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	05/28/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one out of three residents (Resident 1) who were at risk for wandering/elopement received adequate supervision to prevent an elopement (when a resident leaves the facility without supervision) from occurring, when Resident 1 eloped from the facility for the third time on 5/23/25 (Resident 1 had previously eloped from facility on 5/15/25 and 5/20/25). This failure led to Resident 1's elopement on 05/23/25 resulting in a four-day absence, and subsequent hospitalization. Findings: Review of Resident 1's admission RECORD, indicated, Resident 1 was admitted to the facility with diagnoses of toxic encephalopathy (brain dysfunction), brief psychotic disorder (sudden onset of at least one positive psychotic symptom [loss of touch with reality] for more than a day but less than a month), and psychosis (disconnection from reality). Review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool), dated 5/22/25, indicated Resident 1 scored seven out of fifteen points total. A score of seven indicated that Resident 1 had severe cognitive impairment (when a person is likely to experience significant difficulties with mental tasks and may require substantial assistance with daily activities). Review of Resident 1's elopement care plan, initiated 5/16/25, indicated, .Focus .Resident is high risk for elopement r/t [related to] Encephalopathy .Goal .No more elopement/wandering outside facility premises . Interventions .Resident under close staff supervision . Also, .Focus .exit seeking behavior . Goal . No exit seeking behavior x72 hours . Interventions .1:1 [one to one] counseling as needed .Redirection as needed . Review of Resident 1's Progress Notes indicated Resident 1 was originally admitted on [DATE] around 3:00PM, he wanted to leave the facility but refused to sign AMA form (Against Medical Advice form). And then, at around 6:05 P.M., he was nowhere to be found, a non-emergency police report was filed by the facility. Resident 1 was found by police around 8:00PM and was sent to the hospital for welfare check. On 05/16/2025, Resident 1 was re-admitted at the facility, and was placed on Elopement Monitoring. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Progress Notes, written by LN3, indicated, on 5/20/25, a nearby nursing facility contacted Resident 1's home facility (where Resident currently resides) to report that Resident 1 had been found in their parking lot. Requested for resident to have 1 on 1 as the resident constantly wanders. Review of Resident 1's Progress Notes indicated, on 5/23/25, Resident 1 exhibited increased confusion but was still able to verbalize his needs. He was also noted to be aggressive toward staff. Additionally, staff noted that the back door adjacent to room [ROOM NUMBER] was open. Then, at around 7:20PM, Resident 1 could not be located. Staff searched the facility perimeter, and the Director of Nursing (DON), Stockton Police, and Medical Doctor (MD) were notified. Resident 1 was entered into the missing person database. Review of Resident 1's Progress Notes showed staff documented on 5/27/25, that they were able to locate the resident by calling a local hospital. According to the hospital nurse report, .patient Resident 1] was admitted on [DATE] he was found face down unconscious with abrasion (a wound where the skin is scraped or rubbed away) on the face [he] is currently receiving ABT (Antibiotics) for sepsis (a life threatening emergency that happens when your body's response to an infection damages vital organs and, often, causes death) secondary to pneumonia (an infection that inflames air sacs in one or both lungs,) . During a concurrent observation and interview on 5/28/25 at 1:40 p.m. with Maintenance Director (MD) 1, MD 1 stated, he believed Resident 1 went out through the main lobby door because it would be hard for Resident 1 to get out from the facility's side perimeter door. MD 1 pointed out that, in every exit door, the facility had two sets of alarms, 1) Fire Alarm (also called Red Alarm) and, 2) Wander Guard Alarm. Exceptions are the Main lobby door and the west-long exit door which only has the wander guard alarm system. Another exception was the Kitchen/Laundry Access Door, this exit has a double door that does not have any alarm system in place. During the same concurrent observation and interview with MD 1, he showed and checked every door in the facility and noted the following: 1. Main Exit door (also referred as the lobby main door or main lobby door)- This exit has double doors equipped with wander guard. According to MD 1, the facility turns the wander guard off from 8:00 a.m. until about 5:00 p.m MD 1 also stated the facility's wander guard system was designed where if anyone tries to open the door, the wander guard alarm will be triggered. It was observed that the left side of these double doors was wide open while the right side was closed. 2. West-Long Exit Door - This exit door located near room [ROOM NUMBER] was equipped with a wander guard system. It was noted that the code to unlock the wander guard was written on the side of the equipment. It was observed that this exit door was two doors down from Resident 1's room. According to MD 1, this door always remains closed, but then again, it was designed where anyone from inside the facility can open it at any time for fire hazard protection. 