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	12/30/2025

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. (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

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	12/30/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to safely discharge on e of one sampled resident (Resident 1) home with home health agency services (HHA, medical services provided at home) when Resident 1 was discharged home on [DATE], and the home health agency notified the facility they could not start home health services on 12/18/25.This failure had resulted in Resident 1's lack of home health services that caused a delay in the continuity of care following her discharge from the facility and had the potential risk for falls, injuries, and of readmission.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in late 2025 with diagnoses that included displaced fracture of left femur (a broken left thighbone where the pieces have shifted out of alignment) and generalized muscle weakness. Review of Resident 1's doctor's orders indicated the following orders: a.Discharge to home with support on 12/17/25 following cessation [discontinued] of skilled services [high level healthcare tasks that must be performed or supervised by licensed professionals]. b.Occupational Therapy [OT, helps people of all ages do the daily activities (occupations) they need and want to do by improving skills, adapting environments, or changing approaches to enhance independence and quality of life] Clarification effective 12/10/25: Skilled OT 5x/week x [[NAME] times a week for] 8 weeks.c.P.T. [Physical therapy, helps residents improve movement, strength, and balance to regain independence after illness or injury, using exercises, stretches, and assistive devices] clarification of treatment orders.Treatment plan to include: therapeutic exs, therapeutic activities. 5x/wk x 8 weeks.Review of Resident 1's discharge physician orders dated 12/15/25, indicated the following:a.Discharge Disposition: Home.b.Home Health Services Provided: PT [Physical Therapy], RN [Registered Nurse], HHA [Home Health Agency] , Social Worker. c.DME [Durable medical device] needed at home: HSB [hospital bed] with boxes checked for - Physical therapy evaluation and treatment for gait balance and safety measures.RN [registered nurse] for evaluation and instructions for medication, anticoagulation [medicines that prevent blood clots from forming], and pain management.Patient instructed to make follow-up appointment with primary care physician 3-7 days after discharge.Review of Resident 1's Social Services Progress Notes and Activities Progress Notes reports indicated the following: a. 12/12/25 Social Services Progress Notes - .SS [social services] assessment and discharge planning were discussed with resident and her friends ([Resident 1's Emergency Contact] & spouse) at bedside. Per resident, she lives alone with care support as needed from her friend [Resident 1's Emergency Contact].Resident and friends were advised of her short term inpatient rehab for skills need for PT/OT with no projected date yet.b. 12/15/25 Social Services Progress Notes - .Per resident, she no longer wants to continue to stay in the facility to continue rehab and would rather return home with support from her friends.Resident and her friends were informed that because her insurance has not yet sent a LCD [Local Coverage Determination- a decision made by Medicare for insurance coverage], it would be a per preference discharge home with home health services as needed. c. 12/17/25 Activities Progress Notes - .Resident is alert and oriented, can make needs known. She is short term stay, here for rehab.Lives alone.Has caregiver that comes Tuesday and Friday.She is legally blind.Plan discharge is today. d. 12/18/25 Social Services Progress Notes - .SSD was informed by the rep from [HOME HEALTH AGENCY NAME] that they were unable to open the resident for services Per the resident's PCP, resident has not been seen by her PCP for over a year and more so it would require for the resident to follow-up with PCP to establish care again before services can start. During an interview on 12/19/25, at 9:48 a.m., with Licensed Nurse (LN), LN stated Resident 1 was admitted to the facility on [DATE] and was discharged on 12/17/25. LN 1 further stated Resident 1 was considered a short term stay for rehabilitative services following a surgery of a fracture on her left femur at the hospital. LN stated she was the nurse that discharged the resident on 12/17/25 and was notified of the discharge during the change of shift report. LN further stated usually the resident's doctor would order for the discharge and then the social services (SS) and case manager (CM) would start the discharge process. LN stated the SS coordinated with the resident and family and would have sent out the referrals needed for discharge. LN further stated Resident 1 was discharged to her home with her friend present to drive her on 12/17/25. LN stated residents could be discharged home without anyone living with them if they were capable and were provided with HHA services. LN further stated she was not sure if Resident 1's friend lived with her. LN stated it was important to follow the discharge process to know where the residents were getting discharged to, if they were ready and if they were safe for discharge. LN further stated the risk of an unsafe discharge