

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Clearwater Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 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.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to protect the rights of one of three sampled residents (Resident 2) to be free from physical abuse when, Resident 2, who was on continuous one-to-one (1:1 - a high-level intervention where a staff member provides continuous, direct observation of a single patient to prevent harm to themselves or others) observation, was punched in the chest by Resident 3, while Resident 2 wandered into Resident's 3's room unattended on 7/26/25. This failure had the potential to result in physical and psychosocial distress (state of emotional and psychological discomfort that can impact a person's well-being) to Resident 2. Findings: A review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with a diagnosis of, . UNSPECIFIED DEMENTIA [a condition characterized by a gradual decline in memory, language, reasoning, and problem-solving, that interferes with daily life] . WITH OTHER BEHAVIORAL DISTURBANCE . A review of Resident 2's Minimum Data Set, (MDS - a resident assessment tool) dated 6/18/25, indicated Resident 2's cognitive skills (the mental abilities and functions the brain uses to think, learn, remember, pay attention, process information and solve problems) for daily decision making was severely impaired (a significant decline in a person's mental capacity that affects their ability to function independently in daily life, typically requires substantial supervision or assistance). During a concurrent observation and interview on 9/10/25, at 1:23 PM, in Resident 2's room, with Certified Nursing Assistant (CNA) 1 and Resident 2, CNA 1 confirmed Resident 2 was on 1:1 observation. CNA 1 stated her job was to sit with Resident 2 because he was, confused and walks into everyone's room. CNA 1 further stated Resident 2 had a staff member always watching him. Resident 2 was observed awake, calm, and lying in bed. When Resident 2 was asked what happened, Resident 2 did not recall being punched in the chest on 7/26/25. During an interview on 9/10/25, at 1:34 PM, outside of Resident 2's room, (CNA) 2 stated the facility expectation when a resident was on a 1:1 was for safety reasons and to never leave the resident alone. CNA 2 further stated the procedure was to have another staff member relieve them if the staff had to take a break or do something else, CNA 2 explained that did not always happen. CNA 2 stated that when residents who were on 1:1 were left alone, something bad could happen, for example, the resident could fall, get hurt by another resident, or walk out of the facility. During an interview on 9/10/25, at 1:47 PM, Licensed Nurse (LN) 1 stated she was working on 7/26/25 when around 2:45 PM she heard a commotion coming from the hallway. LN 1 stated she came out of a nearby room and observed CNA 3 in the hallway with both Resident 2 and Resident 3. LN 1 stated CNA 3 reported she observed Resident 3 punch Resident 2 in the chest. LN 1 explained that Resident 2 was supposed to have a 1:1 staff member with him while he walked around the unit but confirmed when Resident 2 was punched, staff was not with him. LN 1 stated Resident 2 was on 1:1 observation to prevent something like this incident from happening. LN 1 further stated the abuse could have been prevented if the 1:1 staff member was with Resident 2. During an interview on 9/10/25 at 3:06 PM, CNA 3 stated on 7/26/25 around 2:40 PM she was walking in the hallway near Resident 3's room and saw Resident 3 and Resident 2 in the doorway. CNA 3 further stated she could hear Resident 3 become agitated and yell at Resident 2, and then she observed Resident 3 lunge forward and punch Resident 2 in the chest. CNA 3 stated after the punch happened, she noticed Resident 3 lost his balance and CNA 3 went quickly toward him and caught him and assisted him to the ground. CNA 3 further stated that CNA 4 also witnessed the incident and came quickly to assist from another direction. CNA 3 stated CNA 4 re-directed Resident 2 to walk away, and he did. CNA 3 confirmed Resident 2 did not have a 1:1 staff member with him. During an interview on 9/10/25, at 4:41 PM, CNA 4 was able to recall the incident between Resident 2 and Resident 3 on 7/26/25. CNA 4 stated Resident 2 was walking around the unit when she heard Resident 3 say something loudly to Resident 2. CNA 4 stated she observed Resident 3 come to the doorway of his room, approach Resident 2, and punched Resident 2 in the chest. CNA 4 confirmed Resident 2 did not have a 1:1 staff member present with him at the time of the incident. During a concurrent interview and record review on 9/10/25, at 3:40 PM, the acting Social Services Director (SSD) reviewed Resident 2's electronic health record (EHR -a digital record of a patient's health information). The SSD reviewed Resident 2's progress notes (ongoing records documented by healthcare professionals that track a patient's illness, treatment and progress over time) and stated the records indicated Resident 2 was placed on 1:1 observation on 7/24/25 due to an incident that occurred on 7/23/25 when Resident 2 was found wandering the facility, hitting staff members, going into other resident's room, and tried to escape the facility. During an interview on 9/10/25 at 3:29 PM the Charge Nurse (LN) 2 stated the procedure in the facility</p>		