3. Kitchen/Laundry Access Door - This exit located opposite room [ROOM NUMBER] has double doors. It leads to the kitchen and laundry areas as well as the staff's main exit door that opens to the parking lot. It was noted that neither the kitchen/Laundry Access Door nor the staff main exit door was equipped with any alarm system. MD 1 stated that the Kitchen/Laundry Access Door was not always kept closed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Side Perimeter Door - This perimeter door can be accessed by following the path along the perimeter wall from the activities area, west-long exit door and from Resident 3's bedroom sliding door. The side perimeter door was found broken and unlocked. It could be opened from inside and outside the facility, providing direct access to the facility's roll-off dumpster and main road. During an interview with Licensed Nurse (LN) 1 on 5/28/25 at 2:36PM in front of west nurse station, LN 1 stated that he was working on 5/23/25, PM shift when Resident 1 eloped. LN 1 recalled that one of the CNA's told him that Resident 1 was missing, and he along with other staff started searching around the facility and the vicinity but they failed to find Resident 1. LN 1 stated, he was the one who called their DON to report that Resident 1 eloped. LN1 also said that Resident 1 was not on 1:1 [monitoring] but rather was only on visual monitoring - meaning, a CNA will check the resident every 15 minutes because he was an elopement risk, he was confused, he likes to move around and walks fast . During an interview with LN2 on 5/28/25 at 2:45PM inside west nurse station, LN2 stated that she never worked with Resident 1, but she knows who he was because he walks up and down the hall. LN2 stated, she believed that, given Resident 1's behavior, he belonged to a locked unit and not in any facility like where Resident 1 currently resides. During a concurrent observation and interview on 5/28/25 at 2:57PM, Resident 3 stated that he feels safe in the facility only sometimes because the back door of the facility was broken for many months now, and sometimes, homeless people as well as animals went through that side door. Resident 3 showed the surveyor the facility's side door by following the facility's perimeter trail; it led to the one and the same broken side perimeter door noted during interview with MD 1. During an interview with both the DON and the Administrator on 5/28/25 at 4:18PM, the DON stated that, the first time Resident 1 left the faciity on 5/15/25, the facility did not consider the incident as an elopement because that was when Resident 1 was originally admitted . At that time, Resident 1 was AAOx3 (Awake, alert and oriented to time, place and person) and he expressed that he wanted to leave the facility immediately after admission but refused to sign the AMA (Against Medical Advice) form. The DON added, at that time, the facility only reported Resident 1 as a missing person because he was on a psych med (drugs used to treat mental health conditions) and they were fulfilling their due diligence. For both Resident 1's safety and the facility's best interest they requested that Resident 1 be evaluated at the hospital. According to the DON, Resident 1 was readmitted to the facility the following day - 5/16/25. According to the DON, the second elopement happened on 5/20/25. Resident 1 was seen in the vicinity of a neighboring facility, and he was re-directed back to the facility shortly after. The facility did not report this as an elopement incident because Resident 1 was only gone for just about 10-15minutes. From that second elopement, according to the DON, Resident 1 was noted to be aggressive as evidenced by pushing a CNA, and the facility could only do visual checks from a distance. The DON stated that Resident 1 was not technically placed on 1:1 observation but rather was monitored through routine Q (every) 15minutes visual checks. According to the DON, Resident 1's orientation was fluctuating between 1 to 3, although he can verbalize what he wants. The DON continued, there was a gray area wherein the facility cannot just let Resident 1 leave because he was on Seroquel (medicine used to help people with mental health conditions). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regarding Resident 1's third elopement on 5/23/25, the DON stated that her staff called her right away after they failed to find Resident 1 around the facility and vicinity for approximately 10mintues. According to the DON, she felt that the facility did their due diligence as they did not wait 24 hours to report the elopement incident on 5/23/25. The DON also stated that both her and the administrator were in close communication during the incident. The DON explained she went around the vicinity of the facility looking for Resident 1 until around 2:00AM, the facility also reached out to local hospitals to check if Resident 1 was in any of them and they did a missing person report. Both the DON and the Administrator believed that Resident 1 might have eloped either through the Main lobby exit door or through a sliding glass door in a patient room that leads to the backyard. The DON also stated that Resident 1 went missing on 5/23/24 and they were lucky to learn on 5/27/25 that he had been admitted to a local hospital on 5/24/25. When asked what actions were taken following Resident 1's first elopement, the DON stated that they have implemented Q15 minutes visual checks. When asked what actions were taken following Resident 1's second elopement, the DON stated that they have continued the Q15 minutes visual checks because it was effective during his first elopement. The DON explained that Q15 minutes visual checks meant all staff were expected to keep an eye on Resident 1, with a designated CNA assigned on a rotating schedule to check on Resident 1 every 15 minutes. Review of the facility's Q15 minutes check for safety logs dated 5/16/25, 5/18/25, 05/20/25, 05/21/25, 05/22/25 and 05/23/25 were received. The DON stated that the logs were incomplete. Breakdown of the Q15 minutes check for safety log are as follows: · 5/16/25 o The form was blank from