

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2024
NAME OF PROVIDER OR SUPPLIER Brookside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40583</p> <p>Based on observation, interview, and record review, the facility failed to ensure the privacy of one of ten sampled residents (Resident 8) during wound care.</p> <p>This failure resulted in Resident 8 being exposed during wound care to anyone walking by his room, denying Resident 8's right to privacy and dignity.</p> <p>Findings:</p> <p>A review of Resident 8's ADMISSION RECORD, indicated Resident 8 was admitted to the facility with diagnoses which included pressure ulcers (wounds to the skin and muscle of varying depths) and a suprapubic catheter (a flexible tube that drains urine from the bladder through a small incision in the lower abdomen).</p> <p>During a wound care observation with licensed nurse (LN) 1, on 10/11/24, at 10:48 AM, LN 1 did not draw the privacy curtain around Resident 8's bed and LN 1 did not close the door to Resident 8's room at any time during wound care.</p> <p>During an interview with LN 1, on 10/11/24, at 11:32 AM, LN 1 acknowledged she did not draw the privacy curtain while performing wound care for Resident 8. LN 1 explained providing privacy to Resident 8 was important because a lot of people walk by, and they could see Resident 8.</p> <p>During an interview with the Director of Nursing (DON) and the Infection Preventionist (IP), on 10/11/24, at 1:30 PM, the DON and IP explained the importance of drawing the privacy curtain was to maintain the dignity of the resident.</p> <p>A review of the facility policy titled, Resident Rights, dated 2023, indicated, .Privacy and Confidentiality. The resident has a right to personal privacy .Personal privacy includes .medical treatment .personal care .</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40583</p> <p>Based on observation and interview, the facility failed to maintain a homelike environment when seven Resident rooms were dirty and unkept.</p> <p>These failures had the potential to negatively impact the residents' feelings of self-worth and self-esteem.</p> <p>Findings:</p> <p>During a tour of the facility on 10/11/24, between 10:26 AM and 10:45 AM, the following was observed:</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] had stains on the floor, the curtain was not hanging correctly with five hooks off the track, and there were tears on the inner lining. The privacy curtain dividing bed A from bed B was dirty with five dime size brown, grey spots and a grey, brown stain going up the seam for the length of the curtain. -room [ROOM NUMBER] had dirty floors with multiple black, grey areas. The curtain's six hooks were hanging off the rails with the lining torn, and the privacy curtain was dirty with multiple black stains and three moderate sized grey stains. -room [ROOM NUMBER] had dirty floors with a small number of black stains and debris. The curtains had one hook hanging off the rails with the inner lining torn. -room [ROOM NUMBER] had dirty floors with a moderate amount of small to medium size brown debris, and the privacy curtains were dirty with one moderate size brown [NAME] colored stain. -room [ROOM NUMBER] had dirty floors with 6 nickel size spots, 19 dime size spots, and 6 quarter size spots and one silver dollar size spot, all grey brown in color running the length of the room. The privacy curtains were dirty with four large (hand size) grey stains. -In room [ROOM NUMBER] the end of the curtain was hanging off the rail with 3 hooks off the rail. -room [ROOM NUMBER] had an overbed table with ashes and two cigarette butts on it. The table's edges were lifting and the table was in disrepair. <p>During a concurrent observation and interview with licensed nurse (LN) 1, on 10/11/24, at 11:23 AM, LN 1 confirmed the issues in the above listed rooms. LN 1 explained the floors and privacy curtains should be clean and they were not. LN 1 further explained the curtains should hang correctly and not be hanging off the rails. LN 1 stated the overbed table in room [ROOM NUMBER] should not look like that and should not have cigarette butts and ashes.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Director of Nursing (DON) and Infection Preventionist (IP), on 10/11/24, at 1:30 PM, the DON explained the dirty floors in the above rooms were an issue with infection control. The DON explained the curtains needed to be able to be closed to keep the room temperature and for the room to be a homelike environment.</p> <p>A review of the facility policy titled, Resident Rights, dated 2023, indicated, .The resident has the right to a dignified existence .The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40583</p> <p>Based on observation, interview, and record review, the facility failed to maintain its infection prevention control program when infection control practices, including Enhanced Barrier Precautions (EBP-a set of measures used to prevent the spread of infection) were not maintained during wound care for one of ten sampled residents (Resident 8).</p> <p>This failure had the potential for cross-contamination (the transfer of harmful bacteria, parasites, or viruses from one person, object, or place to another) to Resident 8 and to residents residing in the facility, negatively impacting their health and well-being.