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	03/10/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based an observation, interview, and record review, the facility failed to ensure a resident's right to a quiet environment was maintained for one of three sampled residents (Resident 1) when Resident 1 could not get rest due to continuous noise from Resident 1's roommate from 2/26/26 through 3/4/26.This failure resulted in Resident 1's having sleepless nights that led to migraines (extreme headaches) and emotional and psychological distress.Findings:During a review of Resident 1's clinical record titled, admission RECORD, dated 3/6/26, the record indicated Resident 1 was admitted on [DATE] with a diagnoses which included respiratory failure, heart failure, anxiety disorder (group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and takotsubo syndrome (is a temporary, reversible heart condition often triggered by intense emotional or physical stress, causing sudden chest pain, breathlessness, and mimicking a heart attack).During a review of Resident 1's clinical record titled, MDS, (Minimum Data Set, an assessment tool) dated 2/19/26, under Section C-Cognitive Patterns, the MDS indicated, Resident 1 had a BIMS (Brief Interview for Mental Status) score of 12 out of 15 suggesting Resident 1 had moderate cognitive impairment.During an interview on 3/5/26 at 10:53 a.m. with Resident 1 while she was in her room, Resident 1 explained that her roommate was admitted a week ago and her roommate had been constantly yelling whenever the roommate was awake either during the day, evening, or night. Resident 1 stated her roommate's continuous yelling was giving her a migraine headache and keeping her awake at night. Resident 1 stated the staff told her to put on earphones, but she would not be able to hear her TV or the fire alarm in case of an emergency. Resident 1 stated she was in this room first and she did not want to change rooms. Resident 1 stated she told the Social Service Director (SSD) her concerns and the SSD indicated there were no other rooms available and that the facility policy was to keep the rooms filled.During a concurrent observation and interview on 3/5/26 at 1:04 pm with Certified Nurse Assistant (CNA) 1 in Resident 1's room, Resident 1's roommate woke up and stated, help me, take it off repeatedly while CNA 1 was at the bedside calming her down and attending to her. CNA 1 stated Resident 1's roommate repeatedly yelled, help me when she was awake. Licensed Nurse (LN)1 entered the room to calm Resident 1's roommate down, but she was still yelling, help me.During an observation on 3/5/26 at 1:22 p.m. at the [NAME] Nurses' Station and conference room, Resident 1's roommate could be heard repeatedly yelling, help me.During a review of Resident 1's roommate's clinical record titled, admission RECORD, dated 3/6/26, the record indicated Resident 1's roommate was admitted to the facility on [DATE] with a diagnosis that included vascular dementia, unspecified severity, with agitation (condition such as a stroke that disrupt blood flow to the brain and lead to problems with memory, thinking, and behavior).During a review of Resident 1's roommate's clinical record titled, MDS, (Minimum Data Set-an assessment tool) dated 3/5/26, under Section C-Cognitive Patterns, the MDS indicated Resident 1's roommate had a BIMS (Brief Interview for Mental Status) score of 8 out of 15 suggesting a moderate cognitive impairment with noticeable difficulties with memory and orientation.During a review of Resident 1's roommate's clinical record titled, Nursing-Clinical admission Evaluation, dated 2/26/26, under section Neuro/Mental/Behavioral, (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the evaluation revealed the boxes for non-compliant, anxious, psychosis, and poor safety awareness were checked. The evaluation under section admission Notes indicated, .Resident kept on yelling out 'help me' throughout the shift.During an interview on 3/5/26 at 2:40 p.m. with LN 1, LN 1 stated Resident 1's roommate yelled constantly and that Resident 1 had complained of headaches, sleep deprivation, and anxiety. LN 1 stated she tried to calm Resident 1's roommate down as much as she could, but when she left the room, the roommate started yelling again.During an interview on 3/6/26 at 9:50 a.m. with the SSD, the SSD stated his understanding of the facility's process was, the resident who had issues with noise in the room would be moved to a different room whether the resident