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 01/27/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review the facility failed to implement effective interventions to keep two residents (Resident 1 and Resident 2), in a sample of eleven, who had a prior altercation in the facility's dining room on 1/1/26, apart to prevent further incidents. As a result, on 1/5/26 Resident 1 and Resident 2 were in the facility's dining room again when they got into a physical altercation and Resident 1 was transferred to the hospital due to his injuries and ultimately a different facility.This deficient practice revealed that care planned interventions to keep Resident 1 and Resident 2 safe were not implemented resulting in injuries to Resident 1 including left wrist and left eye swelling, a hematoma of the left zygoma (swelling, bruising, and potential tenderness to the cheekbone), an abrasion (a scraped skin injury) to the forehead, complaints of pain, and was transferred to the emergency room. Although Resident 1 could not articulate how this made him feel, potentially due to a diagnosis of an unspecified intracranial injury (a brain injury where the exact nature is not fully defined during the initial diagnosis and includes symptoms of headaches, dizziness, confusion, or memory loss), a reasonable person in Resident 1's position, who was subjected to physical abuse and a facility initiated transfer (not initiated or requested by the resident) to another skilled nursing facility after discharge from the emergency room, would be expected to experience significant psychosocial harm including fear, anxiety, depression, withdrawal, and feelings of hopelessness.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in 2025 with diagnoses which included traumatic subarachnoid hemorrhage (bleeding in the space around the brain leading to sudden, severe headaches, and confusion) and unspecified intracranial injury. The admission record indicated Resident 1 as his own responsible party (makes decisions for one self). Resident 1's admissions record further indicated a representative listed as Resident 1's Representative Payee (a payee receives the recipients benefit checks, pays the nursing home for the cost of care and manages personal needs funds). No other person's were listed on Resident 1's contacts. A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in 2025 with diagnoses which included unspecified intracranial injury and generalized anxiety disorder (characterized by persistent, excessive, and uncontrollable worry about everyday events or activities).During an interview 1/27/26 at 1:40 p.m., Licensed Nurse (LN) 2 stated she had seen Resident 2 being aggressive when he grabbed a Certified Nursing Assistant (CNA) by his shirt (on 1/15/26).During an interview on 1/27/26 at 1:51p.m., CNA 2 stated some days Resident 2 was nice and some days Resident 2 was not nice. CNA 2 stated before the incident (on 1/5/26) Resident 2 had yelled at staff when Resident 2 did not get his way. CNA 2 stated Resident 1 did not have behavior issues while residing at the facility. During an interview on 1/27/26 at 2:58 p.m., the Social services Director (SSD) stated on 1/5/26 he went to the dining room after hearing a loud sound coming from the dining room. The SSD stated upon arriving inside the dining room he saw staff had separated Resident 2 from Resident 1. The SSD stated on 1/5/26 Resident 2 had rolled his wheelchair (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 01/27/2026
NAME OF PROVIDER OR SUPPLIER: Brookside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1221 Rosemarie Lane Stockton, CA 95207	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the dining room where Resident 1 was watching TV. The SSD stated Resident 2 then struck Resident 1 with his hands several times on the left side of Resident 1's face. The SSD stated Resident 1 was evaluated and sent out to hospital. The SSD stated on 1/1/26 Resident 2 had a prior physical altercation with Resident 1. The SSD further stated to avoid further incidents from happening Resident 2 should have been on 1:1 care (used for residents requiring constant, uninterrupted, and direct observation for safety, behavioral, or medical reasons). The SSD stated behavior monitoring every hour for Resident 2 should have been implemented and both Resident 1 and Resident 2 should have been kept separate from each other for safety after the first incident.During an interview on 1/27/26 at 3:10 p.m., LN 1 Stated Resident 2 had been aggressive in the past and had refused to follow directions from staff. LN 1 stated since Resident 2 had been aggressive and had a prior altercation with Resident 1 (1/1/26), Resident 2 should have been kept away from Resident 1. LN 2 stated the second altercation between Resident 1 and Resident 2 could have been avoided if staff had always kept an eye on Resident 2. LN 2 stated when the second altercation happened (1/5/26) Resident 1 got injured and something even worse could have happened to Resident 1.During an interview on 1/27/26 at 3:24 p.m., CNA 1 stated Resident 2 did not follow staff's