

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 08/13/2025
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 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</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 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care (the diagnosis, treatment, and management of residents with breathing or other cardiopulmonary (heart and lung) disorders) consistent with professional standards of practice for two of two sampled residents (Resident 1 and Resident 2) with a tracheostomy (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs) when: 1. Registered Nurses (RNs) provided care for Resident 1 and Resident 2 without documented competencies (measurable patterns of knowledge that enabled individuals to perform a skill successfully) for tracheal suctioning (a procedure that cleared mucus (a sticky substance produced by the body) and secretions (liquid substance produced by the body) from the trachea (a tube-like structure that allowed air to travel to and from the lungs) through a tracheostomy tube (a removable tube inserted in tracheostomy)), and tracheostomy care (maintaining a clean tracheostomy tube, that included cleaning the inner cannula; a removable tube that fits inside the larger outer cannula of a tracheostomy tube), and changing dressings (specialized medical dressing used to cover and protect the opening created in the neck to help manage secretions and prevent infection); 2. Tracheostomy care and tracheal suctioning care plans (a document that outlined a resident's health needs, goals, and the specific actions (interventions) a nurse took to achieve those goals) were not created for Resident 1 and Resident 2; and 3. RNs were not always available in the facility 24 hours a day, seven days a week from 7/28/25 through 8/7/25, to carry out Resident 1's and Resident 2's physician order for as needed tracheostomy suctioning (a respiratory task that falls within the scope of practice for trained healthcare professionals, particularly registered nurses and respiratory therapists). These deficient practices placed Resident 1 and Resident 2 at increased risk for the development of infection such as Pneumonia (when harmful germs enter the lungs, multiply, and cause illness), desaturation (a decrease in blood oxygen levels), aspiration (inhaling or drawing something into the lungs other than air), and acute respiratory distress (a serious lung condition that prevented enough oxygen from getting into the blood). This created a likelihood serious physical harm (significant injury or damage that could have long-lasting or potentially life-threatening consequences), hospitalization, and/or death would occur, if not corrected immediately. The Immediate Jeopardy (IJ-a threat to resident health or safety which requires immediate corrective action due to the likelihood of serious injury or harm) began on 7/28/25, when the facility failed to provide competencies to nursing staff regarding tracheostomy suctioning, no care plans were in place related to tracheostomy care, and the facility did not ensure a RN was on duty for an entire 24 hour period to provide tracheostomy suctioning as needed to Resident 1 and Resident 2. The Administrator (ADM) and Director of Nursing (DON) were notified of the IJ on 8/7/25, at 5:43 PM. On August 7th, 2025, at 8:01 PM, a removal plan was provided by the facility. The State Agency verified the facility's implementation of the removal plan while onsite at the facility. On 8/7/25, at 8:35 PM, the ADM and DON were notified that the IJ immediacy was removed. There was no non-compliance identified at a lower level upon removal. Findings: 1a. During a review of Resident 1's clinical document titled, admission RECORD, the document indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis which included respiratory failure (a serious condition that makes it difficult to breathe on your own), hypoxia (a condition where there was an inadequate supply of oxygen to the body's tissues), and the presence of a tracheostomy. A review of Resident 1's clinical document titled, Order Summary, dated 7/29/25, ordered by the Medical Director, (Med Dir - a physician who oversees resident care), the document indicated, .Perform suctioning via tracheostomy PRN [as needed] for audible secretions, visible mucus, increased work of breathing, or [oxygen saturation; the amount of oxygen you have circulating in your blood] &lt; [less than] 92% [percent]. Use sterile technique [free from germs] with suction catheter [a sterile, flexible tube, used to remove secretions and other fluids from the airways of residents who cannot clear them on their own],pre oxygenate [the administration of oxygen to a resident before a procedure]. During a concurrent observation and interview on 8/7/25, at 9:15 AM, with Resident 1, in Resident 1's room, Resident 1 was observed to have a tracheostomy. Resident 1 stated she had asked the facility staff to please perform her tracheostomy care, stating the last time it was done was on 8/5/25, two days prior. Resident 1 stated the facility staff informed her that there was not anyone able to do her tracheostomy care. Resident 1 stated the last time she had tracheostomy care was on 8/5/25. During an interview on 8/7/25, at 12:47 PM, with Licensed Nurse (LN; a Licensed Vocational Nurse, I VN) ? I N 2 stated she had asked Respiratory Therapist (RT) ? on 8/5/25 if the RT staff would provide</p>		

