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	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Healthcare Center	1517 East Knickerbocker Drive Stockton, CA 95210

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs of one of three sampled residents (Resident 3), when Resident 3 was repeatedly yelling for help and activated the call light (a device used to request assistance), and staff did not respond in a timely manner.This failure placed Resident 3 at risk for unmet care needs, accidents or injury, and had the potential to negatively affect Resident 3's psychosocial well-being (overall emotional and social health).Findings:Review of Resident 3's admission RECORD indicated Resident 3 was admitted to the facility with diagnoses of peripheral vascular disease (disease affecting blood vessels outside the heart and brain), type 2 diabetes mellitus, chronic obstructive pulmonary disease (chronic lung disease causing airflow obstruction), congestive heart failure (impaired ability of the heart to pump blood effectively), polyneuropathy (damage to multiple nerves that can cause pain, numbness, tingling, or weakness), peptic ulcer (ulcer of the stomach or upper small intestine), acquired absence of right leg below knee, and acquired absence of left leg below knee.Review of Resident 3's Minimum Data Set Assessment (MDS - an assessment tool) dated 3/28/26, in the section titled Brief Interview for Mental Status (BIMS) [to check a resident's thinking and memory], Resident 3's BIMS score was 15, which indicated Resident 3 had intact cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe).During an observation on 5/27/26 at 11:23 AM in the hallway across from Resident 3's room, Resident 3 repeatedly yelled for help and for a Certified Nursing Assistant (CNA). Resident 3's room was located three rooms down the hallway from the nurse's station, where two staff members were sitting, and one staff member passed by Resident 3's room without responding to Resident 3's request for help. During an observation on 5/27/26 at 11:30 AM in the hallway across from Resident 3's room, Resident 3 continued yelling for help and for a CNA. The fire alarm was activated as part of scheduled maintenance of the facility's fire alarm system, and a staff member closed Resident 3's room door without checking on Resident 3 or asking what assistance was needed. During an observation on 5/27/26 at 11:34 AM in the hallway across from Resident 3's room, after the fire alarm had stopped, Licensed Nurse (LN) 2 opened Resident 3's room door and entered Resident 3's room. Resident 3's room call light was activated as evidenced by illuminated call light above Resident 3's room entrance door. During a concurrent observation and interview on 5/27/26 at 11:43 AM in the hallway across from Resident 3's room with LN 2, Resident 3 yelled for help and for a CNA, while the call light was activated as a staff member passed by Resident 3's room without responding to Resident 3's requests for assistance or the activated call light. LN 2 acknowledged that Resident 3 had been yelling for help and for a CNA for approximately 20 minutes and that a staff member closed Resident 3's room door during the fire drill. LN 2 acknowledged that the call light had been activated for nine minutes and had not been answered despite staff passing by the room. LN 2 stated that residents' call lights should be answered by staff as soon as possible, generally within one to two minutes, to meet residents' needs and help prevent agitation and falls. During an interview on 5/27/26 at 12:30 PM with Resident 3, Resident 3 stated that he initially yelled for help and for the CNA and did not activate the call light because, in the past, when he used his call light, staff would just pass by and ignore him. Resident 3 further stated that he had been yelling for help for approximately 15 minutes while waiting for staff assistance.During an interview on 5/27/26 at 3:45 PM with the (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant Director of Nursing (ADON), the ADON stated that staff were expected to answer residents' call lights within two to three minutes. The ADON further stated that having a resident wait more than 10 minutes was too long and could place the resident at risk for agitation, falls, and other unmet care needs. Review of facility's policy and procedure (P&P), titled Call Lights revised in 3/18, the P&P indicated .Monitoring the lights and making sure the lights are answered promptly, regardless of who is assigned to each resident.

