STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555105	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Care Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 32525 Based on observation, interview and record review, the facility failed to ensure residents were free from verbal and physical abuse for 2 of 5 sampled residents (Resident 3 and Resident 5), when Resident 3 hit resident 5 on her face and shoulder after Resident 5 shouted and cursed at him to stop staring at her. This failure resulted in physical pain for Resident 5 and the altercation had the potential to diminish the psychosocial well-being of both residents. Findings: According to Resident 3 ' s ' Admission Record ' the facility admitted him in 2023 with multiple diagnoses that included head trauma and communication deficit. According to the most recent Brief Interview for Mental Status (BIMS, a tool used to test memory and recall) contained in his quartely assessment, he scored 10 out of 15 which indicated he had moderate cognitive impairment. A review of Resident 3 ' s ' .Post Event Note ' dated 5/6/24 indicated the event date was on 5/3/24 at 6:35 p. m. when, A female resident [Resident 5] shouted at (name of Resident 3) to stop looking at her while he was passing by . then struck female resident on the face and shoulder. Resident 5 ' s ' Admission Record ' was reviewed and indicated she was admitted by the facility in 2023 with a diagnoses that included depression and anxiety. Resident 5 scored 15 out of 15 in the most recent BIMS assessment which indicated she was cognitively intact. A review of Resident 5 ' s ' .Post Event Note ' dated 5/6/24 indicated the event date was 5/3/24 at 6:35 p.m. and , Resident was in wheelchair in hallway when she went passed [sic] by another resident [Resident 3] and shouted at him Don ' t look at me! The other resident who was passing by in the wheelchair struck her in the face (L [left] cheek) and left shoulder with back of his hand. The note indicated Resident 5 was given medication for pain. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with Resident 3 on 5/13/24, at 1:28 p.m., he was observed sitting in wheelchair and was interviewed in the Social Services Director ' s (SSD) office. Resident 3 was able to carry out a meaningful conversation and stated Resident 5 shouted at him in a mean way and he got upset and hit her on the face and shoulder using his closed fist. Resident 3 stated the incident happened a weeks ago in the hallway close to the nurse ' s station. Resident 3 stated he felt demeaned by Resident 5 in front of other people who were in the hallway. An interview was conducted with Licensed Nurse (LN 1) on 5/13/24, at 2:21 p.m. LN 1 stated Resident 5 had behaviors of being verbally loud and cursing at other residents if they came close to her space. LN 1 stated the altercation between Resident 5 and Resident 3 happened on 5/3/24 near the nurse ' s station hallway. LN 1 stated Resident 5 verbally cursed Resident 3 and he got upset and hit her on the face. During an interview with a Certified Nursing Assistant (CNA 1) on 5/13/24, at 2:29 a.m., she stated Resident 5 had behaviors of yelling and cursing at other residents if they came close to her space. CNA 1 stated she did not witness the incident between Resident 3 and Resident 5 but was aware they had a physical altercation when Resident 3 hit Resident 5 on her face. During an observation and interview with Resident 5 on 5/13/24, at 2:33 p.m., she was observed in the hallway sitting in her wheelchair and agreed to be interviewed in her room. Resident 3 stated she was sitting in the hallway near the nurses station when Resident 3 started staring at her and she shouted at him, stop staring at me. Resident 5 stated she may have cursed at him for staring at her. Resident 5 stated she was hit hard on the face and shoulder by Resident 3 and she was in pain, and the nurse gave her pain pills. An interview was conducted with the Operations Manager (OM) on 5/13/24 at 3:35 p.m. The OM stated the incident between Resident 3 and Resident 5 was witnessed by staff and another Resident (Resident 4, currently in the hospital). The OM stated Resident 5 had behaviors of shouting at peers and when she yelled at Resident 3 on 5/3/24, the resident got upset and hit her. The OM stated Resident 4 was angry with Resident 3 for hitting Resident 5 and he verbally cursed and threatened Resident 3. The OM stated the altercation happened in the hallway and the staff told him it happened very fast and the staff were not able to stop it from escalating into a fight. A review of the facility ' s ' Abuse , Neglect and Exploitation ' policy dated 2023 indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .