

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  06/25/2025
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)
F 0550  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.  (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

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  06/25/2025
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>Based on observation, interview, and record review, the facility failed to ensure residents' rights to be treated with dignity were honored for 1 of 3 sampled residents (Resident 1) when Resident 1 was not offered to wear her own clothing. This failure had the potential to negatively impact Resident 1's psychosocial well-being. Findings: During a concurrent observation and interview on 6/24/25, at 10:38 a.m., with Resident 1, Resident 1 was observed sitting in bed and wearing a hospital gown. Resident 1 stated the nursing staff had not offered her to be dressed up while having her own clothing here. Resident 1 further stated she would love to wear her own clothes. Resident 1 stated that always being in a hospital gown made her feel she was not being taken care of. Resident 1 further stated that during the care conference meeting (a meeting where the resident, family, and facility care team discuss the resident's care plan, goals and progress) which Ombudsman (an advocate for long term care residents in a skilled nursing facility) attended, she was in a hospital gown. Resident 1 explained that always wearing a hospital gown was a dignity issue affecting her emotions and causing her distress. During a concurrent observation and interview on 6/24/25, at 2:05 p.m., Certified Nurse Assistant (CNA) 1 stated Resident 1 had her own clothing. CNA 1 confirmed Resident 1 was wearing a hospital gown. During a concurrent observation and interview on 6/24/25, at 4:13 p.m., CNA 2 confirmed Resident 1 was wearing a hospital gown but had her own clothes in her closet. CNA 2 stated always being in a hospital gown could result in feeling down. During an interview on 6/25/25, at 8:16 a.m., CNA 3 stated after breakfast she was dressing up the residents in her group. CNA 3 further stated residents did not look presentable when always wearing a hospital gown and could lead a resident to feel disappointment, feeling ignored, and not being taken care of. During a concurrent observation and interview on 6/25/25, at 9:43 a.m., with Resident 1, Resident 1 was observed sitting in bed wearing a hospital gown. Resident 1 expressed her concern about having her own clothes in her closet then pointed to her gown, and stated she was still in a hospital gown and that made her feel discriminated against. During an interview on 6/25/25, at 9:58 a.m., CNA 4 stated she made rounds with her assigned residents from 8-9 in the morning. CNA 4 further stated she made rounds as per her routine and asked residents if they would like to be dressed up, or if they needed assistance to be dressed up. CNA 4 confirmed that she did not ask Resident 1 if she wanted to be dressed up. CNA 4 stated having clothing available, but being in gown always could possibly affect Resident 1 emotionally by feeling distressed. During a phone interview on 6/25/25, at 10:46 a.m., Ombudsman stated she attended a care conference meeting for Resident 1. Ombudsman further stated Resident 1 was in a hospital gown during a care conference meeting and she questioned the facility why resident presented wearing a hospital gown when she had her own clothing. Ombudsman stated, they don't follow through with her. During a concurrent interview, and record review, on 6/25/25, at 12:31 p.m., with the Assistant Director of Nursing (ADON), Resident 1's care plans, and the facility Policy and Procedure (P&amp;P) titled, Activities of Daily Living (ADLs), dated August 2024, were reviewed. The ADON confirmed Resident 1 had her own clothes in the closet. The ADON stated her expectation from CNAs were to offer Resident 1 to be dressed up or assist her with dressing up. The ADON further confirmed that Resident 1's care plans did not indicate her refusal to be dressed up or preferred to wear a hospital gown. The ADON stated her expectation would be to see a care plan for preferences to wear a hospital gown or refusal to be dressed up. A review of the P&amp;P for ADLs indicated, .Policy: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care . The ADON acknowledged the facility P&amp;P was not followed. The ADON stated there was a dignity issue when Resident 1 had her own clothing but was wearing a hospital gown and added that it could affect her well-being.</p>		

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  06/25/2025
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 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>(continued on next page)</p>

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  06/25/2025