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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 permit Resident 1 to return to the facility following a hospitalization and in accordance with a facility established policy when:1. Resident 1 was transferred to the hospital on 4/7/26 for a suprapubic catheter (a medical device inserted through an incision in the lower stomach that helps drain urine from your bladder) change and the facility did not allow Resident 1 to return to the facility on 4/8/26 when the hospital informed the facility Resident 1 was ready to be sent back; and2. Resident 1's medical record did not include documentation from the physician which indicated the needs that could not be met by the facility and the attempts the facility made to meet those needs. This deficient practice resulted in actual psychosocial harm to Resident 1, who reported feeling mentally distressed, anxious, uncertain about his future placement, experiencing loss of appetite and believing he had lost the home he had established at the facility. The deficient practice further caused emotional distress to Resident 1's family and had the potential to compromise the resident's health, safety, continuity of care, and resident rights protections guaranteed under federal regulations.Findings:1. Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with a diagnosis of, but not limited to quadriplegia, unspecified (paralysis of both arms and both legs) and tracheostomy status (the person has a tracheostomy or trach opening in the neck for breathing). During a review of Resident 1's clinical record titled, Order Summary Report, dated 5/22/26, with active orders as of 3/11/26, indicated, . Feeding Assistance Needed with meals . TRACH STOMA (the opening in the neck where the tracheostomy tube goes): Cleanse around the stoma site & apply dry dressing .During a review of Resident 1's MINIMUM DATA SET (MDS - resident assessment tool) titled, Section C - Cognitive Patterns [how a person thinks, remembers, learns, and makes decisions], dated 3/18/26, indicated, . BIMS Summary Score 15 [the person's memory and thinking abilities are intact or normal].Review of Resident 1's MDS, RESIDENT ASSESSMENT AND CARE SCREENING Nursing Home Discharge (ND) item Set dated 4/7/26, in section A . Entry/discharge reporting indicated, Resident 1 was discharge with return anticipated to the facility.Review of Resident 1's clinical record titled, SBAR [Situation, Background, Assessment, Recommendation - a structured way for healthcare staff to communicate important information about a patient] & INITIAL COC [Change of Condition - a change in a person's health status]/ALERT CHARTING [documenting and monitoring a significant change or concern in a person's condition] & SKILLED DOCUMENTATION [written notes by healthcare professionals showing the medical care and services provided], dated 4/7/26, indicated, . Initial COC Alert Charting Notes . Per NP [Nurse Practitioner] Sent Pt [patient] ER [Emergency Room] for suprapubic change . During a review of Resident 1's hospital record titled, [Name of Hospital] DC [Discharge] planning note, dated 5/27/26, indicated, . CM [Case Manager] received a VM [Voice Message] from one of the representatives at [Name of Facility] . unable to accept [Resident 1] back d/t [due to] continuous suctioning [removing mucus, saliva, or fluids using a suction machine] . believe he needs sub-acute care [specialized medical care for people who are not sick enough to stay in a hospital but still need more care than can be provided at home] . 4/9/26 Pt [Patient] can not return . 4/10/26 patient is medically cleared to return to SNF [Skilled Nursing Facility] . 4/13/26 Patient is medically clear to discharge to SNF . Patient came from [Name of Facility] and they are refusing to take him back. They are stating that patient requires frequent suctioning . 4/14/26 . pt [Patient] is medically clear for discharge back to SNF . 4/20/26 . Patient refused back by [Name of Facility] due to unable to assist with continued suctioning . 4/21/26 . Medically cleared for discharge. SW [Social Worker] following up on placement . Facility DON [Director of Nursing] refuses patient return. Facility DON states patient requires 24 hour respiratory. [Name of Hospital] SW alerts patient does not require 24 hour respiratory, and does not require suctioning. Facility DON insists the patient does require (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suctioning and 24 hour respiratory services the facility cannot provide.During an interview on 5/27/26 at 7:57 AM with Resident 1 in his room, Resident 1 stated that he was transferred to the hospital on 4/7/26 for a suprapubic catheter replacement and expected to return to the facility after the procedure. Resident 1 stated that the hospital was prepared to discharge him back to the facility on 4/8/26; however, he was informed that the facility would not allow him to return. When asked how the situation affected him, Resident 1 stated that it was very concerning and upsetting. Resident 1 stated, I don't have any problems with anybody at the facility. I cannot understand why I was transferred out for a suprapubic catheter replacement and then was not allowed to come back. Resident 1 stated that no one discussed with him any concerns regarding his tracheostomy stoma before the facility refused readmission. Resident 1 explained that the tracheostomy stoma was old and stable and stated that he did not require deep suctioning. Resident 1 stated that he occasionally required oral suctioning for excessive saliva but had never been informed that this would prevent him from returning to the facility. Resident 1 further stated that if he had known the facility was capable of changing his suprapubic catheter on-site, he would not have requested transfer to the hospital. Resident 1 stated that he only requested hospital transfer because nursing staff had informed him that the catheter could not be changed at the facility. Resident 1 stated that the refusal to readmit him caused significant emotional distress. Resident 1 stated, I really felt terrible and mentally disturbed. I thought I had already found my home there, and then this happened. Resident 1 further stated that the situation also affected his family. Resident 1 stated that when his [AGE] year-old mother learned that he was not being allowed to return to the facility, she became stressed, nervous, and anxious, which caused him additional emotional distress. Resident 1 stated that his brother was also affected by the situation. Resident 1 stated that during the period he remained hospitalized awaiting placement, he experienced anxiety and uncertainty about his future because he did not know where he would be discharged . Resident 1 stated that he lost his appetite and felt emotionally overwhelmed by the entire