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	03/27/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51584 Based on observation, interview, and record review, the facility failed to ensure 2 of 14 residents (Resident 15 and Resident 57) with urinary catheters (flexible tube used to empty the bladder) were treated with dignity and their privacy was protected, when Resident 15 and resident 57's urinary catheter bag (a drainage bag attached to a catheter (tube) that is inside the bladder to collect urine) was exposed and was not placed in a dignity bag (a bag used to the cover and hold the catheter drainage/collection bag so it is not visible). This failure had the potential to cause psychosocial harm to Resident 15 and Resident 57. Findings: 1. A review of Resident 57's ADMISSION RECORD, indicated Resident 57 was admitted to the facility with multiple diagnoses including paraplegia (paralysis that occurs in the lower half of the body) and neuromuscular dysfunction of bladder, unspecified (condition where the nerves and muscles controlling bladder function does not work properly, leading to difficulty emptying or controlling the bladder). During an observation on 3/24/25, at 11:05 AM, Resident 57 was lying in the bed. Resident 57's urinary catheter bag was observed without any cover. Resident 57 stated that he would prefer his catheter bag to be covered. During a concurrent observation and interview on 3/24/25, at 11:09 AM, with Licensed Nurse (LN) 1, LN 1 confirmed Resident 57's urinary catheter bag did not have a cover. LN 1 stated that the catheter bag should be covered. LN 1 further stated having a dignity bag at all times would protect the resident's privacy and dignity. 2. A review of Resident 15's ADMISSION RECORD, indicated Resident 15 was admitted to the facility with multiple diagnoses including benign prostatic hyperplasia without lower urinary tract symptoms (a non-cancerous condition where the prostate gland grows larger, potentially causing urinary problems, but not necessarily resulting in lower urinary tract symptoms) and chronic kidney disease, unspecified (a condition where the kidneys are damaged and can not filter blood effectively leading to a buildup of waste in the body) . (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

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	03/27/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/24/25, at 1:56 PM, Resident 15 was watching TV and lying in bed. Resident 15's urinary catheter bag was observed without any cover. During a concurrent observation and interview on 3/24/25, at 2:35 PM, with LN 1, LN 1 confirmed Resident 15's urinary catheter bag did not have a cover. LN 1 stated that the catheter bag should be covered. LN 1 added when Resident 15's catheter bag was not covered, it put Resident 15 at the risk of emotional distress and violated his privacy. During a concurrent interview and record review on 3/24/25, at 11:52 AM, with the Director of Nursing (DON), the DON stated the catheter bags should be off the floor and with a dignity bag cover at all times. The DON added it was to protect the residents' right to privacy. The DON further stated that if a resident's catheter was left uncovered, then it would put the resident at risk to feel embarrassed. Review of the facilities P&P titled, Dignity, revised February 2021, indicated .Staff promote, maintain, and protect resident privacy . Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered .

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	03/27/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 51681 Based on interview, and record review, the facility failed to ensure one out of twenty-eight (28) sampled residents (Resident 102) received follow-up appointment care when, Resident 102 was not informed about his post-surgery appointment in advance. This failure resulted in Resident 102 missing his follow-up doctor's appointment which had the potential to result in readmission to the hospital when post follow-up care from a provider was not completed. Findings: Review of Resident 102's ADMISSION RECORD indicated, Resident 102 was admitted to the facility with diagnosis including surgical aftercare following surgery on the circulatory system (a system of organs that includes the heart, blood vessels, and blood which is circulated throughout the body). The record indicated Resident 102 was his own responsible party (can make decisions for himself). During an interview on 03/24/25 at 3:43 PM, Resident 102 stated that he missed his appointment on 3/21/25 with the cardiothoracic surgeon (a medical doctor specializing in surgical procedures of the heart, lungs, esophagus, and other organs within the chest) because nobody had told him about it. Review of Resident 102's hospital discharge summary titled Discharge Summary, dated 3/7/25, included instructions for a follow up visit with the cardiothoracic surgeon, scheduled for 3/21/25. During an interview on 3/26/25, at 12:52 PM, the Medical Operations Receptionist (MOR; from an outside facility) confirmed Resident 102 was a no-show for his follow-up appointment with the cardiothoracic surgeon on 3/21/25 and Resident 102's appointment was re-scheduled for 3/28/25. During an interview on 03/26/2025 at 1:24 PM with the Appointments, Scheduling and Transportation Coordinator (ASTC), he confirmed that the appointment with cardiothoracic surgeon on 3/21/25 for Resident 102 was written in the discharge orders from the hospital at the time of admission in the facility. Appointments are important because it ensures the resident is well and does not need to be readmitted (to hospital) again and, for Resident 102 to miss his important after open-heart surgery was unacceptable. During an interview on 3/26/2025 at 3:19 PM with the Director of Nursing (DON), he stated that, ASTC was the one ultimately responsible for ensuring appointments were followed through, the orders were in place in the chart. The facility also have a calendar to ensure the appointments are followed. The DON attributed Resident 102's missed appointment to a possible transportation issue although he was not sure. According to the DON, the risk of missing an important follow up doctor's visit was the potential for delayed specialty care. Resident 102 missing an appointment did not meet his (DON) expectations. During interview with ASTC on 03/26/2025 at 3:54 PM, he stated that he found out that Resident 102 was not informed regarding the appointment at all and therefore, refused to leave the facility. ASTC stated moving forward, he planned to give residents a notice to ensure nothing was missed. (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	03/27/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure Taking Residents to Appointments, revised in December 2016, indicated .residents should be consulted regarding the appointment .review with the resident the appointments if they agree to go to the appointments .the responsible party will be notified of the date and time (of the appointment) .notify the supervisor if the resident refuses to go to the appointment .