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, and record review, the facility failed to document and investigate the grievances for one resident (Resident 1) with a facility census of 98, regarding her care concerns. This failure had the potential for Resident 1's care concerns to not be honored and addressed timely. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2025 with diagnoses which included polyneuropathy (a general term for peripheral nervous system disorders that impact nerve function in multiple areas of the body), multiple sclerosis (a disease in which the immune system eats away the protective covering the nerves, resulting nerve damage disrupts communication between the brain and the body), post-trauma TIC stress disorder (there is a connection between trauma, stress, and the development or worsening of tic-like movements as a manifestation of trauma related stress). During a concurrent interview and record review on 6/24/25, at 10:38 a.m., with Resident 1 in her room, Resident 1 stated she filed grievances at the facility and kept personal copies of the grievances that she filed. Resident 1 further stated she took the original grievance forms to the Social Services department. Resident 1 stated she felt that her grievances were not being addressed by the facility in a timely manner. Review of the record titled, GRIEVANCE FORM, dated 6/6/25, indicated Resident 1's concerns were voiced to the Administrator (ADM), the Director of Nursing (DON), and the Social Services Director (SSD). Resident 1 stated the ADM, the DON, and the SSD were notified about her multiple concerns, and no action was taken. Resident 1 further stated she was frustrated about not having all concerns being addressed. During a concurrent interview and record review on 6/25/25, at 11:28 a.m., with the SSD, the facility Grievances Binder and Resident 1's medical record was reviewed. The SSD stated regarding grievances that if a resident had a grievance, the facility had the resident complete a grievance form. Review of Resident 1's record titled, GRIEVANCE FORM, dated 6/6/25 was reviewed with the SSD. Further review of the record indicated Resident 1 had voiced her concerns about care and medications to the ADM, the DON, and the SSD on 6/6/25. The SSD confirmed that the section titled, Step Taken to Investigate the Grievance. Summary of the Pertinent Facts or Conclusions Regarding the Concern. was blank. The SSD further confirmed steps were not taken to investigate Resident 1's concern about the medications. The SSD stated each concern should have been investigated and the steps needed to be taken to address Resident 1's concern. Review of Resident 1's social services progress notes indicated Resident 1's concerns were not addressed. The SSD confirmed that there was no progress note regarding an investigation or the actions that were taken by facility to address Resident 1's concerns after receiving grievance on 6/6/26. The SSD stated all the sections of the grievance form dated 6/6/25 should have been completed and the concerns should have been addressed by the facility. The SSD further stated that the facility policy was not followed. During a concurrent interview and record review on 6/25/25, at 12:31 p.m., with the Assistant Director of Nursing (ADON), Resident 1's Grievance form dated 6/6/25 was reviewed. The ADON stated the SSD had been designated as the Grievance Official. The ADON confirmed that there was a Grievance submitted to the SSD on 6/6/25 which included Resident 1's concerns about her care. The ADON confirmed that the investigation and conclusions sections on Resident 1's Grievance form were left blank. The ADON stated all sections on the Grievance form should have been completed to address Resident 1's concerns. The ADON further stated there was a risk of not meeting Resident 1's needs. The ADON stated that the facility P&amp;P was not followed. A review of the facility Policy and Procedure (P&amp;P) titled, Resident and Family Grievances, revised on October 2022, indicated, .Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Policy Explanation and Compliance Guidelines: 1. Social Services Director has been designated as the Grievance Official. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations 10 Procedure .d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form .1. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. 11. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgment of complaint/grievances</p>		