situation.During an interview on 5/27/26 at 12:02 PM, with Resident 1's Family Member (FM), in Resident 1's room via Resident 1's electronic device, the FM stated that the situation caused significant stress and emotional hardship for Resident 1 and the family. The FM stated, My brother was really stressed out. We thought he had finally found a place that he could call home, but the facility took that away from him. The FM stated that prior to the hospitalization, Resident 1 had adjusted well to the facility and appeared comfortable residing there. The FM stated that Resident 1 was transferred to the hospital for replacement of a suprapubic catheter and not because of respiratory issues. The FM stated that Resident 1's condition was stable and that the hospital was prepared to discharge him back to the facility shortly after the catheter replacement. The FM stated, the facility refused to readmit him, resulting in Resident 1 remaining hospitalized for more than a month while awaiting placement. The FM stated that Resident 1 did not require deep suctioning and had never required such services to the family's knowledge. The FM further stated that Resident 1 occasionally required oral suctioning due to excessive saliva but did not have respiratory problems requiring specialized respiratory interventions. The FM stated that the prolonged hospitalization created uncertainty regarding Resident 1's future placement and caused considerable emotional distress. The FM stated that Resident 1 became discouraged and upset after learning that he would not be allowed to return to the facility. The FM further stated that the situation significantly affected the family. The FM stated, I have my own work and responsibilities, but I had to spend time helping my brother deal with everything that was happening. The FM stated that the greatest concern was the impact on their [AGE] year-old mother. According to the FM, when their mother learned that the facility would not accept Resident 1 back, she became extremely stressed, nervous, and anxious about her son's future care and living arrangements. The FM stated that the family's understanding was that Resident 1's respiratory condition had remained stable and that he only required occasional oral suctioning for excess saliva. The FM stated that they did not believe Resident 1 required deep suctioning or respiratory services beyond the facility's capability and could not understand why he (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not permitted to return after the hospital had determined he was ready for discharge.During a concurrent interview and record review on 5/22/26 at 4:25 PM, with Licensed Nurse (LN) 1, Resident 1's Care Plan Report, Progress Notes, Discharge Planning Notes, Physician and Nurse Practitioner progress notes, electronic medication administration record (eMAR - a computerized record used by nurses to track medications), and electronic treatment administration record (eTAR - a computerized record used to track treatments ordered for a person) were reviewed. LN 1 stated she did not find any documentation of an Interdisciplinary Team (IDT - a group of healthcare professionals who work together to care for a person) meeting or discharge planning IDT meeting related to Resident 1's transfer, discharge, or refusal of readmission. LN 1 further stated she did not find documentation indicating that Resident 1 required suctioning beyond routine oral suctioning. LN 1 reviewed the resident's MDS assessment dated [DATE] and stated that Section O (Special Treatments, Procedures, and Programs) indicated No for suctioning. LN 1 stated she did not find a care plan addressing tracheostomy stoma care, including specific problems, goals, or interventions related to respiratory management, suctioning needs, or discharge planning. LN 1 stated she did not find documentation from the attending physician or nurse practitioner identifying specific resident needs that could not be met by the facility. LN 1 further stated she did not find documentation supporting that Resident 1 required deep suctioning or specialized respiratory services beyond the facility's capability. LN 1 stated she did not find licensed nurse progress notes documenting that Resident 1 required deep suctioning, experienced respiratory distress requiring deep suctioning, or received deep suctioning while residing at the facility. LN 1 reviewed active physician orders and identified an order dated 3/12/26 stating, SUCTION: May do oral suctioning PRN [as needed] for secretions as needed, and an order dated 3/12/26 stating, YANKAUER SUCTION [a suction device used to remove saliva, mucus, or fluids from the mouth and throat] - Change every day if used and PRN, as needed. LN 1 stated these orders addressed oral suctioning only. LN 1 further stated she did not find physician orders in the eMAR or eTAR for deep suctioning, tracheal suctioning (removing mucus from the windpipe to help a person breathe), respiratory therapy treatments, or other respiratory interventions requiring specialized respiratory services. LN 1 concluded that based on her review of the available records, she did not find documentation supporting that Resident 1 required deep suctioning, that the resident's needs could not be met by the facility, or that the resident required transfer or non-readmission due to respiratory care needs.During an interview on 5/27/26 at 7:45 AM, Licensed Nurse (LN) 2 stated that Resident 1 was readmitted to the facility on [DATE]. LN 2 stated that Resident 1 was alert and oriented to person, place, time, and situation (A&O x4 - the person is awake, alert, and knows who they are, where they are, the date/time, and what is happening) and required staff assistance with feeding due to quadriplegia. LN 2 stated that staff routinely assisted Resident 1 during meal times and, to her knowledge, Resident 1 had not experienced swallowing difficulties, choking episodes (times when food, liquid, or another object gets stuck and makes it difficult to breathe or swallow), or aspiration-related incidents (events where food, liquid, saliva, or stomach contents go into the lungs instead of the stomach) since admission to the facility. LN 2 stated that Resident 1 had been admitted to the facility on [DATE] and, during his stay, she was not aware of any change in condition related to the resident's tracheostomy stoma that required transfer to a higher level of care. LN 2 stated that she could not recall any incident in which Resident 1 required deep suctioning, emergency respiratory intervention, or hospitalization due to respiratory distress. LN 2 stated that the only suctioning provided to Resident 1 was oral suctioning when the resident experienced excessive saliva or oral secretions. LN 2 stated that Resident 1 did not require tracheal or deep suctioning during her care of the resident