STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055304	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	1221 Rosemarie Lane Stockton, CA 95207

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on interview and record review, the facility failed to ensure Resident 2 ' s rights were protected when, a. Resident 2 left the facility in the morning of 9/1/24, and upon his return in the afternoon, he was not allowed to enter the facility; b. The facility told Resident 2 he left AMA (choosing to leave against medical advice), but did not provide Resident 2 an explanation, a copy of the AMA form, or notify Adult Protective Services (APS, provides emergency intervention for vulnerable dependent adults and seniors) per their policy; and, c. Resident 2 was hospitalized on [DATE], and the hospital attempted to transfer him back to the facility on [DATE], but the facility refused to allow him to return. This failure resulted in Resident 2 waiting in the hospital for two days for placement in another facility out of the area and had the potential for Resident 2 to experience emotional distress due to leaving a familiar area. Findings: A review of Resident 2 ' s Admission Record indicated Resident 2 was admitted to the facility in the fall of 2023 with diagnoses including, but were not limited to, lower back pain, cirrhosis of the liver (permanent scarring that damages the liver and interferes with its functioning), depression (a persistent feeling of sadness and loss of interest that interferes with activities of daily living), and schizophrenia (a serious mental disorder in which a person interprets reality abnormally). A review of Resident 2 ' s Minimum Data Set [MDS, a federally mandated resident assessment tool] Section GG-Functional Abilities and Goals - Discharge, dated 9/1/24, indicated Resident 2 needed set up or clean up assistance with activities including eating, dressing, oral and personal hygiene. Further, the MDS indicated Resident 2 used a manual wheelchair for mobility and needed assistance to get into and/or out of the wheelchair. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document, Against Medical Advice (AMA) Form, dated 9/1/24, and signed by the Director of Nursing (DON) and witnessed by a Licensed Nurse, indicated, .[Resident 2 ' s name] .I am leaving on my own insistence and against the advice of my attending physician .I have been informed of the dangers/risks to my health .I fully understand the information that has been discussed and have been given the opportunity to ask questions . There was no signature by Resident 2. Review of Resident 2 ' s hospital record, Consultation dated 9/2/24, indicated, .Pt [patient] is reportedly not welcome to return to [facility name] pt needs continued nursing care, Social work will need to assist with placement . Review of Resident 2 ' s hospital record, Social Work Note dated 9/2/24, indicated, .received call from [facility staff name] .administrator stated pt can not return . During an interview with the San [NAME] County Long Term Care Ombudsman (Omb- advocate for residents in long term care facilities) on 9/19/24 at 2:25 p.m., the Omb stated Resident 2 borrowed an electric wheelchair from a resident (Resident 4) at the facility. The Omb stated the process for residents leaving the facility on a pass was for residents to sign out in the facility logbook and they could leave for four hours. The Omb stated Resident 2 signed out when he left the facility, and when Resident 2 returned, he was not allowed to re-enter the facility. The Omb stated Resident 2 called an ambulance when the facility wouldn ' t let him back in and called the Omb to appeal. During an interview with the DON on 9/19/24 at 2:45 p.m., the DON stated residents going out of the facility on a pass needed an order from their physician. The DON stated the pass was for four hours and if residents needed more than four hours, they needed an order from the physician. During an interview with Resident 4 on 9/19/24 at 3:00 p.m. outside in the facility courtyard, Resident 4 stated he loaned his electric wheelchair to Resident 2 two to three weeks ago. Resident 4 stated Resident 2 needed to go to the mall to get a new cellphone. Resident 4 stated it was difficult to travel to the mall with a manual wheelchair. Resident 4 stated Resident 2 knew how to operate his electric wheelchair and he only loaned his electric wheelchair to people he trusted. Resident 4 stated the DON returned his wheelchair to him later that day and told him Resident 2 was not returning to the facility. During an interview by phone on 9/19/24 at 3:24 p.m. Resident 2 stated he signed out in the facility logbook for going out on pass when he left the facility in the electric wheelchair which he borrowed on 9/1/24. Resident 2 stated he was not allowed to re-enter the facility when he returned that same day. Resident 2 stated facility staff did not explain, and he did not know what AMA meant. Resident 2 stated he did not sign an AMA form. Resident 2 stated he called an ambulance when he was not allowed to re-enter the facility. Resident 2 stated the ambulance took him to the acute care hospital emergency department, and he was there for about four days. Resident 2 stated that after four days the emergency department sent him to a care home in a different city. