

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

Printed: 10/09/2026
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 07/23/2026
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, facility failed to ensure accurate documentation of resident's medical records for one of three sampled residents (Resident 2) when Resident 2's nurse's progress notes were not being recorded consistently documenting the monitoring of Resident 2's condition for a medication error which occurred on 7/17/26. This failure placed Resident 2 at risk of potential harm and unnoticed side effects from the medication error. Findings: A review of Resident 2's admission RECORD, indicated Resident 2 was initially admitted to the facility in late 2025 with multiple diagnoses including chronic obstructive pulmonary disease with acute exacerbation (sudden worsening of lung disease), dementia with agitation (thinking skills decline and communication becomes hard, restlessness, verbal outbursts, and repetitive pacing), and generalized anxiety disorder. A review of Resident 2's record titled, eINTERACT Change in Condition Evaluation - V 5.2 - V 1 indicated that a medication error occurred on 7/17/2026. A review of Resident 2's record titled, Care Plan Report indicated .The resident has an alteration in neurological [mental] status r/t medication error Valproic Acid [seizure medication and/or mood stabilizer] taken from another resident. Monitor/document/report PRN [as needed] s/sx [signs and symptoms] of tremors [shaking], rigidity [muscle tightening], dizziness, changes in level of consciousness, slurred speech. During a concurrent interview and record review of Resident 2's medical record titled Progress Notes *NEW*, with the Assistant Director of Nursing (ADON) on 07/22/26, at 2:50 p.m., the ADON confirmed that there were no progress notes regarding the medication error on 7/18/26 pm shift, 7/18/26 night shift, 7/19/26 night shift, 7/20/26 am shift, 7/20/26 pm shift and 7/20/26 night shift. The ADON stated that she expected the licensed nurses to document monitoring in the progress notes every shift for 72 hours. During a telephone interview with Licensed Nurse (LN) 1 on 7/23/26 at 10:16 a.m., LN1 stated that on the night of 7/17/26 during the night shift at around 11pm, Resident 2 came to the medication cart and drank a little cup of valproic acid while he was looking to the other side. LN 1 continued that he had poured the medication for another resident. LN 1 further stated that he tried contacting the Medical Doctor and the Responsible Party for the resident and started her on monitoring as a standard procedure for 72 hours. LN 1 stated that he came in the next night as well but did not document the progress notes. LN 1 stated that he should have documented on Resident 2's status. During another interview with the ADON on 7/23/26 at 1:55pm, the ADON stated that documentation was very important and it was equally important to document correctly. The ADON added that not documenting could put the resident at risk for not being monitored when they should have been. A review of the facility's undated policy and procedure (P&P), titled Medication errors indicated, .Monitor and document the resident's condition, including response to medical treatment or nursing interventions. Document actions taken in the medical record.		

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who resided at the facility since 2013 and was transferred to a General Acute Care Hospital (GACH) in 4/2026, was readmitted to the facility after Resident 1 was cleared by the GACH to return to the facility on 6/4/2026. This deficient practice resulted in Resident 1 remaining at the GACH after Resident 1 was deemed appropriate for discharge back to the facility resulting in Resident 1's temporary loss of residence and had the potential for negative psychosocial outcomes. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was initially admitted to the facility in early 2013 and readmitted in July 2026 with multiple diagnoses including cholecystitis (the swelling and irritation of the gallbladder, most often caused by gallstones), resistance to carbapenem (bacteria that resist carbapenems, which are powerful last-resort antibiotics, making infections very hard to treat and is spread mainly from person to person through contact with wounds, stool, or unclean hands and medical equipment) and functional quadriplegia (the complete inability to move all four limbs due to severe debility, frailty, or end-stage chronic illness, occurring without direct physical injury or structural damage to the brain or spinal cord). During an interview on 7/23/26 at 10:40 AM, the Admissions Coordinator (AC) confirmed Resident 1 was at the GACH and was ready to come back to the facility on 6/4/26. The AC stated they did not have a male bed, or an empty room to accommodate Resident 1 as he needed isolation (infection control practice that separates patients with contagious diseases from healthy people or other patients to stop the spread of infection) due to his diagnosis of resistance to carbapenem. During a concurrent interview and record review of the daily census for the month of June, with the Assistant Director of Nursing (ADON) on 7/23/26 at 10:54 AM, it was noted that on 6/21/26, room [ROOM NUMBER], which had two (2) beds, was empty. The ADON confirmed that the room was empty and stated that another resident was admitted to the facility on [DATE]. Upon further review it was noted that from 6/24/26 to 6/28/26, two rooms had only 1 occupant each and one empty bed and both the residents were females. The ADON stated that the facility could have tried to move those female residents to one room to accommodate Resident 1's need for isolation and admitted him at that time. During another interview on 7/23/26 at 1:00 PM, the AC stated that they could have brought Resident 1 back to the facility on 6/21 when room [ROOM NUMBER] was empty and could have been more strategic when 2 female rooms had only one occupant each, who could have been moved together, creating an isolation room for Resident 1. During another interview on 7/23/26 at 1:55 PM, the ADON stated they should have admitted Resident 1 back to the facility as soon as they had availability. The ADON further stated that this failure had a potential risk to cause stress and anxiety to Resident 1 and his family members. The ADON stated that it was important to readmit residents back to the facility, as soon as possible, as it was their right and their home. A review of the facility's undated policy and procedure (P&P) titled, readmission to Facility, the P&P indicated, . It is the policy of this facility to protect the resident's right to readmission by initiating a bed-hold and permitting each resident to return to the facility after they are hospitalized or placed on therapeutic leave, regardless of payment source. Residents who seek to return to the facility after the expiration of the bed-hold period [7 day period] or when state law does not provide for bed-holds, are allowed to return to their previous room if available or immediately to the first available bed in a semi private room .		