and that she was not aware of any physician orders directing staff to perform deep suctioning. LN 2 stated that nursing staff had received training related to tracheostomy care and that the facility had access to a Respiratory Therapist (RT) who could provide consultation and assistance if respiratory concerns arose. LN 2 stated that, since Resident 1's admission, the tracheostomy stoma site had remained stable. LN 2 further stated that routine care (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respiratory Therapist (RT) and helps ensure that respiratory care needs can be addressed on all shifts. Based on her review of the staffing schedules, the SC stated that the facility maintained consistent RN coverage during AM, PM, and NOC shifts and had the staffing resources necessary to respond to residents requiring respiratory interventions, including deep suctioning if needed.During an interview on 5/27/26 at 3 PM, with Licensed Nurse (LN) 4, LN 4 stated that residents experiencing substantial emotional or psychological stress may experience a variety of negative outcomes, including decreased appetite, reduced food intake, weight loss, anxiety (feeling worried, nervous, or afraid), and depression (feeling very sad for a long time). LN 4 stated that loss of appetite is a common response to stressful life events and can occur when an individual experiences uncertainty, fear, emotional distress, or major changes in living arrangements. LN 4 further stated that major life changes can have different effects on different individuals depending on their physical condition, coping abilities, support systems, and underlying medical conditions. LN 4 explained that some individuals may become withdrawn (keeping to oneself and avoiding other people), anxious, depressed, or lose interest in eating and participating in activities. LN 4 stated that even healthy individuals without significant medical conditions may experience loss of appetite and emotional distress when exposed to stressful situations. LN 4 added that residents residing in skilled nursing facilities are often more vulnerable because they may already have multiple medical diagnoses, physical limitations, chronic illnesses, and psychosocial stressors. LN 4 stated that for a resident with complex medical conditions, the emotional impact of losing a perceived home, experiencing uncertainty regarding future placement, or undergoing a major disruption in living arrangements could potentially contribute to anxiety, depression, decreased appetite, and weight loss. LN 4 stated that such stressors may negatively affect a resident's overall physical, mental, and emotional well-being.During an interview on 5/27/26 at 3:07 PM, with the Assistant Director of Nursing (ADON), the ADON stated that it was her expectation that licensed nursing staff document significant interactions, events, assessments, interventions, resident requests, and communications involving residents in the medical record. The ADON stated that any important interaction involving Resident 1, including discussions regarding bed-hold status, transfer or discharge-related matters, resident concerns, requests, needs, physician communications, changes in condition, or other significant events, should have been documented in the nursing progress notes. The ADON stated that documentation serves as an important communication tool among members of the interdisciplinary team and supports continuity and consistency of care. The ADON further stated that if significant events or interactions are not documented in the medical record, other members of the care team would have no record to reference regarding what occurred, what actions were taken, or what follow-up may be required. The ADON stated that residents with identified clinical conditions requiring ongoing monitoring or interventions should have an individualized care plan that includes the identified problem or focus area, measurable goals, and specific interventions to address the resident's needs. The ADON stated that if Resident 1 required ongoing monitoring, treatment, or interventions related to his tracheostomy stoma, she would expect the condition to be addressed through the care planning process with corresponding focus statements, goals, and interventions. The ADON further stated that significant resident events, changes in condition, physician notifications, resident assessments, interventions, resident responses, and other clinically relevant information should be documented in the medical record to ensure continuity of care and accurate communication among interdisciplinary team members. The ADON stated that documentation of important resident-related events was necessary to support clinical decision-making, care planning, and ongoing resident management and that events not documented in the medical record cannot be readily communicated or verified by other members of the interdisciplinary team.During an interview on 5/27/26, at 10:11 AM, the Director of Nursing (DON) confirmed Resident 1 was admitted to the facility with a stable tracheostomy. The DON confirmed Resident 1 was transferred to the hospital on 4/7/26 for a suprapubic catheter change and on 4/8/26 the hospital case manager requested Resident 1 to be readmitted to the facility. The DON (continued on next page)

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	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Healthcare Center	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	confirmed that on 4/9/26, the hospital case manager was informed that the facility would not readmit Resident 1 because the facility was unable to meet Resident 1's care needs. The DON explained that the needs that could not be met at the facility specifically was in the event of an emergency, such as choking that would require deep suctioning (a medical procedure used to clear heavy mucus or blockages from the lower respiratory tract). The DON stated the facility did not have a respiratory therapist available on-site to provide immediate intervention. The DON stated Resident 1's need that could not be met was a risk, in case Resident 1 had an episode of choking. The DON confirmed there was no documentation in Resident 1's progress notes that indicated Resident 1 required deep suctioning or had an episode of choking, and Resident 1 did not have any events related to a need for deep suctioning, nor any recorded concern about it. The DON stated it was about the risk for Resident 1, but no actual events happened or were documented during Resident 1's stay at the facility.During an interview on 5/22/26, at 5:10 PM, the Administrator (ADM) stated Resident 1 appealed the discharge with the court and Resident 1 won the appeal. The ADM stated the facility will need to readmit Resident 1 to the facility within 72 hours.Review of facility policy and procedure (P&P) titled, Transfer or Discharge Documentation, revised 12/16, indicated, Policy Statement: When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Policy Interpretation and Implementation: Each resident will be permitted to remain in the facility, and not be transferred or discharged unless . the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility . If a resident exercises his or her rights to appeal a transfer or discharge notice he or she will not be transferred or discharged while the appeal is pending . When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: . The basis for the transfer or discharge; . If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: the specific resident needs that cannot be met; . facility's attempt to meet those needs . receiving facility's service(s) that are available to meet those needs . That an appropriate notice was provided to the resident and/or legal representative . The date and time of the transfer or discharge . The new location of the resident . The mode of transportation . A summary of the resident's overall medical, physical, and mental condition . The signature of the person recording the data in the medical record .Review of facility P&P titled, Transfer or Discharge Notices, revised 3/25, indicated, Policy Statement: Residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman. Policy Interpretation and Implementation: . Except as specified . the resident . are provided with written notice . Under the following circumstances, the notice of transfer is given as soon as it is practicable but before the transfer or discharge . The resident . are notified in writing . The specific reason for the transfer or discharge, including the basis . The effective date of the transfer or discharge . The specific location ZXXX

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	555307	A. Building B. Wing	05/27/2026

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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 complete a Notice of Discharge (NOD - an official, written document stating a nursing home intends to discharge a resident from the facility) for Resident 1 when the facility refused to readmit Resident 1 on 4/9/26, following Resident 1's transfer from the facility to the hospital on 4/7/26, resulting in a facility-initiated discharge without a completed NOD provided to Resident 1 and to the Ombudsman (advocate to protect resident rights).This failure resulted in Resident 1 being discharged without a clear and coordinated discharge plan, including continuity of care, placed Resident 1 at risk for an unsafe transition of care, and prevented timely Ombudsman advocacy and oversight to protect resident rights.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with a diagnosis of, but not limited to quadriplegia, unspecified (paralysis of both arms and both legs) and tracheostomy status (the person has a tracheostomy or trach opening in the neck for breathing).Review of Resident 1's clinical record titled, SBAR [Situation, Background, Assessment, Recommendation - a structured way for healthcare staff to communicate important information about a patient] & INITIAL COC [Change of Condition - a change in a person's health status]/ALERT CHARTING [documenting and monitoring a significant change or concern in a person's condition] & SKILLED DOCUMENTATION [written notes by healthcare professionals showing the medical care and services provided], dated 4/7/26, indicated, . Initial COC Alert Charting Notes . Per NP [Nurse Practitioner] Sent Pt [patient] ER [Emergency Room] for suprapubic change .Review of Resident 1's Minimum Data Set (MDS, an assessment tool), in the section titled, RESIDENT ASSESSMENT AND CARE SCREENING Nursing Home Discharge (ND) item Set, dated 4/7/26, in section A . Entry/discharge reporting indicated, Resident 1 was discharge with return anticipated to the facility.During a review of Resident 1's hospital record titled, [Name of Hospital] DC [Discharge] planning note, dated 5/27/26, indicated, . CM [Case Manager] received a VM [Voice Message] from one of the representatives at [Name of Facility] . unable to accept [Resident 1] back d/t [due to] continuous suctioning [removing mucus, saliva, or fluids using a suction machine] . believe he needs sub-acute care [specialized medical care for people who are not sick enough to stay in a hospital but still need more care than can be provided at home] . 4/9/26 Pt [Patient] can not return . 4/10/26 patient is medically cleared to return to SNF [Skilled Nursing Facility] . 4/13/26 Patient is medically clear to discharge to SNF . Patient came from [Name of Facility] and they are refusing to take him back. They are stating that patient requires frequent suctioning . 4/14/26 . pt [Patient] is medically clear for discharge back to SNF . 4/20/26 . Patient refused back by [Name of Facility] due to unable to assist with continued suctioning.4/21/26.Medically cleared for discharge. SW [Social Worker] following up on placement . Facility DON [Director of Nursing] refuses patient return. Facility DON states patient requires 24 hour respiratory. [Name of Hospital] SW alerts [Resident 1] does not require 24 hour respiratory, and does not require suctioning. Facility DON insists the patient does require suctioning and 24 hour respiratory services the facility cannot provide.During a telephone interview on 6/3/26 at 3:38 PM with the Director of Social Services (DSS), the DSS stated that she was responsible for preparing and issuing discharge notices. The DSS confirmed that the only notice maintained by the facility for Resident 1 was a Transfer Notice dated 4/7/26. The DSS stated that once the facility determined on 4/9/26 that Resident 1 would not be returning to the facility because Resident 1's needs could not be met, a Notice of Discharge (NOD) should have been issued to both the resident and the Long-Term Care Ombudsman. The DSS confirmed that the facility did not have a Notice of Discharge for Resident 1. The DSS further stated that two notices should have been completed, one for the resident and one for the Ombudsman. The DSS stated that she typically faxed the notice to the Ombudsman but acknowledged that this did not occur for Resident 1. The DSS stated that providing the Notice of Discharge to the resident was important so the resident could understand (continued on next page)