direction when staff helped Resident 2 with care. CNA 1 stated at times Resident 2 got angry with staff and refused to get his clothes changed. CNA 1 stated both Resident 1 and Resident 2 should have been kept separate from each other after the first altercation to avoid a second altercation from happening. CNA 1 stated Resident 2 would not have hurt Resident 1 if staff had kept an eye on Resident 2. CNA 1 further stated Resident 2's behavior should have been monitored.During an interview on 1/27/26 at 3:32 p.m., with Resident 3, Resident 3 stated on 1/5/26 he witnessed staff put Resident 1 on a gurney (a hospital bed with wheels) in the hallway outside the dining room. Resident 3 stated the staff were getting ready to take Resident 1 to the hospital after Resident 1 got hurt during an altercation with Resident 1. Resident 3 stated he saw blood and bruises on Resident 1's face.During a concurrent interview and record review on 1/27/26 at 4:45 p.m., with the Director of Nursing (DON), the DON stated the second altercation between Resident 1 and Resident 2 could have been avoided if Resident 2 was monitored for his aggressive behavior. The DON further stated if both Resident 1 and Resident 2 were kept separate from each other the incident on 1/5/26 would not have happened. The DON noted that failing to separate residents with a history of altercations posed a safety risk. The DON confirmed Resident 1 had swelling on his left wrist and swelling under his left lower eye after the second altercation with Resident 2.During a phone interview on 1/29/26 at 1:51 p.m., with the Director of Rehab (DOR), the DOR stated on 1/5/26 at the time of the second incident she was in her office when she heard yelling and screaming coming from the dining room. The DOR stated when she entered the dining room, she saw Resident 2 hitting Resident 1's face and chest area several times with his hand. The DOR stated she redirected Resident 2 to sit back in his wheelchair, because Resident 2 was trying to stand up. The DOR stated staff separated Resident 1 and she separated Resident 2 who was at that time yelling and cursing using derogatory words. The DOR stated she heard Resident 1 say that Resident 2 hit him. The DOR further stated there was a prior altercation between Resident 1 and Resident 2 on 1/1/26 and she was the witness to that first incident too. The DOR stated on 1/1/26 around 5 p.m. she was in her office when she heard yelling in the dining room. The DOR stated on 1/1/26 she saw Resident 2 stand up from his wheelchair, push Resident 1, and then swung and hit Resident 1. The DOR stated when Resident 2 pushed Resident 1, Resident 1 pushed Resident 2 back. The DOR stated she redirected Resident 2 to sit back in his chair. The DOR stated Resident 2's mother was there in the dining room on 1/1/26 and Resident 2's mother told staff that Resident 1 had tried to grab her food and Resident 2 did not like that. The DOR stated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition noted after the altercation.Review of Resident 1's Care Plan, initiated on 1/2/26 and revised on 1/7/26, indicated, Focus.alleged resident to resident altercation .Goal .No Altercation.Interventions.monitor for pain.separate residents.Review of Resident 1's Interdisciplinary Notes, dated 1/5/26, indicated, . [Resident 1] observed [Resident 2] and Family Member eating, went over to the table and tried to grab food from the visitors plate. [Resident 2] stood up and pushed [Resident 1] away and then [Resident 1] reached over the table, pushed [Resident 2] and then hit him in the head.[Resident 1 and Resident 2] were separated by Stations [a designated workspace within a healthcare facility] and will be monitored for delayed mental Anguish and physical injuries.Date.of Event 1/1/26.Review of Resident 1's Change in Condition Evaluation, dated 1/5/26, indicated, . [Resident 1] physically abused.left wrist and lower left eye swelling.Review of Resident 1's Care Plan, initiated on 1/5/26 and revised on 1/7/26, indicated, Focus.alleged resident to resident altercation .Goal .No Altercation.Interventions.Send resident to acute [hospital] for further eval [evaluation] .Review of Resident 1's Progress Notes, dated 1/5/26, indicated, .[Resident 1] had an altercation with [Resident 2] on 1/5 at 3PM. It was noted that [Resident 1] was struck on the left side of the face multiple times.Upon interview with [Resident 1], [Resident 1] noted that [Resident 2] had approached [Resident 1] and struck [Resident 1] out of nowhere, when asked if [Resident 1] feels safe, [Resident 1] did not answer. AMR [American Medical Response-ambulance company] was in the room upon interview and [Resident 1] was transported to [Hospital].Review of Resident 1's Progress Notes, dated 1/5/26, indicated, .[Resident 1] was physically abused by [Resident 2].According to the Activity Director, who witnessed the incident, she was engaged in another task when she turned around and observed [Resident 2] approach [Resident 1] and strike [Resident 1] multiple times to the head shielding with his left arm.Upon assessment [Resident 1] was noted to have swelling of the left wrist, swelling under the left lower eye, and vomited. [Resident 1] denies any pain, but nauseated [feels sick to the stomach].