had been in the room longer than the roommate and the newly admitted resident (roommate) remained in the original room. The SSD could not tell the facility's process for pairing roommates.During an interview on 3/6/26 at 1:02 p.m. with the Director of Nursing (DON), the DON stated she was working on pairing Resident 1 with another resident who was more appropriate for Resident 1 as a roommate.During an interview on 3/6/26 at 2:01 p.m. with the Administrator (ADM), the ADM stated she was not aware of Resident 1's roommate's behavior and she was working on room changes.During a review of the facility's undated Policy & Procedure (P&P) titled, Change of Room or Roommate, this P&P indicated, .It is the policy of this facility to conduct changes to room and/or roommate assignments when considered necessary.Reasons for a change in room or roommate could include.Incompatibility of residents in a shared room.The facility may make an emergency change in room or roommate assignment should it become necessary for the safety, health and well-being of the resident.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to protect, secure, and maintain personal belongings for one of three sampled residents (Resident 1) when Resident 1's black safe box (that contained valuables and collectibles) was not accounted for when Resident 1's belongings were transferred from another facility three days from admission. This failure resulted in Resident 1's black safe box missing and had caused her emotional distress for losing her valuables and collectibles. Findings:During a review of Resident 1's clinical record titled, admission RECORD, dated 3/6/26, the record indicated Resident 1 was admitted on [DATE] with diagnoses that included respiratory failure, heart failure, and muscle weakness.During a review of Resident 1's clinical record titled, MDS, (Minimum Data Set, an assessment tool) dated 2/19/26, under Section C-Cognitive Patterns, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which suggested Resident 1 had moderate cognitive impairment.During an interview on 3/5/26 at 10:53 a.m. with Resident 1 while she was in her room, Resident 1 explained her personal belongings, including her black safe box, were transferred to this facility from another facility three days after her admission. Resident 1 stated she did not receive her personal belongings in her room till days after they were delivered because the facility could not locate where her things were. Resident 1 also stated when staff finally brought her personal belongings into her room, she stated her black safe box was nowhere to be found. During an interview on 3/5/26 at 2:20 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 had stated she was missing her black safe box. CNA 1 stated that she had not seen the safe in Resident 1's room. During an interview on 3/5/26 at 3:54 p.m. with CNA 2, CNA 2 stated she would inform the Social Service Department when a missing item could not be found.During an interview on 3/6/26 at 9:15 a.m. with the Social Service Director (SSD), the SSD explained that Resident 1 was admitted from the acute hospital and her personal belongings were transported from another facility. The SSD also explained that there was no documentation Resident 1's personal belongings were received by this facility upon delivery. The SSD could not tell if the black safe box was included in the delivery. The SSD stated that staff looked for the safe but could not locate it. The SSD also stated a personal inventory was completed after her admission but could not tell the date the inventory was completed. During a concurrent interview and record review on 3/6/26 at 10:30 a.m. with LN 2, Resident 1's clinical electronic file was reviewed. LN 2 stated Resident 1's personal inventory could not be found in her file. LN 2 stated facility no longer kept paper charts, and all records were uploaded to the electronic file. LN 2 stated that it should have been uploaded and it was probably not done. During an interview on 3/6/26 at 1:02 p.m. with the Director of Nursing (DON), the DON stated an inventory sheet should have been completed at the time Resident 1's personal belongings were delivered and should have been completed within 24 hours of admission.During a review of the facility's record titled, Resident Personal Belongings Inventory, this record revealed that Resident 1's inventory list was completed on 2/19/26 and 2/20/26 three months after her admission. Both inventory lists did not indicate the black safe