

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 07/28/2026
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 0605 Level of Harm - Actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of three resident's (Resident 1) drug regimen (a detailed plan for taking medication) was free from unnecessary drugs, failed to obtain informed consent (ICO -process where a doctor explains a mind-altering medication, its risks, and benefits, alternatives, ensuring the patient or legal guardian agrees freely before treatment) for the use psychotropic medication (mind altering drugs) prior to Resident 1 starting the medications, failed to monitor for adverse side effects (ASE -harmful, negative, unintended reactions caused by medication treatment) of multiple psychotropic medications with black box warnings (BBW -life threatening risks), and failed to assess, intervene, and transfer Resident 1 to an acute care setting (hospital) until the evening of 8/13/26 when a family member/responsible party (RP) insisted that Resident 1 was transferred to the hospital due to a change in Resident 1's status. These failures resulted in Resident 1 being admitted to a general acute care hospital (GACH) intensive care unit (ICU - a special hospital room for people who are very sick and need close monitoring) where Resident 1 was treated for being over-medicated on benzodiazepines (prescription psychotropic central nervous system (CNS - the main control center of the body made up of the brain and spinal cord) medication depressant (slows down brain activity) to treat anxiety and other conditions) which required the use of the reversal agent medication that reversed the sedative effect of benzodiazepines and low blood glucose (when the levels of sugar in the blood drop below a normal range). Additionally, this failure resulted in the absence of Resident 1's and the RP's right to be informed of and consent to the treatment with the use of psychotropic medications. Findings: A review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (brain disorder that causes shaking, muscle stiffness and movement problems) bipolar disorder (mental health condition that causes shifts in mood) depression, (mood disorder that causes persistent feelings of sadness), dementia (mental decline that interferes with daily life), and anxiety (excessive worry and fear). A review of Resident 1's, Minimum Data Set, (MDS - a resident assessment tool), Section C - Cognitive Patterns (an assessment of the mental abilities and functions the brain uses to think, learn, remember, pay attention, and process information) dated 7/8/26, indicated Resident 1's BIMS (BIMS - Brief Interview for Mental Status - a screening tool used to assess a resident's cognitive function. Scoring = 13-15 indicates normal intact cognitive function, 8-12 moderate cognitive impairment, 0-7 signifies severe cognitive impairment) was 11 out of 15 which indicated Resident 1 had moderate cognitive impairment. A review of Resident 1's MDS, Section E - Behaviors, dated 7/8/26 indicated Resident 1 did not exhibit any physical behaviors directed towards others (hitting, kicking, pushing, or grabbing), or verbal behaviors directed towards others (threatening, screaming or cursing). A review of Resident 1's electronic medical record (EMR) (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
--	-------	-----------

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 07/28/2026
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 0605 Level of Harm - Actual harm Residents Affected - Few	under the Medication Administration Record, (MAR -a written or electronic chart that tracks what medications a person receives), dated July 2026, indicated Resident 1 was on the following psychotropic medications: Mirtazapine [antidepressant medication] Tablet 15 MG [milligram -a unit of measure] Give 1 tablet by mouth at bedtime for depression.Start Date 7/6/2026. QUetiapine Fumarate [antipsychotic medication-mind altering drug typically used for the treatment of symptoms related to mental illness] Oral Tablet 25 MG.Give 0.5 [half] tablet by mouth at bedtime for manage bipolar.Start Date 7/2/26. Ativan [lorazepam -a benzodiazepine medication that slows down the central nervous system (CNS) to help treat anxiety] Oral Tablet 1 MG.Give 1 tablet by mouth two times a day for Anxiety m/b [manifested by] inability to Relax.Start date 7/9/26. Depakote [divalproex Sodium -a prescription medication used to treat bipolar disorder] Tablet Delayed Release 250 MG.Give 1 tablet by mouth three times a day for.mood stabilization.Start Date 7/9/26. A review of Resident 1's MAR record did not indicate any nursing documentation related to helping re-direct Resident 1 with non-pharmacological interventions (NPI -evidence based, non-medication attempts used to prevent and treat behavior) for anxiety, depression, and mood disorder that the medication may only partially treat. The MAR and EMR record did not reveal that informed consent (ICO) was obtained for these four medications prior to initiating the medications. A review of Resident 1's EMR titled, Care Plan Report, (a personalized document that outlines a resident's healthcare needs, goals, and interventions) dated 7/7/26, under the Focus section, indicated Resident 1 was prescribed one or more of medication with a Black Box Warning (BBW -quetiapine, mirtazapine, tramadol (pain medication)) with a goal that the adverse effects (undesired or harmful reactions of the medications) would be managed to prevent serious injury. An additional goal indicated that Resident 1 and RP 1 would be informed of the risks associated with BBW medications. The care plan Interventions section revealed that the medications should be administered as ordered when Resident 1 and RP 1 were informed of the warnings and potential side effects on Resident 1. Additionally, the interventions indicated that Resident 1 would be assessed weekly for any symptoms or changes possibly related to the BBWs and to notify the doctor of any changes to Resident 1's condition. A review of Resident 1's EMR titled, Care Plan Report, dated 7/13/26, indicated Resident 1 was on a mood stabilizer (Divalproex) with a goal that Resident 1 would be free from discomfort or adverse reactions related to anti-anxiety therapy. The plan of care under