[Resident 1] then sent to hospital for further evaluation and for treatment for the sustained injuries.Review of Resident 1's Interdisciplinary Notes, dated 1/12/26, indicated, . The Activities Director was observing as [Resident 2] approach [Resident 1] and strike [Resident 1] multiple times to the head shielding with his left arm. Both [Resident 1 and Resident 2] were immediately separated by staff and guided to their respective rooms and assessed. [Resident 1] has a diagnosis of traumatic brain injury and is not able to verbalize a coherent thought. Repetitive in his simple answers.Date.of Event 1/5/26.Review of Resident 1s HOSPITAL EMERGENCY RECORD, dated 1/5/26, indicated, .[Resident 1] sent here for evaluation left eye and left wrist after altercation with another resident.LEFT/EYE/WRIST SWELLING.This occurred around 10 to 11 AM whereby [Resident 2] was punching [Resident 1] several times, injuring [Resident 1's] left wrist mainly. [Resident 1] was hit in the head a few times as well.pain is rated at 6 out of 10 in severity [Pain severity describes the intensity of pain, typically measured with scales [0-10, using words, or faces] that classify it as mild [1-3], moderate [4-6], or severe [7-10]] .hematoma [a closed wound where blood collects and fills a space inside your body] of the left zygoma.[Resident 1] also has abrasion of the forehead.advised of diagnosis of left wrist pain.Splint [stabilizes and protects an injured body part [like a bone, joint, or muscle] by holding it in place] applied to left wrist.PAIN: [Resident 1] is c/o [complaining of] pain the injuries from altercation left upper eye and left wrist.Review of Resident 2's Care Plan, initiated on 5/22/25 and revised on 9/9/25, indicated, Focus.[Resident 2] has episodes of aggressive behavior toward staff, Laid hand on CNA during redirection .Goal .No more aggressive behavior .Interventions.Notify MD if behavior continues, Allow resident to verbalize feelings, 1:1 counseling and redirection as needed.Review of Resident 2's Progress Notes, dated 1/1/26, indicated, .[Resident 2] had physical (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Brookside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Rosemarie Lane Stockton, CA 95207	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	altercation with [Resident 1].Review of Resident 2's Change in Condition Evaluation, dated 1/1/26, indicated, . [Resident 2] physically abused.Review of Resident 2's Care Plan, initiated on 1/2/26, indicated, Focus.alleged resident to resident altercation.Goal .No Altercation.Interventions.Encourage resident to verbalize feelings.as indicated, separate residents.Review of Resident 2's Progress Notes, dated 1/4/26, indicated, .[Resident 1] on [status post monitoring] for physical altercation with another resident. No episodes noted. Plan of care ongoing.Review of Resident 2's Interdisciplinary Notes, dated 1/5/26, indicated, . [Resident 1] was enjoying lunch with his mother in the Dining Room when [Resident 1] reached over the table to take food from [Resident 2's] mothers plate. [Resident 2] pushed [Resident 1] away and [Resident 1] turned around and hit [Resident 2] in the head. [Resident 1] also has had a traumatic brain injury and is unable to verbalize his thoughts, is repetitive in statements, i.e. Give me Food, Give me Food.[Resident 1 and Resident 2] will be separated by Station and will be monitored for delayed mental and physical injuries. Date.of Event 1/1/26.Review of Resident 2's Progress Notes, dated 1/5/26, indicated, [Resident 2] had a physical altercation on 1/5 with [Resident 1]. [Resident 2] was noted to wheel up in wheelchair to [Resident 1] and strike [Resident 1] multiple times in the head.Review of Resident 2's Change in Condition Evaluation, dated 1/5/26, indicated, . [Resident 2] allegedly struck [Resident 1] multiple times in the head.Unprovoked striking [Resident 1].Review of Resident 2's Care Plan, initiated on 1/6/26, indicated, .Focus.alleged resident to resident altercation (dining room) .Goal .No Altercation.Interventions.resident separated.Review of Resident 2's Interdisciplinary Notes, dated 1/8/26, indicated, .The writer was in the nursing station when alerted by a loud commotion coming from the dining room. The writer immediately went to the dining room and observed the activities director separating [Resident 2] and [Resident 1]. According to the Activities Director, who witnessed the incident, she observed [Resident 2] in his wheelchair approaching [Resident 1] from several tables away and strike [Resident 1] multiple times in the head. [Resident 1] tried to shield his head with his left arm.Date.1/5/26.Review of Resident 2's Change in Condition Evaluation, dated 1/15/26, indicated, . Behavioral Status Evaluation: Physical aggression other behavioral symptoms.[Resident 2] has exhibited ongoing episodes of physical aggression toward staff, over the past several shifts, [Resident 2] has demonstrated increased agitation, verbal outbursts and poor impulse control. On 1/15/26.