box was accounted for. During an interview on 3/6/26 at 2:01 p.m. with the Administrator (ADM), the ADM stated she would have expected the personal inventory to be completed upon Resident 1's admission date and upon delivery of her personal belongings. The ADM stated missing personal items could have led to the residents feeling uncomfortable and potentially experiencing emotional distress due to the loss of something valuable.During a review of the facility's undated Policy & Procedure (P&P) titled, THEFT AND LOSS, the P&P indicated, .The facility shall maintain resident belongings in a safe manner to prevent theft and loss.It is the policy of the facility to maintain an inventory of resident belongings.An inventory of resident personal property shall be completed on admission using the inventory form.Items, which are brought to the facility after admission, shall be added to the inventory list.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who was dependent on staff to carry out activities of daily living (ADLs, tasks of everyday life including eating, dressing, grooming, bathing, showering, and using the bathroom) received services to maintain personal hygiene, when Resident 1 was not provided with showers or bed baths as scheduled from 2/1/26 through 2/28/26.This failure had the potential to cause discomfort, skin impairment, infection, and a decline in emotional and psychological well-being.Findings:During a review of Resident 1's clinical record titled, admission RECORD, dated 3/6/26, the record indicated Resident 1 was admitted to the facility with diagnoses which included muscle weakness.During a review of Resident 1's clinical record titled, MDS, (Minimum Data Set, an assessment tool) dated 2/19/26, under Section C-Cognitive Patterns, the MDS indicated, Resident 1 had a BIMS (Brief Interview for Mental Status) score of 12 out of 15 suggesting Resident 1 had moderate cognitive impairment. The MDS under Section GG-Functional Abilities for Self-Care also indicated, Resident 1 needed .Substantial/maximal assistance.shower/bathe self. During a review of Resident 1's ADL care plan under the column titled, Interventions, (any action a nurse performs to help patients reach expected outcomes) dated 11/19/25, the care plan indicated, .The resident requires (substantial assistance) by (1-2) staff with (bathing/showering) and as necessary.During an interview on 3/5/26 at 10:53 a.m. with Resident 1 while she was in her room, Resident 1 stated she did not get showers, but she got her bed baths every Tuesday and Friday. Resident 1 stated there was a period of time where she received her bed bath just one time.During an interview on 3/5/26 at 2:20 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 received bed baths instead of showers during the evening shift and there were times Resident 1 did not get her bed bath during her scheduled day and time. During an interview on 3/5/26 at 3:54 p.m. with CNA 2, CNA 2 stated Resident 1's shower and/or bed bath schedule was Tuesdays and Fridays. CNA 2 stated she had not seen Resident 1 receive showers and/or bed baths.During a review of the facility's undated document titled, WEST PM SHOWERS, the document indicated Resident 1 was scheduled for showers in the afternoon every Tuesdays and Fridays. During a concurrent interview and record review on 3/5/26 at 5:50 p.m. with the Director of Staff Development (DSD), Resident 1's Documentation Survey Report from 2/1/26 through 2/28/26 was reviewed. The report revealed a code, NA (Not Applicable) was documented on Mondays, 2/2/26, 2/9/26, 2/16/26, and 2/23/26 for bathing/shower days. The DSD stated the code NA also indicated refusals. The DSD confirmed there were no other days marked on the report that showers and/or bed baths were provided. During a concurrent interview and record review on 3/5/26 at 5:30 p.m. with the DSD, Resident 1's Task: GG - Shower/Bath from 2/4/26 through 2/28/26 was reviewed. The task revealed a check mark under the column Resident Refused on 2/17/26, 2/20/26, and 2/27/26. The DSD confirmed there were no other days marked on the task that showers and/or bed baths were provided. During a concurrent interview and record review on 3/5/36 at 5:30 p.m. with the DSD, Resident 1's WEEKLY SUMMARY BODY SHOWER CHECKLIST, dated 2/3/26, 2/10/26, and 2/24/26 were reviewed. The checklist for 2/3/26 and 2/10/26 indicated Resident 1 refused shower and/or bed bath and the checklist for 2/24/26 indicated Resident 1 had a bed bath. The DSD confirmed there were no