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	06/05/2026

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 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 one of four sampled residents (Resident 1) remained free from abuse (willful infliction of injury, and/or intimidation resulting in physical harm, pain or mental anguish) when Resident 2 hit Resident 1 with his cane. This failure caused Resident 1 to feel threatened 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 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included paraplegia (loss of movement or feeling of the lower half of the body) and depression (mental health condition that causes ongoing sadness, low energy and loss of interest). A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section C- Cognitive Patterns, dated 5/22/26, indicated, .Brief Interview of Mental Status (BIMS) [screening tool to assess cognitive impairment].BIMS Summary Score.15. (a score of 13 to 15 points suggests that cognition is intact). During an interview on 6/4/26 at 12:13 PM with Resident 1, Resident 1 stated he had previously argued with Resident 2 and Resident 2 came at me but was stopped by a staff member. Resident 1 further stated on 5/22/26 he was being pushed up the ramp into the van by two staff members when Resident 2 came running up behind him, cursed at him and stated he was going to kill him. Resident 1 stated Resident 2 was able to get in between the staff members and hit him on the head. Resident 1 stated after that he had requested a temporary restraining order against Resident 2. During an interview on 6/4/26 at 3:54 PM with the facility receptionist (FR), the FR stated on 5/22/26, she observed Resident 2 running up behind Resident 1 as he was being pushed into the van and she knew Resident 2 could be dangerous. The RF stated Resident 2 held his cane horizontally and hit hard at the back of Resident 1's high backed wheelchair. The RF stated she then stood in front of Resident 2 and talked to him until other staff arrived. During an interview on 6/4/26 at 2:54 PM with Resident 2, Resident 2 stated on 5/22/26 he was sitting out front and he heard Resident 1 verbally berate another resident, so Resident 2 slapped Resident 1. Resident 2 denied hitting Resident 1 with his cane. During a telephone interview on 6/16/26 at 11:26 AM with certified nurse assistant (CNA) 5, CNA 5 stated on 5/22/26 she pushed Resident 1, in his wheelchair, into the van and did not see Resident 2 come up behind them. CNA 5 further stated Resident 1 informed her he had been hit by Resident 2, then the FR came and stood with Resident 2. CNA 5 stated she proceeded to put Resident 1 in the van to prevent him from being hit. During a telephone interview on 6/17/26 at 11:42 AM the Director of Nursing (DON) stated the facility staff are taught to be aware of and intervene in situations that could lead to abuse. The DON further stated the facility had tried to prevent an altercation by assigning 1-1 staff to Resident 1 and Resident 2, but it made Resident 1 uncomfortable and Resident 2 became agitated with 1-1 staff, so they were monitored from a distance. The DON stated incidents of abuse had the potential to cause residents to feel depressed, unsafe, paranoid and fearful. During a review of a facility policy and procedure (P&P) titled Abuse, Neglect and Exploitation, dated 2025, the policy indicated, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.Identifying, correcting (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and intervening in situations in which abuse.is more likely to occur.and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review the facility failed to follow their discharge planning policy for one of four sampled Residents (Resident 1) when Resident 1's electronic health record (EHR) did not contain documentation of Resident 1's discharge goals and needs. This deficient practice had the potential to delay Resident 1's discharge and to not involve him in the planning process. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in late 2025. A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section C- Cognitive Patterns, dated 5/22/26, indicated, .Brief Interview of Mental Status (BIMS) [screening tool to assess cognitive impairment].BIMS Summary Score.15. (a score of 13 to 15 points suggests that cognition is intact). During an interview on 6/4/26 at 12:01 PM with Resident 1, Resident 1 stated he had no discharge plan and when he asked the social services director about a plan he was told they would return to discuss it, but they never came back. During a concurrent interview and record review on 6/5/26 at 10:24 AM with the interim social services director (ISSD), the ISSD confirmed there was no documentation in Resident 1's EHR to indicate a discharge plan had been created. The ISSD stated she would expect to see discharge planning notes on admission and on the social services evaluation. The ISSD further stated discharge planning was done to make sure the facility coordinated goal setting with the residents needs, identified any barriers, advised of realistic options and initiated any referrals that may be needed. During an interview on 6/5/26 at 11:16 AM with the Director of Nurses (DON), the DON stated it was her expectation that Resident 1 would have a discharge plan implemented. The DON further stated discharge planning should have started for Resident 1 on admission. During a review of a facility policy and procedure (P&P) titled, Discharge Planning Process, dated 2025, the P&P indicated, . Discharge planning is a process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge.The facility will determine the resident's expected goals and outcomes regarding discharge upon admission.subsequent assessment information and discharge goals will be included in the resident's comprehensive plan of care.