[Resident 1] became agitated and attempted to physically grab a CNA by his shirt.Notified MD.Review of Resident 2's Care Plan, initiated on 1/16/26, indicated, .Focus.physical aggression towards staff member .Goal .[Resident 2] will demonstrate reduced aggressive behaviors.Interventions.set clear, firm boundaries regarding unacceptable behavior.During a review of a facility policy and procedure titled Abuse, Neglect and Exploitation, dated 2025, the document indicated, .It is the policy of this facility to provide protections for health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.Physical Abuse includes, but is not limited to hitting, punching, biting, and kicking.Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging [insult or belittlement] and derogatory [criticism or disapproval] terms to residents.The facility will implement.The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict.The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to ensure Resident 1's rights to return to the facility were honored following a transfer to the emergency room due to a resident-to-resident altercation where Resident 1 was the victim when:1. Resident 1 was inappropriately discharged from the facility following an emergency room visit and admitted to a sister facility (a closely related, often co-owned or affiliated, location-frequently in senior living, healthcare, or industrial sectors-that share ownership, management, or services) on 1/6/26;2. Resident 1's reason for discharge did not meet the requirements which would allow for a facility-initiated discharge to occur; and3. Resident 1 was not provided with a bed hold notice and the facilities bed hold policy was not followed.This failure resulted in Resident 1 not being afforded the right to return to the facility following a transfer to the emergency room. This failure also had the potential to result in transfer trauma (a condition characterized by a range of symptoms that can occur when someone is moved from one environment to another, particularly affecting older adults) to Resident 1, with a potential outcome of decreased physical and emotional well-being.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in 2025 with diagnoses which included traumatic subarachnoid hemorrhage (bleeding in the space around the brain leading to sudden, severe headaches, and confusion) and unspecified intracranial injury. The admission record indicated Resident 1 as his own responsible party (makes decisions for oneself).Review of Resident 1's Physician Progress Note, dated 12/9/25, the note indicated, .Reason for visit: Dementia.The patient has a significant past medical history of dementia, cognitive decline secondary to traumatic brain injury.and anxiety.requires frequent reorientation and redirection due to his cognitive impairments. His medical history is limited as he is unable to provide much information.He is not in acute distress but requires close monitoring for his overall care and cognitive state.During a phone interview on 2/18/26 at 9:26 a.m., with Resident 1, Resident 1 stated his hand was sprained and he was sent to the hospital because he was in pain. When asked about the incident Resident 1 stated, that guy borrowed twenty-three thousand dollars . Resident 1 was unable to answer who had borrowed the twenty-three thousand dollars. Resident 1 kept on repeating himself stating, he has aneurism, he has aneurism, he sprained [Resident 1's] hand. Resident was unable to answer when asked if a staff had discussed with Resident 1 about his transfer to another facility. Resident 1 was unable to answer if he had got into an altercation with another resident. Resident 1 further repeated himself by stating, .the Chinese guy turned [Resident 1's] bed over. Resident 1 was unable to answer who had an aneurism and who turned his bed over.During an interview on 1/27/26 at 1:51 p.m., CNA 2 stated Resident 1 did not have behavior issues while residing at the facility. During a concurrent interview and record review on 1/27/26 at 4:45 p.m., with the Director of Nursing (DON), the DON stated on 1/5/26 Resident 1 was sent to the hospital for evaluation after a second altercation occurred between Resident 1 and Resident 2 (aggressor). The DON stated Resident 1 was transferred to another facility after being discharged from the hospital.During a phone interview on 1/29/26 at 1:51 p.m., with the Director of Rehab (DOR), the DOR stated Resident 1 had been nice, he smiled and talked, and she had never seen Resident 1 with any aggressive behavior issues before the incident on 1/5/26 occurred.During a phone interview on 2/18/26 at 8:29 a.m., with the Assistant Director of Nursing (ADON), the ADON stated on 1/5/26 Resident 1 and Resident 2 had got into an altercation where Resident 2 struck Resident 1's head multiple times. The ADON stated Resident 1 was sent to the hospital after the altercation. The ADON further stated Resident 1 was transferred from the hospital to a sister facility because Resident 1 had got into multiple altercations with Resident 