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	03/27/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 51681 Based on interview, record review and the facility policy review, the facility failed to ensure that Notice of Medicare Non-Coverage (NOMNC - a form required by the Centers for Medicare & Medicaid Services that providers must deliver to patients receiving certain Medicare services such as skilled nursing or rehabilitation services before those services are terminated, informing them of the end of coverage and their appeal rights) was received by the representative of one out of three sampled residents (Resident 26). As a result, Resident 26 and her representative did not have knowledge neither choice to appeal changes in cost of Skilled Nursing Services. Findings: Review of ADMISSION RECORD indicated Resident 26 was her own responsible party. Review of Resident 26's Notice of Medicare Non-Coverage form, indicated .Service Start/admitted : 11/15/24 .Services Will End: 12/16/24 . The form did not have Resident 26's signature. During an interview with Case Manager (CM1) on 03/26/2025 at 9:57a.m., CM 1 stated Resident 26 opted for her representative to review and sign the NOMNC form. CM 1 stated she mailed the NOMNC form on 12/13/2024 to Resident 26's representative using standard/regular mail instead of certified mail with return receipt request to verify delivery. CM 1 explained that she did not make any follow up regarding the form. CM 1 stated a follow up call should have been made but she did not do it. CM 1 stated NOMNC form was important for the resident/representative to receive because it informed resident/representative of their rights and option to appeal. CM 1 confirmed that it had been three months and she had not done any follow up about Resident 26's NOMNC form. During a phone interview on 3/26/2025 at 10:18a.m., Resident 26's representative stated that she never received any phone call from the facility discussing anything about Medicare Form. Resident 26's representative stated she never received any NOMNC form from the facility. Resident 26's representative stated the mailing address in the facility's Medicare Attestation Form (a form used only when a member refuses to sign) was incorrect. Review of the facility's policy titled, Medicare Advance Beneficiary and Medicare Non-coverage Notices dated September 2022 indicated, .Residents are informed in advance when changes will occur to their bills . If a resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage is issued to the resident at least two calendar days before benefits end. (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	03/27/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CMS Form Instructions for the Notice of Medicare Non-Coverage indicated, Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents. The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature .If the provider chooses to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS) The burden is on the provider to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

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	03/27/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50925 Based on interview, and record review, the facility failed to complete the Pre-Admission Screening and Resident Review (PASRR - a required assessment for individuals with mental illness, intellectual or developmental disabilities, or related conditions, so that a determination of need, appropriate setting, and a set of recommendations for services to be included in the individual's plan of care is provided) Level II evaluation for one of twenty-eight sampled residents (Resident 90) when, Resident 90's PASRR Level II evaluation was not completed after having a positive result with the Level I screening. This failure had the potential for Resident 90 to not receive the necessary services to meet their mental and psychosocial (the link between social factors and individual thought and behavior) needs. Findings: A review of Resident 90's ADMISSION RECORD, indicated Resident 90 was admitted to the facility in late 2024 with diagnoses which included dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). A review of Resident 90's letter from the California Department of Health Care Services (DHCS), dated 1/27/25, indicated .SUBJECT: NOTICE OF PASSR LEVEL I SCREENING RESULTS .Re: A SERIOUS MENTAL ILLNESS (SMI) LEVEL II MENTAL HEALTH EVALUATION IS REQUIRED .Your Level I Screening indicates that a SMI Level II Mental Health Evaluation is required and an ID [intellectual disability]/DD [developmental disability]/RC [related conditions] Level II Mental Health Evaluation is not required .Result: Positive for SMI; Negative for ID/DD/RC .Level II Mental Health Evaluation Referral: Required for SMI; Not Required for ID/DD/RC .Your facility will be contacted within two to four days to set up an appointment for an evaluator to conduct a Level II Mental Health Evaluation . A review of Resident 90's letter from the California Department of Health Care Services (DHCS), dated 1/27/25, indicated .SUBJECT: NOTICE OF ATTEMPTED EVALUATION .Re: UNABLE TO COMPLETE LEVEL II EVALUATION FOR SERIOUS MENTAL ILLNESS (SMI) .Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening . During a concurrent interview and record review on 3/26/25, at 6:24 p.m., with the Social Services Director (SSD), the SSD confirmed Resident 90 had a PASRR level I screening done on 1/27/25 which indicated Level II evaluation was required. The SSD verified Resident 90's PASRR level II evaluation was not scheduled and stated she has never done this process herself because it was part of the admission's process. The SSD stated that it was expected for Resident 90's PASSR level II evaluation to have been completed and it was part of the facility's process for new admissions. The SSD confirmed Resident 90's PASRR level II evaluation should have been scheduled by either Admissions or Social Services. The SSD stated it was important to have the PASRR level II evaluation to have been completed because it would have helped with Resident 90's care plan. The SSD further stated that if Resident 90's PASRR level II was not completed, his mental health diagnoses needed to be determined to address his needs and to manage his care. (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	03/27/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/27/25, at 9:14 a.m., with the Admission Coordinator (AC), the AC stated the admissions staff looked into the PASRR level I screening during the admission process. The AC checked the PASRR online portal and confirmed that the copy of Resident 90's PASRR level II letter dated 1/27/25, stated unable to complete PASRR level II evaluation. During an interview on 3/27/25, at 9:22 a.m., with the Business Office Manager (BOM), the BOM stated if a resident required PASRR Level II, it will be triggered with the Minimum Data Set (MDS - a federally mandated resident assessment tool). When asked what would trigger a PASRR level II, the BOM stated if there was a change in resident's condition then they would qualify for PASRR level II. The BOM further stated that the admissions staff was responsible for obtaining the PASRR level I screening and the PASRR Level II evaluation was the MDS Coordinator's (MDSC) responsibility. During a concurrent interview and record review on 3/27/25, at 9:28 a.m., with the MDSC, the MDSC stated he usually received a call from PASRR for level II screenings and did not recall receiving a call for Resident 90's PASSR level II screening. The MDSC reviewed Resident 90's chart and confirmed a PASRR Level II should have been done based on his medical diagnoses list and medications he was taking. The MDSC stated the expectation was that after the PASRR level I screening was completed and determined positive then a PASRR level II should have been scheduled. The MDSC further stated it was important to complete PASRR level II evaluation because it would affect Resident 90's level of care through proper diagnosis and to determine the appropriate treatment. During a concurrent interview and record review on 3/27/25, at 9:42 a.m., with the Assistant Director of Nursing (ADON), the ADON confirmed Resident 90 had diagnoses of dementia, anxiety and psychosis and was suitable for PASRR screening. The ADON reviewed Resident 90's PASRR letter dated 1/27/25 and confirmed that the PASRR level II evaluation was required and was not completed. The ADON stated it was her expectation for Resident 90's PASRR level II evaluation to have been done. The ADON stated that PASRR II evaluations were important to determine resident's proper diagnosis and appropriate interventions needed. A review of the facility's document titled, Admission Criteria, revised 03/2019, indicated .Policy Statement . Our facility admits only residents whose medical and nursing care needs can be met .Policy Interpretation and Implementation .9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process .b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the stat PASARR representative for the Level II (evaluation and determination) screening process .(1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD .(2) The social worker is responsible for making referrals to the appropriate state-designated authority .