the Interventions section revealed Resident 1 would be monitored for side effects that included dizziness and drowsiness and to educate Resident 1 and RP 1 about the risks, benefits and side effects of the medication. A review of resident 1's EMR document titled, Care Plan Report, dated 7/7/26, indicated Resident 1 used psychotropic medications related to behavior management with a goal for Resident 1 to be free of psychotropic drug related complications which included behavioral impairment. The Interventions section revealed nursing staff would be monitoring each shift for side effects and to review Resident 1's behaviors. Additional review of the interventions revealed the staff were to educate Resident 1's family about the risks and benefits and the side effects. A review of Resident 1's EMR document titled, Progress Notes, dated 7/8/26 at 10:09 PM, under the, Physician's Order Note, the note text indicated, .Ativan Oral Tablet 1 MG [Lorazepam].Give 1 tablet by mouth two times a day for Anxiety m/b [manifested by] inability to Relax Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction.The system has identified a possible drug interaction with the following orders.Depakote [divalproex/valproic acid] Tablet Delayed Release 250 MG (milligrams).Severity: Severe.Interaction: Valproic acid may increase the serum concentration [the amount of a specific medicine present in the fluid part of the blood] of lorazepam. A review of Resident 1's EMR document titled, Interim Medication Regimen Review, (IMRR - a careful check of all the medicines a resident takes to find and (continued on next page)		

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 07/28/2026
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 0605 Level of Harm - Actual harm Residents Affected - Few	stop harmful side effects, drug mixes, and dosing mistakes) dated 7/2/26, by the pharmacist consultant (PC) indicated in the section Action Required, that Resident 1 would need monitoring for CNS adverse effects such as drowsiness and the psychotropic medications quetiapine and mirtazapine required a consent form from Resident 1 or the RP. The document was signed by the physician (MD). During a telephone interview on 7/28/26 at 9:17 AM with Resident 1's responsible party, the RP stated that when Resident 1 was initially admitted to the facility she was doing well. The RP further stated that Resident 1 would get out of bed and sit at the nurse's station and socialize, was calm and happy. The RP stated on 7/8/26 at 9:52 PM she received a voice mail from the facility staff that stated Resident 1 had gotten agitated and aggressive and that the MD had recommended a new medication for her mood. The RP explained that she did not talk to anyone about the medication, they only left the voice mail message. The RP further stated she had never observed Resident 1 with aggressive behavior. The RP stated she went to see Resident 1 after the incident on 7/8/26 and the staff told her Resident 1 was now fine, and no other behavior occurred. The RP further stated the facility never explained or told her about the new medication or explained any risks or side effects. The RP added she was never asked to sign anything related to psychotropic medications or gave any verbal or written consent for any medications. The RP stated on 7/13/26 she visited Resident 1 at 9 AM and found Resident 1 lying in bed backwards (feet were at the head of the bed) and was very drowsy. The RP further stated Resident 1 would not open her eyes and could not speak, she only moaned when the RP tried to shake her shoulders and touch her to wake up. The RP stated Resident 1's condition alarmed and upset her so much that she made a video recording of trying to wake up Resident 1. The RP explained she went to get the Licensed Nurse (LN) 1. The RP stated LN 1 told her Resident 1 was drowsy from her medication and LN 1 would talk to the MD about Resident 1's condition. The RP stated LN 1 did not seem concerned with Resident 1's change in condition. The RP added she asked LN 1 to have the MD call her to discuss the medication that caused Resident 1 to be so drowsy. The RP stated she had to leave for work around 10:30 AM and trusted LN 1 to take care of Resident 1. The RP explained when she returned to the facility on 7/13/26 around 5 PM, she was upset to find Resident 1 on her hands and knees on the floor with her face up against the wall and was still very drowsy. The RP further explained she went to tell the nurse (LN 2) about Resident 1's condition and asked LN 2 to send Resident 1 out to the hospital since this was not normal for Resident 1. The RP explained that LN 2 came back and told her the MD said not to send Resident 1 to the hospital and to just monitor Resident 1 and the MD cut down her anxiety medication. The RP stated 2 staff members came in and helped Resident 1 get back into bed and checked her for injuries. The RP further stated Resident 1 was still very hard to wake up. The RP explained she was so upset that Resident 1's condition had not changed since the morning she insisted that LN 2 call 9-1-1 and send Resident 1 to the hospital. The RP further explained the ambulance came and had to give her medication to bring up her blood glucose, and then they transferred Resident 1 to the hospital. The RP explained at the hospital the hospital admitting physician (HMD) told the RP that Resident 1 had to be given medication to reverse the effects of the lorazepam and given more medication to get her blood sugar up to a normal level. The RP added Resident 1 was transferred into the ICU to be monitored. A review of Resident 1's EMR document title, Progress Note, dated 7/8/26 at 9:57 PM, by LN 3 indicated, . [Resident 1] exhibited combative and aggressive behavior during the shift. Resident was verbally aggressive and used profane language towards others, and repeatedly stated that she wanted to leave the place. Staff maintained a calm approach, provided verbal redirection and reassurance. The resident remained in [sic] the facility, no injuries or adverse events occurred. MD.RP was made aware. Received new order for Ativan [lorazepam] 1 mg BID [twice a day] and Depakote (continued on next page)		

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 07/28/2026
