25 at 1 PM, the DON stated they have not sent the notice of discharge/transfer to the ombudsman ' s office. A review of the facility ' s P&P titled, Transfer or Discharge, Facility-Initiated, dated 10/22, the P&P indicated, .Notice of Transfer or Discharge (Emergent or Therapeutic Leave) .4. Residents who are sent emergently to an acute care setting, such as hospital, are permitted to return to the facility .5. Under the following circumstances, the notice is given as soon as it is practicable .c. An immediate transfer or discharge is required by the resident ' s urgent medical needs .Notice of Discharge after Transfer 1. If discharge is initiated by the facility after an emergency transfer to the hospital, the reason for discharge is based on the resident ' s status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care). 2. If the facility does not permit a resident ' s return to the facility (i.e., initiates a discharge) based on inability to meet the resident ' s needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights. 3. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. 4. Notice to the Office of the State LTC Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative . (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an online article published by the California Advocates for Nursing Home Reform (CANHR) titled TRANSFER AND DISCHARGE RIGHTS, updated 9/4/24, the article indicated, .Written Notice Before transferring or discharging a resident, the facility must provide written notice to the resident and the resident ' s representative in a language and manner they understand . The facility must send a copy of the notice to the long-term care ombudsman program. Except when specified below, the notice must be given at least 30 days before the resident is transferred or discharged . Exceptions to 30-Day Notice .there are a few exceptions to the 30-day notice requirement. Federal regulations permit notice to be made as soon as practicable before transfer or discharge when: the health or safety of individuals in the facility would be endangered; the resident ' s urgent medical needs require a more immediate transfer; the resident ' s health has improved sufficiently to allow a more immediate transfer or discharge; or the resident has resided in the facility less than 30 days . Even if an exception to the 30-day notice requirement is satisfied, the facility must nevertheless provide written notice in advance of a proposed transfer or discharge and an opportunity to appeal .California law requires nursing homes to give reasonable advance notice in writing in all cases of transfer or discharge . (https://canhr.org/transfer-and-discharge-rights/)