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	03/27/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 51485 Based on interview and record review, the facility failed to provide necessary services to maintain personal hygiene for 2 of 28 sampled residents (Resident 357 and Resident 11) when, showers were not provided to Resident 357 and Resident 11 at least two times a week as scheduled. This failure had the potential for poor hygiene, infection, and emotional distress for Resident 357 and Resident 11. Findings: 1. A review of Resident 357's ADMISSION RECORD indicated Resident 357 was admitted to the facility with diagnoses including fracture of shaft of humerus left arm (broken bone of the left upper arm), fracture of lower end of left radius (broken bone on the left lower arm), fracture of shaft of left tibia (broken left lower leg), generalized muscle weakness, and abnormalities of gait and mobility. During an interview on 3/24/25, at 11:09 AM, Resident 357 stated she had not received a shower since she was admitted to the facility. A review of the facility's undated shower schedule indicated Resident 357 was scheduled to receive a shower on Monday and Thursday on the evening shift. As per shower schedule, Resident 357 was due for a shower on 3/17/25 and 3/20/25. Review of Resident 357's shower record indicated Resident 357 did not receive a shower on 3/17/25 and 3/20/25 as scheduled. During a concurrent interview and record review on 3/25/25, at 04:35 PM, Licensed Nurse (LN) 9 stated residents received a shower twice a week as per the shower schedule and as needed or requested. LN 9 confirmed Resident 357 did not receive a shower on 3/17/25 (Monday) and 3/20/25 (Thursday) as scheduled. During a concurrent interview and record review on 3/27/25, at 10:22 AM, the Assistant Director of Nursing (ADON) stated CNAs (Certified Nursing Assistant) were expected to provide a shower or bed bath to the residents twice a week as per shower schedule and resident preference. The ADON confirmed that Resident 357 had no record of shower since admission. The ADON stated if residents did not receive a shower as scheduled then residents would smell bad and would be placed at risk of skin breakdown, poor hygiene, and infection especially if the residents were not able to take care of themselves. 2. A review of Resident 11's ADMISSION RECORD indicated Resident 11 was admitted to the facility with diagnoses including hemiplegia affecting the left nondominant side (a condition characterized by paralysis or weakness on one side of the body), transient cerebral ischemic attack (mini-stroke), generalized muscle weakness, and abnormalities of gait and mobility. (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	03/27/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/25, at 11:51 AM, Resident 11 stated she only had a shower once since she was admitted to the facility. Resident 11 stated the only time she had a shower was a week after she was admitted . Resident 11 stated she did not know her shower schedule. A review of the facility's undated shower schedule indicated Resident 11 was scheduled to receive a shower on Tuesday and Friday on the morning shift. A review of Resident 11's Care Plan Report, dated 3/12/25 indicated .has an ADL Self Care Performance Deficit r/t [related to] weakness, impaired mobility, left sided weakness .Functional Abilities-BATHING: Resident requires substantial/maximal assistance . During a concurrent interview and record review on 3/27/25, at 10:22 AM, the Director of Staff Development (DSD) stated CNAs provided showers to resident as per the shower schedule twice a week and upon request. Resident 11's March 2025 shower record was reviewed with the DSD. The DSD confirmed Resident 11 did not receive a shower on 3/7/25 (Friday) as scheduled. The DSD stated Resident 11 was placed at risk of infection, and her wounds would have gotten worse when a shower was not provided as scheduled. The DSD stated showers should be done as scheduled as it would affect a resident's hygiene and dignity when not done. A review of the facility's undated policy and procedure titled Bath, Shower/Tub, indicated .The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin .Documentation 1. The date and time the shower/tub bath was performed .3. All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath .

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	03/27/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 51681 Based on observation, interview, and record review, the facility failed to ensure effective pain management was provided for one of twenty-eight sampled residents (Resident 463), when Resident 463 complained of pain and was not assessed or given pain medication for approximately 2 hours. This failure resulted in Resident 463 waiting for an extended period of time for pain medication and had the potential to experience emotional distress from inadequate pain relief. Findings: Review of Resident 463's ADMISSION RECORD, indicated Resident 463 was admitted to the facility with diagnosis of periprosthetic fracture around the internal prosthetic right knee joint (a break or crack in a bone, surrounding the knee replacement implant). Review of Resident 463's undated pain care plan titled Clinical Care Plan Detail, indicated, .risk for PAIN, has acute/chronic pain .decreased mobility .hx [history] of right periprosthetic knee fx [fracture] following assault s/p [state after intervention] ORIF [Open Reduction and Internal Fixation; a surgical procedure used to repair severely broken bones and stabilizing them with hardware like screws, metal plates] . In the section titled New Intervention, indicated, .Address resident's choices to managing his/her pain .Administer Medication as ordered .Anticipate the resident's need for pain relief and respond immediately to any complaint of pain . assess for location, severity and characteristic of pain . Review of Resident 463's electronic medical record indicated a physician order was written on 3/25/25 for . Norco Tablet 5-325mg 1tablet by mouth every 6hours as needed for moderate pain [4-6 (pain scale)] . During a concurrent observation and interview on 3/26/25 at 4:25 PM, inside Resident 463's room, Resident 463 was complaining of 10/10 pain level (pain scale 1-10; 1=mild and 10=severe) on her right leg with noted facial grimacing. Resident 463 stated she had been asking for her pain medication since 3:00PM. Resident 463 pressed her call light again. CNA 1 responded to Resident 463's call light at 4:37PM. Resident 463 asked for her pain medication and CNA 1 stated, I will tell [LN 1] again and then left. During an interview with CNA 1 on 3/26/25 at 4:57 PM by the hallway near Resident 463's room, CNA 1 confirmed that Resident 463 had been asking for her pain medication since 3:00PM. CNA 1 added she had notified LN 1 three times already. CNA 1 stated it was not good for the resident if pain medication administration was delayed, because it could make them hyper and that their blood pressure might go high. (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	03/27/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LN 1 on 3/26/25 at 5:02PM by the hallway near Resident 463's room, LN 1 confirmed CNA 1 informed her of Resident 463 being in pain and requesting pain medication. LN1 stated that the doctor changed Resident 463's pain medication to Norco (a medication used to relieve moderate to sever pain) and that their pharmacy had not delivered the medication yet. LN1 stated she did not have time to assess Resident 463 and had not assessed Resident 463 since start of her shift at 3:00PM. During a concurrent interview and record review with the ADON on 3/26/25 at 5:09PM at the ADON's office, the ADON confirmed that Norco was ordered for Resident 463 on 3/25/25. The ADON confirmed Resident 463's MEDICATION ADMINISTRATION RECORD indicated Norco had not been given to Resident 463 yet since 3/25/25. The ADON explained if Norco was not delivered by their pharmacy yet, LN 1 could have used their e-kit (emergency kit) and administered the Norco as ordered. The ADON expressed that her expectation was for Resident 463 to have been assessed at the start of the shift since Resident 463 was complaining of pain. The ADON continued to state that it was unacceptable to leave the resident in pain. The ADON further stated LN 1 should have prioritized Resident 463 and have readily acted on it. A review of the facility policy titled, Administering Medications, revised April 2019, indicated, .Medication are administered in a safe and timely manner, and as prescribed . Medication administration are determined by resident need and benefit, not staff convenience. Factors that are considered include .c. honoring resident choices and preferences, consistent with his or her care plan .