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 0605 Level of Harm - Actual harm Residents Affected - Few	[divalproex sodium] 250 TID [three times a day] .All needs attended and met by the staff. Resident is now resting comfortably in bed. During a concurrent interview and record review on 7/28/26 at 2:45 PM with LN 3, Resident 1's EMR was reviewed. LN 3 confirmed she documented a change in condition evaluation (CIC -formal medical functional assessment when a patient exhibits an unexpected shift in their health or behavior) dated 7/8/26 at 9:24 PM that indicated Resident 1 had become agitated and exhibited aggressive and combative behavior during the shift. LN 3 explained on 7/8/26 around 6:15 PM LN 3 observed Resident 1 walking towards the nurse's station while rolling a bedside table towards the nurse's station. LN 3 further explained Resident 1 kept saying she wanted to leave the facility. LN 3 explained once we attempted to re-direct Resident 1 to her room, and told her she could not leave, Resident 1 became very agitated and started yelling. LN 3 added that Resident 1 was not physically aggressive and did not try to hit anyone, but LN 3 feared Resident 1 would become physical due to being agitated. LN 3 explained that Resident 1 had approached the nurse's station quickly, so LN 3 thought Resident 1 was being aggressive and combative. LN 3 confirmed Resident 1 did not hit or strike and did not act like she would hit or strike anyone. LN 3 stated once Resident 1 was re-directed she was able to calm down. LN 3 stated it was unlike Resident 1 to be so verbally aggressive and yell at staff. LN 3 added that Resident 1 was normally calm and liked to sit at the nurse's station and visit with staff. LN 3 presented a text message on her personal cell phone that was sent to the MD on 7/8/26 at 6:28 PM, the MD responded via text message .please try to redirect., LN 3 responded via text message with, .We tries [sic] before texting you, she doesn't want to listen to anyone. The MD replied, Leave her alone and start Depakote [Divalproex/Valproic acid] 250 [MG] tid [three times a day] .Start Ativan [lorazepam] 1 mg bid [twice a day] routine . LN 3 stated that Resident 1 was not started on the medications until the next day 7/9/26 and was able to calm down after being left alone using NPI. LN 3 stated she then called Resident 1's RP and left a voice mail message. LN 3 confirmed she did not obtain informed consent (ICO -process where a doctor explains a mind-altering medication, its risks, and benefits, alternatives, ensuring the patient or legal guardian agrees freely before treatment) from the RP or Resident 1 to start the divalproex or lorazepam. LN 3 reviewed Resident 1's MAR and confirmed she gave Resident 1 the first dose of lorazepam on 7/9/26 at 5 PM. LN 3 stated she did not verify if informed consent to take the psychotropic medication was received and did not try to get informed consent. LN 3 stated Resident 1 did not display further aggressive behaviors after the incident on 7/8/26 and was not informed by other staff of any behaviors after 7/8/26. During an interview on 7/27/26 at 1:35 PM, with LN 1, LN 1 confirmed she was familiar with Resident 1. LN 1 recalled she admitted Resident 1 to the facility and that her baseline (normal state and awareness) was alert (fully awake), calm, cooperative, and confused. LN 1 added that on admission in early July 2026 Resident 1 had a baseline of confusion but was alert and interacted with staff and family and could hold a conversation and verbalize her needs. LN 1 explained Resident 1 worked with physical therapy to get stronger and would push a wheelchair or walker and walk to the nurse's station to visit with staff. LN 1 explained when she was told about Resident 1 being aggressive on 7/8/26, she was surprised because that was not common behavior of Resident 1. During a concurrent interview and record review on 7/27/26 at 1:55 PM with LN 1, Resident 1's EMR progress note dated 7/1/26 at 8 PM by LN 1 was reviewed. The progress note indicated, . [Resident 1] admitted to [facility name] .under [MD].Alert and oriented to self and confused, Able to move all extremities [arms and legs] .On regular diet able to feed herself. Able to make needs known.Oriented to her room. Further review of Resident 1's EMR, LN 1 confirmed Resident 1 was started on psychotropic medications on admission (Mirtazapine and QUETiapine). LN 1 stated she did not get informed consent from Resident 1 or the RP and stated they were supposed to (continued on next page)		

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 07/28/2026
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 0605 Level of Harm - Actual harm Residents Affected - Few	make sure it was done by the physician before starting the medications. Additional review of Resident 1's EHR progress note dated 7/13/26 at 3:17 PM by LN 1 indicated, resident was awake and consumed this morning, resident eat [sic] 50-75% of her breakfast and lunch and took her medication [sic] by mouth and resident came to visit the resident [sic] and resident was looking drowsy [sic], Notified MD and got an order to hold (not administer) the lorazepam and depakote till [until] resident is not [sic] fully awake, then decrease Ativan [lorazepam] 0.5 mg bid [twice daily] from tomorrow.family is aware. LN 1 explained on the morning of 7/13/26 she came into work around 6:30 AM and observed Resident 1 sitting unclothed on the side of her bed. LN 1 stated she asked night shift staff to help Resident 1 get dressed and back to bed. LN 1 confirmed she thought that was odd behavior for Resident 1. LN 1 added around 9 AM that same morning she was approached by Resident 1's RP and told that Resident 1 was drowsy. LN 1 confirmed she went to check on Resident 1 and confirmed Resident 1 was drowsy and hard to wake up. LN 1 stated she told the RP that she would contact the MD before the RP left. LN 1 stated on 7/13/26 at 10:41 AM she sent a text message to the MD that indicated Resident 1 was drowsy due to her medication and that the RP wanted to talk to him and suggested that they may want to send Resident 1 out to the hospital. LN 1 shared the text message exchange; the MD responded back via text message to hold the lorazepam and depakote [divalproex] until Resident 1 was more awake and indicated to decrease the lorazepam. LN 