other checklists completed for review. During an interview on 3/6/26 at 9:01 a.m. with CNA 3, CNA 3 stated when residents refused showers, she offered bed baths or offered a different time or day for the shower. During an interview on 3/6/26 at 9:09 a.m. with Licensed Nurse (LN) 1, LN 1 stated she would have checked with the resident the reason for refusing a shower and/or bed bath. LN 1 also stated she would have offered to reschedule for another time of the day or the next day.During an interview on 3/6/26 at 11:05 a.m. with the DSD, the DSD stated he would have expected the Interdisciplinary Team (a group of professionals with different backgrounds who work together to provide comprehensive patient care) to address Resident 1's plan of care and to have asked Resident 1 her preference or offer an alternative schedule for a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower and/or bed bath. The DSD confirmed there were no other days that the staff offered an alternative schedule. The DSD stated Resident 1's needs were not met. During a review of the facility's undated Policy & Procedure (P&P) titled, Resident Showers, the P&P indicated, .It is the policy of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide needed care and treatment to two out of three sampled residents (Resident 1 and Resident 2) when:1. Resident 1 missed 2 scheduled appointments for a follow up order with the cardiologist within 2 weeks from discharge from the acute hospital and the follow up order was not transcribed into Resident 1's electronic file, and 2. Resident 2's attending physician was not notified of Resident 2's 3 consecutive days of poor intake either meal refusals or 0 to 25% consumed. These failures had the potential for Resident 1 not to receive required care in a timely manner and the potential for delayed treatment for Resident 2 that could lead to weight loss and could possibly result in a decline in health and well-being.Findings: 1. During a review of Resident 1's clinical record titled, admission RECORD, dated 3/6/26, the record indicated Resident 1 was admitted to the facility with diagnoses including respiratory failure, heart failure, and hypertension (high blood pressure). During a review of Resident 1's clinical record titled, MDS (Minimum Data Set, an assessment tool), dated 2/19/26, under Section C-Cognitive Patterns, the MDS indicated, Resident 1 had a BIMS (Brief Interview for Mental Status) score of 12 out of 15 suggesting Resident 1 had moderate cognitive impairment. During a review of resident 1's clinical report titled, Care Plan Report, (a form where you can summarize a person's health conditions, specific care needs, and current treatments) dated 12/2/25, the report indicated, .Resident has altered cardiovascular status.The resident will be free from complications of cardiac problems.Notify MD of significant abnormalities. This report also indicated, .Resident has hypertension. During an interview on 3/5/26, at 10:53 a.m. with Resident 1 while Resident 1 was in her room, Resident 1 stated that she missed two appointments with the cardiologist on 1/7/26 and again on 1/21/26. Resident 1 stated that the SSD was informed of her appointments, but the SSD did not follow through and so it was not carried out. Resident 1 stated she called the cardiologist's office on 2/23/26 to make an appointment for herself and came to find out that she already had a schedule set for 2/25/26 which she did not know about it. Resident 1 stated that staff did not inform her of the scheduled appointment otherwise she would have missed it again. Resident 1 showed two letters from her cardiologist, one indicating she had missed her appointment on 1/7/26 and the other letter indicating she had missed her appointment on 1/21/26. Resident 1 stated it was important to her to see a cardiologist because her heart was not functioning well and her valves were not working properly. During an interview on 3/5/26, at 2:40 p.m. with Licensed Nurse (LN) 1, LN 1 stated she was not aware of Resident 1's appointments to the cardiologist. During an interview on 3/6/26, at 9:50 a.m. with the SSD, the SSD stated Resident 1 informed him of Resident 1's scheduled appointment on 1/7/26 and 1/21/26 and he was aware of it. The SSD explained that Resident 1 missed those appointments due to lack of communication and it was not coordinated with the different departments. The SSD also explained that he did not upload the information into Resident 1's electronic file for the nurses and the department