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  06/25/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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  06/25/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) received treatment and care in accordance with professional standards of practice when:1. There was no follow up for Resident 1's appointment with a neurology specialist (specialty doctor who specialized in diagnosing and treating diseases and disorders of brain, spinal cord, nerves, and muscles); and,2. A care plan was not initiated for Resident 1's diagnosis of polyneuropathy (a general term for peripheral nerves system disorders that impact nerve function in multiple areas of the body. Symptoms can include pain, a pins-and-needles sensation, numbness, and weakness).These failures had the potential to result in a worsening nerve condition and/or other serious medical complications including a delay in care without proper interventions.Findings:1. A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2025 with diagnoses which included polyneuropathy, and multiple sclerosis (MS, a disease in which the immune system eats away at the protective covering of nerves, resulting nerve damage disrupts communication between the brain and the body).During an interview on 6/24/25, at 10:38 a.m., with Resident 1, Resident 1 stated she had a history of being on life support (the use of specialized equipment to maintain a person's essential body functions to stay alive) for a year and woke up with burning pain and pin-needle sensation, and was diagnosed with neuropathy during her hospital stay several months ago. Resident 1 further stated she also had a history of MS with nerve damage affecting the left side of her body. Resident 1 stated the Director of Nursing (DON), and the Social Services Director (SSD) were notified during the first week of May 2025 that she needed a neurology appointment and was still waiting to hear if the facility had followed up with the appointment.A review of Resident 1's Social Services Progress Note, dated 4/18/25, indicated, .Resident also requested to be seen by a neurologist. SSD to send a referral to Neuro as soon as order received .A review of Resident 1's clinical record titled, Order Summary Report, dated 5/7/25, indicated there was an active order from the physician to make a neurology appointment.A review of the facility's record titled, GRIEVANCE FORM, dated 6/6/25, indicated Resident 1 had a concern about not being seen by a neurologist till that date.A review of Resident 1's record titled, Progress Notes, dated 5/28/25, indicated a care conference was held per the resident's request and attended by the Ombudsman (advocate for residents in a long term care facility), the Director of Rehabilitation, the SSD, the Assistant Director of Nursing (ADON), and the DON. Further review of the record indicated Resident 1 verbalized her worries regarding the delay in a neurology referral. The care conference intervention included the SSD to follow up with the neurology referral.During a concurrent interview and record review on 6/25/25, at 11:28 a.m., Resident 1's medical record was reviewed with the SSD. The SSD confirmed that there was an active order for a neurology appointment for Resident 1 which was dated 5/7/25. The SSD further confirmed that one of Resident 1's concerns on the Grievance form dated 6/6/25 was that she had not been seen by a neurologist till that day (6/6/25). The SSD stated he sent a neurology referral on 5/7/25 and a second referral to another neurologist on 5/28/25 when Resident 1 voiced her concern about a delay with the neurology appointment. The SSD further stated he did not follow up with the neurology appointment since the referral was sent to the second neurologist. The SSD explained there was a delay with care that could possibly affect Resident 1's health, and he should have followed up with the second neurologist after he didn't hear from the neurologist. During a concurrent interview and record review on 6/25/25, at 12:31 p.m., with the ADON, Resident 1's care conference note, dated 5/28/25 was reviewed. The ADON confirmed that according to the care conference note on 5/28/25, the SSD was to follow up with the neurologist after the referral was sent on 5/28/25. The ADON stated the neurology appointment was important, especially with Resident 1's diagnosis of polyneuropathy. The ADON stated there was a delay in care that Resident 1's neuropathy could worsen, and a possibility for Resident 1 to end up being sent out to the hospital.2. A review of Resident 1's clinical record titled, Care Plan Report, indicated a care plan for polyneuropathy was not initiated since Resident 1 admitted to the facility.During a concurrent interview and record review on 6/25/25, at 12:31 p.m., with the ADON, Resident 1's medical record was reviewed. The ADON confirmed Resident 1 was admitted in 2025 with a primary diagnosis of polyneuropathy. The ADON further confirmed Resident 1's care plans did not include a care plan to address Resident 1's diagnosis of polyneuropathy. The ADON stated the care plan was an important tool and a communication method that would guide nursing staff how to provide resident centered care for residents. The ADON further stated her expectation from nursing staff was to initiate and implement interventions to meet Resident 1's needs, and make sure all diagnoses were care planned. The ADON</p>		

