STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055188	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Skilled Nursing Hospital	2620 Flores Street San Mateo, CA 94403

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, interview and record review the facility failed to ensure food were stored and prepared in a sanitary manner when these were observed during kitchen tour:1. The walk-in refrigerator had one grape and one nut on the floor.2. There was ice built up in the freezer on the center support.3. Debris were found under the Freezer: one small potato, one packet of mustard, red onion skin, and debris.4. Five items were found opened but not dated in the cabinet: hot green salsa, food coloring, vanilla extract, cinnamon sticks, browning and seasoning sauce.5. One item found opened with no label and no date: chili oil.6. Three fruit flies were found in the kitchen.7. The interior of two ovens were not cleaned.8. One dirty spatula was stored in the clean utensil drawer.9. Six water pitchers were wet and stored in an enclosed cabinet. These failures had the potential for contaminated and/or expired food items to be served to residents.Findings: During a concurrent observation and interview with the Dietary Supervisor (DS) on 4/13/26 at 9:13 AM, these were observed during initial kitchen tour:1. The walk-in refrigerator had one grape and one nut on the floor. 2. There was ice built up in the freezer on the center support, next to the freezer door. 3. Debris were found under the freezer: one small potato, one packet of mustard, red onion skin, and debris. 4. Five items were found opened but not dated in the cabinet: hot green salsa, food coloring, vanilla extract, cinnamon sticks, browning and seasoning sauce. 5. An opened jar of chili oil was found with no label and no date. 6. Three fruit flies were found in the kitchen. 7. The interior bottom of two ovens were lined with aluminum foil. In one oven there was a piece of black charred lump (approximately 2 inches in diameter). In the other oven, approximately 1/5 of the surface of the aluminum foil had a layer of black/brown stain and two rips near the front. 8. One dirty spatula was stored in the clean utensil drawer. 9. Six water pitchers were wet and stored in an enclosed cabinet. During the concurrent interview, the DS stated they used the ovens for breakfast service. The DS stated they did not burn or over cook any food items in the ovens during breakfast. The DS acknowledged the aluminum foil lining the ovens did not look like they were changed prior to breakfast service. The DS acknowledged the light bulb in the walk-in refrigerator was very dim. The DS acknowledged the dim lighting made it difficult for staff to properly clean the area and for supervisor(s) to check if the walk-in refrigerator was clean. The DS stated he will get maintenance to look at the freezer door to diagnose the cause of the ice built up. The DS acknowledged food items should be dated when opened so that these items can be tracked and discarded per policy. The DS identified the container with no label and no date as chili oil. The DS acknowledged there were fruit flies in the kitchen. The DS stated the wet water pitchers should not be stored in an enclosed cabinet. They needed to be air dried before staff could store them away. Review of the facility's policy titled CLEANING AND DEFROSTING FREEZERS, dated 2023, found no language directing staff to inspect and maintain door seals around the freezer to prevent ice built up. Review of the facility's policy titled CLEANING STOVE AND HOOD, dated 2023, indicated .Stove will be cleaned and sanitized after each use. Review of the facility's policy titled CANNED AND DRY GOODS STORAGE, dated 2023, indicated .Food storage areas will be clean, dry, and free of pests. Review of the facility's policy titled WATER PITCHERS, dated 2023, indicated .Water pitchers will be sanitized utilizing the dishwashing procedure. Review of the facility's policy (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	titled DISHWASHING PROCEDURES (DISHMACHINE), dated 2023, indicated .Allow racks of dishes/trays/utensils to air dry. If drying space is not ample for dishes to air dry, use utility carts. Review of the facility's policy titled Storage Room, not dated, indicated .All the food storage areas should be clean and well organized.The dry storage should be well-lighted and cool . Review of the facility's policy titled SANITATION AND INFECTION CONTROL, dated 2023, indicated .All open food items will have an open date and used-by-date per manufacturer's guidelines.