

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

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 04/28/2026
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)		
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interview and record review the facility failed to arrange transportation to and from the office of an ophthalmologist (specialist in the treatment of vision) in the provision of an eye examination for 1 of 11 sampled Residents (Resident 1). This failure led Resident 1 to miss his initial ophthalmologist appointment and the potential for delayed treatment for Resident 1 could have resulted in a decline in health and well-being. Findings: Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with diagnoses including type 2 diabetes mellitus (a chronic metabolic condition characterized by insulin resistance and relative insulin deficiency), unspecified osteoarthritis (a medical term used when a physician diagnoses degenerative joint disease, but the specific location of the joint(s) affected has not been explicitly documented or identified yet), unspecified glaucoma (eye diseases that damage the optic nerve, often due to abnormally high pressure inside the eye), and paraplegia (the partial or complete loss of motor and sensory function in the lower half of the body, usually caused by a spinal cord injury). A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 2/24/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 (Brief Interview for Mental Status score of 15 means that cognitive function is completely intact). During an observation and interview on 4/27/26 at 1:50 p.m., with Resident 1 in his room, Resident 1 stated he had made a request to the Social Services Director (SSD) to be seen by an ophthalmologist since 11/25. Resident 1 further stated he was almost blind and Resident 1 was having difficulty seeing and reading. During a concurrent interview and record review on 4/28/26 at 4:33 p.m., with the Social Services Director (SSD), the SSD stated he had scheduled an appointment for Resident 1 to be seen by an ophthalmologist on 4/2/26. The SSD stated he had rescheduled Residents 1's ophthalmology appointment from 4/2/26 to 5/22/26 due to a transportation conflict. The SSD further stated the facility did not have a transportation vehicle available to take Resident 1 for the ophthalmology appointment on 4/2/26. The SSD stated in the past when facility's transportation vehicle was not available the facility used their sister facility's (a building or location that shares the same parent company or ownership as another nearby location, allowing the two sites to share resources, staff, or operational frameworks) van for transportation. The SSD stated the sister facility's transportation van was not available on 4/2/26 for transportation. During an interview on 4/30/26 at 8:16 a.m., with the Director of Staff Development (DSD), the DSD stated Resident 1's doctor's order dated 11/19/25 indicated Resident 1 may have ophthalmology consult for cataract (a clouding of the eye's natural lens. This buildup of proteins prevents light from passing through, making vision appear blurry, hazy, or faded). The DSD stated the SSD should have facilitated the appointment for Resident 1 when there was an order from Resident 1's doctor. The DSD stated a delay in treatment could have caused Resident 1's health to get worse and Resident 1 could have gotten mad. The DSD stated there was no documentation indicating the SSD had communicated with the sister facility to arrange for transportation for Resident 1's ophthalmology appointment on 4/2/26. During an interview on 4/30/26 at 12:18 p.m., with Administrator (ADM) 2, ADM 2 stated there was no documentation indicating communication was made to arrange for transportation for Resident 1 on 4/2/26 to his appointment. A review of Resident (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's Progress Notes, dated 1/16/26 at 3:24 p.m., indicated, .Scheduled [appointment] for ophthalmology consult for right eye redness for 4/2/26 at 8:30 AM at valley optometry.A review of Resident 1's Progress Notes, dated 4/2/26 at 9:28 a.m., indicated, .[Resident 1's] ophthalmology appointment for 4/2 was rescheduled to 5/22 [at 11:40 a.m.] due to transportation conflict. SSD to call ophthalmology office and add resident to list in case of early drop outs .A review of the facility's policy and procedures (P&P) titled, Provision of Physician Ordered Services, dated 2025, indicated, .The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality .Facility will maintain a schedule of diagnostic tests.in accordance with the physicians orders.Qualified nursing personal will submit timely requests for physician ordered services.Documentation of consultants, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record.In instances where diagnostic testing or consultants are not available to be performed on-site OR the Physician has requested that the services be performed at an off-site facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments .		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to ensure 1 out of 11 sampled residents (Resident 1) received proper foot treatment and care, when Resident 1 was not seen by a podiatrist (a specialist physician and surgeon who diagnoses and treats conditions affecting the foot, ankle, and lower leg) to prevent complications from his long and thickened toenails and nail avulsions (detachment of toenail from the bed) to some of his toenails. This failure had the potential for Resident 1 to sustain skin injury and/or to acquire an infection and not achieve his highest practicable well-being. Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including type 2 diabetes mellitus (a chronic metabolic condition characterized by insulin resistance and relative insulin deficiency), and paraplegia (the partial or complete loss of motor and sensory function in the lower half of the body, usually caused by a spinal cord injury). A review of Resident 1's Minimum Data Set (MDS- an assessment tool) Cognitive Patterns, dated 2/24/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 (Brief Interview for Mental Status score of 15 means that cognitive function is completely intact). During an interview on 4/27/26, at 12:12 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 1 needed help with his ADL care (Activities of Daily Living care and assistance provided to individuals who struggle to perform fundamental, routine self-care tasks independently due to aging, injury, illness, or disability). CNA 2 further stated Resident 1 had thick toenails. CNA 2 stated Resident 1 had told CNA 2 in the past to be careful when putting socks on his feet because Resident 1's toenails and feet were hurting. During a concurrent observation and interview on 4/27/26, at 1:50 p.m., with Resident 1 in his room, Resident 1 stated his wound care doctor had informed him that he needed to be seen by a podiatrist. Resident 1 further stated he had made a request to the Social Services Director (SSD) to be seen by a podiatrist back in November of 2025. Resident 1 explained no one at the facility provided nail care to Resident 1 since being admitted to the facility. Resident 1 stated he had all his toenails when he first came to the facility, but his toenails grew long and he experienced nail avulsions when some of his toenails were caught in his socks. During a concurrent observation and interview on 4/27/26, at 2:35 p.m., with Licensed Nurse (LN) 3, LN 3 confirmed Resident 1 had long and thick toenails on his right foot second, third and fourth toe. LN 3 further confirmed Resident 1 was missing toenails on his second, third, fourth and pinky toe on his left foot. LN 3 stated Resident 1 also had a missing toenail on his right foot pinky toe. LN 3 further stated Resident 1 had experienced left foot toenail avulsion when his long toenails got caught in his socks. LN 3 stated Resident 1 should have been seen by a podiatrist for his nail care. During a concurrent interview and record review of Resident 1's medical record on 4/28/26, at 2:50 p.m., with LN 3, LN 3 stated she could not find any documentation indicating Resident 1 had been seen by a podiatrist. During a concurrent interview and record review on 4/28/26, at 4:33 p.m., with the Social Services Director (SSD), the SSD stated he had sent a referral to the facility's in-house podiatry company on 2/26/26 but was not seen. Another referral was sent to an outside podiatry clinic on 4/9/26 for Resident 1 to be seen by a podiatrist. The SSD further stated he called on 4/15/26, to follow up on the status for Resident 1's podiatry appointment and was told Resident 1's podiatry referral was under review. The SSD stated a podiatrist had visited the facility once a month in the past to provide podiatry care to the residents. The SSD confirmed Resident 1 was not seen by a podiatrist since Resident 1's admission to the facility in late 2025. The SSD stated he should have followed up and scheduled a podiatry appointment for Resident 1 to be seen by the in-house podiatrist. During a concurrent interview and record review of Resident 1's medical record on 4/28/26, at 5:44 p.m., with the Director of Nursing (DON), the DON confirmed Resident 1 had missing toenails on his left foot including the second, third, fourth and pinky toe. The DON stated Resident 1 was also missing his right foot pinky toenail. The DON further stated she could not find any documentation indicating Resident 1 was seen by a podiatrist for nail care. The DON explained (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 should have been seen by a podiatrist since Resident 1 was diabetic and had missing toenails. The DON stated Resident 1 could have had an infection, and wounds on Resident 1's toes could have worsened from having long and thick toenails. The DON further stated she could not find documentation indicating Resident 1 had ever refused to be seen by a podiatrist. During an interview on 4/30/26 at 8:16 a.m., with the Director of Staff Development (DSD), the DSD stated a podiatrist had visited the facility once a month in the past to trim nails of diabetic residents. The DSD stated a diabetic resident with long and thick nails could get an infection when nail care was not provided by a podiatrist. The DSD stated the SSD made appointments for residents with diabetes to be made by a podiatrist for nail care. The DSD stated the SSD should have facilitated the appointment for Resident 1 when there was an order from Resident 1's doctor to see a podiatrist. The DSD stated a delay in treatment could have caused Resident 1's health to get worse and Resident 1 could have gotten mad. During an interview with the outside podiatry company's staff (OPCS) member on 4/29/26 at 3:04 PM, the OPCS confirmed a referral came through for Resident 1 but all of their referrals go overseas to be processed so a referral could be sitting for 30 days. The first person that touched the referral was on 4/20/26, and it was found that due to Resident 1's type of insurance there were only certain places he could be seen and their company was not one of them. The OPCS stated they did not have any documentation that anyone from the facility called them to follow up on the referral so a fax was sent to the facility on 4/20/26 to let the facility know Resident 1 could not be seen by their company due to Resident 1's insurance. A review of Resident 1's doctors order, dated 2/1/26 at 11:07 a.m., indicated, May have podiatrist consult. A review of Resident 1's Change in Condition Evaluation, dated 2/13/26 at 9:44 p.m., indicated, .left foot 2nd and 3rd nail is coming off. Recommendation of Primary Clinician. consult with podiatrist. A review of Resident 1's Change in Condition Evaluation, dated 2/13/26 at 9:43 p.m., indicated, .right foot [pinkie toe] nail is detached from the toe. [Resident 1's] on the left foot 2nd and 3rd nail is coming off. Recommendation of Primary Clinician. consult with podiatrist . A review of Resident 1's Change in Condition Evaluation, dated 3/10/26 at 2:43 a.m., indicated, . [Resident 1] noted with left foot 2nd toe fully off with purulent drainage [puss] observed, area appeared red and, swollen and looks infected. Recommendation of Primary Clinician [doctor ordered wound care consult, podiatry consult]. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 2/20/26 at 7:56 a.m., indicated, .LEFT SECOND TOENAIL IS DETACHED FROM NAIL BED. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 2/20/26 at 8:06 a.m., indicated, .RIGHT SMALL TOENAIL IS DETACHED FROM NAIL BED. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 2/20/26 at 8:02 a.m., indicated, .LEFT THIRD TOENAIL IS PARTIALLY DETACHED AND ACTIVELY DETACHING FROM NAIL BED. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 2/24/26 at 10:15 a.m., indicated, .LEFT SECOND TOE Avulsed Nail. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 2/24/26 at 10:25 a.m., indicated, .LEFT THIRD TOE Avulsed Nail. there is a Small amount of serous drainage noted [clear drainage with some blood coloring the drainage pink]. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 2/24/26 at 10:26 a.m., indicated, .RIGHT SMALL TOE Avulsed Nail. there is a Small amount of serous drainage. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 3/12/26 at 1:42 p.m., indicated, .LEFT SECOND TOE Avulsed Nail. there is a moderate amount of serous drainage. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 3/19/26 at 3:40 p.m., indicated, .LEFT SECOND TOE open WOUND. there is a Moderate amount of serous drainage noted. wound is deteriorating. A review of Resident 1's Nursing -Weekly Skin Alteration non-pressure Evaluation, dated 3/24/26 at 3:14 p.m., indicated, .LEFT SECOND TOE open WOUND. there is a Moderate amount of serous drainage. [doctor] recommends Podiatry consult. A review of Resident 1's Progress Notes, dated 2/26/26 at 1:59 p.m., indicated, .SSD sent referral to podiatry for [Resident 1] to be seen. A review of Resident 1's Progress Notes, dated 3/18/26 at 7:05 a.m., indicated, .Left Second Toe is an (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Open wound measurements are 3cm length x 3cm width x 0.5cm depth. There is a Moderate amount of serous drainage noted. Wound bed has 26-50% granulation [new, connective tissue that forms at the base of a wound], 26-50% slough [a moist, pale yellow, or white stringy tissue that forms in wounds as a result of dead cells and prolonged inflammation] . The wound is deteriorating. Bone is exposed. Consults recommended Podiatry - For amputation [the surgical removal of all or part of a limb or body extremity]. A review of Resident 1's Progress Notes, dated 4/9/26 at 1:11 p.m., indicated, .Sent referral for Podiatry Consult to [company name] Podiatry. A review of Resident 1's Progress Notes, dated 4/10/26 at 1:32 p.m., indicated, .Called [company name] Podiatry to [follow up] Podiatry referral spoke to [podiatry company staff member] and [podiatry company staff member] stated that referral is under review. A review of Resident 1's Progress Notes, dated 4/27/26 at 3:52 p.m., indicated, .Left Second Toe is an open wound measurements are 0.5 cm length x 0.5 cm width. Wound bed has 76-100% eschar [a thick, dry, and hardened layer of dead tissue that forms over a wound]. Review of Resident 1's care plan initiated on 3/25/26, in the section titled Focus indicated [Resident 1] with an open wound to LEFT SECOND TOE ., in the section titled Goal indicated Wound will show signs of healing. in the section titled Interventions indicated .Assess and document wound weekly and [as needed] .May have [wound doctor] evaluate and treat. Review of Resident 1's care plan initiated on 2/24/26, in the section titled Focus indicated [Resident 1] HAS AVULSED NAIL TO THE LEFT THIRD TOE, AND RIGHT SMALL TOE ., in the section titled Goal indicated Toenail bed will remain clean and free from [signs and symptoms] of infection. in the section titled Interventions indicated .Assess and document wound weekly and [as needed] .May have [wound doctor] evaluate and treat. A review of the facility's policy and procedures (P&P) titled, Activities of Daily Living (ADLs), dated 2025, indicated, .The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for .Bathing, dressing, grooming .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. A review of the facility's policy and procedures (P&P) titled, Nail Care, dated 2025, indicated, .Assessments of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care. Report unusual or abnormal conditions of the nails to the physician. Identify conditions that increase risk for foot or nail problems, such as diabetes. Routine cleaning and inspection of nails will be provided during ADL care. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nails should be kept smooth to avoid skin injury. Only licensed nurses shall trim or file fingernails of residents with diabetes. Toenails of residents with diabetes or circulation problems shall be filed only. If a resident has toe infection, diabetes mellitus, toenail trimming should be performed by a physician. A review of the facility's policy and procedures (P&P) titled, Provision of Physician Ordered Services, dated 2025, indicated, .The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality .Facility will maintain a schedule of diagnostic tests in accordance with the physicians orders. Qualified nursing personnel will submit timely requests for physician ordered services. Documentation of consultants, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record. In instances where diagnostic testing or consultants are not available to be performed on-site OR the Physician has requested that the services be performed at an off-site facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments.		