</p> <p>Findings:</p> <p>A review of Resident 8's ADMISSION RECORD, indicated Resident 8 was admitted to the facility with diagnoses which included pressure ulcers (wounds to the skin and muscle of varying depths) and a suprapubic catheter (a flexible tube that drains urine from the bladder through a small incision in the lower abdomen).</p> <p>During a wound care observation with licensed nurse (LN) 1, on 10/11/24, at 10:48 AM, LN 1 gathered supplies for Resident 8's wound care, a gauze roll, normal saline (fluid used to cleanse wounds), xeroform (a non-adherent gauze dressing), and a dry dressing. LN 1 did not don (put on) a gown, brought the supplies into Resident 8's room, placed the clean supplies on Resident 8's bedside table which had a towel covering it, and Resident 8's breakfast tray was on it. LN 1 performed hand hygiene, donned gloves, and removed the dressing from Resident 8's suprapubic catheter. LN 1 cleansed the area with normal saline, and patted the area dry. LN 1 did not perform hand hygiene and applied new dressing, and then doffed (took off) the gloves and performed hand hygiene. LN 1 prepared to do the dressing change to Resident 8's right hip. LN 1 performed hand hygiene and donned gloves. LN 1 did not don a gown. LN 1 removed the old dressing, cleansed the area, and patted the area dry, wearing the same gloves. LN 1 applied xeroform to the wound bed. LN 1 requested a staff member to bring her a gauze dressing. While waiting, LN 1 doffed gloves, performed hand hygiene, and donned a new pair of gloves. LN 1 removed the catheter tubing securement device from Resident 8's leg and placed it on Resident 8's wheelchair. LN 1 did not perform hand hygiene, went to the wound treatment cart, opened the wound treatment cart with contaminated gloves, entered drawers 1, 3, and 4, removed a pair of scissors from the cart, opened a large absorbent dressing, cut it in half, put the other half back in the treatment cart, and returned the scissors to the treatment cart without cleaning and sanitizing the scissors. LN 1, still wearing the same gloves, resecured the tubing on Resident 8's leg, and then applied the dry dressing over the xeroform on Resident 8's right hip.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LN 1, on 10/11/24, at 11:32 AM, LN 1 acknowledged she placed the clean dressings on Resident 8's dirty bedside table. LN 1 explained there was a risk of infection to Resident 8 from the dirty bedside table. LN 1 acknowledged she did not don a gown for the wound care for Resident 8. LN 1 acknowledged she did not perform hand hygiene during the suprapubic catheter care, the right hip wound, before opening and entering the wound treatment cart, removing and applying the dressing to the suprapubic catheter drainage tube, and applying the dry dressing to the right hip wound. LN 1 explained by not donning the gown for wound care there was a risk for spread of infection. LN 1 further explained by not doing hand hygiene during wound care there was a risk of contamination to Resident 8 and Resident 8 could get an infection. LN 1 acknowledged she was wearing contaminated gloves when she opened and entered drawers 1, 3, and 4 of the wound treatment cart. LN 1 further acknowledged she used the scissors from the cart and cut the dry dressing in half, returning both the scissors and half of the dry dressing to the wound care cart, stating she did not clean and sanitize the scissors.</p> <p>During an interview with the Director of Nursing (DON) and the Infection Preventionist (IP), on 10/11/24, at 1:30 PM, the DON stated her expectations for wound care would be to ensure the area where supplies were placed was clean, to perform hand hygiene, remove the old dressing, remove her gloves, perform hand hygiene and cleanse the wound and apply new dressing. The IP explained by not following EBP there is a risk for cross-contamination. The IP further explained placing contaminated items in the wound treatment cart and accessing the cart with contaminated gloves places residents receiving wound care at risk for cross-contamination.</p> <p>A review of the facility policy titled, Infection Prevention and Control Program, dated 2023, indicated, .All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services .Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures .</p> <p>A review of the facility policy titled, Clean Dressing Change, dated 2022, indicated, .It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination . each wound will be treated individually .When multiple wounds are being dressed, the dressings will be changed in order of least contaminated to most contaminated .Set up a clean field on the overbed table with needed supplies for wound cleansing and dressing application .If the table is soiled, wipe clean .Place a disposable cloth or linen saver on the overbed table .Establish area for soiled products to be placed .Wash hands and put on clean gloves .remove the existing dressing .Remove gloves .Wash hands and put on clean gloves .Cleanse the wound as ordered .Pat dry with gauze .remove gloves .Wash hands and put on clean gloves .Apply topical ointments or creams and dress the wound as ordered .</p> <p>A review of the facility policy titled, Enhanced Barrier Precautions (EBP), dated 2023, indicated, .Enhanced Barrier Precautions .refer to the used of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices .</p>		