2.During a phone interview on 2/18/26 at (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:56 a.m., with Director of Nursing (DON) 1, DON 1 stated Resident 1 was admitted to a sister facility on 1/6/26. DON 1 stated Resident 1 was confused, and Resident 1 repeated himself. DON 1 stated Resident 1 did not have any responsible person listed on his health record besides himself. DON 1 further stated Resident 1 had a Responsible Payee's (RP) contact name listed on his medical record for financial decisions only (a person appointed to Resident 1 to assist with management of benefit payments and to pay bills). During a phone interview on 2/18/26 at 10:59 a.m., with the Administrator (ADM), the ADM stated on 1/5/26 Resident 2 hit Resident 1's face in the dining room. The ADM further stated Resident 1 had discoloration around his eyes and Resident 1's wrist was hurting because Resident 1 tried to block Resident 2 from hitting him. The ADM stated Resident 1 was sent to the hospital after the altercation. The ADM stated she did not discuss with Resident 1 about his transfer to the sister facility. The ADM stated Resident 1 was listed as his own responsible party on his admissions record. The ADM stated to keep Resident 1 and Resident 2 separate and avoid any further altercations, she had called the hospital and notified the hospital to transfer Resident 1 to another facility. The ADM stated to ensure Resident 1's safety, he was sent to a sister facility. The ADM further stated she could not find any documents that stated Resident 1 was notified about his transfer to sister facility.During a phone interview on 2/18/26 at 10:38 a.m., with the Representative Payee (RP), the RP stated no one had notified her about Resident 1's transfer to another facility prior to Resident 1's discharge from the hospital. RP stated she was not responsible for making Resident 1's healthcare decision's. The RP further stated she was listed on Residents 1's healthcare record as Resident 1's financial contact person.During a phone interview on 2/19/26 at 2:21 p.m., with the Social Services Director, the SSD stated before the incident Resident 1 was alert and oriented. The SSD stated Resident 1 was his own self-representative and had a BIMS of 13 (Brief Interview for Mental Status; a score of 13 indicates that a person is cognitively intact) before being transferred to the sister facility. The SSD stated when Resident 1 was a resident of the facility, Resident 1 was friendly and approachable to staff and other residents. The SSD stated sometimes Resident 1 used to repeat himself when asking for food. The SSD stated Resident 1 stayed at the facility for almost a year before being transferred and Resident 1 never had a behavioral issue. The SSD stated it was an unfortunate situation that happened with Resident 1 and that Resident 1 had to be transferred to a sister facility. During a phone interview on 2/19/26 at 2:41 p.m., with Licensed Nurse 4, LN 4 stated Resident 1 was confused sometimes and used to repeat himself when asking for food at the facility. LN 4 stated Resident 1 was nice to staff and other residents. LN 4 further stated Resident 1 would let the staff know if another Resident needed help. LN 4 stated Resident 1 would always thank staff when staff helped Resident 1 with his activities of daily living. LN 4 stated the facility staff notifies residents of their upcoming transfer or discharge verbally and document the notification in the residents health record prior to being transferred to another facility. LN 4 stated Resident 1's transfer to another facility happened fast. LN 4 stated when a resident was transferred to a new facility without prior notice the resident could get scared as the resident would not be familiar to the new facility.During a concurrent interview and record review, on 2/20/26, at 1:39 p.m., Resident 1's electronic medical record (EMR) and an undated blank facility form titled NOTICE OF TRANSFER / DISCHARGE, were reviewed with the ADM. The ADM reviewed the transfer/discharge notice and confirmed the following were appropriate facility-initiated discharge reasons: a residents needs can no longer be met, a residents health has improved, the safety of residents is endangered, the resident failed to pay, and the facility is closing. The ADM confirmed Resident 1's discharge was facility initiated and Resident 1's safety was endangered by his own presence in the facility. The ADM explained, Resident 1's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Brookside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Rosemarie Lane Stockton, CA 95207	