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review on 9/19/24 at 3:35 p.m. with the facility administrator (ADM), DON, and the Assistant Director of Nursing (ADON) in the DON ' s office, the ADM stated Social Services was responsible for discharge orders. The ADM stated the AMA process was to talk to the resident first to avoid an AMA, if possible, then ask the resident where they were going, so APS could follow up. They would then notify the resident ' s physician (MD) regarding AMA and provide an opportunity for the MD to convince a resident to stay. The AMA form should be filled out and signed by the resident, and the facility sends the Omb a notice of AMA. The DON confirmed Resident 2 did not sign the AMA form or receive a copy, and APS was not notified of Resident 2 ' s AMA discharge. The DON confirmed Resident 2 did not know his rights regarding the AMA discharge. The DON stated Resident 2 ' s MD was notified of Resident 2 ' s AMA discharge, but confirmed there was no MD progress note regarding the event. The DON confirmed Resident 2 was not allowed to re-enter the facility when he returned that same day. The DON acknowledged that the AMA discharge was unsafe for Resident 2. The DON confirmed there was no transfer notice or discharge notice in Resident 2 ' s medical record, and Resident 2 did not receive a copy of a transfer notice or discharge notice. During an interview with Certified Nursing Assistant 1 (CNA) 1 on 9/19/24 at 4:21 p.m., CNA 1 stated she saw Resident 2 outside when she arrived at work on 9/1/24 and Resident 2 tried to get back into the facility. CNA 1 stated Resident 2 was told he needed a MD note to be out of the facility for more than four hours, and needed a MD note to get back into the facility. CNA 1 stated that Resident 2 just stayed outside. During an interview with the Social Services Director (SSD) and the ADM on 9/20/24 at 12:35 p.m., the SSD stated that on 9/1/24 Resident 2 left in a motorized wheelchair and went AMA. The ADM stated leaving AMA was a discharge. The ADM stated when residents left the facility AMA, the facility was no longer responsible for their care, and as a result, Resident 2 was not allowed to re-enter the facility. The ADM stated Resident 2 was upset when he returned, so the police were called. The ADM and SSD agreed that Resident 2 did not receive a medication reconciliation list or discharge instructions, since he left AMA. The ADM stated that nursing needed to be consulted on whether Resident 2 ' s MD condoned the AMA discharge. ADM stated AMA discharges were not typically safe; that ' s why it was an AMA. During an interview with CNA 2 on 9/20/24 at 1:50 p.m., CNA 2 stated she was at the facility when Resident 2 left the facility in the electric wheelchair on 9/1/24. CNA 2 stated her assigned resident (Resident 4) loaned Resident 2 his electric wheelchair. CNA 2 stated that at 2:20 p.m. the DON and Licensed Nurse (LN) 2 were outside waiting for Resident 2. CNA 2 stated Resident 2 came up and the DON and LN 2 didn ' t let him in. Resident 2 told the DON and LN 2 he didn ' t know he couldn ' t leave with someone else ' s wheelchair. CNA 2 reported the DON told Resident 2 he didn ' t have a pass and didn ' t sign out. A review of a facility document titled, Resident Sign Out Binder, undated, indicated Resident 2 signed out of the facility on pass on 9/1/24 at 10:20 a.m. During an interview with Resident 6 on 9/20/24 at 2:15 p.m. in his room, Resident 6 stated he signed out in the facility logbook whenever he left the facility. Resident 6 stated that he could leave on his own if he came back in 4 hours. Resident 6 stated if he didn ' t come back in four hours, the facility would call the police, in case of an accident. Resident 6 stated he didn ' t need a MD order to leave; he just signed the logbook. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy and procedure (P&P), undated, titled, Resident Out on Pass Procedure, undated, the P&P indicated, .Residents sign out binder to be kept at the nurse ' s station. LTC residents needing to go out on pass must sign out .may not exceed a duration greater than the allotted four hours .Residents must sign back in upon returning to the facility .Residents must be in the facility prior to sundown . A review of a facility P&P titled, Transfer and Discharge (including AMA), the P&P indicated, .3. When a resident exercises his or her right to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending .13. Discharge Against Medical Advice (AMA) .a .Under no circumstances will the facility force, pressure, or intimidate a resident into leaving AMA .b. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility .d. Notify Adult Protection Services, or other entity as appropriate .