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure there was an effective pest control program when fruit flies were found in the kitchen. Additionally, three broken window screens and one sliding door screen were observed during tour. These damaged screens are potential entry points for flying pests. These failures did not ensure residents' environment was free from pests.Findings: During a concurrent kitchen observation and interview on 4/13/26 at 9:13 AM, three fruit flies were seen in the kitchen. These observations were confirmed with the Dietary supervisor during an interview. During a concurrent observation and interview on 4/14/26 at 8:29 AM, These were found at the courtyard:Sliding door screen had a hole.One window screen had a hole.Two window screens had damaged/bent frames. Leaving a gap for flying pest.These observations were confirmed with the Maintenance Assistance (MAS) during an interview. The MAS said he checks screens daily. The MAS could not explain how he failed to detect the damaged screens.Review of the facility's policy titled SANITATION AND INFECTION CONTROL, dated 2023, indicated .The facility will ensure a pest control prevention program provides monthly inspections, treatment, and prevention of vermin and insect infestation.Pest control is designed to maintain a sanitary environment which prevents contamination, transmission or spread of disease by insects or rodents.Keep screens on all doors and windows.Review of the facility's policy found no language directing staff to check, maintain/repair screens on a regular basis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to ensure target behaviors for the use of Zyprexa (an anti-psychotic medication that changes brain chemistry to stabilize mood and reduce hallucinations=seeing or hearing things that are not there) were accurate, specific, and individualized for Resident 2, one of five residents on these types of medication. This failure did not ensure staff were monitoring the right target behaviors and/or formulated appropriate interventions for Resident 2 within her care plans.Findings:Review of Resident 2's medical record titled MH Progress Note (Mental Health), dated 1/17/24, indicated Resident 2 .has been experiencing feelings of depression, .her current condition has left her bedridden, which has led to feelings of hopelessness.She also has a history of bipolar disorder (a mental illness characterized by extreme mood swings: emotional highs and deep depressions). She has had three suicide attempts.She reports having panic attacks.She is currently on.low dose .(Zyprexa) for her mental Health issues. The . (Zyprexa) is now 2.5 mg daily and was recently at 5 mg daily .she is open to adjusting her medication to help with her depression . Review of Resident 2's Minimum Data Set (MDS: a standardized resident assessment tool), dated 3/21/26, indicated Resident 2 had normal memory and normal reasoning skills. There were no issues with her moods or behaviors. She was on an anti-psychotic medication. There was an active diagnosis of bipolar disorder. During a concurrent interview and record review on 4/14/26 at 2:35 PM, the MDS Nurse (MDS 1) was asked to search for information regarding the use of Zyprexa for Resident 2. MDS 1 found a physician order dated 1/11/26 for the use of Zyprexa. The target behaviors for the use of Zyprexa was documented as .For Bipolar disorder .(manifested by) having auditory and visual hallucinations. MDS 1 stated he was the one who assessed Resident 2 when he coded her MDS assessments. MDS 1 stated he thinks Resident 2 has auditory hallucinations. However, MDS 1 could not elaborate regarding specifics such as: was it a familiar voice? was it a stranger's voice? was the voice telling her to harm herself? MDS 1 was asked to search for Resident 2's care plan regarding the use of Zyprexa. After reviewing all the Zyprexa interventions, MDS 1 stated the interventions were generic and not individualized for Resident 2. During an interview on 4/15/26 at 8:54 AM, Certified Nursing Assistant, CNA 1 stated she was Resident 2's nursing assistant for today. CNA 1 was asked if she got shift to shift report regarding behaviors for Resident 2. CNA 1 stated for Resident 2, no one told her what behaviors she should help the nurse monitor for. During an interview on 4/15/26 at 9:03 AM, Registered Nurse, RN 1 was asked about behavior monitoring for Resident 2. RN 1 stated Resident 2 was on Zyprexa at nighttime. RN1 stated the Zyprexa was for Resident 2's paranoia and staff were supposed to monitor for paranoia. During an interview on 4/16/26 at 10:24 AM, this data were reviewed with the Administrator:MDS 1 thought the Zyprexa was for Resident 2's auditory hallucination.CNA 1 was unaware Resident 2 was to be monitor for specific behavior(s).RN 1 thought the Zyprexa was for Resident 2's paranoia.Current documentation within Resident 2's records incorrectly identified visual and auditory hallucinations as target behaviors for the use of Zyprexa.Mental Health records back in 2024 indicated the Zyprexa was prescribed for mood swings, and depression.The Administrator provided no additional documents, and stated staff will work to correct this error. Review of the facility's policy titled Care Plans, revised on 11/01/2017, indicated The resident care plan is the vehicle employed by the interdisciplinary team for achieving desirable resident outcomes. It addresses the actual and potential physical, environmental, and psychosocial needs and problems identified by the interdisciplinary team . The care plan identifies the individual needs and