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety was endangered by Resident 2, who still resided in the facility as of 2/20/26. The ADM confirmed Resident 1 was not endangering the safety of others in the facility. The ADM stated at the time Resident 1 was sent to the emergency room, it was considered a transfer, and it was expected that Resident 1 would return to the facility. The ADM stated after conducting her investigation of the resident to resident incident and reviewing information with the team, it was determined that it would be best to discharge Resident 1 and have him admitted to the sister facility. The ADM stated she does not recall the time in which that decision was made, but she had called the hospital to inform them of the plan to admit Resident 1 at the sister facility. The ADM reviewed Resident 1's EMR and confirmed there was no physician note regarding Resident 1's discharge from the facility. The ADM confirmed Resident 1's record did not contain a note from the physician that indicated the needs that could not be met by the facility, what they did to attempt to meet those needs, and what needs the accepting facility could meet that the resident's current facility could not. The ADM confirmed a bed hold notice was not given to Resident 1. The ADM explained that a bed hold document was typically given to a resident before they were transferred. The ADM stated the bed hold assures the resident can return and the bed hold was for a seven-day time period. The ADM stated that Resident 1 was a mellow kind of guy, was sweet, friendly, and good natured. The ADM explained that Resident 1 had friends at the facility whom he participated in activities with and got along well with the staff.Review of Resident 1's Progress Notes, dated 1/1/26, indicated, . [Resident 1] had physical altercation with [Resident 2].Review of Resident 1's Change in Condition Evaluation, dated 1/1/26, indicated, . [Resident 1] physically abused.No change of condition noted after the altercation.Review of Resident 1's Care Plan, initiated on 1/2/26 and revised on 1/7/26, indicated, Focus.alleged resident to resident altercation .Goal .No Altercation.Interventions.monitor for pain.separate residents.Review of Resident 1's Interdisciplinary Notes, dated 1/5/26, indicated, . [Resident 1] observed [Resident 2] and Family Member eating, went over to the table and tried to grab food from the visitors plate. [Resident 2] stood up and pushed [Resident 1] away and then [Resident 1] reached over the table, pushed [Resident 2] and then hit him in the head.[Resident 1 and Resident 2] were separated by Stations [a designated workspace within a healthcare facility] and will be monitored for delayed mental Anguish and physical injuries.Date.of Event 1/1/26.Review of Resident 1's Change in Condition Evaluation, dated 1/5/26, indicated, . [Resident 1] physically abused.left wrist and lower left eye swelling.Review of Resident 1's Care Plan, initiated on 1/5/26 and revised on 1/7/26, indicated, Focus.alleged resident to resident altercation .Goal .No Altercation.Interventions.Send resident to acute [hospital] for further eval [evaluation] .Review of Resident 1's Progress Notes, dated 1/5/26, indicated, . [Resident 1] had an altercation with [Resident 2] on 1/5 at 3PM. It was noted that [Resident 1] was struck on the left side of the face multiple times.Upon interview with [Resident 1], [Resident 1] noted that [Resident 2] had approached [Resident 1] and struck [Resident 1] out of nowhere, when asked if [Resident 1] feels safe, [Resident 1] did not answer. AMR [American Medical Response-ambulance company] was in the room upon interview and [Resident 1] was transported to [Hospital].Review of Resident 1s HOSPITAL EMERGENCY RECORD, dated 1/5/26, indicated, .Nursing Procedure: Nurse Notes: [ADM] called and per [ADM] when [Resident 1] gets discharged [Resident 1] will go to Noble care center .Review of Resident 1's physician's orders, order dated 1/5/26, the order indicated, .Order Details.Ordered by.Current Primary Physician.Description.may have 7 day bed-hold.Review of an undated facility policy and procedure (P&P) titled Bed Hold Notice, the P&P indicated, .It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization or therapeutic (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leave. Bed-Hold means holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization.at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or the resident representative written information that specifies.The duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility.The reserve bed payment policy in the state plan policy, if any.The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed.Conditions upon which the resident would return to the facility.The resident requires the services which the facility provides.In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or the resident representative within 24 hours. The facility will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative.The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record.Review of an undated facility P&P titled Transfer and Discharge (including AMA [Against Medical Advice]), the P&P indicated, .It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. Transfer and Discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical place or not.Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions.The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.The health of individuals in the facility would otherwise be endangered.The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay.The facility ceases to operate.