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  06/25/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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  06/25/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure medications were available for administration for 1 of the 3 sampled residents (Resident 1), when anxiety medication was not available for Resident 1. This failure had the potential to negatively impact Resident 1's health and well-being. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included post-traumatic stress disorder (PTSD, a mental health condition that develops after experiencing a traumatic event) and anxiety (a mental health condition characterized by excessive worry, fear, and unease). During a concurrent observation and interview on 6/24/25, at 10:38 a.m., with Resident 1, Resident 1 stated she was okay until she ran out of Xanax (medicine to treat anxiety). Resident 1 further stated she requested anxiety medication and did not receive until it was delivered by the pharmacy on 6/21/25 at 3:30 p.m. Resident 1 stated the unavailability of the anxiety medication made her feel distressed and increased her anxiety level. A review of Resident 1's medical record titled, MEDICATION ADMINISTRATION RECORD (MAR), dated 6/20/25 through 6/21/25, indicated, .Alprazolam [anxiety medicine, generic name for Xanax] Oral Tablet 0.5 MG [milligrams, a unit of measure] .Give 1 tablet by mouth every 8 hours as needed for anxiety M/B [manifested by] verbalizing of uneasiness-Start Date 6/11/2025 . Further review of the record indicated the anxiety medicine was not available for administration on 6/21/25, and resident missed 2 doses. During a phone interview on 6/25/25, at 10:27 a.m., with the Pharmacist (PHARM), the PHARM stated the process for facilities to request a refill of a controlled substance (drug that has a high potential for abuse) was for the facility to print the request for refilling controlled substances for the physician to approve and sign. The PHARM further stated that once the physician approved it, the facility would fax the prescription to the pharmacy, and they would fill it. The PHARM explained Resident 1's Xanax order was for every 8 hours and PRN (as needed) for anxiety. The PHARM stated the facility was responsible to reach out to them to request the refill before running out of the medication. The PHARM further stated his expectation was not followed by the facility to ensure Resident 1 had her anxiety medication available. During a concurrent interview and record review on 6/25/25, at 7:58 a. m., with Licensed Nurse (LN) 1, Resident 1's record titled, MEDICATION ADMINISTRATION RECORD (MAR), dated 6/20/25 through 6/21/25 was reviewed. LN 1 stated nurses were responsible for printing out the order and placing it in the physician folder for the physician to approve and sign. LN 1 further stated that after the physician signed the order, the nurses would fax it to the pharmacy and the pharmacy would deliver the medication. LN 1 stated nurses needed to place the refill order when 2 to 3 days of the medicine were left and not wait until running out of the medication to place the order. LN 1 confirmed that Resident 1 missed 2 doses of her PRN Xanax when she requested to take medication on 6/21/25 at 3 am, and then again 8 hours later the same day. LN 1 stated not having the anxiety medicine available could affect Resident 1's health and well-being by causing agitation and the possibility to exhibit behavior such as screaming or acting different. During a concurrent interview and record review on 5/25/25, at 12:31 p.m., with the Assistant Director of Nursing (ADON), Resident 1's MEDICATION ADMINISTRATION RECORD, dated 6/1/25 to 6/30/25 was reviewed. The ADON confirmed Resident 1 was taking Xanax for anxiety and received the last dose of Xanax on 6/20/25 at 6:32 p.m., missed 2 doses of Xanax on 6/21/25, and then received the next dose on 6/21/25 at 3:19 p.m. The ADON stated for medication specifically such as Xanax it was necessary to place the refill order in advance to ensure medication was available. The ADON further stated missing 2 doses of PRN Xanax could possibly place Resident 1 at risk for increased anxiety that could lead to inability to relax, be restless, and behavior changes. The ADON stated there was a risk for emotional distress that could affect Resident 1's health in general. The ADON further stated she expected the nurses to order the Xanax in advance and her expectation was not met by the licensed nurses. A review of a facility provided record titled, Medication Ordering and Receiving From Pharmacy Provider, dated 2010, indicated, .If not utilizing cycle fill or anniversary fill system, all medications shall be reordered in advance .</p>		

