

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 02/10/2026
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on interview, and record review, the facility failed to ensure a resident was free from misappropriation of property for one of four sampled residents (Resident 1), when two facility staff members had accepted money from Resident 1 to buy food. This failure had placed the resident at risk for financial hardship which could eventually affect the psychosocial well-being of Resident 1. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including sensorineural hearing loss (permanent hearing loss caused by aging, noise or infections), cognitive communication deficit (difficulty with speaking, listening, reading, or writing caused by problems with thinking skills) and focal traumatic brain injury with loss of consciousness (damage to one area of the brain that resulted in a being knocked out or not awake). A review of Resident 1's Progress Notes, dated 11/26/25, indicated, .Resident stated that the facility driver and RNA [Restorative Nurse Assistant] used his own money to buy food. A review of Resident 1's IDT [Interdisciplinary team, group of healthcare professionals] - Interdisciplinary Post Event Note, dated 12/1/25, indicated, .Resident stated to admission director that the facility driver and RNA used his own money to buy food. Situation reported to SPD [Stockton Police Department]. SPD investigated and they conclude No Crime. MD [physician] made aware. Interventions. Ombudsman [long term advocate] and [Department] notified. Monitor psychosocial well-being of resident. A review of Resident 1's Care Plan Report, dated 11/26/25, indicated, .Alleged Financial Abuse. Interventions. Monitor psychosocial well-being of resident. A review of a facility provided document titled, PATIENT LOSS/REFUND REQUEST FORM, dated 12/1/25, indicated, .Reason for refund: Staff members used resident debit card to purchase lunch meal. Refund amt [amount] \$63.77 [dollars]. A review of a facility provided document (receipt) titled, Walk In Order, dated 11/20/25, indicated, .Total 63.77 Cash 95.65 Change 31.68. During an interview on 2/10/26, at 9:57 AM, with the Director of Staff development (DSD), the DSD stated that depending which staff was available either the RNA, or sometimes the driver would accompany a resident to go out on pass (OOP). The DSD further stated he expected staff to keep the resident safe during the transport and where they were going. The DSD stated staff were not allowed to have access with anything financial. The DSD further stated he expected staff to never accept anything from the resident such as compensation or food. The DSD stated the risk if a resident did not know that staff had spent a significant amount of money without his/her approval would potentially upset the resident. The DSD stated that based on the staff members' statements of the incident, the driver was given food but the person who bought the food was RNA 1. The DSD explained that staff (RNA 1 and Driver) were not informed by Resident 1 for the amount they could buy food with. The DSD stated Resident 1 ended up making a complaint. The DSD further stated staff should have not accepted any kind compensation or treats from the resident. The DSD stated it was not acceptable to use a resident's money even if the resident initially consented. During an interview on 2/10/26, at 10:35 AM, with the Social Service Director (SSD), the SSD stated it was not recommended for staff to accept gifts from residents. The SSD further</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated that when a resident went OOP with a staff member, accepting gifts or utilizing the resident's money for personal use, even if the resident offered, was not acceptable. The SSD stated staff should have explained to Resident 1 that they could not accept his offer to buy them food while OOP. During a concurrent interview and record review on 2/10/26, at 10:51 AM, with the Assistant Director of Nursing (ADON), Resident 1's electronic health record (EHR) was reviewed. The ADON stated when staff accompanied a resident for OOP, she expected staff to make sure the resident was safe and sound when they were transported to and from the facility. The ADON further stated staff were not allowed to have access to a resident's money or cards and expected staff not to accept gifts from residents. The ADON stated in regards to the alleged incident, Resident 1 offered to use his money to buy food for RNA 1, the Driver and himself. The ADON further stated staff bought food for the three of them and they shared the food, but then Resident 1 complained the next day. After reviewing Resident 1's Progress Notes, the ADON stated RNA 1 and the Driver should have not accepted even if Resident 1 offered to buy the staff members' food. The ADON further stated according to their facility policy staff should never use a resident's money for personal reasons. The ADON explained it was not acceptable because a resident's money was not to be used by staff. The ADON stated the next day after the alleged incident, Resident 1 reported that staff used his money to buy food, but he did not deny that he consented for the staff to use his money. The ADON further stated that maybe Resident 1 did not expect the bill to be so high and it was almost one hundred dollars. The ADON