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Brookside Care Center	1221 Rosemarie Lane Stockton, CA 95207

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide a notice of transfer/discharge to Resident 1 and the State Long-Term Care Ombudsman office (acts as an independent advocate for residents, protecting their health, safety, welfare, and rights) when, Resident 1 was transferred to the emergency room due to injuries as a result of a resident-to-resident altercation that occurred on 1/5/26 where Resident 1 was the victim and Resident 1 was then discharge from the facility while Resident 1 remained in the emergency room. Resident 1 was admitted to a sister facility (a closely related, often co-owned or affiliated, location-frequently in senior living, healthcare, or industrial sectors-that share ownership, management, or services) after being discharged from the emergency room on 1/6/26.This failure violated Resident 1's right to be notified timely of a discharge and informed of how to appeal the decision of a facility-initiated discharge. This failure also resulted in the State Long-Term Care Ombudsman being uninformed of the discharge decision and removed the opportunity for the State Long-Term Care Ombudsman to advocate on Resident 1's behalf. Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in 2025 with diagnoses which included traumatic subarachnoid hemorrhage (bleeding in the space around the brain leading to sudden, severe headaches, and confusion) and unspecified intracranial injury. The admission record indicated Resident 1 as his own responsible party (makes decisions for oneself).Review of Resident 1's Physician Progress Note, dated 12/9/25, the note indicated, .Reason for visit: Dementia.The patient has a significant past medical history of dementia, cognitive decline secondary to traumatic brain injury.and anxiety.requires frequent reorientation and redirection due to his cognitive impairments. His medical history is limited as he is unable to provide much information.He is not in acute distress but requires close monitoring for his overall care and cognitive state.During a phone interview on 2/18/26 at 9:26 a.m., with Resident 1, Resident 1 stated his hand was sprained and he was sent to the hospital because he was in pain. When asked about the incident Resident 1 stated, that guy borrowed twenty-three thousand dollars . Resident 1 was unable to answer who had borrowed the twenty-three thousand dollars. Resident 1 kept on repeating himself stating, he has aneurism, he has aneurism, he sprained [Resident 1's] hand. Resident was unable to answer when asked if a staff had discussed with Resident 1 about his transfer to another facility. Resident 1 was unable to answer if he had got into an altercation with another resident. Resident 1 further repeated himself by stating, .the Chinese guy turned [Resident 1's] bed over. Resident 1 was unable to answer who had an aneurism and who turned his bed over.During a phone interview on 2/18/26 at 8:29 a.m., with the Assistant Director of Nursing (ADON), the ADON stated on 1/5/26 Resident 1 and Resident 2 had got into an altercation where Resident 2 struck Resident 1's head multiple times. The ADON stated Resident 1 was sent to the hospital after the altercation. The ADON further stated Resident 1 was transferred from the hospital to a sister facility because Resident 1 had got into multiple altercations with Resident 2. The ADON stated she was not aware if anyone from the facility had discussed with Resident 1 about his transfer to another facility.During a phone interview on 2/18/26 at 8:56 a.m., with Director of Nursing (DON) 1, DON 1 stated Resident 1 was admitted to a sister facility on 1/6/26. DON 1 stated Resident 1 was confused, and Resident 1 repeated himself.During a phone interview on 2/18/26 at 10:59 a.m., with the Administrator (ADM), the ADM stated on 1/5/26 Resident 2 hit Resident 1's face in the dining room. The ADM further stated Resident 1 had discoloration around his eyes and Resident 1's wrist was hurting because Resident 1 tried to block Resident 2 from hitting him. The ADM stated Resident 1 was sent to the hospital after the altercation. The ADM stated she did not discuss with Resident 1 about his transfer to the sister facility. The ADM stated to keep (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 and