STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE CARE CENTER	1221 ROSEMARIE LANE , STOCKTON, California, 95207

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F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of 2 FRI's. Facility Reported Incident Number(s): #2631418 and #2609102 The inspection was limited to the specific complaint(s) or facility-reported incident(s) investigated and does not represent the findings of a full inspection of the facility. 1 deficiency was identified for FRI number 2631418 at F689. No deficiency was issued for FRI number 2609102.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was provided with an environment free from accident hazards when certified nursing assistant (CNA) 1 provided care to Resident 1 alone, but based on Resident 1's assessed needs required two staff members, and Resident 1 had an air mattress (a mattress that works by using air chambers that redistribute pressure, improve blood flow, and reduce friction for residents with limited mobility) placed on	F0689		11/18/2025

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F0689 SS = G	Continued from page 1 his bed without a physician's order or monitors in place to ensure the correct settings were maintained. These failures resulted in Resident 1 falling from his bed and sustaining a broken bone in his right big toe on 9/25/25. Findings: A review of Resident 1's "ADMISSION RECORD," indicated, Resident 1 was admitted to the facility with diagnoses of cerebral infarction (part of the brain does not get enough blood and oxygen causing brain tissue to die), left hemiplegia (little to no use of one side of the body), and severe obesity (significant excessive body weight that poses serious health risks). A review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool), dated 10/8/25, revealed a score of 14 out of 15 total points which indicated Resident 1 had normal memory, thinking, and understanding abilities. A review of Resident 1's "Weight Summary", dated 9/1/25, indicated Resident 1's weight was 362.4 pounds. A review of Resident 1's "Care Plan Report", revised 5/5/22, indicated, "...The resident [Resident 1] has an ADL [activities of daily living] self-care performance deficit r/t [related to] left sided weakness...BED MOBILITY...The resident requires extensive assistance with 2+ [two or more] persons physical assist to turn and reposition in bed as necessary...date initiated 01/02/2023..." Review of Resident 1's "Progress Notes", dated 9/25/25, indicated Licensed Nurse (LN) 1 documented, "...Called by the CNA [certified nursing assistant] in charge and he stated resident [Resident 1] slid from his bed now on the floor...found resident laying on his back on the floor...CNA [CNA 1] stated he turns on his left side then slid on the bed..." A review of Resident 1's "Radiology Results Report" dated 9/26/25 indicated, "...Reason for Study...ACUTE PAIN DUE TO TRAUMA...CONCLUSION: Acute fracture proximal phalanx right great toe [broken bone in the right big toe]..." During a phone interview with CNA 1 on 10/21/25 at 2:18 PM, CNA 1 stated that Resident 1's fall occurred when he was preparing to change Resident 1 and the mattress "broke and he rolled out." At the time of the incident, CNA 1 stated he was positioned on the right side of	F0689		

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F0689 SS = G	Continued from page 2 Resident 1's bed and asked Resident 1 to roll over onto his left side. CNA 1 confirmed that the facility required two staff members to assist Resident 1 with Activities of daily living (ADLs, basic skills you need in regular daily life to care for yourself and/or others); however, he was alone at the time of the incident. CNA 1 reported that the air mattress, which had been installed the day prior, was unstable when Resident 1 turned. CNA 1 stated he was unsure who installed the air mattress for Resident 1 the day prior. During a concurrent observation and interview with Resident 1 in his room on 10/21/25 at 1:41 PM, it was observed that Resident 1 was able to move the right side of his body but was unable to move his left side. No air mattress was observed. Resident 1 stated on the day of the fall (9/25/25), CNA 1 assisted him with changing his brief (a disposable product used by people who cannot control their bladder and/or bowels). Resident 1 stated CNA 1 instructed him to turn to his left side but when he did so, the air mattress deflated on the left side, causing him to fall onto the floor. Resident 1 stated that only CNA 1 was present during the incident. Resident 1 further stated he can turn by himself, but since the fall, two staff members have now assisted him during care. Resident 1 stated the air mattress was removed on 9/25/25 after his fall. During an interview with the Director of Staff Development (DSD) on 10/21/25 at 2:09 PM, the DSD stated that the facility's protocol for a newly installed air mattress included verifying that the mattress settings were appropriate for the resident's weight and checking the overall firmness of the bed. Additionally, nurses were trained to ensure that the mattress remains properly inflated and is not flat. The DSD further stated that both he and the Director of Rehabilitation (DOR) trained staff on proper air mattress repositioning. They emphasized that residents who were immobile or morbidly obese should be turned with the assistance of two CNAs at a time. Regarding Resident 1, CNA 1 was the only staff member assisting him during the incident and was subsequently written up for not following the protocol. A review of the facility's memo titled, "CORRECTIVE ACTION MEMO" dated 9/25/25 indicated, "...Type of Violation: Violation of Safety Rules...employee [CNA 1]...failure to follow company protocol regarding repositioning or doing ADL's care for morbid obesity patients have to be 2 people assist to prevent fall..." During a concurrent interview and record review with	F0689		