1 stated she told the RP and held Resident 1's medication including the divalproex on 7/13/26 at 12:15 PM due to Resident 1 still being asleep. LN 1 further stated at the end of the shift around 3:30 PM she documented the progress note dated 7/13/26 at 3:17 PM and gave the on-coming nurse (LN 2) a review of the events with Resident 1 during the day shift (7AM - 3:30PM). During an interview on 7/27/26 at 2:34 PM with LN 2, LN 2 confirmed on 7/13/26 she was working the evening shift (3 PM - 11:30 PM) and was assigned to care for Resident 1. LN 2 stated that she observed Resident 1 sleeping at the beginning of her shift. LN 2 added that she was told by a Certified Nursing Assistant (CNA -unable to recall the which CNA) that Resident 1 had eaten dinner and added that the CNA did rounds around 5:30 to 6PM. LN 2 explained at around 6 PM Resident 1's RP came into the facility and found Resident 1 on the ground kneeling between the bed and the wall. LN 2 stated she went to Resident 1, assisted her back to bed, and assessed her for injuries. LN 2 further stated Resident 1 was sleepy but arousable to pain (woken up or made to react by applying physical pain stimulus). LN 2 explained that the RP was upset and wanted to know what medication Resident 1 had been given and requested LN 2 to contact the MD and send Resident 1 out to the hospital. LN 2 added that she contacted the MD, and he stated to just continue to monitor. LN 2 shared with the RP what the MD had suggested, and the RP insisted that Resident 1 be sent to the hospital. LN 2 explained that she called 9-1-1 and requested an ambulance to transport Resident 1 to the hospital. LN 2 added that Resident 1 was acting different from her baseline and stated that Resident 1 was usually up and walking around after dinner. A review of Resident 1's EMR document titled, RT- [Respiratory Therapy] Daily Treatment Note, dated 7/12/26 at 4:47 PM by Respiratory Therapist (RT) 1 indicated, .RT assessed pt [patient -Resident 1], difficult to arouse x2 [two times]. RT had to perform a sternal rub [medical technique of applying painful rub onto a person's sternum/chest to test a person's level of consciousness] to achieve arousal. Informed nurse, nurse stated difficulty to arouse due to recent admin [administration] of medication.RT will continue to monitor and assess as needed. MD/nurse informed. During a phone interview on 7/29/26 at 3:08 PM with RT 1, RT 1 confirmed he wrote the RT Daily Treatment Note dated 7/12/26 at 4:47 PM. RT 1 stated he did not remember the name of the nurse he informed and stated it was the evening shift nurse towards the end of his shift on 7/12/26 around 5:00 PM. RT 1 further stated he remembered this incident because it was not very common to (continued on next page)		

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 07/28/2026
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 0605 Level of Harm - Actual harm Residents Affected - Few	have to try to wake someone with a sternal rub, usually people wake up to the sound of their name or a gentle touch. RT 1 added he wanted to make sure he checked on Resident 1 a second time and that was when the nurse told him that Resident 1 had difficulty waking up due to her medication. RT 1 stated he did not notify the MD even though his note indicated it, the process was he was supposed to notify the nurse who was supposed to notify the MD. A review of Resident 1's EMR document titled, RT- Daily Treatment Note, dated 7/13/26 at 4:08 PM by RT 2 indicated, .RT assessed pt [patient - Resident 1] difficult to arouse x3 [three times]. RT had to perform sternal rub to achieve arousal. Informed nurse, nurse stated difficulty to arouse due to recent admin. [administration] of medication.RT will continue to monitor and assess as needed. MD/nurse informed. During a phone interview on 7/29/26 at 3:30 PM with RT 2, RT 2 confirmed she wrote the RT -Daily Treatment Note dated 7/13/26 at 4:08 PM. RT 2 stated she informed Resident 1's nurse for the day shift about Resident 1's condition. RT 2 stated that LN 1 told her that Resident 1 was like that due to the medications she was taking. RT 2 explained that because she was not familiar with Resident 1 and her baseline, she checked her three times throughout the day and then notified the day shift nurse because it was not common for a person to be arousable only to pain. RT 2 explained that LN 1 acted like that was Resident 1's baseline (normal) when she was medicated. RT 2 stated Resident 1 was not combative, just difficult to arouse each time she attempted to work with her. RT 2 explained that Resident 1 was too drowsy and unable to participate in the respiratory practices RT 2 attempted to do with her. RT 2 further explained she documented she notified the MD/nurse because that was what the RT's were supposed to document. RT 2 added that by telling the nurse the condition of Resident 1, it was expected that LN 1 would notify the MD of Resident 1's condition. RT 2 could not confirm if the MD had been notified of Resident 1's difficulty in waking.A review of Resident 1's EMR document titled, eINTERACT Change in Condition (CIC) Evaluation, dated 7/13/26 at 7:55 PM by LN 2, indicated under the section, Mental Status Evaluation, indicated Resident 1 had an altered level of consciousness (ALOC - condition of the mind-such as sleeping that is significantly different from a normal state). In addition, the CIC indicated Resident 1 was .sleepy but arousable to pain. During a follow-up interview on 7/30/26 at 5:06 PM with LN 2, LN 2 confirmed she was working the evening shift on 7/12/26 and was assigned to Resident 1. LN 2 stated she was not alerted by an RT or anyone that Resident 1 was difficult to arouse on 7/12/26. LN 2 further stated she did not notify the MD since she did not recall being told this by an RT. LN 2 stated if she had been told she would have immediately assessed Resident 1 and notified the MD and recommended Resident 1 be sent out to a hospital for ALOC. LN 2 could not recall any significant change with Resident 1 on 7/12/26, stated she medicated her for pain, and recalled that Resident 1 was just sleepy. During a phone interview on 7/29/26 at 10:13 AM with the MD, the MD stated on 7/8/26 he was informed (by LN 3) that Resident 1 was confused and combative which was different