Resident 2 separate and avoid any further altercations, she had called the hospital and notified the hospital to transfer Resident 1 to another facility. The ADM stated to ensure Resident 1's safety, he was sent to a sister facility. The ADM further stated she could not find any documents that stated Resident 1 was notified about his transfer to sister facility.During a phone interview on 2/19/26 at 2:21 p.m., with the Social Services Director, the SSD stated the facility notifies Residents in writing 48 hours before being discharged or transferred to another facility. The SSD stated Resident 1 was sent to the hospital on 1/5/26 after an altercation with Resident 2. The SSD further stated after being discharged from the hospital Resident 1 was transferred to a sister facility for Resident 1's safety. The SSD stated he was unable to find any documentation which indicated Resident 1 was notified about his transfer prior to being sent to the sister facility. The SSD stated Resident 1 was his own self-representative and had a BIMS of 13 (Brief Interview for Mental Status; a score of 13 indicates that a person is cognitively intact) before being transferred to the sister facility.During an interview on 2/20/26, at 1:39 p.m., the ADM confirmed Resident 1's discharge was facility initiated and Resident 1's safety was endangered. The ADM stated at the time Resident 1 was sent to the emergency room, it was considered a transfer, and it was expected that Resident 1 would return to the facility. The ADM stated after conducting her investigation and reviewing information with the team, it was determined that it would be best to discharge Resident 1 and have him admitted to a sister facility. The ADM stated she does not recall the time in which that decision was made, but she had called the hospital to inform them of the plan to admit Resident 1 at the sister facility. The ADM confirmed a discharge notice was not given to Resident 1 when the facility had decided to discharge Resident 1 from the facility. The ADM stated the importance of providing a transfer/discharge notice was for a resident to be aware of the reason for the discharge and so they have the information and opportunity to appeal the discharge. The ADM stated the discharge notice should also be provided to the ombudsman office as well. During an interview on 2/20/26, at 4:24 p.m., the Ombudsman (OMB) confirmed a notice of transfer/discharge was not received from the facility regarding Resident 1's discharge from the facility on 1/5/26.Review of Resident 1's Change in Condition Evaluation, dated 1/5/26, indicated, . [Resident 1] physically abused.left wrist and lower left eye swelling.Review of Resident 1's Progress Notes, dated 1/5/26, indicated, . [Resident 1] had an altercation with [Resident 2] on 1/5 at 3PM. It was noted that [Resident 1] was struck on the left side of the face multiple times.Upon interview with [Resident 1], [Resident 1] noted that [Resident 2] had approached [Resident 1] and struck [Resident 1] out of nowhere, when asked if [Resident 1] feels safe, [Resident 1] did not answer. AMR [American Medical Response-ambulance company] was in the room upon interview and [Resident 1] was transported to [Hospital].Review of Resident 1s HOSPITAL EMERGENCY RECORD, dated 1/5/26, indicated, .Nursing Procedure: Nurse Notes: [ADM] called and per [ADM] when [Resident 1] gets discharged [Resident 1] will go to Noble care center .Review of an undated facility P&P titled Transfer and Discharge (including AMA [Against Medical Advice]), the P&P indicated, .It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. Transfer and Discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical place or not. The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided.The specific reason and basis for transfer or discharge.The effective date of transfer or discharge.The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is to be transferred or discharged .An explanation of the right to appeal the transfer or discharge to the State.The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests.Information on how to obtain an appeal form.Information on obtaining assistance in completing and submitting the appeal hearing request.The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. The facility will maintain evidence that the notice was sent to the Ombudsman.