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<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>Based on observation, interview, and record review, the facility failed to ensure medications were administered within professional standards of practice, to one resident (Resident 4) in a sample of four, when Resident 4's medications were left at her bedside. This failure had the potential for Resident 4 not taking her medications and/or another resident taking Resident 4's medication, negatively impacting the resident's health and well-being. Findings: During a concurrent interview and observation, on 8/6/25, at 12:50 PM, Resident 4 was in her room and two liquid medications were observed to be on her bedside table. Resident 4 explained the medications were her protein and her lactulose. A review of Resident 4's clinical document titled, Medication Administration Record (MAR), dated 8/1/25 through 8/31/25, the document indicated, . Lactulose [promotes bowel movements] . and, [brand name liquid protein] . During an interview with Licensed Nurse (LN) 1, on 8/6/25, at 1:05 PM, LN 1 confirmed he had left Resident 4's liquid protein and lactulose on her bedside table. LN 1 stated he should not have left the medications there. LN 1 explained he should have watched Resident 4 take her medications. LN 1 further explained there was a risk for another resident taking Resident 4's medication and there was a risk Resident 4 would not have taken her medication that was left on her bedside table. During an interview with the Assistant Director of Nursing (ADON), on 8/6/25, at 1:35 PM, the ADON stated the importance of not leaving medications at the residents bedside was another resident could take the medication, placing that resident at risk. A review of the facility policy titled, Medication Administration, dated 2025, the document indicated, . Medications are administered by licensed nurses . in accordance with professional standards of practice . Observe resident consumption of medication .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation and interview, the facility failed to ensure one of four sampled residents (Resident 4) received food that was safe and at an appetizing temperature when Resident 4's lunch meal on 8/7/25 was served cold and Resident 4's cold drink was served warm. This failure had the potential for Resident 4 to not obtain her nutritional requirements due to unpalatable food, negatively affecting Resident 4's health and well-being. Findings: During an interview with Resident 4, on 8/6/25, at 12:50 PM, Resident 4 stated the food was always cold and the drinks were always warm. During a concurrent observation and interview with Dietary Aide/Cook (DA/Cook) 1, on 8/6/25, at 12:56 PM, in Resident 4's room, the DA/Cook 1 took the temperatures of the food items on Resident 4's lunch tray that had been delivered at 12:52 PM. The temperatures were as follows: Taco Casserole 115 degrees Fahrenheit (F - a unit of measure); Mixed Vegetables 102 degrees F; Cranberry Juice 60 degrees F. During an interview with the Registered Dietitian (RD), on 8/12/25, at 1:59PM, the RD stated the above food items were in the danger zone for food safety with the danger zone (temperatures that allow for rapid bacteria growth) being 40 degrees F to 140 degrees F for hot foods and above 40 degrees F for cold drinks. The RD explained the safe holding temperature for food was > 140 degrees F. The RD further explained foods in the danger zone could cause foodborne illness when consumed. According to the Food Safety and Inspection Service U.S. Department of Agriculture's website, .Danger Zone (40 F - 140 F) .Leaving food out too long at room temperature can cause bacteria (such as Staphylococcus aureus, Salmonella Enteritidis, Escherichia coli O157:H7, and Campylobacter) to grow to dangerous levels that can cause illness. Bacteria grow most rapidly in the range of temperatures between 40 F and 140 F, doubling in number in as little as 20 minutes. This range of temperatures is often called the Danger Zone . https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/danger-zone-40f-140f</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary kitchen environment when:1. Spoiled grapes were available for resident consumption; and,2. Water from a floor sink (a drain in the floor that dirty water flows into) overflowed into the walk-in refrigerator; and,3. The resident refrigerator/freezer was not clean, contained outdated items, contained staff lunch bags and undated food containers, and was not monitored for temperature. 1. During an interview with Resident 4, on 8/5/25, at 2:22 PM, Resident 4 stated when she had asked for fresh fruit, she had been given a bag of 'rotten grapes'.During a concurrent observation and interview, on 8/6/25, at 11 AM, with the Dietary Manager (DM), in the walk-in refrigerator, three bags of grapes were observed to be in a box dated 7/14/25. The grapes were removed and were soft with blackened patches and white patches on the grapes, in a slimy liquid. The DM confirmed the appearance of the grapes. The DM stated when the grapes arrived they were good for 4-5 days, not 3 weeks.During an interview with the Registered Dietitian (RD), on 8/12/25, at 1:59 PM, the RD stated the grapes should have been thrown away and not available for resident consumption. The RD explained if there were signs of mold on the grapes it could potentially spread to other food in the refrigerator and could cause foodborne illness among residents receiving food from the kitchen.A review of the facility policy titled, Food Safety Requirements, dated 2025, indicated, .Food safety practice shall be followed throughout the facility's entire food handling process .Storage of food in a manner that helps prevent deterioration or contamination of the food, including growth of microorganisms (germs) .2. During a concurrent observation and interview with the Dietary Manager (DM), in the walk-in refrigerator, on 8/6/25, at 11 AM, a blanket was noted to be on the floor of the walk-in refrigerator. The DM stated there had been a leak in the walk-in refrigerator the day before. During an interview with the Maintenance Director (MNT Dir), on 8/6/25, at 11:35 AM, the MNT Dir stated the leak in walk-in refrigerator had not been a leak. The MNT Dir explained the floor sink on the other side of the wall overflowed due to a cap covering the drain, and the dirty water went through the wall into the walk-in refrigerator.During a follow up interview with the DM, on 8/6/25, at 11:45 AM, the DM stated the water from the floor sink had been mopped up yesterday and the blanket left on floor. The DM explained the refrigerator had been cleaned the day prior, however the DM also confirmed the moderate amount of debris still on the floor of the walk-in refrigerator consisting of one hair-net, 3 butter packets, 4x8 inch piece of box material and tape, an 8 1/2 x 11 sheet of stickers, and a stalk of celery with blackened edges.During an interview with the Registered Dietitian (RD), on 8/12/25, at 1:59 PM, the RD stated the water leaking into the refrigerator was concerning as it could mean the refrigerator may not be properly sealed. The RD explained the water provides a damp environment that could encourage mold and bacteria growth (germs), spoiling the food and rendering the food unsafe to eat. The RD further explained the risk to the residents was foodborne illness. 