

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/02/2026
NAME OF PROVIDER OR SUPPLIER Clearwater Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1517 East Knickerbocker Drive Stockton, CA 95210	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for one of four sampled residents (Resident 1) when Resident 2 struck Resident 1 on his head with a metal cane (walking stick used for stability) on 4/6/26. This deficient practice resulted in Resident 1 sustaining a head laceration (cut) that required hospital transfer for the treatment and wound closure with staples (a metal fastener used by doctors to close deep cut or surgical incision). Findings: A review of Resident 1's clinical record titled, admission RECORD indicated Resident 1 was admitted to the facility in 2026, with diagnoses of, but not limited to, Cerebral Infarction (a type of brain injury caused by a blocked blood vessel) and vascular dementia (a decline in thinking and memory skills caused by reduced or blocked blood flow to the brain) and depression (a mood disorder characterized by feeling of sadness). A review of Resident 1's Minimum Data Set (MDS, an assessment and care screening tool) dated 3/31/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 10 (The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment. 8 to 12 points suggest moderate cognitive impairment. 13 to 15 points suggest that cognition is intact). A review of Resident 2's clinical record titled, admission RECORD indicated Resident 2 was admitted to the facility in 2021, with diagnoses of, but not limited to muscle weakness and dementia (a decline in thinking and memory skills). A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS score of 10. During an interview on 6/2/26, at 11:53 a.m., Resident 2 stated Resident 1 entered his room, used the bathroom, and left without flushing the toilet. During a review of Resident 1's clinical record titled, Progress Notes dated 4/6/26, the progress notes indicated, . cut to right side back of head with two staples intact and well approximated [the edges of the skin fit closely with no overlap] to right back of head. cut was obtain due to recent altercation from resident to resident [Resident 2 to Resident1] . During a review of Resident 1's physician order dated 4/7/26, the physician order indicated, . monitor & assess (cut with 2 staples) on (right back of head) Q [each] shift for any changes in size, appearance, skin breakdown & worsening during treatments & notify MD [Medical doctor] if any. During an interview on 6/2/26, at 12:25 p.m., Resident 1 stated Resident 2 came into his room and struck his head with a metal cane. Resident 1 explained that injury caused him pain, and he had to go to hospital for treatment. Resident 1 stated he felt sad. During a telephone interview on 6/2/26 at 2:39 p.m., the Certified Nurse Assistant (CNA) explained, she was passing by in the hallway (outside Resident 1's room) when she saw Resident 2 was standing outside Resident 1's room with a metal cane raised in the air on 4/6/26. The CNA explained she was able to separate Resident 1 and Resident 2. The CNA stated she did not see Resident 2 strike Resident 1 with cane. The CNA also stated she had noticed blood coming from back of Resident 1's head. During an interview on 6/2/26 at 12:05 p.m., Licensed Nurse (LN) 1 stated, she was at the nurse's station when the altercation between Resident 1 and resident 2 occurred on 4/6/26. LN 1 stated the CNA witnessed Resident 2 standing outside Resident 1's room with a cane raised in the air. LN1 further stated she immediately assessed Resident 1 and observed bleeding from Resident 1's head. LN1 identified a 3-centimeter (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(cm-a unit of measurement) laceration to the back of Resident 1's head. LN1 stated Resident 1 was transferred to the hospital for further evaluation and treatment. Review of Resident 1's care plan ALLEGED ALTERCATION (RESIDENT TO RESIDENT), initiated on 4/6/26, indicated, .CNA witnessed [Resident2] .standing.with a cane in his hand lifted up in the air .Resident [Resident 1] will have no further incidents .Resident [Resident 1] will have no psychological effects from altercation . Review of Resident 1's care plan SHORT TERM SKIN, dated 4/6/26 indicated, .[Resident 1] has skin cut on the right side back of head with moderate bleeding 4/6/26 back from ER [emergency room] monitor & assess (cut with two staples) on (right back of head) for any changes in size, appearance, skin breakdown & worsening during treatments and notify MD if any . During a review of Resident 2's care plan ALTERCATION (RESIDENT TO RESIDENT), dated 4/6/26, the care plan indicated, .CNA1 witnessed [Resident 2] .standing.with a cane in his hand lifted up in the air .[Resident 2] will have no further incidents . A review of a facility policy titled Resident-to Resident Altercations, revised date 12/16, indicated, .Facility staff will monitor residents for aggressive/inappropriate behavior toward other residents . A review of a facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention, revised date 4/21, indicated, .Residents have the right to be free from abuse.This includes but is not limited to freedom from.physical abuse.		