from her baseline. The MD stated he did not assess Resident 1 on 7/8/26 and relied on nursing staff to give him accurate details of her behavior. The MD stated he did not start with the lowest dose possible of lorazepam or order it only as needed because he felt like Resident 1 already had anxiety and needed a stronger dose for agitation. The MD also stated on 7/8/26 he started Resident 1 on divalproex three times a day at the same time as the lorazepam to help manage Resident 1's moods. The MD confirmed that mirtazapine, quetiapine, divalproex, and lorazepam all had BBWs and when used together could cause sedation. The MD stated he was not informed by nursing staff that Resident 1 had calmed down prior to starting the medications. The MD confirmed he told LN 3 to redirect Resident 1 when he gave the orders for the lorazepam and divalproex. The MD confirmed Resident 1 did not have capacity to sign her own medical documents and expected the nurses to contact the resident's RP and read the consent form (continued on next page)		

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 07/28/2026
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 0605 Level of Harm - Actual harm Residents Affected - Few	with the risk, benefits and alternatives (RBAs- harmful side effects, expected outcomes and other available treatment options like non-pharmacological interventions [NPIs]) to psychotropic medications. The MD stated if the nurses did not get the consent from the residents or the RPs prior to administration of the psychotropic drugs it did not meet his expectation. The MD stated he was not notified of a change in Resident 1's condition by the nurses or RT on 7/12/26. The MD stated he was notified in the evening of 7/13/26 that Resident 1 had a fall and was drowsy. The MD explained based on that information the facility could manage drowsiness and told the nurse to continue to monitor. The MD explained Resident 1's ALOC and waking only to painful sternal rub had not been communicated to him and had it been he would send Resident 1 out to the hospital. The MD added the nurses needed to document when they used NPI and what the interventions were so he could properly monitor the resident's responses to medication and justify the continued need for medication. The MD further added that the nurses needed to do better adverse side effect monitoring and communicating with him. The MD stated the risk to the residents if not properly monitored for ASE of medications could be worsening of condition and over sedation. During a concurrent interview and record review on 7/28/26 at 3:44 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), Resident 1's EMR was reviewed. The ADON and DON reviewed Resident 1's entire EMR and were unable to locate any documentation or paper copies in medical records where Resident 1 or the RP was given informed consent for the psychotropic medication administered to Resident 1 that included lorazepam, divalproex, mirtazapine and quetiapine. The ADON confirmed all four medications required ICO prior to administration. The ADON and DON further reviewed Resident 1's MAR and confirmed there were no documented NPIs for the administration of lorazepam prior to giving the medication and during the medication administration from 7/9/26 to 7/13/26. The ADON added she was used to seeing a lower dose of lorazepam 0.5 MG once or twice a day as needed and stated it was unusual to start the medication as routine versus on an as needed basis. Resident 1's EMR documents titled, RT- Daily Treatment Note dated 7/9/26 at 4:37 PM, indicated, Resident 1 was, .Pleasant and cooperative. the ADON confirmed via MAR review this was documented prior to the first dose of lorazepam on 7/9/26 being given to Resident 1. During a continued review of Resident 1's EMR with the DON and ADON on 7/28/26 at 4:15 PM a review of the RT- Daily Treatment Notes dated 7/12/26 by RT 1 and 7/13/26 by RT 2 were reviewed with the ADON and DON. The DON stated it was her expectation when residents had a significant change in condition (CIC) like ALOC, the MD should be notified, and the cause should be evaluated. During a review with the DON and ADON of the facility policy and procedure titled, Use of Psychotropic Medication(s), the ADON and DON confirmed the facility policy was not followed for initiating psychotropic medications by educating Resident 1's RP of the RBAs to include the BBW, and the lack of EMR documentation of Resident 1's continued behaviors and NPI's after starting the medication. The ADON added the policy was not followed since the lowest dose possible was not used and the monitoring of ASE lacked continuity. A review of Resident 1's medical records from the [General Acute Care Hospital Name -GACH] by hospital admitting physician (HMD) in the section, History and Physicals, dated 7/13/26 at 23:45 [11:45 PM] indicated, .History of Present Illness [HPI -current medical problem] . [Resident 1] .presented to the ED [Emergency department] from her SNF [skilled nursing facility] due to altered mental status. She was late [sic] at her baseline mentation on Wednesday [7/8/26] as noted by [RP]. Reportedly that night she became verbally abusive.and additional medications were added. Since then she has become progressively more lethargic. They [RP] left and came back later that evening at approximately 1830 [6:30 PM] and found her on the floor.History is provide by [RP] at bedside.she [Resident 1] was reportedly hypoglycemic [low blood sugar] upon EMS [emergency medical (continued on next page)		

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 07/28/2026