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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 observation, interview, and record review the facility failed to ensure activities of daily living (ADL, personal care tasks which include bathing, dressing, eating, and transferring in and out of bed) were provided to maintain proper hygiene for two of four sampled residents (Resident 1 and Resident 4) when: 1. Resident 1 and Resident 4's fingernails were untrimmed and soiled; and, 2. Resident 1 did not receive his scheduled shower. These failures had the potential for Resident 1 and Resident 4 to sustain injury and/or infection related to having long, unclean fingernails and had the potential to cause psychosocial distress due to the lack of hygiene. Findings: 1a. A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included paraplegia (partial or complete paralysis of the lower half of the body) and depression (mental health condition that causes ongoing sadness, low energy and loss of interest). During a review of Resident 1's clinical document titled, Care Plan Report, revised 2/10/26, the document indicated, .The resident has an ADL self -care deficit.PERSONAL HYGIENE: The resident requires (Substantial assistance) by (1) staff with personal hygiene. During a concurrent observation and interview on 6/4/26 at 11:46 AM, in Resident 1's room, Resident 1 stated his fingernails were digging into his contracted (fingers curled into the palm due stiffening and tightness) right hand and could cause his hand to bleed. Resident 1's fingernails on both hands were observed to be long and uneven with a thick brown substance under his right thumb nail. During a concurrent observation and interview on 6/4/26 at 1:51 PM, with licensed nurse (LN) 1, LN 1 stated she usually trimmed Resident 1's fingernails. LN 1 confirmed Resident 1's fingernails were long and soiled and needed to be trimmed. During a concurrent observation and interview on 6/5/26 at 10:10 AM, with LN 5, LN 5 confirmed Resident 1's hands were contracted and his nails were long and unclean. LN 5 stated there was the potential for injury and infection when Resident 1's fingernails were long and unclean. LN 5 further stated Resident 1's fingernails could dig into his contracted hands and cause wounds. LN 5 stated the facility could take preventative measures such as keeping Resident 1's fingernails trimmed and clean. 1b. A review of Resident 4's admission RECORD, indicated Resident 4 was admitted to the facility with diagnoses which included depression (mental health condition that causes ongoing sadness, low energy and loss of interest). During a review of Resident 4's clinical document titled, Care Plan Report, revised 11/11/25, the document indicated, .The resident has an ADL self -care deficit.PERSONAL HYGIENE: The resident requires (Substantial assistance) by (1) staff with personal hygiene. During a concurrent observation and interview on 6/4/26 at 3:46 PM, in Resident 4's room, Resident 4's fingernails on her right hand were observed to be long and unclean with a brownish substance under the nails. Resident 4 stated the facility staff did not cut her fingernails. During a concurrent observation and interview on 6/4/26 at 4:35 PM, in Resident 4's room, with LN 4, LN 4 stated the certified nurse's assistants (CNAs) usually trimmed residents' nails on Sundays. LN 4 further stated Resident 4's fingernails on her right hand did not appeared to have been trimmed or cleaned. LN 4 stated when Resident 4 had long, unclean nails she was at risk of scratching herself and getting an infection. During an interview on 6/5/26 at 11:16 AM with the Director of Nurses (DON), the DON stated she was aware of an issue with Resident 1's and Resident 4's fingernails being long and unclean. The DON further stated if Resident 4 received an injury from his long nails he would be at risk of delayed healing due to his medical condition and both Resident 1 and Resident 4 were at risk of injury and/or infection. During a review of a facility policy and procedure (P&P) titled, Nail Care, dated 2025, the P&P indicated, .The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health.Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis.Routine nail care, to include trimming and filing, will be included on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. 2. A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included paraplegia (partial or complete paralysis of the lower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	half of the body) and osteoarthritis (joint pain and stiffness). A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section GG-Functional Abilities, dated 5/22/26 indicated, .Self-Care.Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self. the section was coded, .01.Dependent -Helper does ALL of the effort. Resident does none of the effort to complete the activity. During a concurrent observation and interview on 6/4/26 at 11:43 AM, in Resident 1's room, a sign pinned to Resident 1's bulletin board indicated, .shower schedule.Tuesday, Thursday and Saturday after lunch.Management 5/23/26. Resident 1 stated there were several times he did not receive a shower when scheduled on the evening shift. Resident 1 further stated the facility had adjusted the schedule to accommodate his needs and he would receive a shower after lunch today. During an interview on 6/4/26 at 3:07 PM with Resident 1, Resident 1 stated he had not received his shower because the CNA assigned to care for him was sent out of the facility to accompany another resident on an appointment. During an interview on 6/5/26 at 9:16 AM with CNA 4, CNA 4 stated Resident 1 preferred to receive his shower after lunch but she could not provide it after lunch on 6/4/26 because she was sent out with another resident. During an interview on 6/5/26 at 10:20 AM with the Director of Staff Development (DSD), the DSD stated CNA 4 was taken off her assignment with Resident 1 on 6/4/26 because she was one of the CNAs who agreed to go to appointments. The DSD further stated he did not check with Resident 1's nurse prior to removing CNA 4 from Resident 1's care. During an interview on 6/5/26 at 11:16 AM with the DON, the DON stated Resident 1 required a lot of assistance and she was not aware that CNA 4 had been removed from his care on 6/4/26. The DON further stated it was important for Resident 1 to receive his scheduled shower to remain clean and to prevent infection. The DON stated Resident 1 had the right to choose his shower schedule and to receive a shower on those days. During a review of a facility P&P titled, Resident Shower, dated 2026, the P&P indicated, .It is the practice 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.Residents will provided showers as per request or as per facility schedule protocols.