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	01/28/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) at risk of wandering/elopement received adequate supervision to prevent an elopement (when a resident leaves the facility without supervision) from occurring, when:1. Resident 1 did not have a care plan (a personalized, living document developed by healthcare professionals, patients, and families to manage health conditions, define care needs, and establish goals for daily living, treatment, and support) developed to address his known drug use; and,2. Resident 1 left the facility unsupervised with staff unaware of his location on 1/25/26.These failures had the potential to cause psychosocial harm and/or potential injury to Resident 1.Findings:1. A review of Resident 1's admission RECORD, dated 1/27/26, indicated Resident 1 was admitted to the facility in January of 2026 with a diagnosis of, but not limited to, sepsis (a life-threatening emergency caused by the body's extreme, dysfunctional immune response to infection, leading to tissue damage, organ failure, and potential death), acute osteomyelitis of the right ankle and foot (a serious, rapid-onset infection and inflammation of the bone, often caused by the bacteria Staphylococcus aureus), and type 2 diabetes mellitus (a chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells cannot effectively use insulin).During a review of Resident 1's [ACUTE HOSPITAL NAME] History and Physical (H&P), dated 1/15/26, the H&P indicated, Resident 1 had a history of recent Methamphetamine (Meth- a type of drug that lets people stay awake and do continuous activity with less need for sleep) drug use.During a concurrent interview and record review on 1/27/26, at 3:20 PM, with the Social Services Director (SDD), Resident 1's electronic health record (EHR) was reviewed. The SSD confirmed that Resident 1 had a history of drug use. The SSD stated she must have missed reading that information and upon reading it again, she stated she would have developed a care plan and got Resident 1 a psychiatric consultation (an in-depth evaluation of mental, emotional, and physical health, typically involving comprehensive interviews to assess symptoms, review history, and establish a diagnosis) as well to address his health care needs. The SSD further stated a care plan and psychiatric consultation was not completed for Resident 1. The SSD stated Resident 1 would want to leave the facility and get in contact with his drug supplier if the interventions were not put in place.During a concurrent interview and record review on 1/28/26, at 11:50 AM, with the Assistant Director of Nursing (ADON), Resident 1's care plans were reviewed. The ADON confirmed that the facility staff did not create or develop a care plan for Resident 1's known history of drug use. The ADON stated that care plans were important because they helped to develop a resident's plan of care so the staff would know what goals and interventions were needed to meet specific resident needs. The ADON further stated if care plans were not developed, the staff would not have a detailed plan of care to best meet the needs of a resident. The ADON stated that care plans provided guidance for the staff.During a review of the facility's policy and procedure (P&P) titled, Care Plans - Baseline, revised 12/16, the P&P indicated, .A baseline plan of care to meet the resident's (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediate needs shall be developed for each resident within forty-eight (48) hours of admission.During a review of the facility's P&P titled, Wandering and Elopements, revised 7/17, the P&P indicated, .If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.2. During a phone interview on 1/27/26, at 2:11 PM, with Licensed Nurse (LN) 4, LN 4 stated Resident 1 had asked for a lighter to smoke cigarettes during the early morning medication pass on 1/25/26. LN 4 further stated she told Resident 1 that she did not have access to a lighter at that time in the morning. LN 4 stated Resident 1 then proceeded to pack his belongings while she continued her medication pass. LN 4 further stated that around 5:15 AM, she went to Resident 1's room and he was longer there. LN 4 explained that she looked for Resident 1 throughout the building but was unable to locate Resident 1. LN 4 stated she then proceeded to report the missing whereabouts of Resident 1 to the ADON and LN 5.During a phone interview on 1/27/26, at 2:25 PM, with LN 5, LN 5 stated she contacted the ADON and the Director of Nursing (DON) to inform them of the situation that Resident 1 was not in the building. LN 5 further stated she reviewed the facility camera footage and confirmed that Resident 1 left the outside gate of the facility at 4:57 AM on 1/25/26. LN 5 stated that it was dangerous for Resident 1 to leave the facility because he had a peripherally inserted central catheter line (PICC- a thin, flexible tube inserted into an arm vein and advanced to a large vein near the heart for long-term [weeks/months] IV treatments like antibiotics, chemotherapy, or nutrition). During a phone interview on 1/27/26, at 9:35 AM, with Family Member (FM) 1, FM 1 stated Resident 1 was known to be homeless and had a long history of drug use. FM 1 further stated Resident 1 walked approximately 20 miles (a unit for measuring distance) from the facility to FM 2's house and arrived around 8:30 AM on 1/26/26. FM 1 stated Resident 1 complained of foot pain to her. FM 1 further stated Resident 1 had a pair of scissors and was possibly trying to remove the PICC line. FM 1 stated after leaving the facility that Resident 1 went to go do drugs before arriving at FM 2's house on 1/26/26. Resident 1 was unaccounted for approximately 27 hours and 30 minutes. FM 1 further stated it was not safe for Resident 1 to leave the facility. FM 1 explained Resident 1 was currently at a local hospital.During an interview on 1/27/26, at 11:44 AM, with LN 1, LN 1 stated that she was surprised Resident 1 had left the facility. LN 1 further stated that it could have been very dangerous for Resident 1 to leave