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 0605 Level of Harm - Actual harm Residents Affected - Few	services] arrival and was administered D10 [solution of 10 grams of sugar in water].blood sugar was initially 96 mg/dl [milligram per deciliter -normal blood sugar 70-110 mg/dl] however upon repeat it was 68.Urinalysis showed possible mild UTI [urinary tract infection].Urine toxicology [lab test that analyzes urine to detect the presence of legal or illegal drugs] was presumptively positive for benzodiazepines [prescription medicines that slow down your central nervous system like lorazepam] Medicine [HMD] was consulted for admission.Review of Systems.unable to be completed due to patient's mental status.General Appearance: Obtunded [reduced state of alertness], localizes the pain but not interactive.Neurological [relating to the nervous system, which includes the brain, spinal cord, and all the nerves in the body]: Obtunded, moves all extremities in response to pain.Pertinent Previous Studies personally reviewed: ED notes, SNF medication list.Assessment/Plan 1. Toxic metabolic encephalopathy [a temporary brain malfunction leading to confusion or changes in alertness from chemical imbalance] .due to polypharmacy [taking multiple medications at the same time] from lorazepam, Depakote [divalproex sodium], tramadol, Seroquel [quetiapine] exacerbated [worsened] by hypoglycemia.admission Status.2. Benzodiazepine intoxication [taking more sedative medication like lorazepam than the body can process] .4. Hypoglycemia.Continue D10 [dextrose 10 grams in water] for now.Suspect hypoglycemia is due to poor intake and poor mental status.Orders.flumazenil, 0.2 mg, IV, ONCE STAT [prescription medication injected intravenously to reverse the effects of benzodiazepine immediately].Dispo: [disposition -final plan] Admit to ICU.I expect that the patient's stay will require at least 2 midnights in workup and treatment of conditions above and will require interventions.and close monitoring that cannot occur at a lower level of care as the patient has a high likelihood of deteriorating without treatment. A review of the facility provided policy and procedure (P&P) titled, Use of Psychotropic Medication(s), dated 2026, indicated, .this policy to ensure that residents only receive psychotropic medications when other nonpharmacological interventions are clinically contraindicated.these medications should only be used to treat the resident's medical symptoms.without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is i		

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 07/28/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review the facility failed to ensure the informed consent (ICO -when a resident or their legally authorized representative must agree, authorize, or be given the right to decline to take a prescribed mind-altering medication after being fully informed about its purpose, potential benefits, risks, and alternatives) for psychotropic medications (mind altering drugs that affect brain activities associated with mental processes, mood and behavior include the categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics to sleep) included the risks, side effects, the benefits and/or the Black Box Warnings (BBW -the most serious type of warning the U.S. Food and Drug Administration can require on a medication label) for two of three sampled residents (Resident 1 and Resident 2). This failure resulted in Resident 1, Resident 1's Responsible Party (RP -authorized person to make healthcare choices for a patient who lacks the ability to make their own informed medical decisions and signs medical consents) and Resident 2 not being informed of the risks, benefits and alternatives (RBA -Risks are the potential harms or side effects, benefits are the expected positive outcomes, and alternatives are other choices or treatments options), not given the right to refuse, and not given the right to refuse participation in the psychotropic drug treatment. Findings: 1a. A review of Resident 1's electronic medical record (EMR -digital versions of paper charts that store a patient's medical history, diagnoses, progress notes and medications in an electronic format) under the Medication Administration Record, dated July 2026, the MAR record indicated Resident 1 was on the following psychotropic medications: Mirtazapine [antidepressant medication] Tablet 15 MG [milligram -a unit of measure] Give 1 tablet by mouth at bedtime for depression. Start Date 7/6/2026. Quetiapine Fumarate [antipsychotic medication] Oral Tablet 25 MG. Give 0.5 [half] tablet by mouth at bedtime for manage bipolar [mood disorder] . Start Date 7/2/26. Ativan [lorazepam -a benzodiazepine medication that slows down the central nervous system (CNS) to help treat anxiety] Oral Tablet 1 MG. Give 1 tablet by mouth two times a day for Anxiety m/b [manifested by] inability to Relax. Start date 7/9/26. Depakote [divalproex sodium -a prescription medication used to treat bipolar disorder] Tablet Delayed Release 250 MG. Give 1 tablet by mouth three times a day for mood stabilization. Start Date 7/9/26. During a phone interview on 7/28/26 at 9:17 AM with Resident 1's RP, the RP stated she was never informed by a Licensed Nurse (LN) or the Physician (MD) of any psychotropic medication given to Resident 1. The RP stated she was aware that Resident 1 was previously on mirtazapine for sleep and quetiapine for anxiety. The RP stated she was upset to find that Resident 1 had been given lorazepam and divalproex without being given the benefits, risks, and alternatives (RBA) or the right to decline or discuss other treatment options. The RP stated on 7/13/26 she found Resident 1 very drowsy and unable to wake up easily when the RP visited Resident 1. The RP stated that was when the nurse told her Resident 1 was taking the psychotropic medications. During a concurrent interview and record review on 7/28/26 at 3:44 PM with the Assistant Director of Nursing (ADON) and Director of Nursing (DON), Resident 1's EMR was reviewed. The ADON and DON were unable to locate any documentation or paper copies that documented Resident 1 or Resident 1's RP were given informed consent (ICO's) for the use of the psychotropic medication mirtazapine, quetiapine, lorazepam, and divalproex. The ADON stated she checked with the facilities medical records department, and they were also unable to find any physical record of the ICO's. The ADON and DON confirmed all four medications required ICO prior to administration to Resident 1, even when a resident came to the facility and had already been taking the medication, the facility was required to obtain ICO. 1b. A review of Resident 2's admission RECORD indicated Resident 2 was admitted to the facility with diagnoses which included fracture of (continued on next page)		

