

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: 056372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Brookside Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications that were discontinued, expired, or no longer needed were destroyed in accordance with facility policy and procedures (P&P) and regulatory requirements for non-controlled medications logs (a non-controlled medication is a medication that is not classified as a controlled substance or narcotic but still requires proper handling and disposal), when the non-controlled medication disposition logs (document used to record the destruction of a medication for tracking purposes) revealed 163 medications were destroyed with only one licensed nurse signature, and an additional 20 medications were destroyed without any licensed nurse signature. This failure prevented the facility from maintaining an effective system to account for medications designated for destruction and had the potential to result in medication diversion, loss, or improper disposal of medications. Findings: During a concurrent interview and record review on [DATE], at 11:58 AM, with the Assistant Director of Nursing (ADON), the facility's Non-Controlled Medication Disposition Logs for [DATE] were reviewed. The Non-controlled Medication Disposition Logs indicated the following; 1. 163 medications were documented as destroyed with only one licensed nurse signature. 2. 20 medications were documented as destroyed without any licensed nurse signature on the disposition logs. The ADON verified and confirmed the Non-Controlled Drug Disposition Logs had one licensed nurse signature and not two licensed nurse signatures. ADON stated the facility's current practice did not require two licensed nurses to witness and sign for the destruction of non-controlled medications. ADON further stated the facility process was for one nurse to dispose of the medication and sign the medication disposition log. During a concurrent interview and record review on [DATE], at 8:15 AM, with the Administrator (Admin) and ADON, the facility Policy and Procedure (P&P) titled, Disposal of Medications, dated 2023 was reviewed. The P&P indicated,.b. For the State of California, non-controlled substances shall be destroyed by the care center in the presence of either a pharmacist and a licensed nurse employed by the care center, two licensed nurses employed by the care center, or an administrator and a licensed nurse employed by the care center.c. A medication disposition log shall be used for documentation and shall be retained for at least one year. The log shall contain the resident's name, medication name and strength, prescription number if applicable, quantity destroyed, date of disposition, and signatures of the two witnesses. The Admin and ADON acknowledged the facility's P&P required two authorized witnesses to observe and document medication destruction. The Admin and ADON both acknowledged the facility's P&P was not followed.		

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure received a new Preadmission Screening and Resident Review evaluation (PASRR- a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) was conducted for one (1) of three (3) sampled residents (Resident 63) reviewed for PASRR requirements, when the facility failed to complete a PASRR Level I screening and refer for further PASRR evaluation after Resident 63 was diagnosed with unspecified psychosis (a mental health disorder involving a loss of contact with reality, such as hallucinations or delusions, not caused by substance use or a known medical condition) on May 8, 2020, and bipolar disorder (a mental health disorder characterized by significant changes in mood, energy, and activity levels) on March 1, 2023. This failure had the potential for Resident 63 to be placed in an inappropriate care setting, that was unable to provide specialized mental health services and support. Findings: During a record review of Resident 63's admission Record (clinical record containing demographic and admission information), the admission Record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses which included hemiplegia affecting the right dominant side (paralysis on one side of the body), muscle weakness, difficulty walking, aphasia (difficulty speaking or understanding language), syncope and collapse (fainting), hyperlipidemia (high cholesterol), stimulant (a class of drugs that speed up central nervous system activity) abuse, hypertension (high blood pressure), malaise (general discomfort or weakness), and cerebral infarction without residual deficits (stroke without lasting impairment). During a record review of Resident 63's PASRR Level 1 Screening dated April 8, 2020, the PASRR Level 1 Screening indicated the screening was negative at the time of admission and further evaluation was not recommended. During a record review on June 18, 2026, at 1:48 p.m., Resident 63's electronic medical record (EMR) was reviewed. The EMR indicated the resident received the following diagnoses after admission to the facility: 1. Unspecified psychosis not due to a substance or known physiological condition, with an onset date of May 8, 2020. 