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	07/02/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure that accommodation of needs was met when call lights (system/device used by residents to call staff for assistance) were not answered in a timely manner for 2 of the 4 sampled residents (Resident 1, and Resident 3). This failure had the potential for residents' needs to be neglected and to negatively affect their psychosocial well-being for a census of 119. Findings: During a concurrent observation and interview on 7/2/25 at 10:51 AM, Resident 1 stated he waited too long for his incontinent brief (a type of absorbent undergarment) to get changed and the staff does not come on time when he uses the call light. Resident 1 stated even in the morning or evening time they still take longer to come when he presses the call light. At 10:58 AM Resident 1's call light was pressed because Resident 1 needed assistance to move from the bed and by 11:18 AM, there was still no response from staff. A review of Resident 1's Care Plan titled, ADL [Activities of Daily Living] Self Care Performance deficit r/t [related to] weakness, impaired mobility, stroke with right sided weakness [damage to the brain from interruption of its blood supply]. Resident 1's interventions included, Encourage the resident to use call light to call for assistance. TOILETING: Resident requires substantial/maximal assistance. During an interview on 7/2/25 at 11:38 AM, Resident 2 stated it took a little while for the staff to answer the call light, sometimes the waiting times were around 30-40 minutes. During an observation on 7/2/25 at 11:19 AM, in the hallway, Resident 3's call light was turned on. At 11:28 AM the call light was answered by the medical records director who then asked the nursing staff to assist Resident 3. During an interview on 7/2/25 at 11:47 AM, Resident 3 stated he used the call light to ask for assistance and sometimes it took 30 minutes for the staff to respond. Resident 3 stated for a BM (bowel movement), he used the bedpan and sometimes he went to the toilet with assistance. Resident 3 stated he also used an incontinent brief and needed help from staff. During an observation on 7/2/25 at 1:39 PM, Resident 3's room was observed to have the call light turned on and staff responded to the call-light at 1:51 PM. A review of Resident 3's admission RECORD, indicated Resident 3 had a diagnosis of generalized muscle weakness, and other abnormalities of gait and mobility. During an interview on 7/2/25 at 12:10 PM, Resident 4 stated she used an incontinent brief during the daytime, and she went to the toilet with assistance. Resident 4 stated the staff today is taking too slow to answer the call light. Resident 4 stated the longest time she had to wait was 20 minutes. Resident 4 stated, during the evening shift the wait times for the call light response is longer. During an interview on 7/2/25 at 3 PM, the Assistant Director of Nursing (ADON) stated her expectations were for staff to answer the call lights within 1-2 minutes or at least less than 5 minutes. The ADON stated 15 minutes or more was too long. The ADON stated if the residents' incontinent brief was not changed on time or if they were not being toileted, there would be a risk for a UTI (urinary tract infection - an infection that can make it painful and uncomfortable to urinate), skin breakdown, and the residents could get up by themselves and they could fall. The ADON stated that the resident's dignity could also be affected if a continent (ability to voluntarily retain and release urine and feces) resident that needs assistance in going to the bathroom was not toileted on time, and they will have no choice but to urinate on the bed. A review of an undated facility document titled, Call Lights, indicated, .To assure residents receive prompt assistance. All staff shall know how to place the call light for a resident and how to use the call light system.Nursing and Care Duties.3. Monitoring the lights and making sure that lights are answered promptly, regardless of who is assigned to each resident.

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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 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. Based on interview and record review, the facility failed to ensure transportation was provided for two out of four sampled residents (Resident 1 and Resident 4), when Resident 1 missed a scheduled physician's appointment on 6/26/2025 at 11 AM and Resident 4 arrived late to a scheduled appointment on 6/20/25 and was not able to be seen. This failure resulted in Resident 1 and Resident 4 missing a scheduled physician's appointment. Findings:1. A review of Resident 1's admission RECORD (a document that contains the resident's demographic information) indicated Resident 1 had a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (one side of the body becomes very weak or completely unable to move or paralyzed) and generalized muscle weakness. During an interview on 7/2/25 at 10:54 AM, Family Member (FM) 1 stated Resident 1 had an appointment with his primary care provider on June 26 at 11 AM, but the appointment was rescheduled because Resident 1 missed the appointment due to transportation issues. During an interview on 7/2/25 at 2 PM, the Receptionist stated she was not notified until the day of Resident 1's appointment on 6/26/25. The receptionist stated she arranged the transportation on 6/26/25 and when the transport came, Resident 1 was not ready to go yet, and that was why Resident 1 missed his appointment. During an interview on 7/2/25 at 2:24 PM, the Social Service Director (SSD) stated Resident 1 missed his appointment on 6/26/25. The SSD stated the charge nurse that was assigned to Resident 1 that day was not aware that Resident 1 had an appointment scheduled. The SSD stated Resident 1 used the facility owned transportation for medical appointments. A review of Resident 1's physician's orders, dated 6/4/25, indicated, .Appointment with [primary care physician] on 6/26/25 @ [at] 11 AM . A review of Resident 1's Progress Note dated 6/26/25, indicated, .Received call from Pt's [patient's family member]. [Family member] inquired why Pt was unable to make appointment this AM. Notified that d/t [due to] transport servicing another resident, this appointment would have to be rescheduled. 2. A review of Resident 4's admission RECORD, indicated Resident 4 had a diagnosis of fracture of the upper end of the left tibia (broken left shinbone, near the knee), sprain of the left foot, generalized muscle weakness, and other abnormalities of gait and mobility. During an interview on 7/2/25 at 12:10 PM, Resident 4 stated she missed her appointment with the orthopedic doctor (doctors who focus on caring for the bones, joints, ligaments, nerves, and tendons [the tissue that connects bones and joints]) on 6/20/25, and it was rescheduled to 6/24/25. Resident 4 stated she was picked up late by transportation and when she got to her appointment, she was told she had missed her appointment time by half an hour, and the doctor could no longer see her on that day. Resident 4 stated the transportation used for her appointments was owned by the facility. Resident 4 stated she feels like she was not important when the transportation did not prioritize her scheduled pick up. A review of Resident 4's medical record, indicated in the physician's order list, . RESCHEDULED Appointment with [orthopedic doctor] on 6-24-25 at [time], [address]. Facility TRANSPORTATION . During an interview on 7/2/25 at 1:23 PM, License Nurse (LN) 1 stated it was the nurse's responsibility to check if any of their assigned residents had an appointment for the day. During an interview on 7/2/25 at 3:30 PM, the Assistant Director of Nursing (ADON) stated that there was miscommunication among the staff regarding appointments. The ADON stated both the LN's and Certified Nursing Assistants were responsible for checking the residents' appointments. The ADON stated if a resident missed their appointment, there would be an interruption in the residents' care. A review of undated facility document titled, Transportation, Social Services, indicated, Policy Statement Our facility shall help arrange transportation for residents as needed.Except in emergencies, the resident or his or her representative (sponsor) shall be expected to arrange for transportation (e.g., to outside physician or clinic appointments or for a planned transfer or discharge from the facility) .