

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Noble Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2740 North California Street Stockton, CA 95204	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43071</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents' (Resident 1) needs were accommodated promptly, when Resident 1's call light was not within his reach.</p> <p>This failure had the potential of Resident 1's needs not being met and to cause psychosocial and/or physical harm for Resident 1 when unable to contact staff when needed.</p> <p>Findings:</p> <p>Review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in 2022 with multiple diagnoses including myocardial infarction (heart attack, usually occurs due to blockage of blood flow to the heart muscle), respiratory failure (inability to breathe normally), weakness, and history of falling.</p> <p>Review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 2/7/24 indicated Resident 1 needed assistance with daily living activities.</p> <p>Review of Resident 1's fall risk assessment dated [DATE], indicated Resident 1 was at high risk for falls.</p> <p>Review of Resident 1's change in condition report dated 4/10/24 indicated Resident 1 had a fall. Further review indicated, Found resident on A bed with a lac [laceration/cut] to his right eye brow. Lots of blood. Cleaned up resident. Pressure placed on lac to stop bleeding. Body check done. Notified MD [Medical Doctor]. Sent to [hospital name] ED [Emergency department] for further evaluation and treatment .</p> <p>During a concurrent observation and interview on 4/11/24, at 11:35 a.m., Resident 1 asked the Department (California Department of Public Health staff member) to help him wash his hands. Resident 1 stated he did not know how to call facility staff for help. Resident 1's call light was hanging on the wall near the outlets and was not within Resident 1's reach.</p> <p>(continued on next page)</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/11/24, at 11:43 a.m., Certified Nursing Assistant (CNA) 1 verified Resident 1's call light was not within his reach and was hanging on the wall by the outlets. CNA 1 further stated the call light was not supposed to be there, it was supposed to be right on the bed, close to the resident, within his reach. CNA 1 stated call lights should be within residents' reach so that if residents needed help they could call staff.</p> <p>During a concurrent observation and interview with Resident 1, CNA 2 and Licensed Nurse (LN) 1 on 4/11/24, at 2:30 p.m., CNA 2 stated she was assigned to Resident 1. CNA 2 pointed at the call light and asked Resident 1 if he knew what it was, Resident 1 replied it was some kind of a mic (microphone). Resident 1 stated no one ever informed him that it was his call light and to use it to call for help. CNA 2 stated Resident 1 was transferred over from another unit within the facility. CNA 2 stated she did not inform Resident 1 of the call light and its purpose.</p> <p>During an interview on 4/11/24, at 2:37 p.m., LN 1 stated Resident 1 was able to use the call light and was able to make his needs known. LN 1 stated staff should have informed Resident 1 of the call light and its purpose. LN 1 further stated staff should remind Resident 1 of the call light daily multiple times since his memory was not so good. LN 1 stated call lights should be within residents reach at all times since the resident may need to call for help, to meet their needs, and to provide assistance.</p> <p>During an interview on 4/11/24, at 3:02 p.m., the Assistant Director of Nursing (ADON) stated Resident 1 was able to make his needs known. The ADON further stated Resident 1 would use the call light and would alert the CNA and nurses if he needed something. The ADON stated Resident 1 was able to use his call light and it should be within his reach so he could alert the staff when he need something. The ADON stated Resident 1 had diagnoses of dementia (group of thinking and social symptoms that interferes with daily functioning such as forgetfulness, limited social skills, and thinking abilities) and staff needed to remind Resident 1 to use his call light every time staff checked on him. The ADON stated Resident 1 was at risk of falling and if his call light was not within reach, he could potentially fall, and his needs would not be met.</p> <p>During an interview on 4/11/24, at 4:01 p.m. the Operation Manager (OM) stated call lights should be accessible to residents at all times in case they needed help. The OM stated if a call light was not within a resident's reach, then the resident would end up waiting a long time for assistance, could potentially have an emergency, resident needs might go unmet, and would pose a fall risk and safety risk for the resident.</p> <p>Review of Resident 1's care plan revised 4/12/24, indicated, . [Resident 1] is at risk for falls and/or self injury r/t [related to]: poor safety awareness .4/10/24 had a fall with injury .Interventions .Follow facility fall protocol . Provide assistance in ADLS [Activities of Daily Living] .The resident needs prompt response to all requests for assistance .</p> <p>Review of a facility policy titled Call Lights: Accessibility and Timely Response dated 2023, indicated, .The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance .All residents will be educated on how to call for help by using the resident call system .The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room .</p>		