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	03/27/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50778 Based on observation, interview, and record review, the facility failed to ensure medications were administered according to the physician orders for one of twenty-eight sampled residents (Resident 43) when, Resident 43's medications were not administered in a timely manner and some medications were missed on 3/24/25. This failure had the potential to result in causing Resident 43 to experience preventable medication-related adverse events (undesirable medical occurrence experienced by a resident) of a serious nature related to high blood pressure (a condition in which the force of the blood pushing against the blood vessel walls is consistently too high), breathing difficulties, and pain. Findings: During an interview on 3/24/25, at 12:05 PM, Resident 43 stated she normally received her medication at 7:30 AM, but she still had not received her AM medications. Resident 43 stated she had used the call light to ask for her medications at least 10 times today. During an interview on 3/24/25, at 12:07 PM, Certified Nursing Assistant (CNA) 2 stated she answered Resident 43's call light at least five time today and Resident 43 was asking for her medications each time. During an interview on 3/24/25, at 12:09 PM, Licensed Nurse (LN) 4 stated Resident 43's medications were due at 8 AM and 9 AM and there were thirteen AM medications to administer to Resident 43 in total. LN 4 stated the risk to the resident when the medications were given late would depend on the medication. LN 4 stated late pain medications would result in pain, blood pressure medications could cause high blood pressure and COPD (Chronic obstructive pulmonary disease: a group of diseases that cause airflow blockage and breathing related problems and is a long-term lung disease) and asthma medications (medications the help reduce swelling and mucus production inside the airways and lungs) could cause respiratory distress (a condition where breathing becomes difficult making one work harder to breathe and may result in not enough oxygen in the body). During a concurrent observation and interview on 3/24/25, at 12:30 PM, LN 4 removed thirteen medications from the medication cart in preparation to administer the medications to Resident 43. LN 4 stated there were 12 PM medications due to be given to Resident 43 but they could not be administered because they would be given too close together because since the AM medications were just administered. (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	03/27/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 3/27/25, at 11:06 AM, Resident 43's Medication Administration Record (MAR), dated 3/25, was reviewed with the Director of Nursing (DON). Review of Resident 43's MAR indicated the following medications were scheduled to be given in the morning between 8 AM and 9 AM on 3/24/25, but were documented as given after 12 PM: amlodipine (medication used to treat high blood pressure), ferrous sulfate (medication to treat and prevent iron deficiency), fluoxetine (medication used to treat depression), Furosemide (a medication used to treat high blood pressure and edema-fluid retention in the body), artificial tears solution (a liquid for the eyes designed to relieve dry eye discomfort), fluticasone propionate (medication used to treat inflammation in the airways and nose), ipratropium bromide (medication that helps to relax the muscles in the airways, making it easier to breathe), hydrocodone-acetaminophen (medication used to treat pain), saline nasal solution (a mixture of salt and water used to moisturize and cleanse nasal passages), Wixela-fluticasone-salmeterol (a inhaled medication used to treat asthma and COPD), potassium chloride (a medication used to treat low potassium levels in the body), gabapentin (a medication used to treat nerve pain), and Spiriva Respimat (medication that relaxes muscles in the airways and increases air flow to the lungs). Resident 43's MAR indicated gabapentin was to be administered at 8 AM and 12PM. The DON confirmed Resident 43's medications scheduled for the AM were administered around noon and was administered late. The DON stated because the AM medications were given at noon, some of the noon scheduled medication could not be given as scheduled. The DON stated the risk to the resident when medications were administered late was the potential for the resident to not get the correct dose on time and would contradict what the orders were. The DON stated the administration of the AM medications at noon was outside of the facility policy and procedure on medication administration. Review of a facility policy and procedure titled, Medication Administration General Guidelines, dated 1/25, indicated, .Medications are administered as prescribed .Medications are administered within 60 minutes of scheduled time .routine medications are administered according to the established medication administration schedule .