problems of the resident, states the resident's goal in measurable terms, and documents realistic approaches that the interdisciplinary team will employ to achieve the desired outcomes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility did not ensure coordination and collaboration with Hospice agency on developing and ongoing communication of plan of care for one of three residents, Resident 11.This failure could delay Hospice service when changes of condition occurs. Findings:During a review of Resident 11's Face Sheet, indicated, admitted on [DATE] with diagnoses including: Hemiplegia and hemiparesis following cerebral Infarction (weakness and paralysis of extremities due to dead brain tissue) Dementia(a decline in mental ability that interferes with daily life activities), Encounter for Palliative Care(a specialized care for people with serious illness focusing on relieving symptom, comfort and support).During an observation on 4/13/26 at 11 AM, resident in bed, have both eyes closed, not responsive to name call.During a review of Resident 11's physician's order, On Hospice - Pathways Home Health and Hospice Services, dated 12/18/25.During a review of Care Plan, started 12/18/25, indicated resident needs Hospice care secondary to: cerebral atherosclerosis, Vascular Dementia, limited food intake and expected weight loss, high risk for pressure ulcers, Other special needs: pain management, special wound care, respiratory support for SOB and anxiety. Approaches: assist resident of position of comfort, honor resident's wishes expressed in Advanced Directive, Hospice referral, manage pain, provide food and fluids of choice, provide oxygen per MD order. All approaches by nursing discipline only. No ongoing process of communication with the hospice agency found, when changes occur, who to contact, when to transfer. No IDT (Interdisciplinary) approaches found.During a concurrent interview and record review on 4/16/26 at 10 AM, with MDS (Minimum Data Set) 1,Resident 11's care plan, dated 12/18/25 was reviewed. The care plan indicated, Hospice Referral, MDS 1 stated the care plan should indicate collaboration and communication with Hospice agency. There should be a specific hospice case manager or point of contact for all communication. The hospice has their own binder and when hospice staff comes, they enter their notes on their binder. MDS 1 confirmed, the care plan has no indication of ongoing coordination of care for residents with Hospice agency.During a concurrent interview and record review on 4/16/26 at 11 AM, with Social Services Director (SSD),Resident 11s care plan, dated 12/18/25 was reviewed. SSD stated, I am the IDT member of the facility to work with Hospice agency to coordinate care. The care plan does not indicate which Hospice agency. No information about the Hospice agency on the care plan. SSD acknowledged. Review of facility Policy and Procedure, dated 6/14, indicated, Policy: The facility and the hospice agency will develop systems of communication and develop a coordinated plan of care to meet the resident's needs.Procedure: 2. A plan of care is developed by the facility's IDT and hospice nurse coordinator. 3. The plan of care is based on an assessment of the individual's needs and identifies the care and services that the facility and the hospice team will provide.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure Resident 2's drug regimen was free from an unnecessary drug (Zyprexa) when staff failed to provide accurate monitoring of her target behavior. Resident 2 was one of five residents on these types of medication. This failure had the likelihood for Resident 2 to be administered an unnecessary medication (Zyprexa).Findings: Review of Resident 2's medical record titled MH Progress Note (Mental Health), dated 1/17/24, indicated Resident 2 .has been experiencing feelings of depression, .her current condition has left her bedridden, which has led to feelings of hopelessness.She also has a history of bipolar disorder (a mental illness characterized by extreme mood swings: emotional highs and deep depressions). She has had three suicide attempts.She reports having panic attacks.She is currently on.low dose .(Zyprexa) for her mental Health issues. The . (Zyprexa) is now 2.5 mg daily and was recently at 5 mg daily .she is open to adjusting her medication to help with her depression . Review of Resident 2's Minimum Data Set (MDS: a standardized resident assessment tool), dated 3/21/26, indicated Resident 2 had normal memory and normal reasoning skills. There were no issues with her moods or behaviors. She was on an anti-psychotic medication. There was an active diagnosis of bipolar disorder. During a concurrent interview and record review on 4/14/26 at 2:35 PM, the MDS Nurse (MDS 1) was asked to search for information regarding the use of Zyprexa for Resident 2. MDS 1 found a physician order dated 1/11/26 for the use of Zyprexa. The target behaviors for the use of Zyprexa was documented as .For Bipolar disorder .