

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 05/13/2026
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 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 ensure 1 of 26 sampled residents (Resident 68), remained free from abuse (verbal, mental, sexual, or physical abuse) when, Resident 95 hit Resident 68 on his head on 5/4/26. This failure caused Resident 68 to feel sad and fearful for his safety while residing in the facility and had the potential to result in emotional distress and ongoing fear. Findings: A review of Resident 68's admission RECORD indicated Resident 68 was admitted with the diagnosis of depression (persistent feeling of sadness), paraplegia (the loss of movement and feeling in the lower half of the body). During an interview on 5/11/26 at 2:57 PM, Resident 68 stated on 5/4/26 around 10:30 AM, while smoking a cigarette in the courtyard located in the front portion of the facility, himself and another resident (Resident 95), began to disagree on the way Resident 68 spoke to another resident. Resident 68 stated, Resident 95 threatened to physically harm him while expressing his affiliation with a gang and the harm he has done to people in the past while they were arguing back and forth. Resident 68 then stated that Resident 95 began to walk towards him while yelling when the Activities Assistant (AA) heard them and quickly attempted to diffuse the situation. Resident 68 stated Resident 95 was able to reach over the AA and hit Resident 68 on the head prior to Resident 95 walking back in the facility. Resident 68 stated he was afraid because of the incident and the threats to further harm him that were made by Resident 95. Resident 68 stated he called the police for protection and made a report. During an interview on 5/11/26 at 3:19 PM, the AA stated on 5/4/26 around 11 AM she was walking outside to courtyard when she heard Resident 95 and Resident 68 arguing. The AA stated she witnessed Resident 95 walk towards Resident 68 who was in a wheelchair and hit Resident 68 on the back of the head and then walked back in the facility. The AA stated she attempted to diffuse the situation, separate both residents, and call for assistance, but was unable to prevent Resident 95 from hitting Resident 68 in the head. The AA stated after the incident occurred, she reported it to the Administrator (ADM). During an interview on 5/11/26 at 4:38 PM with Resident 95, Resident 95 stated on 5/4/26 Resident 65 was being rude to another resident who had memory issues. Resident 95 stated he defended that resident and told Resident 68 he should not talk to people like that. Resident 95 then stated that he and Resident 68 began to argue only verbally until Resident 68 called him a derogatory word that made him get up and pop Resident 68 in the back of his head one time. Resident 95 stated he felt like Resident 68 deserved it and that Resident 68 had previously been rude to other residents and staff members at the facility. Resident 95 stated that he believed if someone finally hit Resident 68, then he would be nicer to people. Resident 95 stated the evening of the incident that the police came and searched his room for weapons and took his statement. Resident 68 stated the police did not find any weapons and that he had no plans on harming Resident 68 after the incident. During an interview on 5/11/26 at 5 PM, the ADM stated the incident occurred on 5/4/26 around 10:45 AM. The ADM stated she was aware of the incident and stated the facility initiated an investigation into what occurred. The ADM stated the facility's investigation determined that the incident did occur and the conclusion on the facility's behalf considered the incident between Resident 68 and Resident 95 did occur. The ADM stated she expected the staff to protect all the residents in the facility. The ADM acknowledged the negative (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
FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID: Facility ID: 055304 If continuation sheet Page 1 of 3		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impact physical abuse can have on a resident's mental health and stated Resident 68 is scheduled to have a psychological evaluation. During a review of the facility's undated policy and procedure (P&P) titled, "Abuse, Neglect and Exploitation," the P&P indicated, "It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. The facility will make sure 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to ensure an allegation of physical abuse was reported in a timely manner, within 2 hours to the department for 2 of 26 sampled residents when Resident 95 hit Resident 68 on 5/4/26 and it was not reported to the required entities until 5/5/26. This failure led to the delayed immediate protection of Resident 68 and delayed abuse investigation process. This failure had the potential to put Resident 68's psychosocial, physical health and safety at risk. Findings: A review of Resident 68's admission RECORD indicated Resident 68 was admitted with the diagnosis of depression (persistent feeling of sadness), paraplegia (the loss of movement and feeling in the lower half of the body). During an interview on 5/11/26 at 2:57 PM, Resident 68 stated on 5/4/26 around 10:30 AM, he was assaulted by another resident while in the courtyard of the facility smoking a cigarette. Resident 68 stated after the altercation multiple staff witnessed the incident. Resident 68 stated after he was assaulted, he waited in his room for a few hours to see if the staff was going to check on him or notify the police. Resident 68 stated after waiting for a while he called the police himself to report the incident on 5/4/26 at 3:30 PM. Resident 68 stated he was afraid during this time due to the type of threats the aggressor made to him and his level of vulnerability and inability to defend himself. During an interview on 5/11/26 at 3:19 PM, the Activities Assistant (AA) stated on 5/4/26, around 11 AM, while she was walking outside to facility's courtyard, she heard Resident 68 and Resident 95 arguing. The AA stated she witnessed Resident 95 walked towards Resident 68 who was wheelchair bound. The AA stated she stood between both Resident 68 and Resident 95 while calling for assistance and trying to diffuse the situation but Resident 95 was able to hit Resident 65 in the back of his head prior to walking back in the facility. The AA stated she reported the incident to the Administrator (ADM). During an interview on 5/11/26 at 4:38 PM, with Resident 95, Resident 95 stated on 5/4/26, Resident 65 was being rude to another resident who had memory issues. Resident 95 stated he defended that resident and told Resident 68 he should not talk to people like that. Resident 95 then stated that he and Resident 68 began to argue only verbally until Resident 68 called him a derogatory word that made him get up and pop Resident 68 in the back of his head one time. Resident 95 stated he felt like Resident 68 deserved it and that Resident 68 had previously been rude to other residents and staff members at the facility. Resident 95 stated that he believed if someone finally hit Resident 68, then he would be nicer to people. During an interview on 5/11/26 at 5 PM, the ADM stated the incident occurred on 5/4/26 around 10:45 AM. The ADM stated she was aware of the incident and stated the facility initiated an investigation into what occurred. The ADM stated she reported the abuse to the required entities the following day 5/5/26 around 11 AM. The ADM stated she believed the report time was 24 hours and not 2 hours. The ADM stated the facility's investigation determined that the incident did occur and the conclusion on the facility's behalf considered the incident between Resident 68 and Resident 95 did occur. The ADM acknowledged the negative impact physical abuse can have on a resident's mental health. During a review of the facility's undated policy and procedure titled, .Abuse, Neglect and Exploitation., indicated, .It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.		