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	03/27/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50778 Based on interview, observation, and record review, the facility failed to ensure safe medication storage practices in two out of five medication carts (a mobile cart stored medication and supplies for immediate use) when: 1. There was opened medication stored in the medication carts that were not labeled with an opened-on date (a date the medication was first opened); 2. An over-the-counter medication (OTC-medication that does not require a prescription) was stored in the medication cart that should have been refrigerated; 3. A Hazardous medication (medications that are known to cause harm if handled incorrectly) was not in the appropriate protective plastic bag (a specially engineered plastic bag/container designed to safely contain and transport hazardous medications, ensuring they are handled in accordance with regulations and best practice); and 4. A resident's rings were in a plastic bag labeled with a room number and placed in a drawer in the medication cart. These failures had the potential for residents in the facility to not get the full benefits of their prescribed medications caused by improper storage and for the staff to potentially experience known harm from hazardous medication handling. Findings: 1. During a concurrent interview and observation on 3/26/25, at 9:50 AM, with Licensed Nurse (LN) 6, at Station 2 Medication Cart 2, a bottle of antacid medication (works to reduce stomach acid to relieve symptoms like heartburn and indigestion) was opened and did not have an opened-on date. LN 6 stated the stock (medication kept on hand until needed) antacid medication should have had an open on date on the container. During a concurrent observation and interview on 3/27/25, at 12 PM, with LN 5, at Station 1 Medication Cart 2, LN 5 confirmed the following OTC medications located in the medication cart were not dated with an open date and should have been: one-daily multivitamins (a medication containing all or most of the vitamins that may not be readily available in the diet), iron tablets (a mineral essential for the body), probiotic (live bacteria that have beneficial effects on your body), nephro vitamins (a multivitamin used to treat or prevent vitamin deficiency due to poor diet and certain illnesses), and folic acid (helps the body make healthy red blood cells-cells that transport oxygen from the to the body's tissues). During an interview on 3/27/25, at 4:05 PM, the Director of Nursing (DON) stated OTC medications in medication cart drawers should have been labeled with opened-on dates. (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	03/27/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/19, indicated, .Medications are administered in a safe and timely manner .When opening a multi-dose container, the date opened is recorded on the container . 2. During a concurrent observation and interview on 3/27/25, at 12 PM, with LN 5, at Station 1 Medication Cart 2, LN 5 confirmed the acidophilus (a bacteria naturally found in the digestive system, urinary tract and other parts of the body and used as a probiotic - a microorganism that when consumed as a dietary supplement maintains or restores beneficial bacteria in the body) OTC medication bottle was opened and located inside the medication cart drawer. LN 5 read the storage details on the bottle of the acidophilus and confirmed the medication should have been refrigerated after opening. During an interview on 3/27/25, at 4:05 PM, the DON confirmed the acidophilus OTC medication bottle that was located in the medication cart should have been stored in the refrigerator after it was opened. The DON confirmed acidophilus medication was not stored according to manufacturer guidelines as indicated on the bottle's label. The DON stated the risk to residents was reduced effectiveness and reduced potency of the medication. During a review of the facility's policy and procedure titled, Medication Storage, dated 1/25, indicated, . Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration . Review of the facility's P&P titled, Storage of medications, revised 4/19, indicated, .Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location . 3. During a concurrent interview and observation on 3/26/25, at 9:50 AM, with LN 6, at Station 2 Medication Cart 2, a bubble pill pack (a card that packages doses of medication within small, clear, light-resistant amber-colored plastic bubbles) of risperidone (medicine that helps with symptoms of some mental health conditions) was marked with a hazardous label located on the top left corner of the package and was not in a plastic bag. LN 6 stated hazardous medication in bubble packs should be stored in a plastic bag to prevent staff exposure to known hazardous medications. During an interview on 3/26/25, at 3:45 p.m., the DON stated that it was his expectation that hazardous medication bubble packs were to be stored in a (protective) plastic bag. The DON stated when handling hazardous medications, LNs wore gloves and took the necessary precautions to protect themselves from exposure. The DON stated the facility policy was not followed. 4. During a concurrent interview and observation on 3/26/25, at 9:50 AM, at Station 2 Medication Cart 2, LN 6 confirmed there was a plastic bag containing a resident's rings labeled with only a room number and were in a locked drawer in the medication cart. LN 6 stated that the resident belongings had been in the cart for a couple of days. LN 6 stated that resident belongings should have been given to Social Services and not stored in the medication cart. During an interview on 3/26/25, at 3:45 p.m., the DON stated that it is his expectation resident's belongings were not to be kept in the medication carts. The DON stated that resident's belongings should go to Social Services. The DON stated that the risk of having resident's jewelry in the medication cart was (it could be) expensive and could get lost. (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	03/27/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled, Resident Rights, revised 2/21, indicated, .Federal and State laws guarantee certain basic rights to all residents .be free from .misappropriation of property .

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	03/27/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49823 Based on observation, interview, and record review the facility failed to follow the menu's prescribed portion sizes for mashed sweet potatoes (yams), and vegetables during lunch service on 3/26/25, and the roast beef entree was served with blackened edges during lunch service on 3/26/25 for a total of 107 residents who received facility prepared meals. These failures had the potential to result in an unprescribed increase or decrease in meal intake based on resident diet ordered, and a potential for the residents' preferences not being met. Findings: During the lunch service tray line observation on 3/26/25 at 11:35 a.m., the [NAME] used a gray scoop to plate the yams and vegetables for all lunches served. The [NAME] removed a second tray of the roast beef entree from the stove, then removed the foil cover from the tray. The roast beef in the second tray had black edges. The cook plated the roast beef with the black edges without removing the black edges from the roast beef during the lunch meal service and covered the roast beef with barbecue sauce. During an interview on 3/26/25 at 4:25 p.m. with the facility Food Services Director (FD) in the kitchen, the FD stated that her expectation was that the overcooked roast beef would be cooked better next time. The FD stated that the risk of serving overcooked roast beef was that the roast beef would not be palatable. During a review of the facility's Spring Cycle Menus Week 4, indicated that the lunch menu portion sizes for yams were one-quarter cup for the regular diet small portions and the controlled carbohydrate (CCHO, a diet that helps people with diabetes[a chronic condition that affects the way the body processes blood sugar] keep carbohydrate [sugars, starches, and fiber that can be broken down to provide the body with energy] consumption at a steady level) diet small portions to be plated using the number 16 blue scoop (one-quarter sized scoop); one-half cup for the regular diet regular portion and regular CCHO regular portion to be plated using the number eight gray scoop (one-half cup sized scoop); and three-quarter cup for the regular diet large portions and the CCHO diet large portions. No portion sizes were indicated for the mechanical soft diet (foods that are soft and easy to chew), pureed diet (foods that have a soft pudding-like consistency), dysphagia mechanical soft diet (foods that are blended, chopped, ground, or mashed so that they are easy to chew and swallow), and the two-gram sodium diet (2GmNa, limits foods high in sodium [a mineral needed by the body to keep fluids in balance] and restricts use of table salt). During a review of the facility's Spring Cycle Menus Week 4, indicated that the lunch menu portion sizes for the vegetables (zucchini and carrots) were one-half cup for the regular small portions, regular portions, and large portions diets; one-half cup for the small CCHO, regular CCHO, and large CCHO diets; one-third cup for the pureed diet, and one-half inch chopped, mashed zucchini only for the dysphagia mechanical diet. (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	03/27/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview by phone with the facility Registered Dietitian (RD) on 3/27/25 at 9:48 a.m., the RD stated that she worked as a consultant for the facility from 2018 to 2021, then in 2021 became full time until 2023, then became part time and worked at the facility 25 to 30 hours per week. The RD stated that the FD did in-services with the dietary staff. The RD stated that she observed tray line in the kitchen two to three times a month. The RD stated that she was onsite every week at least three to four times a week. The RD stated that she also spoke with the FD by phone for questions or concerns. The RD stated that there were different portion sizes to be used for the yams and vegetables depending on the residents' prescribed diet. The RD confirmed that the cook's spreadsheet and the Spring Cycle Menus had the scoop size numbers for the amounts of vegetables and yams to be plated for the residents' prescribed diets during a meal. The RD confirmed that the correct portion sizes were not being followed. During an interview and record review with the FD in the kitchen on 3/27/25 at 11:10 a.m., the FD stated that in-services for the kitchen staff were done monthly and as needed. The FD stated that the cooks needed to follow the menus for portion sizes for all diet types, but it was difficult. The FD confirmed that the chart for the scoop sizes by color was posted on the wall near the stove in the kitchen. The FD acknowledged that the facility policy for portion sizes was not followed during lunch meal service on 3/26/25. A review of a facility policy and procedure (P&P) titled, Food Preparation, dated 2023, the P&P indicated, . Policy .Food shall be prepared by methods that conserve nutritive value, flavor, and appearance .Procedure: 1. The facility will use approved recipes, standardized to meet the resident census .2. Recipes are specific as to portion yield .4. Poorly prepared food will not be served - such food is either to be improved, prepared again, or replaced with an appropriate substitution .

