

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

Printed: 08/27/2026
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 06/26/2026
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 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 report an allegation of physical abuse immediately to the Department for 2 of 3 sampled residents (Resident 2 and Resident 3), when a resident-to-resident altercation involving Resident 2 and Resident 3 occurred on 6/16/26. This failure resulted in a delay in the Department's investigation of a physical abuse allegation and decreased the facility's potential to protect residents from physical and psychosocial harm. Findings: During an interview on 6/25/26, at 1:22 PM, with the front desk receptionist (FDR) 1, FDR 1 stated she was at the front desk when she witnessed the physical altercation between Resident 3 and Resident 2 (on 6/16/26). FDR 1 further stated she and other staff separated both residents immediately. During an interview on 6/25/26, at 2:45 PM, with Licensed Nurse (LN) 1, LN 1 stated the incident between Resident 2 and Resident 3 was reported by FDR 1. LN 1 stated the facility's protocol when there was suspected abuse was for staff to immediately separate the residents, call the police about the incident, notify the Administrator (ADM), and the Director of Nursing (DON). LN 1 stated she filled out a form for the suspected physical altercation and sent it to the Ombudsman (an advocate for residents in long term care), and the police department. LN 1 confirmed she did not fax the form to the Department. LN 1 stated she was not aware that she was supposed to fax the form to the Department. LN 1 further stated that it was important to report abuse allegations. During an interview with on 6/26/26, at 10:32 AM, with the Director of Staff Development (DSD), the DSD stated that he expected the nurses to report abuse allegations immediately to the police, the Ombudsman and to the Department. The DSD further stated he expected nurses to also inform the doctor, the DON, the ADM and the resident's responsible party. The DSD stated that he expected the nurses to fax abuse allegation reports to the Department on the same day immediately especially if there was an injury. During a concurrent interview and record review on 6/26/26, at 11:03 AM, with the DON, a SOC-341 form (the standard California form used to document and report suspected abuse) dated 6/16/26, was reviewed. The DON confirmed the form was not faxed to the Department. The DON stated that the nurse should have faxed it to the Department. The DON further stated that it was important to report, so that the facility and the Department could investigate the suspected abuse allegation. During an interview on 6/26/26, at 11:23 AM, with the ADM, the ADM stated that staff needed to report and follow the facility's protocol when an incident involved an allegation of abuse. The ADM further stated that staff needed to call the police and notify the Ombudsman and the Department by faxing the SOC-341 form. The ADM stated when a staff member did not fax the form to the Department, it was not acceptable, it was not their process, and it did not follow their facility's policy. A review of the facility's undated policy and procedure titled, Abuse, Neglect and Exploitation, indicated, .Employee Training. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources. Reporting/Response. The facility will have written procedures that include 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies. within specified timeframes. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.		

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, and record review, the facility failed to provide routine and emergency drugs and biologicals for 1 of 3 sampled residents (Resident 1), when Resident 1 was prescribed Nitroglycerin (medicine to relieve chest pain) by her cardiologist (heart doctor) on 2/25/26, and it was not communicated to the facility's doctor until 3 days later. This failure resulted in a delay in ordering and having Resident 1's medication available. There was also a potential for a delayed medication administration that could result in unrelieved chest pain for Resident 1. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including heart failure (heart cannot pump blood efficiently enough to meet the body's daily needs), hypertension (high blood pressure), and Takotsubo syndrome (sudden, temporary weakening of the heart muscle causing chest pain and shortness of breath). A review of Resident 1's Progress Notes, dated 2/28/26, at 12:50 PM, indicated, .Resident is requesting for the nitro [nitroglycerin] prescribed by her heart doctor when she went out on the 25th. Called [medical doctor, MD] that resident is requesting for nitro and resident states that she saw the heart doctor and has prescribed a nitro but we do not have an order on file. Per [MD], resident needs to go the hospital, No nitro. [MD] informed that resident refuses to go to the hospital and resident states that she will call the ambulance herself if she is having a heart attack. Resident states on a raised, loud and almost shouting voice that her heart doctor prescribed her the nitro when she went to the appointment on the 25th and why do they not want to prescribe it. During a concurrent interview and record review on 6/25/26, at 3:50 PM, with the Assistant Director of Nursing (ADON), Resident 1's medication administration record (MAR) dated March 2026, was reviewed. The MAR indicated, .Nitroglycerin Tablet Sublingual [under the tongue]. as needed for Chest Pain. Start Date- 2/28/2026 . The ADON stated nurses needed to check for documentation if there were any new orders from the clinic and/or hospital when residents went out for their appointments or went to the emergency room. The ADON further stated that the nurses need to call the facility doctor to notify and carry out the new order. The ADON stated that she expected nurses to also document as a note in the resident's electronic health record (EHR). During an interview on 6/26/26, at 5:08 PM, with Resident 1, Resident 1 stated she went to her cardiology appointment on 2/25/26, when her heart doctor prescribed Nitroglycerin, but the facility did not order it. Resident 1 further stated that she asked the nurse about her Nitroglycerin and was told that it was not ordered in the system. Resident 1 stated when she went to the appointment on 2/25/26, she came back on the evening shift and the Certified Nursing Assistant (CNA) who went with her, handed the documents from the cardiology appointment to the nurse on the evening shift. Resident 1 further stated that the nurse eventually found the paperwork from the appointment in another binder a few days later. During a concurrent interview and record review on 6/26/26, at 8:20 AM, with Licensed Nurse (LN) 2, Resident 1's Office Visit Progress Notes from Cardiology dated 2/25/26, was reviewed. LN 2 stated they had paperwork that residents needed to bring with them when they went out for medical appointments and the doctor's office would fill out that paperwork. LN 2 further stated that sometimes, the doctor's office would give their own paperwork to the resident that had information of their next appointment or prescribed medications or any other orders. LN 2 stated that it was their process to always ask the resident or the person who took the resident to their appointment to see the paperwork. LN 2 further stated the nurses would also document as a progress note about the appointment visit and notify the doctor if there were any new orders including if any medications were prescribed. LN 2 stated Resident 1 asked her for Nitroglycerin and told her that her heart doctor had prescribed it, but when she checked there was no order for it in Resident 1's EHR. LN 2 further stated that when Resident 1 came back from her cardiology appointment, whoever took her to the appointment, misplaced the paperwork. LN 2 stated she eventually found the paperwork that was placed in another binder for a different hallway. LN 2 further stated she called the cardiologist's office (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to verify the orders and then she notified the facility doctor and placed the order in the EHR. LN 2 confirmed Resident 1's order for Nitroglycerin was placed 3 days later after the appointment. During an interview on 6/26/26, at 10:43 AM, with the Director of Nursing (DON), the DON stated that she expected the nurse to notify the facility doctor, carry out the order and make a progress note once the resident came back to the facility even if there were no new orders. The DON further stated that if paperwork was not seen immediately or if the doctor was not notified of the new orders, there would be a delay in care. The DON confirmed that the order for Resident 1's Nitroglycerin was delayed for 3 days. A review of an undated facility policy and procedure titled, Medication Orders, indicated, .Written Transfer Orders (sent with a resident by a hospital or other health care facility) - Implement a transfer order without further validation, if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete, or the date signed is different from the date of admission.		