managers to be alerted of an upcoming appointment. The SSD confirmed Resident 1's appointments were not followed up and so it was not carried out. During a concurrent interview and record review on 3/6/26, at 10:30 a.m. with LN 2, Resident 1's Order Summary Report, dated 3/6/26 was reviewed. The report revealed there was no cardiologist referral order documented in the report. LN 2 confirmed there was no cardiologist referral order recorded in the report. During a concurrent interview and record review on 3/6/26, at 10:30 with LN 2, Resident 1's Discharge Summary, dated 11/18/25 was reviewed. The summary indicated, .Follow cardiologist in 2 weeks. LN 2 confirmed the cardiologist referral order was recorded in Resident 1's discharge summary from the acute hospital on [DATE]. LN 2 stated the appointment was delayed, order was not carried out, and it was not recorded in Resident 1's order summary report. During an interview on 3/6/26, at 1:02 p.m. with the Director of Nursing (DON), the DON stated the cardiologist referral should have been recorded in the order summary report on admission and expected the SSD to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have made the appointment and followed through in a timely manner. The DON stated it was important to see a specialist in a timely manner to make sure the resident was responding well with the treatment plan, to change medications if needed and to order laboratory work if needed. During an interview on 3/6/26, at 2:01 p.m. with the Administrator (ADM), the ADM stated she expected the referral to be carried out in a timely manner within 2 weeks as ordered. The ADM stated a potentially serious condition may not be addressed sooner if appointments were not scheduled timely or appointments were missed. During a review of the facility's undated policy titled, Provision of Physician Ordered Services, the policy indicated, .This policy is to provide a reliable process for the proper and consistent provision ordered services according to professional standard of quality. 2. During a review of Resident 2's clinical record titled, admission RECORD, dated 3/10/26, the record indicated Resident 2 was admitted to the facility with diagnoses including stage 3 kidney disease (moderate damage operating at 30-59% efficiency), diabetes (disorder characterized by high blood sugar), and vascular dementia (condition such as a stroke that disrupt blood flow to the brain and lead to problems with memory, thinking, and behavior). During a review of Resident 2's clinical record titled, MDS (Minimum Data Set, an assessment tool), dated 1/21/26, under Section C-Cognitive Patterns, the MDS indicated, Resident 2 had a BIMS (Brief Interview for Mental Status) score of 11 out of 15 suggesting Resident 2 had moderate cognitive impairment. During a phone interview on 3/4/26, at 1:14 p.m. with the complainant, the complainant stated a concern regarding Resident 2 who was not feeling well for three to four days and had not been eating for almost 7 days before Resident 2 was transferred to an acute hospital for evaluation. During a review of Resident 2's clinical record titled, Documentation Survey Report, dated February 2026, the report revealed a task to record the amount Resident 2 had eaten for breakfast, lunch, and dinner from 2/1/26 through 2/28/26. The report indicated the days and meals Resident 2 had refused or had eaten 0% to 25% of his meals. The meal consumed was recorded including the following:On 2/13/26, the report indicated RR (Resident Refused) for breakfast, 0 (0 - 25%) for lunch, and RR for dinner.On 2/14/26, the report indicated 0 for breakfast, 1 (26% - 50%) for lunch, and RR for dinner.On 2/15/25, the report indicated 1 for breakfast, 0 for lunch, and RR for dinner. On 2/16/26, the report indicated RR for breakfast, 0 for lunch, and RR for dinner.On 2/17/26, the report indicated RR for breakfast, RU (Resident Unavailable) for lunch. During an interview on 3/10/26, at 8:39 a.m. with Resident 2 while Resident 2 was in his room, Resident 2 stated he went to the acute hospital twice since his admission to this facility. Resident 2 stated the reason he went to the hospital the second time was because he was vomiting. During an interview on 3/10/26, at 10:46 a.m. with CNA 4, CNA 4 confirmed Resident 2 was transferred to the acute hospital twice since admission. CNA 4 stated Resident 2 sometimes consumed 30% to 50% of his meals and sometimes 75%. CNA 4 also stated whenever Resident 2 ate less she would help Resident 2 