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	03/27/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on observation, interview, and record review the facility failed to provide safe food storage and preparation as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 107 residents who received facility prepared meals when: 1. Unlabeled open boxes of frozen chicken patties, frozen whole kernel corn, frozen green peas, and frozen green leaf spinach were stored in the walk-in freezer, 2. An expired container of spice was stored in the dry storage room in the kitchen, 3. A thick brownish gummy substance was on the bottom and sides of a large pot used for cooking resident food on the stove, 4. A flat pan with thick brownish gummy substance on the inside edges was on the shelf next to the stove with clean pots and pans, 5. A frying pan with a brownish flaky substance on the inside cooking edges was on the shelf next to the stove with the clean pots and pans, 6. The toaster oven next to the stove had a brownish substance on the shelves, and, 7. The stove top had a grayish discoloration on the grates of the stove. These failures had the potential for the 107 residents who ate facility prepared meals to be at risk for foodborne illnesses. Findings: 1. During the initial kitchen survey observation and interview with the facility Food Services Director (FD) on [DATE] at 8:13 a.m., the FD stated that she had been working at the facility since 2010. The FD stated that she was full time. During an observation and concurrent interview in the walk-in freezer with the FD, undated and opened boxes of frozen chicken patties, frozen whole kernel corn, frozen green peas, and frozen green leaf spinach were seen in the freezer. The FD confirmed that the risk of using undated food items in the freezer was food safety. 2. During the initial kitchen survey observation and interview with the facility FD on [DATE] at 8:13 a.m., an opened container of spice (seasoning salt) with an expiration date of [DATE], was on the shelf in the dry storage area ready to use for food prep. The FD grabbed the spice container and stated that she thought it was an opened date, not an expiration date. The FD confirmed that the date on the opened spice container was an expiration date. The FD stated that the spice container had been mislabeled. The FD acknowledged that she wasn't sure if it was an expiration date or an opened date on the spice container. The FD stated that the risk of using expired spices was food safety. (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	03/27/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation and interview with the FD in the kitchen on [DATE] at 11:00 a.m., a pot on the stove that had a thick, brownish gummy substance on the bottom and sides was being used to prepare lunch for the facility residents. The FD stated that the risk of using the pot with the thick brownish gummy substance on the bottom and sides of the pot was food safety. 4. During an observation and interview in the kitchen with the FD on [DATE] at 11:00 a.m., a flat pan with a brownish substance caked on the inner edges of the pan was on the shelf next to the stove with the clean pots and pans. The FD stated that the risk of using the flat pan with the brownish substance caked on the inner edges was food safety. 5. During an observation and interview with the FD in the kitchen on [DATE] at 11:00 a.m., a frying pan with dried brownish flaky substance on the inside was located on a shelf with the clean pots and pans next to the stove. The FD confirmed the frying pan had a dried brownish flaky substance in it and stated that the risk was food safety. 6. During an observation and interview with the FD in the kitchen on [DATE] at 11:00 a.m., the toaster oven next to the stove had a brownish substance on the shelves. The FD stated that the risk of using the toaster oven with the brownish substance dried on the shelves was food safety. 7. During an observation and interview in the kitchen with the FD on [DATE] at 11:00 a.m., a grayish discoloration was seen on the grates of the stove. The FD stated that the stove was cleaned monthly. The FD stated that the risk was food safety. A review of a facility policy and procedure (P&P) titled, Procedure for Freezer Storage, dated 2023, the P&P indicated, .6. All frozen foods should be labeled and dated . A review of a P&P titled, Procedure for Refrigerated Storage, dated 2023, the P&P indicated, .13. Individual packages of refrigerated or frozen food taken from the original packing box need to be labeled and dated. Freezer burn may occur before that and reduce the maximum shelf life . A review of a P&P titled, Storage of Food and Supplies, dated 2023, the P&P indicated, .Policy: Food and supplies will be stored properly and in a safe manner .6. Dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc.) .Bins/containers are to be labeled, covered, and dated .9. Dry food items which have been opened, such as .spices .will be tightly closed, labeled and dated . A review of a facility P&P titled, Labeling And Dating of Foods, dated 2023, the P&P indicated .Policy: all food items in the storeroom, refrigerator, and freezer need to be labeled and dated .Procedure: Food delivered to facility needs to be marked with a received date .Newly opened food items will need to be closed and labeled with an open date and used by date . (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	03/27/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility P&P titled, Sanitation, dated 2023, the P&P indicated, .Procedure: 1. The Food and Nutrition Services (FNS) Director is responsible for instructing employees in the fundamentals of sanitation in food service .4. The FNS Director is responsible for instructing Food & Nutrition Services personnel in the use of equipment. Each employee shall know how to operate and clean all equipment in his specific work area .8. The Maintenance Department will assist Food & Nutrition Services as necessary in maintaining equipment and in doing janitorial duties which the Food & Nutrition Services employees cannot do and maintain maintenance records on all equipment .9. The FNS Director will write the cleaning schedule in which he designates by job title and/or employee who is to do the cleaning task .11. All utensils, counters, shelves, and equipment shall be kept clean . A review of a facility P&P titled, Ranges and Ovens, dated 2023, the P&P indicated .Ranges .Cleaning Procedure .1. Open top gas range and grill. When top grids are completely cool, remove grills from the range. Immerse grills in a solution of water and grease solvent to soak. Remove encrusted material with a blunt scraper .2. Boil grates and burners in salt/soda or other grease solvent/water solution .Ovens .Cleaning Procedure: 1. Allow sufficient time for ovens to cool before cleaning. 2. Weekly, and as often as necessary, racks and shelves should be removed and cleaned in a warm detergent solution following manufacturer's instructions . A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section ,d+[DATE]. 11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, [DATE] version, indicated, .(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. A review of the US FDA 2022 Food Code, section ,d+[DATE].13, titled, Vended Time/Temperature Control for Safety Food, Original Container., [DATE] version, indicated, .The possibility of product contamination increases whenever food is exposed .Once the original seal is broken, the food is vulnerable to contamination .

