

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Noble Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 North 8th Street Noble, OK 73068	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's call light was in reach for 1 (#1) of 7 sampled residents whose call lights were observed. The ADON identified 74 residents resided in the facility. Findings: On 11/19/25 at 1:21 p.m., Resident #1 was observed in their chair. Their call light was on the floor by the head of the bed. The call light was out of reach of the resident. On 11/19/25 at 1:30 p.m., CNA #1 handed Resident #1 their call light. The resident demonstrated how to use the call light by pressing the button on the end. The CALL LIGHTS ANSWERING policy, revised 02/12/20, read in part, When leaving the room, be sure the call light is placed within the resident's reach. A fall care plan, initiated 04/25/25, showed to keep the call light within the resident's reach. The care plan showed the resident had diagnoses which included frontal lobe and executive function deficit following cerebral infarction. A BIMS, dated 10/30/25, showed the Resident #1 had moderate cognitive impairment with a BIMS of 9. On 11/19/25 at 1:22 p.m., Resident #1 stated they could not see their call light. They instructed the surveyor to give it to them. On 11/19/25 at 1:27 p.m., CNA #1 stated they believe the resident could use their call light. They stated the call light process was to make sure it was within reach of the resident. On 11/19/25 at 1:31 p.m., CNA #1 stated the resident's call light was not in reach. On 11/19/25 at 3:42 p.m., the DON stated call lights should be placed in reach of the residents.</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to maintain infection control practice during incontinent care for 1 (#1) of 3 sampled residents observed for incontinent care. The ADON identified 74 residents resided in the facility. Findings: On 11/19/25 at 10:32 a.m., CNA #1 and CNA #2 entered Resident #1's room to perform incontinent care. They both wore gloves. On 11/19/25 at 10:33 a.m., CNA #1 wiped the resident's abdominal folds and peri area. Resident #1 was turned to their right side. Resident #1 had a bowel movement. CNA #1 wiped the resident's fecal matter, removed the dirty brief, and discarded in a trash bag. With the same gloves, CNA #1 put a new pad under the resident. Resident #1 was turned to their left side and CNA #2 removed the soiled pad and adjusted the new pad. CNA #2 put a new brief on the Resident. Resident #2 was then turned to their right side and CNA #1 adjusted the brief. The brief tab tore. On 11/19/25 at 10:37 a.m., CNA #1 removed their gloves and exited the room to get a new brief. On 11/19/25 at 10:38 a.m., CNA #1 came back with a new brief and put on the resident with CNA #2's assistance. A bowel and bladder care plan, initiated 05/07/25, showed the resident was incontinent of bowel and bladder and needed assistance with toileting. The care plan showed the resident had diagnoses which included frontal lobe and executive function deficit following cerebral infarction. On 11/19/25 at 10:43 a.m., CNA #1 stated the process for glove use during incontinent care was put on gloves prior to providing incontinent care and discard them once procedure was complete. On 11/19/25 at 10:44 a.m., CNA #1 stated they did not change their gloves after cleaning the resident's bowel movement. CNA #1 stated they should have changed them. On 11/19/25 at 3:40 p.m., the DON stated gloves should be changed between dirty and clean.</p>