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  06/25/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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  06/25/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to distribute and serve food in accordance with professional standards for food safety for 1 of the 3 sampled residents (Resident 1) when: 1. The lunch tray did not contain a dietary ticket/identifier; and, 2. The drink on the tray did not match the tray ticket. These failures had the potential to place Resident 1 health at risk for consuming the wrong diet. Findings: 1. Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with multiple diagnoses including but not limited to multiple sclerosis (MS, a disease that causes breakdown of the protective covering of nerves resulting in numbness, weakness, trouble walking, vision change and other symptoms), dysphagia oropharyngeal phase (difficulty swallowing in the oropharyngeal phase, which involves the transfer of food from the mouth to the esophagus. Problems in this phase can lead to coughing, choking, and aspiration). A review of Resident 1's Order Summary Report, dated, 4/10/25, indicated, .Cardiac diet Regular texture, Thin consistency, Allergic to beef and dairy products .During a concurrent observation and interview on 6/24/25, at 2:05 p.m., with Certified Nurse Assistant (CNA) 1, Resident 1's lunch tray was reviewed. Resident 1's lunch tray was observed missing a tray ticket (printed document that accompanies a resident's meal tray, providing specific dietary information and instructions for meal service staff. These tickets ensure that each resident receives the correct food based on their individual needs, including diet orders, allergies, and personal preferences). CNA 1 was unable to identify the accuracy of the foods and drink on the tray stating that she knew that the tray was for Resident 1. CNA 1 stated dietary staff placed foods, drinks, desserts, and the tray ticket according to residents' diet orders on the trays prior to sending trays out to the floor then CNAs would pass the trays by reading and comparing the dietary ticket to the food and drinks on the trays to identify correct diet order was served to the correct resident. CNA 1 further stated there was a potential to place Resident 1's health at risk by delivering and serving the wrong diet. 2. A review of Resident 1's tray ticket for lunch for 6/24/25 indicated, .8oz CRANBERRY JUICE .During a concurrent observation and interview on 6/24/25, at 2:11 pm, with CNA 1, Resident 1's lunch tray was compared with Resident 1's lunch tray ticket. CNA 1 confirmed that the orange juice drink noted on the tray was not matching with the tray ticket. CNA 1 stated tray tickets should match the trays, and it was important to have the same food and drinks. CNA 1 further stated it seemed like dietary placed orange juice instead of cranberry juice. CNA 1 stated she was not sure if the orange juice had the same nutritional value as the cranberry juice. CNA 1 further stated there was a potential not to meet Resident 1's needs. During a concurrent observation and interview on 6/24/25, at 2:14 p.m., Resident 1 stated she did not want to eat the food on the lunch tray and had ordered alternative foods. Resident 1 further stated the dietary staff did not pay attention to serve the correct drink for her either. During an interview on 6/25/25, at 8:47 a.m., with the Certified Dietary Manager (CDM), the CDM stated the dietary department was responsible for assembling and passing meal trays according to tray tickets. The CDM further stated tray tickets were important because they contained the type of diet, like/dislikes, allergies, resident's name and location. The CMD explained the tray tickets should match with the foods and drinks placed on the trays to ensure residents were receiving the correct meals according to their diet orders to meet nutritional needs and safety of the residents. The CDM stated after dietary staff checked the trays, the tray carts would then be delivered by dietary staff to the floor, and the CNAs were responsible for passing the trays to the residents. The CDM further stated that it was necessary to have tray tickets on the trays. The CDM stated there was a possibility for allergic reactions, or serving the wrong meal that could place Resident 1's health at risk. The CDM further stated that her expectation from dietary staff was to place the tray ticket on Resident 1's tray prior to sending the tray out and her expectations were not met. During a concurrent interview and record review on 6/25/25, at 12:31 p.m., with the Assistant Director of Nursing (ADON), the facility Policy and Procedure (P&amp;P) titled, Tray Identification, revised date in April 2007 was reviewed. The review of the facility P&amp;P indicated, .Appropriate identification/coding shall be used to identify various diets .1. To assist in setting up and serving the correct food trays/diets to residents, the food services department will use appropriate identification [e.g., .computer generated diet cards] to identify the various diets .3. Nursing staff shall check each food tray for the correct diet before serving the residents . The ADON confirmed that the facility P&amp;P was not followed by dietary and nursing staff. The ADON stated tray tickets were sets of identification to identify the correct resident, diet and texture, allergies, and like, or dislikes. The ADON further stated there was a potential to place Resident 1's health at risk when the lunch tray was missing the tray ticket and the drink on the lunch tray did not match</p>		