2. Bipolar disorder, unspecified, with an onset date of March 1, 2023. During a continued record review of Resident 63's EMR, the EMR had no documented evidence that a new PASRR Level I screening had been completed after Resident 63 was diagnosed with psychosis and bipolar disorder. The EMR had no documented evidence of a PASRR Level II (an in dept clinical evaluation triggered if an initial screening [level 1] suspects a serious mental illness, intellectual disability, or developmental condition) evaluation or a referral to the appropriate PASRR entity for further review. During a concurrent interview and record review on June 18, 2026, at 2:46 PM, with the Minimum Data Set (MDS) Nurse, Resident 63's EMR was reviewed. The MDS Nurse was unable to locate documentation of a new PASRR Level I screening, PASRR Level II evaluation, or referral for PASRR review after Resident 63 was diagnosed with psychosis and bipolar disorder. The MDS Nurse verified and confirmed the required PASRR documentation was not present in Resident 63's EMR. The MDS Nurse stated, a PASRR Level I and, PASRR Level II evaluation should have been done after the new diagnosis of psychosis on May 8, 2020, and Bipolar March 1, 2023. The MDS nurse stated, the PASRR screening and referral process are the responsibility of the MDS nurse at this facility. During a concurrent interview and record review on June 18, 2026, at 3:23 PM, with the Administrator, the facility's policy and procedure (P&P) titled, PASRR, dated June 2011, was reviewed. The P&P indicated, .It is the policy of this facility to ensure that each resident is properly assessed using the PASRR specified by the state.2. The policy further indicated that, based upon the (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment, the facility would make appropriate referrals to state agencies for the provision of specialized services to residents with mental illness or intellectual disabilities. The Administrator acknowledged the facility did not follow the P&P for Resident 63 after the resident was diagnosed with psychosis and bipolar disorder following admission. The Administrator stated, a PASRR review and referral should have been completed to determine whether the resident required specialized services that are not provided by the facility.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of medication errors for one (1) of fourteen (14) sampled residents (Resident 53) when Insulin Aspart (NovoLog, a rapid-acting insulin used to control blood high blood sugar) was administered one hour and twenty five minutes before Resident 53 received a meal. This failure had the potential to affect Resident 53's blood glucose levels and place Resident 53 at risk for a hypoglycemic event (low blood sugar). Findings: During a review of Resident 53's admission Record (clinical record containing demographic and admission information), the admission Record indicated Resident 53 was admitted to the facility on [DATE], with diagnoses including Type 2 Diabetes Mellitus (DM-a condition in which the body does not properly use insulin to regulate blood sugar levels), ischemic cardiomyopathy (a weakened heart muscle caused by narrowed or blocked arteries), and hypertension (high blood pressure). During an observation on June 17, 2026, at 5:50 AM, Licensed Vocational Nurse 4 (LVN 4) obtained Resident 53's blood glucose level. The blood glucose reading was 128. During an observation on June 17, 2026, at 5:58 AM, LVN 4 administered 7 units (a unit is the standard measurement) of NovoLog insulin to Resident 53. During a concurrent interview and record review on June 17, 2026, at 7:05 AM, with LVN 4, Resident 53's Physician Order and Medication Administration Record (MAR) were reviewed. The Physician Order indicated, Administer Aspart insulin as per sliding scale; if 120-180= 7 units; 181-280 =10 units; 281+=14 units. Call MD if blood glucose greater than 281, subcutaneously (medication injected in the fatty tissue, under the skin) before meals and at bedtime for DM. The MAR indicated Resident 53 received 7 units of NovoLog insulin at 5:58 AM. LVN 4 stated rapid-acting insulin should be administered within a close timeframe to meal consumption usually thirty minutes because administration too early may place a resident at risk for hypoglycemia (low blood sugar). LVN 4 reviewed the administration time and acknowledged the insulin was administered too early in relation to the resident's meal and agreed the medication should not have been administered at that time. During an observation on June 17, 2026, at 7:23 AM, Resident 53 observed receiving the breakfast meal tray approximately one hour and twenty-five minutes after the Aspart insulin was administered. During a concurrent interview and record review on June 18, 2026, at 8:20 AM, with the Administrator (Admin) and Assistant Director of Nursing (ADON), the facility's policy and procedure (P&P) titled, Administering Medications, dated November 2022, was reviewed. The P&P indicated, It is the policy of this facility to accurately prepare administer and document medications given to residents. The Admin and DON stated Resident 53's Physician Order was not followed and the resident was at risk for low blood sugars. The admin and DON further stated, the P&P was not followed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen were followed when: 1. Chipped paint was found in the kitchen dry storage room. 2. A cutting board was found to be worn, with scoring, areas of chipping, and visible discoloration. These failures resulted in an unsanitary kitchen environment and had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) for 78 of 78 sampled residents who received their meals from the kitchen. 1. During an observation on June 15, 2026, at 8:55 AM, in the dry storage room, the wall behind where food is stored was found to have chipped paint. During an interview on June 15, 2026, at 8:58 AM, with the Dietary Supervisor (DS), the DS confirmed the chipped paint was found in the kitchen dry storage room and stated the chemicals from the paint can contaminate the food. During a review of the facility's Policy and Procedure (P&P) Section 8, Sanitation from [name of the company], LLC., dated 2023, the P&P states All. counters, shelves. shall be. maintained in good repair and shall be free from. chipped areas. 