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F0689 SS = G	Continued from page 3 the Administrator (ADM) and the assistant director of nursing (ADON) on 10/30/25 at 12:15 PM, the air mattress invoices were reviewed. The ADM stated that an air mattress was ordered from their vendor on 9/19/25 for another resident (Resident 3). When Resident 3 was discharged from the facility, facility staff switched Resident 3's bed, including the air mattress, with Resident 1's bed. The ADON confirmed the settings for Resident 1's air mattress were never added to Resident 1's treatment or medication administration record so the nurses could verify the mattress settings every shift. During a concurrent interview and record review of Resident 1's medical record with the ADON on 10/30/25 at 2:15 PM, the ADON stated she was unsure who decided to move Resident 3's bed to Resident 1's room, as there was no physician order for an air mattress for Resident 1. During a phone interview with the ADON on 11/3/25 at 10:35 AM, the ADON stated that if an air mattress was applied to a resident's bed without a physician's order, there would be a risk of injury to the resident using the mattress. A review of the facility's Policy titled, "Sufficient Staffing" revised 10/2024 indicated, "...Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care..." A review of the facility's undated "Certified Nursing Assistant – Job Description" indicated, "...Major Duties and Responsibilities...Assist resident with or performs activities of daily living for resident in accordance with the care plans and established policies and procedures...Additional Assigned Tasks...Establish a culture of compliance by adhering to all facility policies and procedures..." A review of the facility's policy titled, "Assistive Devices and Equipment" revised 10/2024 indicated, "...Devices and equipment that assist with resident mobility safety and independence are provided for residents. These include...Specialty mattresses...The following factors will be addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment...Personal fit...equipment or device will be used according to its intended purpose and will be measured to...the resident's size and weight as much as possible...Requests or the need for special equipment should be referred to the appropriate Department..."	F0689		

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Brookside Care Center submits this response and Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements; it shall not be construed as admission of any alleged deficiency cited or any liability.
The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders.
The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party.
Any changes to provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the federal rules of evidence and California evidence code section 1151 and should be inadmissible in any proceeding on that basis.

F689 Free of Accident Hazards/Supervision/Devices

How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:
A) Resident #1 was transferred out to the acute hospital on 9/25/2025 for further evaluation and treatment.
B) LAL Mattress was removed from resident #1 bed on 9/25/25.
C) CNA #1 received individual in-service regarding proper transfer/care of residents on 9/25/25.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken:
D) DON and Clinical Resource Nurse completed an audit on 11/14/2025 of all residents who require assistance at a level of two person for bed mobility.
All residents have the potential to be affected by this potential deficient practice.
No other residents were identified with having this deficient practice.
E) DON and Clinical Resource Nurse completed an audit on 11/14/2025 of facility to determine who was determined by a physician order to need an LAL mattress and had the appropriate mattress. Additionally, to ensure residents not identified as needing one, did not have one.
All residents have the potential to be affected by this deficient practice.
No other areas were identified with having this same deficient practice.

What measures will be put into place or what systemic changes you will take to ensure that the deficient practice will not recur:
F) DSD provided an In-Service to LN and CNA's on 11/18/2025 regarding the proper method of transfer of residents who are identified as requiring a two person assist with transfers/care.
G) DSD and/or designee will conduct random facility rounds focusing on times pertaining to resident care to ensure that staff are adhering to resident plan of care with an emphasis on two person assist/transfer when deemed necessary.
Any deficient practice identified during such rounds will be brought forth to the five-day a week morning manager meeting for immediate validation and resolution.
H) DON and/or designee will conduct weekly audits for the next 30 days to ensure that residents that have been identified with a physician order have an LAL mattress and all other residents have their appropriate mattress as deemed required for them.
Any deficient practice identified during such rounds will be brought forth to the five-day a week morning manager meeting for immediate validation and resolution.
How the facility plans to monitor its performance to make sure that solutions are sustained.
H) Administrator will do trending/analysis and will report quarterly to the QAPI Committee for further evaluation and/or recommendations.

F) 11/14/2025