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 07/28/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the fifth lumbar vertebrae (a break in the fifth vertebra and lowest bone of the lower back above the tailbone), low back pain, depression, anxiety, difficulty in walking, and muscle weakness. A review of Resident 2's EMR under the Medication Administration Record, dated July 2026, the MAR record indicated Resident 2 was on the following psychotropic medications: DULoxetine HCl [a medication used to treat depression and anxiety] Oral Capsule Delayed Release Particles 30 MG.Give 1 capsule by mouth one time a day for depression.Start Date 5/19/2026. Sertraline HCl [a medication used to treat depression] Oral Tablet 100 MG.Give 1 tablet my mouth one time a day for depression.Start Date 5/19/2026. Lyrica [pregabalin -a seizure medication sometimes used for anxiety because it calms overactive nerve signals to the brain] Oral Capsule 50 MG [MG milligram -a unit of measure] .Give 1 capsule by mouth two times a day for anxiety.Start Date 5/30/2026. OLANzapine [an antipsychotic medication that alters the mood] Oral tablet 5 MG.Give 1 tablet by mouth two times a day for bipolar disorder [a mental health condition that causes extreme shifts in mood, energy and activity] .Start Date 5/19/2026. diazePAM [a benzodiazepine medication used to calm the nerves in the brain and treat anxiety] Oral Tablet 10 MG.Give 1 tablet orally every 6 hours as needed for Anxiety m/b [manifested by] inability to relax for 14 days.Start Date 6/29/26. A review of Resident 2's EMR document titled, Nurses Notes, dated 7/2/26 at 14:34 [2:34 PM] by LN 1 indicated, .Nurse [LN 1] received to the consent form to signed [sic] from the [FM -Responsible Party who is authorized to sign ICO], Nurse called the [FM] to get a verbal consent over the phone. [FM] said she will call the facility regarding the consent [ICO] form later today.endorsed to the upcoming shift . A review of Resident 2's EMR document titled, Nurses Notes, dated 7/2/26 at 20:43 [8:43 PM] by LN 3, indicated, .Followed up for getting verbal consent on psychotherapeutic drug from [Resident 2s FM]. [FM] said she is till [sic] waiting to get a call from attorney. Once she gets the call, she will call the facility and tell her decision. During an interview on 7/28/26 at 2:45 PM with LN 3, LN 3 confirmed she wrote the progress note dated 7/2/26 at 8:43 PM. LN 3 explained the forms (ICO) were passed to her from LN 1 and was told to call Resident 2's FM to get verbal consent for the psychotropic medications that Resident 2 was taking. LN 3 further explained Resident 2's FM told her she was waiting to talk to an attorney before deciding to agree to have Resident 2 take the medication. LN 3 stated when the nurses get phone consent for psychotropic medications, they put the call on speaker phone, and two nurses had to hear/witness the verbal consent and then they both sign the ICO that consent was granted. LN 3 could not recall what medications she was trying to obtain ICO for. During a concurrent interview and record review on 7/28/26 at 1:52 PM with the ADON and DON, Resident 2's EMR was reviewed. The ADON and DON reviewed Resident 2's MAR for the month of July 2026 and confirmed Resident 2 was taking the medications duloxetine, sertraline, pregabalin, olanzapine and diazepam for psychotropic purposes. The DON confirmed all 5 medications reviewed required ICO prior to administering the medication. The ADON provided two signed ICO for Resident 2 for the medication of sertraline and olanzapine. The ADON and DON searched Resident 2's EMR and were unable to locate ICO for duloxetine, pregabalin and diazepam. The ADON reviewed Resident 2's progress notes dated 7/2/26 by LN 1 and LN 3 and suggested they were attempting to obtain consent for the other three medications. The ADON stated the facility process was to wait for ICO prior to administering psychotropic medication. The ADON added it was important to obtain ICO because the side effects of the medication could be severe, the Resident or resident representative should be informed of the possible mental status changes or usual behaviors that could happen. The ADON explained the risk to the residents when not informed of the RBAs and their right to refuse or participate in the decision-making process was that the residents could be at risk of falls, confusion, or an altered mental status. During a phone interview on 7/29/26 at 10:13 AM, with the MD, the MD confirmed he (continued on next page)		

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 07/28/2026
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was the MD for both Resident 1 and Resident 2. The MD stated it was his expectation that all psychotropic medications had the required ICO prior to initiating the medication. The MD stated he usually discussed the medications RBAs with the residents and had the nurses follow up and get the signature or verbal consent for the ICO. The MD stated he expected the nurses to read the ICO paperwork to the residents or family and have them sign the ICO. The MD further stated the nurses read the reason for the medication, what the probable side effects, risks associated with taking psychotropic medications, and the reasonable alternative treatment. The MD explained he believed he discussed Resident 2's ICO with Resident 2 and not the family. The MD stated he did not discuss ICO with Resident 1 or Resident 1's family. The MD stated he generally wrote the information on the ICO and expected the nurses to read about the RBAs to the family and have them sign the ICO. The MD added if the ICO's were not being completed it did not meet his expectation. The MD confirmed that psychotropic medications had a black box warning (BBW - is the strongest safety alert the U.S. Food and Drug Administration [FDA] requires for a medication) and had risks of sedation when used in the elderly. A review of the facility provided policy and procedure titled, Use of Psychotropic Medication(s) dated 2026, indicated, .8. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with the residents, their families and/or representatives, other professionals, and the interdisciplinary team. 9. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. 10. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. 11. The facility will document that the resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline. (e.g., written consent form, narrative note, etc.) .		