2. During an observation on June 16, 2026, at 9:03 AM, in the kitchen, a cutting board used to prepare food for residents was found to be worn, with scoring, areas of chipping, and visible discoloration. During an interview on June 16, 2026, at 3:08 PM, with the Dietary Consultant (DC), the DC confirmed the cutting board used to prepare food for residents was found to be worn with scoring, areas of chipping, and visible discoloration. The DC further stated, the cutting board should not be in that condition. During an interview on June 16, 2026, at 3:44 PM, with the Registered Dietician (RD), the RD confirmed the cutting board used to prepare food for residents was found to be worn with scoring, areas of chipping, and visible discoloration. The RD further stated, it is time to replace the cutting board. During a review of the facility's Policy and Procedure (P&P) titled, Section 8, Sanitation from [name of the company], LLC., dated 2023, the P&P stated, All. equipment shall be. maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure used and contaminated materials were handled in a manner that prevented the spread of infection for one (1) of four (4) sampled residents (Resident 40) when a soiled utility cart (a mobile cart with two compartments cart - one for soiled linens, and one for trash, used in nursing homes to store, and transport contaminated materials without spreading germs) was improperly positioned inside Resident 40's room during direct resident care. This failure had the potential to expose Resident 40 to a risk of cross-contamination (the physical transfer of harmful bacteria, viruses, or allergens from one surface, object, or food to another) which could result in negative health outcomes for Resident 40. Findings: During an observation on June 17, 2026, at 7:01 AM, the soiled utility cart was found inside Resident 40's room, past the door's threshold and adjacent to the privacy curtain which was wrapped around Resident 40's bed. A Certified Nurse Assistant 1 (CNA 1) was in the room, providing care and attending to Resident 40. A review of Resident 40's Face Sheet (list of diagnoses and demographics), The Face Sheet indicated Resident 40 was admitted to the facility on [DATE], with diagnoses including fracture of unspecified part of neck of femur (a crack, break, or crush injury to one's thighbone-the longest and strongest bone in the human body), status post Hemiarthroplasty (a partial joint replacement - it replaces only one half of a joint, usually the ball, while leaving the natural socket untouched) and chronic obstructive pulmonary disease with lower respiratory infection (a progressive, long-term lung disease that blocks airflow and makes breathing difficult). During a concurrent observation and interview on June 17, 2026, at 7:02 AM, with the Assistant Director of Nursing (ADON), the ADON confirmed the soiled utility cart was placed inside resident's room. The ADON stated, the cart must stay in the hallways at all times citing infection control issue due to the content of the cart (trash and dirty linens collected from other rooms/residents) and the risk for cross-contamination. During an interview with CNA 1 on June 17, 2026, at 7:11 AM, CNA 1 confirmed the soiled utility cart was in resident's room and stated she usually leaves it outside the resident's room prior to providing care to residents. CNA 1 further stated, the soiled utility cart may have inadvertently rolled into the room and acknowledged having the soiled utility cart inside a resident's room is a significant infection control issue due to increased risk of cross contamination, as the cart contains trash and soiled linens collected from multiple residents. CNA 1 acknowledged the soiled utility cart should always remain outside residents' rooms to maintain proper infection control protocols and safeguard residents' well-being. During an interview on June 17, 2026, at 9:53 AM, with the Director Of Staff Development (DSD), the DSD stated the soiled utility carts must be kept outside residents' room due to possibility of cross-contamination. The DSD stated the soiled utility carts should never be taken inside the residents' rooms, because of high risk for cross-contamination. During an interview on June 17, 2026, at 1:18 PM, with the Infection Preventionist (IP), the IP stated the dirty utility cart must be kept outside the residents' rooms to decrease the risk of and prevent cross contamination. During a concurrent interview and record review on June 18, 2026, at 4:25 PM, with the ADON, the facility's Policy and Procedure (P&P) titled, Laundry - Linen, Soiled, revised May 2025, was reviewed. The P&P stated, POLICY: It is the policy of this facility to use the following guidelines with soiled linen. PROCEDURES: Collecting Soiled Linen 1. Soiled linen shall not come in contact with floor and furniture . 3. Place all soiled linen in designated containers marked Soiled Linen . 5. Keep soiled linen containers properly covered at all times. 6. Do not hold linen against the uniform when transporting . 8. Return soiled linen to the laundry in the designated non-permeable containers . (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Floor Collection of Soiled Linen 1. Soiled linen should be removed from resident's room and placed in containers labeled Soiled Linen with lids secured at all times . Soiled Linen Transfer . 