

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 06/17/2026
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 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 failed to ensure medical records were complete and accurate in accordance with professional standards for one of three sampled residents (Resident 1) when: Resident 1's low air mattress (LAL, a specialized powered air mattress used primarily in healthcare designed to prevent and treat pressure injuries to skin) checks were not documented every shift daily in the medical record per physician's orders; and, Resident 1's turning and repositioning was not documented every two hours in the medical record. These failures resulted in inaccurate documentation in Resident 1's medical record and had the potential for decreased well-being for Resident 1. Findings: 1. A review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility in 2026 with diagnoses which included cerebral infarction (a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke or CVA) and chronic obstructive pulmonary disease (COPD, a long-term disease that cause airflow blockage, breathing related problems, shortness of breath and cough). A review of Resident 1's Minimum Data Set (MDS, a comprehensive care assessment tool), dated 5/26/26, indicated, .Brief Interview for Mental Status [BIMS, a tool to assess cognition, mental processes that deal with knowledge]. 11 [a score of 08 to 12 indicated moderately impaired cognition]. Section GG Functional Abilities [self-care and mobility]. Eating: 03 [Partial/moderate assistance from a helper with the helper providing less than half of the effort]. Oral Hygiene: 02 [Substantial/maximum assistance from one helper with the helper providing more than half of the effort]. A score of 01: Dependent (the helper provided all of the effort to complete the activity or the assistance of two or more helpers was required to complete the activity) was indicated for moving from a sitting to a lying position, rolling from side to side in bed, moving from bed to chair or wheelchair, showering or bathing, and toileting. A review of Resident 1's Physician Order Summary, indicated, .May use LAL [Low air loss mattress, a specialized powered air mattress used primarily in healthcare designed to prevent and treat pressure injuries to skin] as preventive measure for skin breakdown [prolonged pressure on the skin leading to injury]. LN [Licensed Nurse] to check placement and function Qshift [every shift daily]. Order Date. 03/24/2026. A review of Resident 1's Care Plan Report, indicated, .Focus. at risk for pressure injury [Pressure ulcer, a localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or a pressure in combination with friction] development and skin breakdown r/t [related to]. weakness. assistance from staff for bed mobility. hx [history of] CVA with left sided weakness. Goal. Will minimize risks of further pressure injury thru nursing preventative measures. Date Initiated. 03/24/2026. Interventions/Tasks. Apply Low Air Loss Mattress as ordered to relieve pressure points & check placement QS [every shift daily]. A review of Resident 1's April, May, and June 2026 Treatment Administration Record (TAR, a list of prescribed treatments), indicated that Resident 1's low air loss mattress checks were not documented each shift daily in the TARs. During an interview on 6/16/26, at 2:10 p.m., with Licensed Nurse (LN) 1, LN 1 stated that she was not sure where to document the functioning of the low air loss mattress, so she would need to ask someone. During an interview on 6/17/26, at 10:44 a.m., with LN 2, LN 2 stated that the functioning of low air loss mattresses was documented in the TAR by the LNs. During a concurrent interview and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555307	Facility ID: 555307 If continuation sheet Page 1 of 2

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review on 6/17/26, at 2:30 p.m., with the Director of Nursing (DON), Resident 1's April, May, and June 2026 TARs, were reviewed. The DON stated that his expectation was that facility staff accurately documented in the residents' medical records all interventions provided to show what was done for the residents. The DON further stated that the risk of not documenting care provided was that it was not done if it was not documented. The DON stated that his expectation was that staff checked the functioning and settings of the residents' low air loss mattresses every shift and documented the checks in the TAR. The DON further stated that the risk of not documenting the checks was that the settings could be incorrect. The DON acknowledged that the documentation for Resident 1's low air loss mattress functioning was not documented every shift per physician order during the months of April, May, and June 2026. The DON further acknowledged that the facility policy was not followed.2. A review of Resident 1's Care Plan Report, indicated, .Focus.at risk for pressure injury [Pressure ulcer, a localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or a pressure in combination with friction] development and skin breakdown r/t [related to].weakness.assistance from staff for bed mobility.hx [history of] CVA with left sided weakness.Goal.Will minimize risks of further pressure injury thru nursing preventative measures.Date Initiated.03/24/2026.Interventions/Tasks.Turn and reposition q2h [every two hours] and PRN [as needed]. A review of Resident 1's April, May and June 2026 Tasks (a section of the resident' electronic medical record [EMR] where Certified Nursing Assistants [CNAs] document care that they provided to facility residents), lists indicated that turning and repositioning was not documented every two hours daily for Resident 1.During an interview on 6/17/26, at 10:53 a.m., with CNA 1, CNA 1 stated that she documented turning and repositioning residents on the Tasks, list in the EMR. CNA 1 stated that if a resident had surgery on the hip for example, and couldn't be moved, she would document not applicable on the resident's Tasks, list in the EMR.During a concurrent interview and record review on 6/17/26, at 10:57 a.m., with CNA 2, the Tasks, list in the EMR was reviewed. CNA 2 stated that she documented turning and repositioning, baths, showers, and oral care on the Tasks lists in the EMR. CNA 2 further stated that if a resident refused to be turned and repositioned, she documented the refusal and notified the Licensed Nurse (LN). CNA 2 stated that documenting not applicable, on the Tasks, list in the EMR meant that it was not done.During a concurrent interview and record review on 6/17/26, at 2:30 p.m., with the DON, Resident 1's April, May, and June 2026 Tasks, lists were reviewed. The DON stated that his expectation was that facility staff accurately documented in the residents' medical records all interventions provided to show what was done for the residents. The DON stated that the risk of not documenting care provided was that it was not done if it was not documented. The DON stated that his expectation was that residents were turned and repositioned every two hours and the turning and repositioning was documented in the medical record. The DON stated that the risk of not turning and repositioning the residents every two hours was an increased risk of skin breakdown. The DON acknowledged that turning and repositioning for Resident 1 was not documented every two hours each shift during the months of April, May and June 2026. The DON acknowledged that the facility policy was not followed.A review of a facility policy and procedure (P&P) titled, Charting and Documentation, revised July 2017, indicated, .Policy Statement.All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical.condition, shall be documented in the resident's medical record.Policy Interpretation and Implementation.The following information is to be documented in the resident medical record.c. Treatments or services performed.Documentation in the medical record will be objective.complete and accurate.		