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	555307	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what was happening, be aware of his rights, and know how to appeal the discharge decision, including who to contact for assistance. The DSS further stated that failure to provide the notice could place the resident at risk because the resident may not be informed of the discharge plan, available appeal rights, or resources necessary to ensure a safe discharge process. The DSS also stated that the Ombudsman should have been notified and involved in the discharge process because the Ombudsman serves as the resident's advocate. The DSS explained that if Resident 1 had concerns, disagreed with the discharge decision, or needed assistance, the Ombudsman should be aware of the situation and involved to help protect the resident's rights and promote a safe discharge process.During an interview on 6/4/26 at 11:28 AM with the OMB, the OMB stated that the Notice of Discharge (NOD) is a legally required notice that must be provided to both the resident (or the resident's representative) and the Ombudsman when a facility initiates a discharge. The OMB stated that because Resident 1 was a long-term care resident, it was expected that Resident 1 or his representative would receive a written Notice of Discharge at least 30 days prior to the discharge, unless an exception applied. The OMB confirmed receipt of the facility's Notice of Transfer dated 4/7/26 but stated that the Ombudsman program did not receive a Notice of Discharge after the facility determined on 4/9/26 that Resident 1 would not be readmitted because the facility could not meet the resident's needs. The OMB stated that the Notice of Discharge contains important information necessary to protect the resident's rights and ensure a safe and appropriate discharge process. The OMB further stated that the notice provides the resident with sufficient time to understand the discharge decision, prepare for the transition, and exercise appeal rights if the resident disagrees with the discharge. The OMB stated that a copy of the Notice of Discharge must also be provided to the Ombudsman because it was required by law and allowed the Ombudsman to advocate for the resident, review the appropriateness of the discharge, and ensure that the resident's rights were protected throughout the discharge process. The OMB stated that failure to provide the Notice of Discharge to both the resident and the Ombudsman could place the resident at risk of not being fully informed of the discharge decision, available appeal rights, and discharge plan, and could hinder efforts to ensure that the resident is discharged to a safe and appropriate location with necessary services and supports in place.Review of facility policy and procedure titled, Transfer or Discharge Notices, revised 3/25, indicated, Policy Statement: Residents . are notified of . discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman . Policy Interpretation and Implementation: . The resident and representative are notified in writing of the following information . the specific reason for the transfer or discharge . the effective date of the transfer or discharge . the specific location . to which the resident is being transferred or discharged . An explanation of the resident's rights to appeal the transfer or discharge to the state, including the name, address, email, and telephone number of the entity which receives such appeal hearing requests . information about how to obtain an appeal form . how to get assistance in completing and submitting the appeal hearing request . The name, address, and telephone number of the Office of the State Long-term Care Ombudsman . A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident.

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	05/27/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, and interview, the facility failed to develop and implement a comprehensive, person-centered care plan to address the identified tracheostomy stoma care needs for 1 of 2 sampled residents (Resident 1) reviewed for respiratory care. Resident 1 was admitted with a tracheostomy stoma; however, the facility did not develop a care plan that included measurable goals and interventions for monitoring, assessment, and care of the tracheostomy stoma site. The omission existed from admission through the resident's transfer to the hospital, placing the resident at risk for unmet respiratory and nursing care needs, delayed identification of complications, and inconsistent care delivery among staff. Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility 3/11/26 with a diagnosis of, but not limited to quadriplegia, unspecified (paralysis of both arms and both legs) and tracheostomy status (the person has a tracheostomy or trach opening in the neck for breathing). During a review of Resident 1's clinical record titled, Order Summary Report, dated 5/22/26, the active orders as of 3/11/26, indicated, . TRACH STOMA (the opening in the neck where the tracheostomy tube goes): Cleanse around the stoma site & apply dry dressing .A review of Resident 1's clinical record titled, [Name of Facility] Progress Notes - History & Physical, dated 3/13/26, indicated, . He was hospitalized for inability to provide necessary tracheostomy care . PAST MEDICAL/PAST SURGICAL HISTORY . Tracheostomy stoma . assessment and plan . Status post tracheostomy: Continuing tracheostomy care .During an interview with concurrent record review on 5/22/26 at 4:25 PM, Licensed Nurse (LN) 1 reviewed Resident 1's Care Plan Report and stated she was unable to locate a care plan addressing the resident's tracheostomy stoma care needs. LN 1 confirmed there were no identified care plan problems, goals, or interventions related to tracheostomy stoma management, respiratory monitoring, assessment for complications, or monitoring for signs and symptoms of infection. LN 1 stated that the care plan serves as the resident's plan of care and is an important communication tool to ensure all staff involved in the resident's care are aware of the resident's needs, goals, and required interventions.During an interview on 5/27/26 at 9:33 AM, the Assistant Director of Nursing (ADON) stated that it was her expectation that a care plan addressing Resident 1's tracheostomy stoma care needs should have been developed and implemented. The ADON stated that a tracheostomy stoma is a significant clinical condition that requires individualized care-planned interventions to guide staff in the assessment, monitoring, and care of the stoma site. The ADON further stated that an appropriate care plan was important to provide overall direction for care, promote consistent care delivery among staff, monitor for potential complications, identify signs and symptoms of infection, and minimize risks associated with the tracheostomy stoma.Review of facility policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised 3/22, indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: The interdisciplinary team (IDT), in conjunction with the resident . develops and implements a comprehensive, person-centered care plan for each resident. care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being . reflects currently recognized standards of practice for problem areas and conditions.