the hours of 2030 through 2245. o There were no signatures/initials or names noted from the hours of 1800 through 0645 · 5/17/25 o The date on form was cut off, unclear if it was for 5/17/25. o The Form was incomplete from the hours of 2230 and 2245 o The form did not state Resident 1's name o There were no staff signatures/names or initials noted from the hours of 0700 through 0645 · 5/18/25 o There were no staff signatures/initials or names noted from the hours of 0700 through 2245 · 5/19/25 o There was No Q15 minutes safety check form provided by the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	· 5/20/25 o The form was blank from the hours of 0700 through 1415 o The form was blank from the hours of 2115 through 2215 o The form was blank from the hours of 0630 through 0645 o There were no staff signatures/names or initials noted from the hours of 0045 through 0615 A review of the facility's Progress Notes dated 5/20/25 at 1501, staff documented that Resident 1 was last seen at the .nurse's station at around 1350 . and then, .at around 1410 . the neighboring facility called to inform that Resident 1 was found in their parking lot. Cross checking the above progress notes documentation versus the facility's Q15 minutes check for safety log dated 5/20/25, indicated that Resident 1's whereabouts were not logged from 0700 through 1415h. · 5/21/25 o The form was blank from the hours of 1115 through 1145 o The form was blank from the hours of 1430 through 1445 o The form was blank from the hours of 1715 through 1745 o The form was blank from the hours of 2015 through 2215 o The form was blank from the hours of 0630 through 0645 o There were no staff signatures/names or initials noted from the hours of 2230 through 2245 o There were no staff signatures/names or initials noted from the hours of 2300 through 0615 · 5/22/25 o The form was blank from the hours of 0700 through 0845 o The form was blank from the hours of 1115 through 1245 o The form was blank from the hours of 1600 through 1745 o The form was blank from the hours of 1900 through 0645 · 5/23/25 o The form was blank from the hours of 1:45 PM through 2:15 PM o There was no staff name printed under AM CNA and PM CNA (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with the DON on 5/23/25 at 5:07PM, the DON went with surveyor to check the broken side perimeter door. The DON saw and acknowledged that the door was broken, and anyone can easily enter/exit the facility through there. The DON re-checked the west-long exit door's alarm as well and found the wander guard alarm code written on the side of the installed wander guard equipment. During this check, the DON noted that there was a four second lag when resetting the wander guard, meaning, after the alarm was triggered and upon closing of the door and entering the wander guard code, staff would have to wait for four seconds before re-opening the door to ensure the alarm would set off. Otherwise, anyone can leave the door open, and no alarm will be triggered. On 5/29/25, a concurrent video call interview and observation with the DON at 10:16 A.M., was conducted. During the video call, the DON re-tested West-Long Exit door by first entering the wander guard code and then pushing the door open. It was noted that using this method did not trigger the wander guard alarm. The DON also checked their main lobby double doors and found that the left side of the double door was fully open. According to DON, the facility locks all doors after their visiting hours. Visiting hours are from 8:00AM to 8:00PM. During a phone interview on 6/2/25 at 2:02 P.M., with CNA 3. CNA 3 stated he took care of Resident 1 on 5/23/25. CNA 3 stated that before 5/23/25, Resident 1 presented with sundowning like behavior - he was very confused. Staff continued providing Q15 minutes visual checks. On 5/23/25, CNA 3 said, Resident 1's behavior was at baseline; there was no increased confusion, and he was not violent toward anyone. CNA 3 also noted during his shift that, West-short exit door (the exit door near room [ROOM NUMBER]) was broken, he [CNA 3] physically tested the door himself and noted that the alarm was not triggered as he opened the door. CNA 3 thinks that, based on Resident 1's physical strength, it was unlikely he would have been able to open the broken side perimeter door. Therefore, CNA 3 believed that Resident 1 eloped through the kitchen/laundry Access Door. This door leads to the staff exit door, which is not equipped with a wander guard or alarm, and it opens directly into the parking lot. CNA 3 reported that Resident 1 was never on 1:1 with any CNA - he was only on visual check and watch. CNA 3 stated the facility was not set up for patients with mental health issues like that of Resident 1. During a concurrent video call interview and observation with the Assistant Director of Nursing (ADON) on 6/3/25 AT 10:41AM, the ADON showed and confirmed that the exit located opposite room [ROOM NUMBER] led to the kitchen/Laundry area Access Door. The ADON also showed and confirmed that the Kitchen/Laundry Access Door was not equipped with a wander guard alarm nor a red alarm system. During the same interview and observation, it was noted that the Kitchen/Laundry Access doors were open, allowing unrestricted passage. This same kitchen/laundry access door allows direct passage to the staff exit door that leads to the parking lot and was noted without any alarm system. A review of the facility's undated policy and procedure, titled Elopement and Wandering Residents indicated . facility ensures that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks . monitoring for effectiveness and modifying interventions when necessary . 4f. the effectiveness of interventions will be evaluated, and changes will be made as needed .