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	03/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51584 Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 115, when: 1. Two unvaccinated (who did not receive an influenza(flu) vaccine) staff members, the assistant director of staff development (ADSD) and the receptionist (R1) did not wear a mask on 3/25/25 inside the facility; 2. Resident 307's door was left open while on airborne precaution; 3. A staff member was observed not providing hand hygiene (cleansing of hands with soap and water or an alcohol-based hand sanitizer) to residents before lunch during tray pass on 3/26/25, and the same staff member was observed not washing hands/using hand hygiene during lunch tray pass on 3/26/25. These failures in infection prevention and control measures had the potential to spread the infection to staff and other residents in the facility. Findings: 1. Review of facility's staff influenza vaccine record for 2024/2025 flu season indicated the ADSD and R1 declined flu vaccine. During a concurrent observation and interview on 3/25/25, at 5:16 PM, the ADSD and R1 were walking in the hallway by the nursing station and were not wearing a mask. Two residents in a wheelchair were sitting next to the nursing station with three other nursing staff. The ADSD and R1 stated they did not receive the flu vaccine this season. The ADSD and R1 stated they were supposed to wear masks until the end of the season (March 31, 2025). During an interview on 3/25/25, at 5:21 PM, the IP confirmed that unvaccinated staff were mandated to wear the mask until the end of the flu season (March 31, 2025). The IP added if unvaccinated staff did not wear mask, it would put the residents and other staff at risk for acquiring the flu. During an interview on 3/26/25, at 5:02 PM, with the Director of Nursing (DON), the DON stated that his expectation for staff who refused the flu vaccine was to wear the mask. The DON added it was mandated. The DON further stated when unvaccinated staff did not wear a mask, it put the residents and staff at risk of being a carrier of the virus and spreading infection to the facility. Review of facility document titled Messages for [NAME] Healthcare Center dated 11/5/24, indicated, . Mask are required unless you have received the flu vaccine . Review of a facility P&P titled, Infection Prevention and Control Program, revised 10/2018, indicated, .11. Prevention of Infection . 8. Following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC) . (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	03/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Center for Disease Control - Public Health Law Influenza Vaccination Laws for State Long-Term Care Facilities updated May 16, 2024, indicated, . Surgical mask requirements: The healthcare worker must wear a surgical mask during the influenza (flu) season if he or she has been exempted from or declined flu vaccination . https://www.cdc.gov/phlp/php/publications/flu-vaccination-laws-state-ltc-facilities.html 2. A review of Resident 307's medical record titled, ADMISSION RECORD, indicated Resident 307 was admitted to the facility in early 2025 with diagnoses which included Covid-19 (an infectious disease caused by the SARS-CoV-2 virus). A review of Resident 307's medical record order summary, order dated 3/25/25, indicated .COVID 19 Ten (10) Days total Novel Respiratory Isolation: New admission, admitted COVID positive. Keep the room door closed every shift until 3/31/25 . During a concurrent observation and interview on 3/26/25, at 5:25 p.m., with Certified Nurse Assistant (CNA) 3, Resident 307's room with an airborne isolation sign posted outside the room door and the door was opened. CNA 3 confirmed that Resident 307 was on airborne isolation precaution. CNA 3 stated gown, gloves and mask were needed to be worn by staff who would enter Resident 307's room. CNA 3 confirmed that Resident 307's door should be closed but Resident 307 yelled that she did not want the door closed, so the staff left the door open. During an observation of Resident 307's room on 3/26/25, at 5:32 p.m., an airborne precaution sign was posted and PPE (personal protective equipment) bin was outside the door, with the door left open. Resident 307 was observed to be inside the room laying on the bed. During a concurrent observation and interview on 3/26/25, at 5:35 p.m., with CNA 3, CNA 3 was observed performing hand hygiene with the use of hand sanitizer and then donned N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles), gown, and gloves prior to entering Resident 307's room to deliver the meal tray. CNA 3 stated Resident 307's room door had been open because she was screaming and did not want the door closed. The CNA further stated the staff normally closed Resident 307's room door but since Resident 307 was screaming, the staff left it open. During a concurrent observation and interview on 3/26/25, at 5:36 p.m, with CNA 1, CNA 1 confirmed there was an airborne precaution sign posted outside Resident 307's room door. CNA 1 stated usually the door was closed for residents with Covid-19 diagnosis, but Resident 307's door was left open because she was screaming. CNA1 stated that Resident 307's room door should be closed and usually the facility would have a plastic sheet to cover the door way as an alternative. CNA 1 stated the risk of having the room door open for an airborne isolation room was to spread the Covid-19 virus and infecting other residents or staff in the facility. During a concurrent observation and interview on 3/26/25, at 5:44 p.m., with LN 8, LN 8 confirmed Resident 307's room had an airborne precaution sign posted and PPE bin outside the room. LN 8 confirmed the airborne precaution sign posted indicated door to room must remain closed. LN 8 stated usually there was a curtain to cover the room if the room door could not be closed. LN 8 stated that the risk of having the door open was the potential of spreading the virus and risking other residents and staff of getting sick. (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	03/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/26/25, at 5:51 p.m., with the Infection Preventionist (IP), the IP stated Resident 307 had a lot of anxiety when the room door was closed. The IP confirmed during the interview that Resident 307's room door was opened. The IP stated it was her expectation for Resident 307's room door to be closed if airborne precaution was in place. The IP stated the risk of having the door open was to spread infection for both residents and staff. During an interview on 3/26/25, at 6:02 p.m., with the Assistant Director of Nursing (ADON), the ADON stated if a resident had Covid-19 diagnosis, airborne precaution should be in place along with the use of PPE like N95 face masks, gown and gloves by staff. The ADON stated the resident should be in a private room and if another resident had Covid-19 then they could cohort and be placed in the same room. The ADON stated Resident 307's room door should be kept closed. The ADON confirmed that Resident 307 was opened and the CNA staff told her it was because Resident 307 was screaming. The ADON stated it was her expectation for Resident 307's room door to be kept closed. The ADON stated the risk of having the door open was the potential of Covid-19 to spread. During a concurrent observation and interview on 3/26/25, at 6:07 p.m., with CNA 3, CNA 3 confirmed Resident 307's room door was opened again because Resident 307 started screaming again. A review of Resident 307's care plans, initiated on 3/25/25, indicated .Focus .Resident has a DIAGNOSIS OF COVID-19 and is at risk of experiencing respiratory complications including impaired oxygen exchange . Goal .Other residents and staff will not develop s/sx of Covid-19 x 30 days .Interventions .Close windows and door. No visitors allowed . A review of the facility's document titled, Isolation - Categories of Transmission-Based Precautions, revised 9/2022, indicated .Policy Statement .Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents .Airborne Precautions .1. Airborne precautions are indicated when an individual is infected with a pathogen that is very small (5 microns or smaller in size) and can be transmitted long distances through the air .2. Preventing the spread of airborne pathogens requires a room with special air handling and ventilation called an airborne infection isolation room (AIIR) . A review of the Centers for Disease Control (CDC) website, Transmission Based Precautions, dated 4/3/24, indicated .Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission .Recommendation details .Use Airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route .Ensure appropriate patient placement in airborne infection isolation room (AIIR) constructed according to the Guideline for Isolation Precautions. In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the door closed will reduce the likelihood of airborne transmission until the patient is either transferred to a facility with an AIRR or returned home . (https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html#:~:text=In%20settings%20where%20Airborne%20Precautions,an%20AIIR%20or%20returned%20home.) 49823 (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	03/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation on Station 1 during lunch tray pass on 3/26/25 at 1:15 p.m., the Assistant Director of Nursing (ADON) took a food tray to a resident, but did not offer the resident hand sanitizer or an opportunity to wash hands before eating the meal. The ADON went back to the food cart and picked up another tray to deliver to another resident without washing her hands or using hand sanitizer between passing trays. During an interview with the ADON at the tray cart, the ADON stated that she did not know what to offer to the residents to clean their hands prior to eating. The ADON asked a Certified Nursing Assistant, who stated that he gave the residents a washcloth or hand sanitizer to use before eating. The ADON confirmed that she did not use hand sanitizer while passing lunch trays to residents and that she did not offer residents a hand washing opportunity or hand sanitizer before serving them their meals. The ADON stated that the risk for not performing hand hygiene was infection (the presence and growth of germs in or on the body) by cross contamination (the process by which germs are unintentionally moved from one person or object to another). The ADON went and got hand sanitizer to offer residents to use to clean their hands. During an interview on 3/26/25 at 3:45 p.m. with the facility Director of Nursing (DON), the DON stated that his expectation was that staff would wash their hands and/or use hand sanitizer during tray pass at lunchtime. The DON stated that his expectation was that staff offered residents the opportunity to wash their hands before lunch. The DON stated that the risk was that infection could spread by cross contamination. The DON confirmed that facility policy was not followed. A review of an undated facility policy and procedure (P&P) titled, Handwashing/Hand Hygiene Policy Statement, indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections .Policy Interpretation and Implementation .1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections (an infection that develops while a person is in a healthcare facility). 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial [a substance that kills germs] or non-antimicrobial) and water for the following situations . o. Before and after eating or handling food; p. Before and after assisting a resident with meals .

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	03/27/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49823 Based on observation, interview, and record review, the facility failed to ensure it maintained effective pest control services for a census of 115 where 107 residents received facility prepared meals when a live baby cockroach was crawling on a clean colander on the shelf next to the stove in the kitchen. This failure had the potential to spread a variety of diseases and bacteria throughout the facility to its residents, staff, and visitors. Findings: During a concurrent observation and interview on 3/25/25, at 11 a.m., with the Food Services Director (FD) in the kitchen, the following findings were observed and confirmed by the FD: a. A pot on the stove that had a thick, brownish gummy substance on the bottom and sides was being used to prepare lunch for the facility residents. b. A flat pan with a brownish substance caked on the inner edges of the pan was on the shelf next to the stove with the clean pots and pans. c. A frying pan with dried brownish flaky substance on the inside was located on a shelf with the clean pots and pans next to the stove. d. The toaster oven next to the stove had a brownish substance on the shelves. During a concurrent observation and interview on 3/26/25, at 8:25 a.m., with the FD in the kitchen, a baby cockroach was crawling on a colander on the shelf near the stove. The FD acknowledged that there was a baby cockroach on the colander near the stove. The FD stated their process was to report the pest sighting to Maintenance. The FD further stated that the risk was food safety. During a phone interview on 3/27/25, at 9:48 a.m., with the facility Registered Dietitian (RD), the RD stated the facility was working to eliminate the cockroach issue. The RD further stated that two companies provided services for pest control. During a concurrent interview and record review on 3/27/25, at 10:55 a.m., with the Maintenance Director (Main Dr), the Main Dr confirmed that there were two companies that provided pest control services at the facility. The Main Dr stated that one of the companies provided services to the facility monthly, and the other company provided services every two weeks at the facility. A review of a facility policy and procedure (P&P) titled, Storage of Food and Supplies, dated 2023, the P&P indicated, .5. Routine cleaning and pest control procedures should be developed and followed . (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	03/27/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of a facility P&P titled, Sanitation, dated 2023, the P&P indicated, .10. On a monthly basis, a pest control company will inspect and service the Food & Nutrition Services Department. If at any time additional servicing is needed, the pest control company will be notified .