the facility as he was receiving antibiotics through the PICC line. LN 1 stated Resident 1's heart could be impacted, and his infection could have gotten worse.During an interview on 1/28/26, at 11:50 AM, with the ADON, the ADON stated that part of the facility's elopement process when a resident eloped was to contact the Department, the police department, the Ombudsman (an independent, neutral official who investigates, reports on, and helps settle complaints against organizations, acting as a confidential advocate for fairness), and other key personnel of the facility including the DON and the Administrator (ADM). The ADON further stated that she contacted both the DON and the ADM around 7:20 AM on 1/25/26 that Resident 1 was not in the building. The ADON stated the facility was not located in a safe area of town, and it was cold and dark at the time Resident 1 left the facility. The ADON further stated Resident 1 had a PICC line and he had a history of drug use. The ADON stated that she was worried about the safety of Resident 1 and could not confirm if he was safe as the facility staff did not know where he was.During an interview on 1/27/26, at 2:55 PM, with the ADM, the ADM confirmed that he did not contact the Department, the Ombudsman, or Adult Protective Services (an agency that provides intervention services to protect elderly and dependent adults) after Resident 1 had left the faciity on 1/25/26. The ADM stated that it would be difficult for the facility to determine if Resident 1 was safe.During an interview on 1/28/26, at 1:20 PM, with the Medical Director (MD), the MD (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that she did not make an order to discharge Resident 1. The MD further stated Resident 1 had a long-time history of drug use. The MD stated Resident 1 tested positive for Meth use at [ACUTE HOSPITAL NAME] where she worked. The MD further stated Resident 1 left the facility to go smoke Meth with his friends.During a review of the facility's P&P titled, Unusual Occurrence Reporting, revised 12/07, the P&P indicated, .As required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety or welfare of our residents, employees, or visitors.Our facility will report the following events to appropriate agencies.Other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors.Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations.A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, and record review, the facility staff failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of two sampled residents (Resident 1) when the substance use history section of Resident 1's admission nursing assessment was inaccurately documented.This deficient practice had the potential to result in confusion in the care and services for Resident 1 and placed Resident 1 at risk of not receiving appropriate care due to inaccurate and incomplete documentation.Findings:A review of Resident 1's admission RECORD, dated 1/27/26, indicated Resident 1 was admitted to the facility in January of 2026 with a diagnosis of, but not limited to, sepsis (a life-threatening emergency caused by the body's extreme, dysfunctional immune response to infection, leading to tissue damage, organ failure, and potential death), acute osteomyelitis of the right ankle and foot (a serious, rapid-onset infection and inflammation of the bone, often caused by the bacteria Staphylococcus aureus), and type 2 diabetes mellitus (a chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells cannot effectively use insulin).During a review of Resident 1's [ACUTE HOSPITAL NAME] History and Physical (H&P), dated 1/15/26, the H&P indicated, Resident 1 had a history of recent Methamphetamine (Meth- a type of drug that lets people stay awake and do continuous activity with less need for sleep) drug use.During a review of Resident 1's admission NURSING ASSESSMENT, dated 1/16/26, the assessment indicated, Resident 1 never used drugs under the substance use history section.During a concurrent interview and record review on 1/27/26, at 3:20 PM, with the Social Services Director (SSD), Resident 1's electronic health record (EHR) was reviewed. The SSD confirmed that Resident 1 had a history of drug use. The SSD stated she must have missed reading that information and upon reading it again, she stated she would have developed a care plan (a personalized, living document developed by healthcare professionals, patients, and families to manage health conditions, define care needs, and establish goals for daily living, treatment, and support) and got Resident 1 a psychiatric consultation (an in-depth evaluation of mental, emotional, and physical health, typically involving comprehensive interviews to assess symptoms, review history, and establish a diagnosis) as well to address his health care needs. The SSD further stated that a care plan and psychiatric consultation were not completed for Resident 1. The SSD stated that Resident 1 would want to leave the facility and get in contact with his drug supplier if the interventions were not put in place.During a concurrent interview and record review on 1/28/26, at 11:50 AM, with the Assistant Director of Nursing (ADON), Resident 1's EHR was reviewed. The ADON confirmed that Resident 1's [ACUTE HOSPITAL NAME] History and Physical, dated 1/15/26, and Resident 1's admission NURSING ASSESSMENT, dated 1/16/26, had conflicting and inaccurate information. The ADON stated Licensed Nurse (LN) 6 was responsible for the admission assessment for Resident 1 and he did the assessment documentation incorrectly. The ADON further stated that the facility staff do these assessments incorrectly all the time as they were rushing and that they needed to be more careful when doing them.During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 7/17, the P&P indicated, .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.During a review of an undated facility job description titled, Licensed Vocational Nurse, the job description indicated, .Maintains accurate and up-to-date medical records, including nursing assessments, care plans, and progress notes.