2. Soiled linen containers should be used for linen transfer only. The ADON stated the facility's P&P did not include specific guidance regarding the appropriate placement of the soiled utility cart while staff provide care to residents. The ADON stated that staff must consistently follow standard precautions, which are based on the understanding that all blood, body fluids, secretions, and excretions could potentially contain infectious agents. The ADON further stated that, to prevent cross-contamination, the soiled utility cart should never be brought into a resident's room.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a device that allows patients to communicate with nursing staff when they need assistance) was within residents' reach for two (2) of six (6) sampled residents (Residents 36 and 41) when: 1. For Resident 36, the call light was located on the floor on Resident 36's right side of the bed and unreachable. 2. For Resident 41, the call light was wrapped around the bed's left upper side rail, behind Resident 41, with the call button pointing towards the floor and unreachable. This failure prevented Residents 36 and 41 from being able to access their call lights to request assistance, which had the potential for delayed medical care, increased risk for falls, and placed their safety and well-being at risk. Findings: 1. During a review of Resident 36's Face Sheet (a document that gives a summary of resident information), the Face Sheet indicated, Resident 36 was admitted to the facility on [DATE], with diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following a cerebral infarction (stroke) affecting right dominant side, parkinsonism (a progressive brain disorder that primarily affects movement), and repeated falls. During an observation on June 15, 2026 at 9:27 AM, in Resident 36's room, Resident 36 was lying in bed, face up, and awake. The call light was located on the floor on Resident 36's right side of the bed and unreachable. During a concurrent observation and interview on June 1, 2026 at 9:28 AM, with License Vocational Nurse 1 (LVN1), LVN 1 confirmed Resident 36's call light was on the floor and unreachable by Resident 36. LVN 1 stated the call light should be within the resident's reach at all times and not on the floor. During an interview on June 1, 2026 at 9:30 AM, with Resident 36, Resident 36 stated, she was unable to access the call light and stated she would likely need to yell for help in the event she required assistance. During a concurrent interview and record review on June 17, 2026 at 12:45 PM with the Assistant Director of Nursing (ADON), the facility policy and procedure (P&P) titled, Call light/Bell, revised February 2025, was reviewed. The P&P indicated, Policy - it is the policy of this facility to provide the resident a means of communication with nursing staff. Procedure 1. Answer the light/bell within a reasonable time (3-5 minutes). 5. Leave the resident comfortable. Place the call device within resident's reach before leaving room. The ADON acknowledge the P&P was not followed when Resident 36's call light was located on the floor on resident's right side of the bed and unreachable by the resident. The ADON further stated, the expectations was that staff place the call light within the resident's reach and answered the call light within a reasonable time. 2. During a review of Resident 41's Face Sheet, the Face Sheet indicated, Resident 41 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, aphasia (a language disorder that impairs the ability to communicate) and cognitive communication deficit (difficulty with talking, listening, or understanding caused by problems with brain-based thinking skills-such as attention, memory, or organization-rather than a physical issue with the vocal cords or the muscles used to speak). During an observation on June 15, 2026, at 9:53 AM, Resident 41 was in his room, in bed, awake, lying on his right side facing the door. The call light was wrapped around the bed's left upper side rail, behind Resident 41, with the call button pointing towards the floor and unreachable by the Resident 41. During a concurrent observation and interview on June 15, 2026 at 9:54 AM with licensed vocational nurse 2 (LVN 2), LVN 2 confirmed Resident 41's call light was wrapped around the bed's left upper side rail, behind Resident 41, with the button close to the floor and unreachable by the resident. LVN 2 stated the call light must be within resident's reach so he can call for assistance when need it. During an interview on June 15, 2026 at 9:56 AM, with Resident 41, Resident 41 was (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable his verbalize needs or respond to complex questions. However, Resident 41 was able to answer simple yes/no questions by nodding his head vertically to indicate yes and horizontally to indicate no. When asked if he had experienced a stroke, Resident 41 indicated yes. When asked if he could move his left arm, resident 41 indicated no. When asked if he could reach his call light, Resident 41 indicated no. During a concurrent interview and record review on June 17, 2026 at 12:47 PM with the ADON, the facility's P&P titled, Call light/Bell, revised February 2025, was reviewed. The P&P indicated, Policy - it is the policy of this facility to provide the resident a means of communication with nursing staff. Procedure 1. Answer the light/bell within a reasonable time (3-5 minutes) . 5. Leave the resident comfortable. Place the call device within resident's reach before leaving room . The ADON acknowledge the P&P was not followed when Resident 41's call light was found wrapped around the bed's left upper side rail, behind the resident, with the call button pointing towards the floor and unreachable by the resident. The ADON further stated, the expectations was that staff place the call light within resident's reach and answered the call light within a reasonable time.		