eat more. During an interview on 3/10/26, at 11:42 a.m. with LN 4, LN 4 stated Resident 2 was transferred to acute hospital the second time on 2/17/26 due to high laboratory results. LN 4 also stated Resident 2 had been eating an average of 50% to 75%. During an interview on 3/10/26, at 2:41 p.m. with CNA 4, CNA 4 stated When residents refused their meals, she would report to the charge nurse, offer snacks, offer something different or offer an alternative. During an interview on 3/10/26, at 3:02 p.m. with LN 4, LN 4 stated he will complete a change of condition form for low meal intake, he would notify the Primary Care Physician (PCP), and he would also notify the Registered Dietitian (RD). During a review of Resident 2's clinical record titled, Weights and Vitals Summary, dated 3/10/26, the summary indicated, Resident 2 had a weight measuring 163.8 lbs (pounds, a unit of measurement) taken on 2/8/26 at 5:18 p.m. The summary also indicated, Resident 2 had a weight measuring 155.8 lbs taken on 2/16/26 at 11:09 a.m. During a review of Resident 2's clinical record titled, Progress Notes, dated 1/27/26, at 3:20 p.m., under type: Physician Progress Note, the progress notes indicated, .Monitor weight and notify MD (Medical Doctor) if abnormal weight loss or weight gain, monitor intake (food consumed) [and] output (amount of urine), and notify MD/provider if excessive PO (by mouth) intake or poor PO intake. During a review of Resident 2's clinical record titled, Progress Notes, dated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/14/26, at 11:25 a.m., under type: Physician Progress Note, the progress notes indicated, .Monitor weight and notify MD if abnormal weight loss or weight gain, monitor intake [and] output, and notify MD/provider if excessive PO intake or poor PO intake. During an interview on 3/10/26, at 3:40 p.m. with the Assistant Director of Nursing (ADON), the ADON confirmed the days and meals Resident 2 refused his meals and 0-25% of meals consumed. During a subsequent interview on 3/10/26, at 4:09 p.m. with the ADON and the Director of Nursing (DON), the ADON stated the RD should have been notified to check and evaluate the resident and the PCP should have been notified to give recommendations and further instructions or orders. The ADON stated she would check all documentation that the RD and PCP were notified when Resident 2 had refused meals or had low meal intake from 2/13/26 through 2/16/26 and weight loss from 163.8 lbs to 155.8 lbs from 2/8/26 to 2/16/26. During an interview on 3/10/26, at 5:17 p.m. with the ADM, the ADM stated the PCP should have been notified and see what else can be done. The ADM also stated weight loss, skin breakdown, and adverse effect on general health would be a potential risk for delayed treatment. During an interview on 3/10/26, at 5:37 p.m. with the ADON, the ADON confirmed that the PCP and RD were not notified until 3/4/26 at 1:39 p.m. During a review of the facility's undated Policy, titled, Weight Monitoring, the policy indicated, .The physician should be informed of significant change in weight and may order nutritional interventions. During a review of the facility's undated Policy, titled, Nutritional Management, the policy indicated, .The physician will be notified of: significant changes in weight, intake, or nutritional status.

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	03/10/2026

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.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interviews, and record reviews, the facility failed to implement measures to prevent the development and/or worsening of pressure ulcers/injuries (PU/PI, areas of damaged skin caused by staying in one position for too long, usually over an area on the body where a bone is close to the skin's surface) when:1. Resident 1's low air loss (LAL) mattress (a mattress designed to prevent and treat pressure ulcers/injuries in patients with limited mobility which uses an air-filled bladders that inflate/deflate to relieve pressure, combined with tiny holes that blow air to keep skin cool, dry, and moisture free) was not plugged to an emergency outlet when the power in her room was off; and,2. Resident 2's clinical record did not indicate a skin care plan (a written document where you can summarize a person's health conditions, specific care needs, and current treatments) was initiated and no interventions (any action a nurse performs to help patients reach expected outcomes) to prevent the worsening of a PU/PI.These