STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Healthcare Center	105 Terracina Blvd. Redlands, CA 92373

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on interview and record review the facility failed to follow their policy for one of three sampled residents (Resident 1), wound measurements on admission. This failure placed a clinically compromised Residents (Resident 1) health and safety at risk. When the left trochanter wound was not measured four days from admission. Findings: During review of Residents 1 ' s Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: fracture of upper and lower end of right fibula (broken long bone in leg), difficulty walking, diabetes type II (body does not produce enough insulin), hypertension (high blood pressure). During a concurrent interview and record review of Resident 1 ' s Medical Record with the Director of Nursing (DON) reviewed and verified the following: 1. Initial Assessment Record March 09, 2024: Open area from popped blister on left hip, skin is intact otherwise over bony prominences. (no wound measurements) 2. Skin Evaluation done by Treatment Nurse TXT 1) on March 10, 2024: Left hip unstageable 100% slough . (No wound measurements). 3. Skin Pressure Ulcer Weekly dated March 13,2024: Left Trochanter (hip) SDTI Suspected Deep Tissue Injury length 0.6x2.7, depth 0.2 . (wound measurements done 4 days from admission). 4. Skin Assessment March 28, 2024: Right lateral thoracic open skin tear wound, right lateral inferior. During concurrent interview and record review on September 04, 2024, with the Treatment Nurse (TXT Nurse 1) of medical records, skin assessments, TXT nurse 1 states, The Registered Nurses (RN) usually don ' t measurement on the initial assessment, they are supposed to. The skin assessments are weekly. The doctor classified the wound as a DTI. The following day from her admission, I did do the skin assessment, I did not document the measurements of the hip open wound, I should have measured and documented the wound, I did not. (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: 056372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on September 04, 2024, with the Registered Nurse (RN 1), RN 1 states, the initial skin assessment is done by the RN. We do wound measurements on admission. We take a picture and send to the doctor, and document in initial admission and in progress note our findings. We remove the dressings to see the actual wounds. If there is an open blister, we have to measure, if it ' s a closed blister we cover with a Tegaderm(transparent) dressing. During concurrent interview and record review on September 04, 2024, with the Director of Nursing (DON) of medical records, skin assessments, DON states, Resident 1 got the skin tear here, but not the pressure injury, she came in with open wound left hip. The skin tear, the resident herself let us know about them, we think it ' s because of the [medication] patch, it was placed on that side. Record reviewed Policy Care and Treatment Wound Management, DON acknowledgement wound assessment including wound measurements are to be done within 24 hours. DON states, I don ' t see any measurements from the treatment nurse March 10, 2024, the RN does the initial skin assessment, they should be measuring. The measurements weren ' t done until March 13,2024, resident was admitted [DATE]. During a review of the facility ' s policy and procedure titled, Care and Treatment, Wound Management revised [no date], the policy and procedure indicated, It is the policy of this facility to identify wounds as an Arterial Ulcer, Diabetic Neuropathic Ulcer, Pressure Injury, Venous Insufficiency Ulcer, Surgical Wound and Lacerations. 1. A skin assessment will be completed on all residents upon admission and documented on the resident ' s medical record. 2. Wounds maybe measured the following day after admission by license nurse and documented in the medical record.