stated Resident 1 initially reported the incident to the admission director/resident liaison who was no longer employed at the facility. The ADON confirmed the appropriate agencies were notified of the incident. The ADON further confirmed interventions such as monitoring of Resident 1's psychosocial well-being and 72hr monitoring was completed by nursing staff. During a phone interview on 2/10/26, at 3:11 PM, with the Driver, the Driver stated he requested to have another staff member to accompany him during Resident 1's OOP. The Driver further stated he drove Resident 1 to the bank with RNA 1 accompanying them. Next they went to a phone provider store, then to a local restaurant and then to a retail store. The Driver explained that Resident 1 told him and RNA 1 that he was hungry, and they would eat together and told them not to worry because he had a lot of money. The Driver stated when they were about to order, Resident 1 told them to order the food then got mad at them because he did not want to eat. The Driver further stated Resident 1 gave \$100 cash to RNA 1 to buy food. The Driver explained he and RNA 1 wanted to return the food, but Resident 1 told them not to return and to keep their food, and just return his portion of the order. The Driver further explained that after the incident, he and RNA 1 attended an in-service and were educated. The Driver stated he and RNA 1 thought that food was acceptable to receive but not money from a resident. During a phone interview on 2/10/26, at 3:50 PM, with RNA 1, RNA 1 stated the alleged incident occurred late in the afternoon when the Driver asked if he could accompany Resident 1 to the bank. RNA 1 further stated the facility used their own transportation vehicle to transport residents. RNA 1 explained they went to the bank then afterwards Resident 1 told them that he would treat them with food. RNA 1 further explained Resident 1 told them to order what they what they wanted at a local restaurant and ordered the food which they all agreed to. RNA 1 stated Resident 1 gave him \$100 and when the resident received the receipt and the change, Resident 1 then wanted food from another restaurant so he cancelled the order. On the way to another restaurant Resident 1 then changed his mind and redirected them to a gas station. RNA 1 further stated Resident 1 then bought cigarettes and some snacks at the gas station. RNA 1 stated Resident 1 was the one who chose to order food from the restaurant and then complained about them a few days later. RNA 1 further stated they were informed Resident 1 reported that they used his card, but the truth</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was that only \$100 cash (received from Resident 1) was used. RNA 1 stated they attended an in-service and were re-educated about receiving gifts from residents. RNA 1 stated they thought food was okay to receive from a resident. RNA 1 further stated the Driver and himself had violated the facility policy for receiving gifts even if it was food given by a resident because it was not allowed. RNA 1 explained this was also included in the facility's Code of Conduct. During a phone interview on 2/11/26, at 10:59 PM, with the Administrator (ADM), the ADM stated she spoke to Resident 1 after he reported the incident to the admissions personnel at the time. The ADM further stated she saw the receipt saved on the desk by the previous ADM. The ADM stated Resident 1 told her that while running errands with staff (Driver and RNA 1) he had offered to get some food for staff, but did not know how much it would cost. The ADM further stated Resident 1 got upset with how much the food order cost and cancelled part of the order. The ADM explained the two staff members were interviewed and confirmed Resident 1 offered them food. The ADM stated staff were not taking advantage of Resident 1 and they thought he was being generous. The ADM confirmed the facility reimbursed Resident 1's money in the amount of approximately 63 dollars. The ADM stated the facility held conversations with RNA 1 and the Driver about not accepting gifts and how they should just be accompanying the resident while outside of the facility. The ADM further stated that education about not accepting gifts was also provided to the rest of the facility staff. The ADM explained the incident involving Resident 1 happened before her time as the ADM and that no other incidents similar to Resident 1's incident occurred afterwards. The ADM stated the risk would be that a resident could potentially experience emotional distress, concerns about their finances and the way they were being treated. A review of the facility's policy and procedure titled, Abuse, Neglect and Exploitation, dated 2024, the P&P indicated, .Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation or resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms. A review of the facility's policy and procedure titled, Code of Conduct, dated 2025, indicated, .All employees are expected to adhere to acceptable business practices and exhibit a high degree of personal integrity and professionalism at all times. Examples of conduct and behavior that are considered inappropriate and are therefore prohibited by this policy include, but are not limited to, the following. Misappropriation of facility/patient funds, securities, supplies or other assets.</p>		