

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 04/15/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed provide adequate supervision for one of seven sampled residents (Resident 1) when Resident 1 eloped from the facility through the non functioning alarmed front door and was missing from the facility for approximately 20 minutes and eventually located at a corner gas station. This failure to provide adequate supervision placed Resident 1 at risk for injury and psychosocial distress. Findings: During a review of Resident 1's document titled admission RECORD, dated 4/15/26, the record indicated Resident 1 was admitted to the facility with diagnosis that included dementia (a decline in mental ability-specifically memory, thinking, and reasoning-severe enough to interfere with daily life), weakness, and unsteadiness of feet. During a review of Resident 1's document titled Minimum Data Set, (MDS- a standardized, federally mandated assessment tool used to evaluate a resident's functional, medical, psychosocial, and cognitive status) dated 1/16/26, the MDS revealed that in .Section C - Cognitive Patterns. that a Brief Interview for Mental Status (BIMS - a standardized assessment tool used to measure a person's cognitive function) had been completed with a resulting score of 7, indicating that Resident 1 had severe cognitive and memory impairment (a score of 13-15 indicates intact cognition and memory, 8-12 moderate impairment, and 0-7 severe impairment). During a review of Resident 1's document titled Order Summary Report, dated 4/15/26, the report indicated that Resident 1 had a physician's order dated 8/19/25 that indicated, .Q [every] 30 minutes visual check. Nurses pls [please] make sure binder is filled out. every shift .During a review of Resident 1's document titled Type: IDT [Interdisciplinary Team; a group of healthcare professionals] Notes, dated 3/13/26, the note indicated that the IDT had reviewed Resident 1's continued risk for elopement and indicated that Resident 1 had not attempted to elope from the facility in four months. The IDT recommended that Resident 1's supervision level be decreased from one-on-one supervision to visual location checks every 15 minutes. An addendum note was added on 3/23/26 that indicated the visual location checks were changed to every 30 minutes. During a review of Resident 1's document titled Nursing - Elopement Evaluation, dated 4/13/26, the evaluation indicated Resident 1 had an elopement risk score of 28, indicating Resident 1 was at high risk for an elopement attempt. During a review of Resident 1's document titled eINTERACT Change in Condition Evaluation, dated 4/13/26, the evaluation indicated that .resident eloped from the facility @ [at] 11:00 am. Searched for Resident in all the Rooms in the Facility and near by [sic] Facility and Resident was Found on Gas Station near to The Facility at 11:25 am. During a review of Resident 1's document titled Progress Notes, dated 3/13/26 through 4/13/26, indicated no further assessment was completed regarding Resident 1's elopement risk once the supervision level had been downgraded from one-on-one supervision to 30-minute visual location checks. During an interview on 4/15/26 at 12:54 PM with Licensed Nurse (LN) 1, LN 1 stated that the front main entrance door is not alarmed and sometimes, but not all the time, there is someone sitting at the desk by the front door to watch people coming in and out of the door. During an interview on 4/15/26 at 1:13 PM with LN 2, LN 2 stated that all the exit doors are alarmed except for the front main entrance door. LN 2 stated she is unaware that anyone has been assigned to monitor that door for residents exiting unescorted. During an interview on 4/15/26 at 1:42 (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
---	-------	-----------

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 04/15/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PM with the Assistant Director of Nurses (ADON), the ADON stated the alarm on the main entrance door to the facility had not been working for months and that a new system had been ordered but she was unsure when it would be delivered to the facility. The ADON stated that Resident 1 was at risk for elopement but since Resident 1 had not eloped for several months, the IDT had met on 3/13/26 to review the continued need for 1:1 supervision and determined that Resident 1 no longer required that level of supervision so Resident 1 was moved to 30-minute visual location checks. The ADON confirmed that Resident 1 was on 30-minute visual location checks at the time of the elopement on 4/13/26. The ADON stated that the main exit door was not monitored by a staff member at the time of the elopement, so no one saw Resident 1 exit the front door. The ADON stated that the facility should have had someone stationed at the front door to monitor residents going in and out, and if that had been in place, Resident 1 would not have left the facility unescorted. The ADON stated that the risk of not having the front door monitored by a staff member placed residents who were at high risk for elopement, like Resident 1, for leaving the facility unnoticed, increasing the chance of injury to a resident once they were off facility grounds. During an interview on 4/15/26 at 10:58 AM with the Maintenance Director (MTD), the MTD stated that the alarm for the main entrance door had not been working at least since December 2025. The MTD stated that a whole new system had been ordered but had not arrived at the facility and he was not sure when it would arrive. The MTD stated all the exit doors, including the main entrance door had annunciator alarm devices (an audio-visual device that signals when a door is opened or closed, or when it remains in an abnormal state (e.g., left open). It is designed to provide immediate, localized notification to staff or residents that a door has been breached or is being used, making it essential for security, entryway monitoring). The MTD explained that the annunciator alarms on the exit doors at the end of the station hallways were always engaged and would sound an alarm anytime the doors were opened. The MTD stated that the annunciator alarm on the main entrance door was not engaged because it would be alarming all the time when visitors, staff, or residents exited or entered the facility throughout the day. During observations on 4/15/26 at 12:45 PM, 1:18 PM, 1:37 PM, and 1:58 PM there was no staff member sitting at desk by the main entrance door monitoring for residents exiting or entering the facility. During an interview on 4/15/26 at 2:03 PM with the Administrator (ADM), the ADM stated that the alarm system for the front door had not been working since the end of November 2025. The ADM stated that after attempts to fix the system, approval for a new alarm system had been given and had been ordered. The ADM stated that the final payment for the new system had been sent on 4/14/26 and they expected the new alarm system to arrive at the facility by 4/20/26. The ADM confirmed that no one had been assigned to monitor the front door for possible resident elopements and that it should have been done. The ADM stated had there been a staff member assigned to that task, it would have been less likely that Resident 1 would not have left the facility unescorted on 4/13/26. The ADM stated that not having the front door monitored increased the risk of another elopement by any resident who had been identified as an elopement risk and could result in the resident being seriously injured if the resident left the facility grounds. During a review of the facility's undated policy and procedure (P&P) titled, Elopements and Wandering Residents, the P&P indicated, .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents. The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. The facility shall establish and utilize a systematic approach to monitoring and managing resident at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Adequate supervision will be provided to help prevent accidents or elopements. During a review of the facility's undated policy and procedure titled Incidents and Accidents, the P&P indicated, .The purpose of incident reporting can include: assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences (continued on next page)</p>		

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 04/15/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements.</p>		