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	04/29/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a safe and coordinated discharge for Resident 1 when Resident 1 was transferred to an Independent Living Facility (ILF) that could not accommodate his need to use a wheelchair. This failure caused Resident 1 psychosocial distress and had the potential to result in physical injury or harm.Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included complete traumatic amputation (loss of body part due to accident or injury) at level between knee and ankle, of the right lower leg. During a telephone interview on 4/28/26 at 1:59 PM with Family Member (FM) 1, FM 1 stated Resident 1 was transferred from the facility to the ILF on 4/20/26. FM 1 further stated when Resident 1 arrived he was told by the ILF staff that they could not meet his needs since he was in a wheelchair. FM 1 stated the ILF had been informed by the facility that Resident 1 was independent in his care needs and could walk with a walker (mobility aid that provides support and stability while walking). FM 1 stated when they went to the ILF to pick up Resident 1 he was crying and stated that nobody wanted him. During an interview on 4/29/26 at 10:27 AM with the ILF agency manager (AM), the AM stated the facility social worker (SW) informed him that Resident 1 could walk independently up to 150 feet with a walker. The AM further stated the SW assured him that Resident 1 did not need a wheelchair for mobility. The AM stated the ILF was a home for people who were completely independent with their care needs and they did not have staff available to provide hands on assistance. During an interview on 4/29/26 at 10:46 AM with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 needed a wheelchair to get around in the facility, and she had never seen him walk. During an interview on 4/29/26 at 10:52 AM with the facility transporter (FT) the FT stated when he brought Resident 1 to the ILF, the ILF staff asked him if Resident 1 could walk. The FT stated he informed the staff that Resident 1 had an amputated leg and did not walk. The FT stated the ILF reported they had accepted Resident 1 because they were told he was independent and could walk but they could not take him in a wheelchair. During a telephone interview on 4/30/26 at 8:47 AM with Resident 1, Resident 1 stated he told the facility SW a few weeks prior to discharge that he was not ready to go since he was unable to walk. Resident 1 further stated on the day of discharge he arrived at the ILF, and a man came out and said, Take him back, I can't take him in a wheelchair, he only has one leg. Resident 1 stated that it caused him to be upset and he felt really bad. Resident 1 stated at the facility he worked with physical therapy (PT, treatment focused on improving movement, strength, and mobility) and hopped on one leg using a walker, which was scary. Resident 1 stated he was unable to walk but the facility told the ILF he could. During a review of Resident 1's Activities of Daily Living (ADL, Activities of Daily Living, personal care tasks which include bathing, dressing, eating, and transferring in and out of bed) documentation titled, Task: Mobility Devices, dated 3/31/26 through 4/20/26, the document indicated, .What types of mobility devices does the resident normally use for locomotion in the room and in the facility. the options included: cane/crutch, Walker, Wheelchair, and Limb prosthesis. The document indicated .Wheelchair. was used each day, on every shift, except for the evening shift on 4/4/26 which indicated .none of the above. During a (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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NAME OF PROVIDER OR SUPPLIER Clearwater Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1517 East Knickerbocker Drive Stockton, CA 95210	

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 1's clinical document titled, WEEKLY SUMMARY, (comprehensive review of a resident's status over the last seven days) dated 4/19/26 at 10:36 AM, the document indicated, .PLEASE CHOOSE THE APPROPRIATE RESPONSES AND FILL IN THE BLANKS.Ambulation.Wheelchair.most of day.Walker.N/A [non-applicable].Cane/Crutches.N/A.Ambulates.N/A. During a concurrent interview and record review on 4/29/26 at 11:29 AM with the Director of Rehab (DOR), Resident 1's clinical document titled, PT Discharge Summary, discharge date [DATE] was reviewed. The DOR confirmed the document indicated Resident 1 required supervision or touching assistance to ambulate with a front wheeled walker (FWW). The DOR stated Resident 1 was not walking independently in the facility or with nursing staff only with therapy staff. During an interview on 4/29/26 at 1:08 PM with the Social Services Assistant (SSA), the SSA stated when a resident transferred to an ILF the only information the facility provided to the accepting facility was the resident face sheet (document that included demographic information, contact information and diagnoses). The SSA