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	02/04/2025

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 51285 Based on interview, and record review, the facility failed to provide a copy of written Notice of Transfer/ Discharge to the appropriate parties for one of one sampled resident (Resident 1), when the Long Term Care (LTC) Ombudsman (a patient rights advocate) was not notified in writing of Resident 1's transfer to the acute care hospital on 1/9/25. This failure resulted in the State LTC Ombudsman not being informed of Resident 1's transfer and removed the opportunity for the State LTC Ombudsman to advocate on Resident 1's behalf. Finding: Review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility in 2018 with diagnoses which included paraplegia (a condition where there is a loss or impairment of motor and sensory function in the lower half of the body, typically affecting both legs). During a concurrent interview and record review on 2/4/25, at 3:23 p.m., with the Director of Nursing (DON), Resident 1's NOTICE OF TRANSFER/ DISCHARGE, dated 1/9/25 was reviewed. The DON stated Resident 1 was sent to the hospital from the facility on 1/9/25 for concern of abdominal pain. The DON confirmed the attached fax confirmation sheet indicated the fax did not go through. The DON further confirmed the Ombudsman did not receive a written copy of the NOTICE OF TRANSFER/ DISCHARGE form. The DON stated the fax confirmation sheet should have been checked to ensure the fax went through. The DON further stated the Transfer/Discharge notice was for the welfare of the residents. The DON explained the risk included the Ombudsman being unaware and could not follow up with the resident. The DON stated when the facility determined on 1/13/25 that they would be unable to readmit Resident 1 to the facility, a transfer/discharge notice was not provided to the Ombudsman. Review of an undated facility policy and procedure titled, Transfer and Discharge, indicated, .Policy Explanation and Compliance Guidelines .6. The notice must be provided to the resident, resident representative if appropriate, and LTC ombudsman as soon as practicable before transfer or discharge. 7. The facility will maintain evidence that the notice was sent to the Ombudsman .

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51285 Based on observation, interview, and record review, the facility failed to re-admit one of one sampled resident (Resident 1), when Resident 1 was transferred to an acute care hospital on 1/9/25 and was ready to return to the facility on [DATE]. This failure resulted in a violation of Resident 1's right to return to the facility and had the potential to cause psychosocial harm due to not being able to return to the facility. Findings: Review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility in 2018 with diagnoses which included paraplegia (a condition where there is a loss or impairment of motor and sensory function in the lower half of body, typically affecting both legs). During a phone interview on 2/4/25, at 9:33 a.m., with the Hospital Case Manager (HCM), the HCM stated Resident 1 was admitted to the hospital on 1/9/25 and was ready to be discharged on [DATE]. The HCM further stated the hospital was calling the facility everyday since 1/13/25 for bed availability, but the facility said they had no beds available. The HCM explained Resident 1 was still in the hospital waiting for placement. During a concurrent observation and interview on 2/4/25, at 12:15 p.m., with License Nurse (LN) 1, resident rooms were observed on the [NAME] Nurses' station. LN 1 confirmed there were multiple unoccupied beds available at the [NAME] Nurses' station. LN 1 confirmed there was a total of 9 residents on isolation precautions. LN 1 stated the residents were either on contact isolation precautions (a type of infection control precaution used to prevent the spread of infection that are transmitted through direct contact with an infected person or their contaminated environment), or on enhanced barrier precautions (EBP- a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms during high contact care activities with residents who are colonized or infected by organism, or used with residents who have wounds or indwelling medical devices). LN 1 further stated Resident 1 was on a bed hold (ensures that a resident can return to their room or a comparable space if they're temporary absent such as a hospitalization) and the expectation was to be returned to facility after being discharged from the hospital. During a concurrent observation and interview on 2/4/25, at 12:30 p.m., with LN 2, resident rooms were observed on the East Nurses' station. LN 2 confirmed there was 1 unoccupied bed available and 5 residents were on isolation precautions at the East Nurses' station. During a phone interview on 2/4/25, at 1:05 p.m., Resident 1 stated that he had been living at the facility for over 6 years. Resident 1 further stated he had been at the hospital for 3 weeks and he still wanted to come back to the facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/4/25, at 1:30 p.m., with the Admission Coordinator (AC), the facility daily census reports were reviewed. The AC confirmed there were 3 unoccupied beds in the facility on 1/13/25, 2 unoccupied beds on 1/29/25, and 7 unoccupied beds were available on 2/4/25. The AC stated Resident 1 tested positive for Carbapenem Resistant Enterobacteriaceae CRE (group of bacteria that are resistant to carbapenems, a class of powerful antibiotics) and the facility did not expect Resident 1 to return because there was no isolation room available at the facility. The AC further stated that the facility had capability of taking care of any resident, and residents with the same infection could share rooms. During an interview on 2/4/25, at 2:36 p.m., with the Infection Prevention Nurse (IP), the IP stated currently there were 3 residents on contact isolation precautions. The IP further stated Resident 1 tested positive for CRE and required contact isolation. The IP stated the facility had not followed up with the hospital regarding Resident 1's source of infection, if it was active or colonized (bacteria present without causing illness or symtoms), and/ or what kind of antibiotics Resident 1 was on. The IP further stated the facility did not accommodate CRE regardless of the source of infection. The IP confirmed there were no communications between her and the hospital related to concerns about Resident 1's CRE infection and Resident 1 being non-compliant with isolation precautions. The IP stated they could not accept Resident 1 back to the facility. The IP further stated the facility could not accept residents with CRE infections. During a concurrent interview and record review on 2/4/25, at 3:23 p.m., with the Director of Nursing (DON), Resident 1's electronic health record (EHR) and the facility census report for 2/4/25 and 1/13/25 were reviewed. The DON confirmed there were 3 residents in the facility on contact precautions as of 2/4/25. The DON further confirmed there was no documentation in Resident 1's EHR by facility staff discussing about Resident 1's CRE infection or the risk of spreading CRE due to Resident 1's history of noncompliance. The DON stated the facility had not attempted to cohort other residents to re-admit Resident 1. The DON further stated due to Resident 1's CRE infection, the facility could not accept him. The DON stated it was not about the resident; it was about the positive CRE infection. The DON further stated she had no communication with the hospital so she was unaware of Resident 1's CRE source of infection or if it was active. The DON explained it was the IP's responsibility to reach out to the local public health department for guidance on CRE. The DON stated Resident 1 had lived at the facility for almost 7 years and might feel sad for not returning to the facility. During a review of Resident 1's hospital record titled, Physician Note, dated 1/13/25, under the Assessment/ Plan section indicated, .Patient [Resident 1] medically cleared for discharge, awaiting care facility authorization for return pending isolation precautions . Further review of Resident 1's hospital record titled, Physician Note, dated 1/14/25, under the Subjective section indicated, .Patient [Resident 1] .Endorsed severe frustration at having to remain in the hospital . Endorses frustration with his SNF . Review of an online document by the California Department of Public Health (CDPH) titled, Recommendations for Infection Control for Residents with CRE in Long-Term Care Facilities, dated 1/21/16, indicated, .The CDC [Centers for Disease Control and Prevention] has developed guidance to help facilities and regions control spread of CRE .Recommendations: Admission or readmission to a long-term care facility should not be denied based on known colonization or infection with any multidrug-resistant organism (MDRO), including CRE . (continued on next page)

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