3. During a concurrent observation and interview with certified nursing assistant (CNA) 1, on 8/13/25, at 12:55 PM, in the East Wing room where the resident refrigerator was located, the contents of the refrigerator were as follows:two cups containing food items with a paper towel over the top, no date, no name, one cup contains a pinkish pudding like substance, the other one contains grapes;A tamale, dated 7-19-25, room [ROOM NUMBER]A; A thawed frozen food item in the refrigerator with no thaw date, has resident name, no received date.;Four containers of 'chocolate blood (pork blood)' no name, no date on containers;One medium sized container with a green lid containing chicken and vegetables, no name no date on container;Two cartons of eggs, no name no received date, sell by date of 7/2/25;One open can of coconut water, no name no date;Three staff lunch bags one green, one red, one black;One medium container with a red lid containing cooked beans, no name no date;One medium sized container with a red lid containing vegetable looking items, pineapple chunk looking items, tapioca looking items and a pink pudding substance with a black plastic spoon in the container, undated and unlabeled;One bag, dated 8/8/24, room [ROOM NUMBER]A, with a container of rice and a cake with use by date of 8/12/24;One medium sized, opaque container, with a blue edging on the lid, containing food items, unlabeled and undated; One white container with an opaque lid containing food items, undated and unlabeled;One bag of grapes undated and unlabeled;One bag, containing lunch meat, undated for room [ROOM NUMBER]B;The top rack in refrigerator contained unidentifiable debris, a caked on red sticky red substance, and a moderate amount of clean liquid.The freezer contained loose debris, with stains and a brownish substance on the left side and bottom of the freezer. The food items in the freezer were as follows:One piece of cake between two</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation and interview the facility failed to ensure outside garbage bins were kept covered. This failure could have been a contributing factor in the facility harboring pests (cockroaches, flies, ants) with the potential to negatively impact the health and well-being of residents residing in the facility. Findings: During observations made on 8/6/25 at 10:38 AM, 8/7/25 at 11 AM, and 8/13/25 at 10 AM., the lids of the outside garbage bins were noted to be open. During a concurrent observation and interview on 8/13/25 at 10:11 AM, with the Director of Nursing (DON), the DON confirmed the presence of one cockroach on the wall in the conference room. During a concurrent observation and interview on 8/6/25 at 11:45 AM, with the Dietary Manager (DM), the DM confirmed the outside garbage bin lids were left open. The DM explained the outside garbage bin lids should have been kept closed so pests were not attracted to the kitchen. The DM stated the residents could become ill because pests carry germs (a very small virus or bacteria that can make a person ill). During an interview with the Registered Dietitian (RD), on 8/15/25, at 11:47 AM, the RD stated she and the DM were aware of the pests. The RD explained pests should not be in the kitchen. The RD further explained that cockroaches opened up the opportunity for food contamination and the residents would be at risk for foodborne illness (nausea, vomiting, and/or diarrhea caused by eating contaminated food).</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that the kitchen oven was in good working order when the right oven door was hanging open and could not be closed. This failure had the potential to delay meal service and have hot foods not maintained at a safe food temperature (Hot food should be kept at 140 degrees Fahrenheit (F - unit of measurement) or above to avoid rapid bacteria (germs) growth, which could negatively affect the health of 87 residents who received food from the kitchen. During an observation on 8/6/25, at 11:40 AM, in the kitchen, the right-side door of a double oven was hanging open and the right-side door of the oven was not attached to the oven. During a concurrent observation and interview with Dietary Aide/Cook (DA/Cook) 1, on 8/6/25, at 11:45 AM, the DA/Cook 1 stated the right-hand oven door had been broken for three to four months. During an interview on 8/12/25, at 1:59 PM, with the Registered Dietitian (RD), the RD stated a kitchen audit was completed on 5/21/25. The RD stated that the Dietary Manager (DM) and herself were aware the right-hand oven door was broken and had informed the Administrator (ADM). The RD explained the oven was a crucial part of the kitchen and there were food safety concerns when it was broken. The RD further explained she was worried about foods cooked in the oven obtaining and maintaining food safe temperatures (temperatures where rapid bacteria growth is minimal). During an interview on 8/15/25, at 1:12 PM, with the Administrator (ADM), the ADM confirmed the right-hand oven door had been broken from at least 5/21/25 through 8/13/25. The ADM explained the oven should not be broken for three months. The ADM further explained the importance of keeping the oven in good working order was food safety.</p>		