further stated she was under the impression that Resident 1 walked on his own with a front wheeled walker (FWW) and that the facility purchased Resident 1 a walker. During a review of Resident 1's clinical document titled, OT [Occupational Therapy, treatment focused on enabling patients to perform daily activities and tasks] Discharge Summary, discharge date [DATE], the document indicated, .Assessment and Summary of Skilled Services.Patient Progress.Pt was able to complete functional mobility task modified independent, at wheelchair level (recommended). Patient was able to hop up to 150 feet using FWW with SBA [stand by assist] . During a telephone interview on 4/30/26 at 12:26 PM with the Occupational Therapist (OT), the OT stated the term modified independent meant that extra time or a device was required in order to complete a task. The OT further stated the device Resident 1 required was a wheelchair. The OT stated Resident 1 hopped on one leg if he had to, but a wheelchair was recommended as the safest discharge option for him until he received a prosthesis (artificial limb). During an interview on 4/29/26 at 1:28 PM with the facility administrator (ADM), the ADM stated there had been a miscommunication between the facility and the ILF. The ADM further stated that the facility believed the ILF was able to meet Resident 1' s needs. The ADM stated the facility needed to overcommunicate with the facilities they discharged to in order to ensure residents' needs could be met. During a review of a facility policy titled, Discharge Summary and Plan, revised December 2016, the policy indicated, .When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment.Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan.The post-discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and will include.the degree of caregiver/support person availability, capacity and capability to perform required care.a copy of the following will be provided to the resident and the receiving facility.an evaluation of the resident's discharge needs.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure appropriate transfer and discharge information was communicated to the receiving provider for Resident 1. This failure caused Resident 1 to be transferred to a facility that could not meet his needs and had the potential to negatively impact the safety and well- being of Resident 1.Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included complete traumatic amputation (loss of body part due to accident or injury) at level between knee and ankle, right lower leg. During a telephone interview on 4/28/26 at 1:59 PM with Family Member (FM) 1, FM 1 stated Resident 1 was transferred to an Independent Living Facility (ILF) on 4/20/26. FM 1 further stated when Resident 1 arrived he was told by the ILF staff that they could not meet his needs since he was in a wheelchair. FM 1 stated the ILF was informed by the facility that Resident 1 was independent in his care needs and walked with a walker (mobility aid that provides support and stability while walking). FM 1 stated Resident 1 called her to pick him up at the ILF and when she arrived Resident 1 was crying and stated that nobody wanted him. During a telephone interview on 4/30/26 at 9:36 AM with the ILF Agency Manager (AM), the AM stated the facility did not send him any documentation for Resident 1. The AM further stated the facility assured him verbally that Resident 1 was totally independent. The AM stated the ILF staff could not assist Resident 1 with any care needs such as showers, getting in or out of bed, or any type of physical care. The AM stated the staff at the ILF consisted of a cook, the owner and the manager. During an interview on 4/29/26 at 1:08 PM with the Social Services Assistant (SSA), the SSA stated when a resident transferred to an ILF the only information the facility provided to the accepting facility was the resident face sheet (document that included demographic information, contact information and medical diagnoses). During an interview on 4/29/26 at 1:44 PM with the Case Manager Assistant (CMA) the CMA stated after Resident 1 had been discharged she spoke to the Administrator of the ILF, who told her they could not accommodate Resident 1 in a wheelchair. The CMA stated that previously the ILF had been a board and care and had accepted residents in wheelchairs. The CMA further stated it was a miscommunication between the ILF, and the facility and the facility should have expressed that Resident 1 was in a wheelchair and would continue to require it at the ILF. During a review of a facility policy titled, Transfer or Discharge Documentation, revised December 2016, the policy indicated, .When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and the appropriate information will be communicated to the receiving health care facility or provider.Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider.all special instructions for ongoing care.All other necessary information. to ensure a safe and effective transition of care.