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 07/28/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safe and secure order communication among providers when medication orders were communicated via a text messaging system involving nursing staff's personal smart phone (a mobile phone that performs many of the functions of a computer, typically having a touchscreen and internet access) and the physician for one of three sampled residents (Resident 1) based on regulatory requirements on Protected Health Information (or PHI, any information in the medical record that can be used to identify an individual in the course of providing a health care services). This failure could violate residents' health information privacy and confidentiality. Findings: During a concurrent observation and interview on 7/28/26 at 2:45 PM with Licensed Nurse (LN) 3, LN 3 stated on 7/8/26 she had contacted Resident 1's (MD) because Resident 1 became agitated and combative. LN 3 shared her personal smart phone iMessage (text messages from an iPhone) and the following exchange with the MD and LN 3 on 7/8/26 at 6:28 PM was observed and indicated: . [Resident 1's first and last name and room number] we are sending her to the hospital because she very combative right now. She is trying to hit everyone staff plus residents. The MD responded via iMessage, Please try to redirect LN 3 responded via iMessage, We tries [sic] before texting you, she doesn't want to listen to anyone, The MD responded, Leave her alone and start depakote [divalproex -a mood stabilizing medication] 250 tid [three times a day] .Start Ativan [lorazepam] 1 mg [mg -milligram and unit of measure] bid [twice daily] routine. Give her tramadol [a medication for pain], if she has pain. LN 3 stated that was how she was taught to communicate with the MD. LN 3 stated it was common to take orders and give specific resident information on their personal smart phone via iMessage or text message so they could notify the MD when needed. During a concurrent observation and interview on 7/27/26 at 1:35 PM with (LN) 1, LN 1 stated on the morning of 7/13/26 Resident 1's family member (RP) approached her and told her that Resident 1 was drowsy, hard to wake up and wanted to speak to Resident 1's Physician (MD). LN 1 shared her personal smart phone iMessage text messages and the following exchange between LN 1 and the MD on 7/13/26 at 10:41 AM, was observed and indicated, .Hi DR CAN I CALL YOU.[Resident 1's first and last name] Dx [diagnosis] Bipolar [mood disorder that causes extreme shift in moods] Depression restless and weakness. She is little drowsy because of her medication. So maybe family wanna [sic] cut down some medicine and they wanna [sic] talk to you too. May be [sic] they wanna send her to the hospital. The MD responded via text message, Hold Ativan [lorazepam] and depakote [divalproex] till she is more awake, then decrease Ativan [lorazepam] to 0.5 mg [mg -milligrams, a unit of measure] bid [twice daily] from tomorrow. Please get cmp [comprehensive metabolic panel -a blood test that measures 14 different substances to check health] cbc [complete blood count -a blood test used to evaluate overall health] depakote levels [a blood test that shows the amount of divalproex in a person's system] .LN 1 stated that the only way the nurses had to communicate with the MD was by text message from their personal smart phones. LN 1 further stated she was not sure if it violated any privacy laws. LN 1 further stated that using their personal smart phones was the way it had always been done. LN 1 stated it was important to protect the residents' privacy and PHI and that the facility should provide a more secure way of communicating with the MD, if using text messaging was not secure. During an interview on 7/27/26 at 2:34 PM with LN 2, LN 2 stated it was common practice in the facility to communicate with the MD using their personal smart phones. LN 2 added she thought it could be a violation of the Health Insurance Portability and Accountability Act (HIPPA -a U.S. federal law designed to protect sensitive patient health information from being shared) (continued on next page)		

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 07/28/2026
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but that the facility had not given them other secured options. LN 2 stated that this practice was just how the nurses communicated with the MD and added that it was not safe for the nurses or the residents because their PHI could possibly be seen by others. During an interview on 7/28/26 at 4:38 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), the ADON stated that nurses were expected to use a landline (a phone system that connects to a network with wires, cables, rather than using cell towers) telephone only for communicating with the MD. The DON added that communication with the MD via text message related to Resident's PHI and taking orders via text message was not secure and prohibited. The DON added that the facility could not predict who had access to the nurses personal smart phones and that resident PHI should not be on their smart phones. The DON stated it was important to protect the residents PHI due to HIPAA. A review of the facility provided policy and procedure (P&P) titled, Confidentiality of Personal and Medical Records, dated 2026, indicated, This facility honors the residents' right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a resident's records. A review of the facility provided P&P titled, Personal Cell Phones, dated 2025, indicated, .1. This facility prohibits employees from using personal cell phones for any reason, on the nursing units or in working areas of the facility. 2. This includes calls, texts, social [NAME] or any other use of cell phones. A review of the facility provided P&P titled, Verbal Order, dated 2025, indicated, .Physician orders may be received by telephone. Verbal orders are those given to the nurse by the physician in person or by telephone. 1. Repeat any prescribed orders back to the physician or health care provider. A review of a HIPAA journal, titled, Is iMessage HIPAA Compliant?, dated 3/30/2025, the article indicated .iMessage is not HIPAA compliant and should not be used to communicate Protected Health Information (PHI) . [Smart phone brand] does not have any control over how devices are configured, so does not take any responsibility for the privacy and security of PHI however it is created, received, stored, or transmitted by [Smart phone brand] devices. [smart phone brand] will not enter into Business Associate Agreements with covered entities and business associates and specifically states in its terms of service. the fact that [smart phone brand] will not take responsibility for the privacy and security of PHI - and will not enter into a Business Associate Agreement with covered entities and business associates - means it is not possible to use iMessages to communicate PHI. https://www.hipaajournal.com/is-imessage-hipaa-compliant/#:~:text=iMessage%20is%20not%20HIPAA%20compliant,		