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	12/22/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of employee-to-resident physical abuse was reported by the facility for one of three sampled residents (Resident 1) when on 11/17/25, the facility failed to report Resident 1's allegation of physical abuse by a Licensed Nurse to the state agency.This failure resulted in a delayed abuse investigation and had the potential to affect Resident 1's physical and psychosocial well-being.Findings:During an interview on 12/22/25 at 1 PM, in Resident 1's room, Resident 1 stated that a few weeks ago he had his cat food taken away and his arm twisted by Licensed Nurse (LN) 1 and that it was witnessed by a Certified Nursing Assistant (CNA). Resident 1 explained he called the police on 11/17/25 and made a police report because LN 1 got angry with him, grabbed and twisted his left arm hard enough to tear off a bandage on Resident 1's elbow while LN 1 took away Resident 1's bag of cat food. Resident 1 stated he bought cat food with his own money and liked to leave cat food for the stray cats on the patio outside of his room. Resident 1 further stated that in addition to the CNA witnessing the incident, he also told the Director of Nursing (DON) when she came into the room that he was physically hurt by LN 1. Resident 1 explained that he felt like, I'm nothing and a nobody to them, and that he did not feel like the facility cared about him or his rights. Resident 1 further explained that he told the DON that he no longer wanted LN 1 to be his nurse.During an interview on 12/22/25 at 12:45 PM, LN 2 stated that if he observed or heard a report of an alleged abuse, he would report it immediately to his DON or Administrator (ADM). LN 2 explained the process for reporting any type of alleged abuse including resident to resident, or staff to resident, was to check the resident head to toe and make sure the resident was safe and not injured. LN 2 further explained he would then call the doctor to notify him, report the incident to the police, complete the required abuse reporting forms, notify the Ombudsman (an appointed official to advocate for residents and resident rights), the state agency (state agency responsible for investigating alleged abuse and other resident complaints) and document the incident and who he notified in the resident's medical record. LN 2 stated in addition, we would monitor the residents for 72 hours to make sure the residents felt safe. LN 2 stated it was important to report allegations so that it did not happen in the future and to keep the residents safe. LN 2 further stated this was standard abuse allegation reporting procedures for all staff with knowledge of an alleged abuse.During an interview on 12/22/25 at 1:54 PM, CNA 1 stated that on 11/17/25 she was outside in the hallway around 7:30 to 7:45 AM passing breakfast trays to other residents and only walked past Resident 1's room but did not go inside of the room. CNA 1 further stated she remembered that there was a problem with Resident 1 feeding stray cats and that Resident 1 looked upset and LN 1 was in Resident 1's room. CNA 1 explained when the police came and took the report, she was surprised she was listed as a witness because CNA 1 stated she did not witness anything and was not in the room during the time of the allegation. During a concurrent interview and record review on 12/23/25 at 8:55 AM, LN 1 he stated that he could not recall the events on 11/17/25. Reviewed LN 1's progress note (a part of a patient's record, documenting their health status, treatment response, and changes during care to track progress, ensure accountability, and facilitate communication among healthcare providers) dated 11/17/25, indicated: . [at] 0755 [AM] CNA and LN noted [Resident 1] feeding stray cats from inside the [Resident 1's] room. [LN 1] took the bag of cat food that was sitting on top of a chair in room. At this time the CNA were present.0800 [AM] DON made aware of this situation and DON walked to [Resident 1's] room.[Resident 1] stated Your nurse there ([Resident 1 was pointing to the direction of myself [LN 1]) hurt me and twisted my left arm.Cops arrived.0823 [AM].LN 1 was then able to recall the events on 11/17/25 and added that CNA 1 was inside Resident 1's room when the incident occurred and could confirm that LN 1 did not touch or hurt Resident 1. LN 1 stated the DON was aware of the accusation from Resident 1, and LN 1 talked to the police when they came to the facility on [DATE] to make the police report. LN 1 stated he did not call the police to make a report and clarified that Resident 1 called the police to report he was abused. LN 1 further stated it was important to report abuse allegations for patient's rights and safety and added the risk to the residents for unreported abuse allegations were ongoing or continued abuse. During a concurrent interview and record review on 12/22/25 at 3:21 PM, the DON confirmed she was aware of the allegation of abuse to Resident 1 on 11/17/25. The DON further stated that she did not report the allegation of abuse to the required agencies because the police officer told her Resident 1 recanted (took back) his story and the police officer would not be making a police report on the alleged abuse. When asked if the DON had confirmed this information with

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to ensure an allegation of employee-to-resident physical abuse was thoroughly investigated by the facility in a timely manner when on 11/17/25, the facility did not fully investigate an allegation of abuse to Resident 1. This failure resulted in a delayed facility abuse investigation and had the potential to affect Resident 1's physical and psychosocial well-being.Findings: During an interview on 12/22/25 at 1 PM, in Resident 1's room, Resident 1 stated that a few weeks ago he had his cat food taken away and his arm twisted by Licensed Nurse (LN) 1 and that it was witnessed by a Certified Nursing Assistant (CNA). Resident 1 explained he called the police on 11/17/25 and made a police report because LN 1 got angry with him, grabbed and twisted his left arm hard enough to tear off a bandage on Resident 1's elbow while LN 1 took away Resident 1's bag of cat food. Resident 1 stated he bought the cat food with his own money and liked to leave cat food for the stray cats on the patio outside of his room. Resident 1 further stated that in addition to the CNA witnessing the incident, he also told the Director of Nursing (DON) when she came into the room that he was physically hurt by LN 1. Resident 1 explained that he felt like, I'm nothing and a nobody to them, and that he did not feel like the facility cared about him or his rights. Resident 1 further explained that he told the DON that he no longer wanted LN 1 to be his nurse. During an interview on 12/23/25 at 8:55 AM, LN 1 confirmed the Director of Nursing (DON) was aware of the accusation from Resident 1. LN 1 further stated he documented in his progress note dated 11/17/25 at 7:55 AM and indicated that the DON was made aware of the accusations and that Resident 1 called the police to make a report of abuse. During an interview on 12/22/25 at 3:21 PM, the DON confirmed she was aware of the allegation of abuse to Resident 1 on 11/17/25. The DON further stated that she did not conduct a thorough and complete investigation into the allegations because the police officer told her Resident 1 recanted (took back) his story and the police officer would not be making a police report on the alleged abuse. When asked if the DON had confirmed this information with Resident 1, or if she made a progress note documenting this information, she stated, no. When asked if the DON made any attempt to interview Resident 4, Resident 1's roommate, she stated, no. The DON confirmed the facility did not thoroughly investigate the allegation. Review of the facility policy and procedure titled, Abuse, Neglect and Exploitation, undated, indicated, .The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect.b. Establish policies and procedures to investigate any such allegations.V. Investigation of Alleged Abuse.A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse.occur.B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation.4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.6. Providing complete and thorough documentation of the investigation.