failures had the potential for Resident 1 to develop pressure ulcer/injury and Resident 2 resulted in worsening of a pressure ulcer/injury from an intact to open skin in his coccyx (tailbone) area. Findings:1. During a review of Resident 1's clinical record titled, admission RECORD, dated 3/6/26, the record indicated Resident 1 was admitted to the facility with diagnoses including diabetes (condition characterized by high blood sugar levels), muscle weakness, and signs and symptoms involving the musculoskeletal system.During a review of Resident 1's clinical record titled, MDS (Minimum Data Set, an assessment tool), dated 2/19/26, under Section C-Cognitive Patterns, the MDS indicated, Resident 1 had a BIMS (Brief Interview for Mental Status) score of 12 out of 15 suggesting Resident 1 had moderate cognitive impairment.During a review of Resident 1's clinical record titled, Order Summary Report, dated 3/6/26, the report indicated, .BUTTOCKS: CLEANSE WITH NS [normal saline], PAT DRY, APPLY CALMOSEPTINE (an ointment to protect and heal skin irritations) AND LEAVE OPEN TO DRY every shift. This report also indicated, .LAL Mattress. Set mode and settling based on comfort and/or weight every shift.During a review of Resident 1's clinical record titled, Care Plan Report, (a form where you can summarize a person's health conditions, specific care needs, and current treatments) dated 1/12/26, the report indicated, .Patient has MASD (moisture-associated skin damage, term for inflammation and skin erosion caused by prolonged exposure to moisture such as urine, stool, sweat, or wound drainage) bilateral (both sides) Buttocks and is requiring a LAL Matress [sic].During a concurrent observation and interview on 3/5/26, at 12:24 p.m. with Resident 1 while in her room, Resident 1's oxygen concentrator (a machine to provide supplemental oxygen, place it in a well-ventilated area, and plug it into a grounded outlet) had been switched to an oxygen tank to supply her with oxygen. Resident 1 stated the power in her room was turned off because the maintenance staff was fixing a light in the adjacent room. Resident 1 then called the attention of Licensed Nurse (LN) 1 and indicated to LN 1 that Resident 1 could feel her mattress was deflating. LN 1 responded that the power will be off for at least 15 to 20 minutes. LN 1 did not indicate to Resident 1 that she had an alternative plan to prevent the LAL mattress from deflating. LN 3 entered Resident 1's room and told Resident 1 that her LAL mattress would be plugged into an emergency outlet. LN 3 stated the LAL mattress should have been plugged into an emergency outlet before the power was turned off.During an interview on 3/5/26, at 2:40 p.m. with LN 1, LN 1 stated the maintenance staff told her about the power in Resident 1's room to be turned off but she did not know the protocol for the use of emergency extension cords to keep the LAL mattress on and working.During a concurrent interview and record review on 3/6/26, at 11:05 a.m. with the Director of Staff Development (DSD), LN 1's orientation checklist was reviewed. The DSD confirmed that the use of emergency extension cords and emergency outlets to maintain electrical equipment to be working during power shut offs were not included in the orientation checklist. The DSD stated if the LAL mattress was left deflated it could potentially increase the risk for skin breakdowns.During an interview on 3/6/26, at 1:02 p.m. with the Director of Nursing (DON), the DON stated she would have expected the LN 1 to have asked other LNs for assistance. The DON (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated a deflated LAL mattress could be uncomfortable and potentially could be a reason for skin breakdowns.During a review of the undated facility document titled, .Low Air Loss Mattress System.USER MANUAL, this manual indicated, .The [brand name] pump and mattress are intended to help reduce the incidence of pressure ulcers while optimizing patient comfort.Power Switch.Turn ON/OFF the power, the pump will start/stop operation.During a review of the facility's undated Policy and Procedure (P&P) titled, Pressure Injury Prevention Guidelines, the P&P indicated, .Prevention devices will be utilized in accordance with manufacturer recommendations (e.g., heel flotation devices, cushions, mattresses).2. During a review of Resident 2's clinical record titled, admission RECORD, dated 3/10/26, the record indicated Resident 2 was admitted to the facility with diagnoses including diabetes (disorder