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	555307	A. Building B. Wing	05/27/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide post-fall monitoring and interventions to prevent falls and identify changes in condition for one of three sampled residents (resident 5) when Resident 5 had anunwitnessed fall and was transferred to the emergency room (ER) due to hypotension (low blood pressure) and bradycardia (slow heart rate) on 12/10/25 and on 12/17/25. This failure had the potential to delay the identification and treatment of head injuries, hypotension, bradycardia, and other changes in condition, placing Resident 5 at risk for additional falls, injury, and emergency medical intervention.Failure:Review of Resident 5's admission RECORD indicated Resident 5 was admitted to the facility with diagnoses including metabolic encephalopathy (a condition that affects brain function and can cause confusion or altered mental status), acute respiratory failure with hypoxia (a condition in which the body does not receive enough oxygen), muscle weakness, sepsis (a serious infection that can affect the body's organs), protein-calorie malnutrition (poor nutrition due to inadequate protein and calorie intake), depression, anxiety, hypertension (high blood pressure), adult failure to thrive (declining physical health and ability to function), and need for assistance with personal care.Review of Resident 5's Minimum Data Set Assessment (MDS - an assessment tool) dated 12/17/25 indicated that in the section titled Brief Interview for Mental Status (BIMS) [a screening tool used to assess memory and thinking], a staff assessment for Resident 5's mental status was conducted because Resident 5 was not interviewable. The assessment indicated that Resident 5 had memory problems and was moderately impaired in cognitive skills for daily decision-making, which may have limited Resident 5's ability to communicate whether he hit his head during the fall incident on 12/17/25.Review of Resident 5's IDT (interdisciplinary team - staff who work together to coordinate resident care) - FALLS PROGRESS NOTES - V4 (version 4) dated 12/10/25 indicated that on 12/10/25 at 1:45 AM, Resident 5 was found on the fall mat with fluctuating BP ranging from 144/105 to 87/51(low BP, normal 120/80) and HR of 106 beats per min (bpm) to 45 bpm (low HR, normal 60 bpm to 100 bpm). Resident 5 was sent out to the ER. Review of Resident 5's IDT (interdisciplinary team - staff who work together to coordinate resident care) - FALLS PROGRESS NOTES - V4 (version 4) dated 12/22/25 indicated that on 12/17/25 at 2:50 PM, Resident 5 was found on the floor and could not provide a reason for the fall or explain what happened. At approximately 5:00 PM, while Resident 5 was working with the therapist, Resident 5 was noted to have low BP and a low HR. Resident 5 was transferred to the ER on [DATE] at 5:18 PM due to hypotension, bradycardia, and skin that was cold to the touch.Review of the facility's 72-Hour Neuro-Checklist (a form used to document neuro checks after a fall), the neuro-checklist indicated that, .This assessment should be completed at the following intervals for follow-up for all falls. A fall that is unwitnessed, or in which the head is struck, requires neurological checks.To be completed q15 min x 4 [every 15 minutes times 4], Q30 min x 2 [every 30 minutes times 2], Q hour x 2 [every hour times 2]. The neuro-checklist included evaluation of BP (blood pressure), HR (heart rate), RR (respiratory rate), and temperature, level of consciousness (awareness and responsiveness), pupil size and reaction, hand grip strength, and the nurse's initials.During an interview on 5/27/26 at 11:04 AM with LN 5, LN 5 stated that neuro checks and VS monitoring were required after a fall to identify changes in condition, prevent additional falls, and provide timely medical intervention.During an interview on 5/27/26 at 2:45 PM with the Medical Records Director (MRD), the MRD confirmed that neither the electronic health record (EHR) nor any paper record contained a completed neuro-check assessment for Resident 5 following the falls on 12/10/25 and 12/17/25.During a concurrent interview and record review on 5/27/26 at 3:45 PM with the Assistant Director of Nursing (ADON), Resident 5's EHR was reviewed. The ADON stated that neuro checks were required following unwitnessed falls and that no neuro checks were documented in Resident 5's (continued on next page)

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	555307	A. Building B. Wing	05/27/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EHR following the falls on 12/10/25 and 12/17/25. The ADON acknowledged that Resident 5 had cognitive impairment (difficulty with memory and thinking), remained in the facility for approximately two hours following the fall on 12/17/25 before being transferred to the ER, and that a LN should have performed neuro checks during that time. Resident 5's Vital: Blood Pressure record was also reviewed with the ADON and indicated that Resident 5's BP was 144/68 at 8:52 AM and 76/40 at 4:37 PM on 12/17/25. The ADON acknowledged that BP monitoring was part of a neuro check and that, according to the facility's 72-Hour Neuro-Checklist, five neuro check assessments with vital signs should have been completed between the fall at 2:50 PM and the BP reading of 76/40 at 4:37 PM and that hypotension and bradycardia on 12/17/25 were identified by non-nursing staff approximately two hours after the fall and that the lack of monitoring increased Resident 5's risk for another fall.Review of facility's policy and procedure (P&P), titled Falls and Fall Risk, Managing revised in 3/2018, the P&P indicated .Resident conditions that may contribute to the risk of falls include.cognitive impairment.orthostatic hypotension.staff will identify and implement relevant interventions.to try to minimize consequences of falling.Review of facility's policy and procedure (P&P), titled Falls - Clinical Protocol revised in 3/2018, the P&P indicated .In addition, the nurse shall assess and document/report the following.Vital signs.Neurological status.The staff and practitioner will review each resident's risk factors for falling and document in the medical record.cognitive impairment.hypotension.Based on the preceding assessment, the staff and physician will identify interventions to try to prevent subsequent falls and address the risks of clinically significant consequences of falling,.such as hypotension.