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	11/13/2025

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 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. (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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(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	Based on interview, and record review, the facility failed to ensure one out of three sampled residents (Resident 1) was assisted with transportation arrangements to attend a post-surgery appointment on 9/4/2025.This failure resulted in Resident 1 missing a scheduled physician's appointment and caused a delay in care and treatment.Findings:A review of Resident 1's admission RECORD, indicated Resident 1 had diagnoses which included amputation (removal of a limb or other body part by surgery), complications of amputation stump (the remaining part of a limb after it has been surgically removed), and orthopedic aftercare following surgical amputation (care given to the resident, usually by the surgeon who performed the surgery).During a telephone interview on 9/10/25, at 9:24 AM, with the Medical Receptionist (MR) at Resident 1's surgeon's office, the MR stated that Resident 1 did not show up for her appointment on September 4, and it was rescheduled for September 11.During an interview on 9/9/25, at 10:47 AM, with Resident 1 and utilizing Licensed Nurse (LN) 1 as an interpreter, Resident 1 stated she missed one doctor's appointment, and it was rescheduled. Resident 1 stated she used her communication board when there was no Spanish speaking staff.During a follow-up interview on 9/10/25, at 9:50 AM with Resident 1 and LN 1 as an interpreter, Resident 1 stated she did not go to the appointment on 9/4/25 because facility staff told her she needed a CNA (certified nursing assistant) or RNA (Restorative Nursing Assistant) to go with her but no one was available. Resident 1 stated they did not tell her why she needed somebody to accompany her. Resident 1 stated she did not know if the facility asked her son to accompany her to the appointment.During an interview on 9/10/25, at 11:09 AM, with Resident 1's responsible party (RP), and LN 1 as a translator, the RP stated the facility did call him and asked if he could accompany Resident 1 to the appointment as a translator but he did not know how to speak and understand English so he could not be a translator.During a concurrent interview and record review on 9/9/25, at 12:56 PM, with the Treatment Nurse (TN), the TN stated she made sure that she followed up with the receptionist or the scheduler to schedule follow up appointments for the residents with surgical wounds. The TN stated Resident 1 was sent to the hospital on 7/30/25 for evaluation of the gangrene (a serious condition where tissue dies due to a lack of blood supply or infection) on her lower extremities (refers to the legs, hips, thighs, knees, lower legs, ankles, and feet) and possible amputation. The TN stated based on Resident 1's medical record, both of Resident 1's lower extremities (BKA-below the knee amputation) were amputated on 8/4/25 and Resident 1 came back to the facility on 8/12/25. The TN stated Resident 1 had a combination of staples and sutures (medical methods for closing wounds by holding the skin edges together) on both stumps. The TN stated follow up appointments post-surgery were usually scheduled 1-2 weeks after the surgery.During a concurrent interview and record review on 9/9/25, at 1:49 PM, with the Receptionist, the Receptionist stated she received the follow up appointment order from the TN for Resident 1, but she was told Resident 1 needed a Spanish interpreter to translate during the doctor's appointment. The Receptionist stated Resident 1 missed her appointment because the facility was looking for a Spanish speaking staff to accompany her. The Receptionist stated it was her understanding that Resident 1 was just late for the appointment. During a concurrent interview and record review on 9/9/25, at 2:22 PM, with the Assistant Director of Nursing (ADON), the ADON stated there should be a staff member or family member accompanying Resident 1 to her appointment and the facility tried to send staff that spoke Resident 1's language to interpret for Resident 1. The ADON stated she expected the receptionist to make sure that a family member was available to go with Resident 1 or to let the nursing staff know in advance if a nursing staff member was needed. ADON stated if a resident missed their appointment, it could prolong the care and treatment of the resident. During a follow up interview on 9/10/25, at 10:14 AM, with the ADON, the ADON stated that the RN Supervisor told Resident 1 that no one was available to go with her to her appointment that speaks her language. The ADON stated she thought that the facility did not need to send a translator because the doctor's office would have their own translator services and Resident 1 should have gone to the appointment. The ADON stated that follow-up appointments should be made within 2 weeks to remove the staples because otherwise it could cause an infection. During an interview on 9/9/25, at 2:50 PM, with LN 2, LN 2 stated Resident 1's appointment on 9/4/25 was to check the staples and check for possible removal. LN 2 stated the facility could not send a nursing staff member as a translator that day. LN 2 stated that the nurses and the receptionist must coordinate calls to family members for resident appointments. LN 2 stated if a resident missed a doctor's appointment, there would be a delay in care for the resident.During a concurrent interview and record review on 9/10/25, at 10:03 AM, with the