characterized by high blood sugar), muscle weakness, and signs and symptoms involving the musculoskeletal system.During a review of Resident 2's clinical record titled, MDS (Minimum Data Set, an assessment tool), dated 1/21/26, under Section C-Cognitive Patterns, the MDS indicated, Resident 2 had a BIMS (Brief Interview for Mental Status) score of 11 out of 15 suggesting Resident 2 had moderate cognitive impairment. During a phone interview on 3/4/26, at 1:14 p.m. with the complainant, the complainant stated a concern regarding Resident 2 complaining about burning sensation around his buttocks area. During an interview on 3/10/26, at 8:39 a.m. with Resident 2 while he was in his room, Resident 2 had indicated his bottom was hurting. During a review of Resident 2's clinical record titled, Order Summary Report, dated 3/10/26, the report indicated, .COCCYX (tailbone): Wash w/ (with) soap and warm water, pat dry, and apply calmoseptine leave open to air, every shift.During a review of Resident 2's clinical record titled, TREATMENT ADMINISTRATION RECORD (TAR), dated 3/1/26 through 3/31/26, the TAR indicated, .COCCYX: Wash w/ soap and warm water, pat dry, and apply calmoseptine leave open to air, every shift .During an interview on 3/10/26, at 10:46 a.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated Resident 2 had skin issues in his buttocks and around his anal region, and a small area of the skin was peeled off. CNA 4 also stated she repositioned Resident 2 every two hours from side to side and kept him clean and dry.During an interview on 3/10/26, at 12:17 p.m. with LN 5, LN 5 stated Resident 2 had some skin redness but no open area when she checked Resident 2's buttocks and coccyx on 3/9/26. LN 5 explained a physician order to apply calmoseptine was in place and other PU/PI preventive measures such as to keep Resident 2 clean and dry, to report any skin changes, and to rotate Resident 2's position every 2 hours while in bed. During a concurrent observation and interview on 3/10/26, at 2:36 p.m. with LN 5 in Resident 2's room, Resident 2 had an area in his coccyx where the outer skin came off. LN 5 stated the skin was intact and it had a smaller area of redness. LN 5 stated it was smaller when she saw it yesterday and it was not an open wound. LN 5 explained it was now bigger and an open wound approximately measuring 0.3 cm by 0.4 cm with slight drainage. LN 5 also explained it was not an open wound when she checked it yesterday. LN 5 stated Resident 2 might not have been turned and repositioned as frequently as it should have been. During a subsequent interview and record review on 3/10/26, at 2:36 p.m. with LN 5, LN 5 reviewed Resident 2's clinical record for skin integrity care plan titled, Care Plan Report. The clinical record did not reveal a care plan to address Resident 2's high risk for skin breakdowns including interventions (any action a nurse performs to help patients reach expected outcomes) to prevent the development of PU/PI or prevent worsening of an existing PU/PI. LN 5 stated there was no care plan for skin integrity and there should be one to guide staff on what was needed to provide adequate care. During an interview on 3/10/26, at 4:30 p.m., with LN 5, LN 5 stated there should be a care plan for residents who have a high risk for skin breakdown and following the preventive measures would help decrease the risk for skin issues. LN 5 also stated that without skin care plan there would be no interventions for the staff to follow and could potentially increase the occurrence of skin breakdowns and/or worsening of a PU/PI.During an interview on 3/10/26, at 5:15 p.m. with the Administrator (ADM), the ADM stated residents with high risk for skin breakdown should have a care plan to help prevent further skin issues that could possibly lead to infection and a decline in general health. During a review of the facility's undated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy & Procedure (P&P) titled, Pressure Injury Prevention Guidelines, the P&P indicated, .To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or have a pressure injury present.Interventions will be documented in the care plan and communicated to all relevant staff.During a review of the facility's undated Policy titled, Comprehensive Care Plans, the policy indicated, .To develop and implement a comprehensive person-centered care plan for each resident.The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs.The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.