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices for one of three sampled residents (Resident 4) when soiled linens from Resident 4's roommate (Resident 3), who was on Enhanced Barrier Precautions (EBP - use of personal protective equipment or PPE, such as gowns, gloves, and masks, during care of residents who may be at higher risk of spreading germs and infection) were placed on the bathroom sink in the bathroom used by Resident 4, creating a potential source of contamination.This failure had the potential to expose Resident 4 to germs that can cause infection and increase the risk of infection transmission within the facility. Findings:Review of Resident 3's admission RECORD indicated Resident 3 was admitted to the facility with diagnoses of infection of amputation stump, left lower extremity (infection at the site where left lower leg was surgically removed), resistance to vancomycin (a condition in which certain bacteria do not respond to the antibiotic vancomycin, acquired absence of right leg below knee, and acquired absence of left leg below knee).Review of Resident 3's Order Details dated 3/21/26 indicated that the provider ordered EBP for Resident 3 during high-contact resident care activities due to an open wound. Review of Resident 4's admission RECORD indicated Resident 4 was admitted to the facility with diagnoses including cerebral infarction (stroke), type 2 diabetes mellitus, vascular dementia (memory loss and confusion caused by reduced blood flow to the brain), chronic viral hepatitis C (long-term liver infection caused by a virus), visual field defects (partial loss of vision), and protein calorie malnutrition (not getting enough food and nutrients).Review of Resident 4's Minimum Data Set Assessment (MDS-an assessment tool) dated 3/31/26, in the section titled Brief Interview for Mental Status (BIMS) [to check a resident's thinking and memory], Resident 4's BIMS score was 10, which indicated Resident 4 had moderately impaired cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe).Review of Resident 4's Activities of Daily Living (ADL - everyday self-care activities) record titled POC [Plan of Care] Response History from 5/15/26 through 5/27/26, in the section titled Toilet transfer - the ability to get on and off a toilet or commode, indicated Resident 4 independently used the toilet nine times across all shifts.During a concurrent observation and interview on 5/27/26 at 11:53 AM with Certified Nursing Assistant (CNA) 1 in the hallway outside Resident 3's room, an EBP sign was posted at the entrance to Resident 3's room. CNA 1 entered Resident 3's room, provided care following a bladder or bowel accident, changed Resident 3's soiled bed linens, entered the room's bathroom, and placed the soiled linens directly on the bathroom sink. CNA 1 stated that placing soiled linens directly on the bathroom sink shared with Resident 4 created a risk of cross-contamination (the spread of germs from one surface or person to another). CNA 1 further stated that Resident 4 independently used the shared bathroom with Resident 3 and had confusion and forgetfulness that could affect Resident 4's ability to understand and follow infection control practices. CNA 1 acknowledged that placing soiled linens previously used by Resident 3, who was on EBP, directly on the bathroom sink shared with Resident 4 created a higher risk of infection transmission to Resident 4. During an interview on 5/27/26 at 12:35 PM with Resident 4, Resident 4 stated that he could use the bathroom in his room independently.During an interview on 5/27/26 at 3:03 PM with Licensed Nurse (LN) 4, LN 4 stated that soiled linens should not be placed on any surfaces because they could contaminate the surface and increase the risk of infection transmission. LN 4 further stated that staff were expected to use a protective bag for soiled linens if the soiled linens needed to be set down before being placed in the dirty linen hamper.During an interview on 6/1/26 at 9:53 AM with the Assistant Director of Nursing (ADON), the ADON stated that Resident 3 was on EBP because Resident 3 was at increased risk for infection transmission and that placing Resident 3's soiled linens directly on the bathroom sink created an infection control risk.Review of facility's policy and procedure (P&P), titled Enhanced Barrier Precautions revised in 8/2022, the P&P indicated .Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant (MDROs) to residents.EBPs are indicated.for residents infected or colonizes with (continued on next page)

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	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Healthcare Center	1517 East Knickerbocker Drive Stockton, CA 95210

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following.Vancomycin-resistant Enterococci (VRE).EBPs are indicated.for residents with wounds.Review of facility's policy and procedure (P&P), titled Infection Prevention and Control Program revised in 10/2018, indicated .An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Prevention of Infection.educating staff and ensuring that they adhere to proper techniques and procedures.