(manifested by) having auditory and visual hallucinations. MDS 1 stated he was the one who assessed Resident 2 when he coded her MDS assessments. MDS 1 stated he thinks Resident 2 has auditory hallucinations. However, MDS 1 could not elaborate regarding specifics such as: was it a familiar voice? was it a stranger's voice? was the voice telling her to harm herself? During an interview on 4/15/26 at 8:54 AM, Certified Nursing Assistant, CNA 1 stated she was Resident 2's nursing assistant for today. CNA 1 was asked if she got shift to shift report regarding behaviors for Resident 2. CNA 1 stated for Resident 2, no one told her what behaviors she should help the nurse monitor for. During an interview on 4/15/26 at 9:03 AM, Registered Nurse, RN 1 was asked about behavior monitoring for Resident 2. RN 1 stated Resident 2 was on Zyprexa at nighttime. RN1 stated the Zyprexa was for Resident 2's paranoia and staff were supposed to monitor for paranoia. During an interview on 4/16/26 at 10:24 AM, these data were reviewed with the Administrator:1. MDS 1 thought the Zyprexa was for Resident 2's auditory hallucination.2. CNA 1 was unaware Resident 2 was to be monitor for specific behavior(s).3. RN 1 thought the Zyprexa was for Resident 2's paranoia.4. Current documentation within Resident 2's records incorrectly identified visual and auditory hallucinations as target behaviors for the use of Zyprexa.5. Mental Health records back in 2024 indicated the Zyprexa was prescribed for mood swings, and depression.The Administrator provided no additional documents, and stated staff will work to correct this error.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%. This failure resulted in a medication administration total error rate of 9% with a total of three errors out of thirty three opportunities for errors.During a concurrent observation and interview on 04/15/2026 at 8:38 AM with Licensed Vocational Nurse 1 (LVN 1) during medication administration preparation for Resident 25, LVN 1 mixed water with the polyethylene glycol 3350 powder (an unflavored powder used to treat occasional constipation) and was unable to state how much water was used to dissolve the polyethylene glycol 3350 powder. Resident 25 was not informed by LVN 1 that polyethylene glycol 3350 solution was being administered until after Resident 25 had already consumed the polyethylene glycol 3350 solution. During an observation on 04/15/2026 at 9:31 AM during medication administration for Resident 22, Registered Nurse 1 (RN 1) administered a total of eight medications to Resident 22: RN 1 administered Metformin 1000 mg tablet to Resident 22, but the medication was scheduled for administration at 8:00 AM on 04/15/2026.During an observation on 04/15/2026 at 9:31 AM during medication administration for Resident 22, RN 1 administered an inhalation powder with the dosage form of 100 micrograms (mcg) fluticasone furoate and 25 mcg vilanterol per actuation (actuation in a medical inhaler is the act of triggering or releasing the medication from its canister so that it can be breathed into the lungs and it also known as the puff that happens when you use the device) to Resident 22 for chronic obstructive pulmonary disorder (COPD) and RN 1 did not ask Resident 22 to rinse mouth after administration. During a review of Resident 22's MAR dated 04/01/2026 through 04/16/2026, Resident 22's MAR indicated the medication order for inhalation powder with the dosage form of 100 micrograms (mcg) fluticasone furoate and 25 mcg vilanterol per actuation had special instructions to, Rinse mouth well after use.During a review of prescribing information for inhalation powder with the dosage form of 100 micrograms (mcg) fluticasone furoate and 25 mcg vilanterol per actuation, last revised on 11/2024, the prescribing information indicates warnings and precautions that include advising the patient to, rinse his/her mouth with water without swallowing after inhalation to help reduce risk of Candida albicans (a type of fungus) infection of the mouth and pharynx. During a review of the facility's policy and procedure titled, Medication Administration dated 05/2016, indicated: Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices;Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record;Medications are administered in accordance with written orders of the prescriber;Explain to resident the type of medication being administered and the procedure;

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure resident rooms accommodated no more than four residents in each room when one room (Rooms 101) had six residents in the room.This failure had the potential to negatively impact the safety and well-being of residents.Findings:During an observation on 4/13/26 at 10:30 AM, in room [ROOM NUMBER], the room was divided into two sections. The right section had two beds and the left section had four beds. room [ROOM NUMBER] had a common entrance door and a shared bathroom. There was a total of six residents in room [ROOM NUMBER].During observation on 4/14/26 at 10:00 AM room [ROOM NUMBER] measured 581 square feet.During an interview on 4/16/26 at 3:15 PM the Administrator was made aware of this finding.