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	05/20/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47369 Based on interview and record review the facility failed to develop a comprehensive care plan for two of seven sampled residents (Resident 1 and Resident 6) when Resident 1 and Resident 6 were involved in resident-to-resident altercations and post incident care plans were not developed. These failures had the potential for Resident 1 and Resident 6 to not receive adequate care and to have unmet psychosocial needs. Findings: A review of Resident 1's ADMISSION RECORD, indicated she was admitted to the facility in 2024, with diagnoses which included bipolar disorder (a mental health condition that causes changes in a person mood, energy, and ability to function). A review of Resident 1's Progress Notes, dated 4/26/24 at 6:29 AM, indicated, . had an altercation with another Resident .claimed [Resident name] threatened to kill her . A review of Resident 6's ADMISSION RECORD indicated she was admitted to the facility in 2023 with diagnoses which included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). A review of Resident 6's Progress Notes, dated 4/18/2024, at 9:28 PM, indicated, resident was lying in bed, when roommate became angry and splashed her with water . During a concurrent interview and record review on 5/20/24, at 4:18 PM, the Director of Nurses (DON) confirmed there were no care plans developed for Resident 1 or Resident 6 following each incident and there should have been. The DON stated care plans should be in place to indicate what happened, how it could be prevented, the resident's goals and the appropriate interventions for each resident to keep them safe. A review of a facility document titled, CHARGE NURSE .JOB DESCRIPTION, dated 2020, indicated, .Major Duties and Responsibilities .Initiates, reviews and updates care plans as required . (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Comprehensive Care Plans, dated 2023, indicated, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a residence medical, nursing, and mental and psychosocial needs .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47369 Based on interview and record review, the facility failed to ensure professional standards of care were provided for one of seven sampled residents (Resident 7) when Resident 7 sustained a cervical (neck) fracture on 4/8/24 and her medical provider was not informed until 4/26/24. This failure resulted in a delay of treatment, and placed Resident 7 at risk of improper healing and worsening of her injury. Findings: A review of Resident 7's ADMISSION RECORD, indicated she was admitted to the facility in 2019 with diagnoses which included epilepsy (a brain condition that causes recurring seizures) and Alzheimer's disease (a progressive disease that affects the parts of the brain that control thought, memory and language). A review of Resident 7's Progress Notes, dated 4/8/2024, at 11:18 AM, indicated, .Back from ED [emergency department] .due to a fall this morning .Assisted resident back to bed, check for any alteration in skin integrity but none noted .with new order of Cefdinir [an antibiotic medication used to treat an infection] .Noted and carried out . The note included results from tests performed at the hospital which included: .Cervical spine CT [computed tomography, computerized x-ray imaging] .Impression is nondisplaced fracture [bone remains aligned] through the right C3 transverse process [bony process of third neck bone] extending to transverse foramen [opening that is occupied by the vertebral artery and vein] . During an interview on 5/20/24, at 3:10 PM, Licensed Nurse (LN) 5 stated he cared for Resident 7 on 4/8/2024, when she returned from the ED. LN 5 further stated he received discharge documents from the hospital which indicated a discharge diagnosis of multiple falls and urinary tract infection (UTI) and that was the information he gave to the medical provider. A review of Resident 7's clinical document titled, Emergency Department Patient Discharge Instructions, indicated, .Visit Date 04/08/2024 . page 2 indicated, .Discharge Diagnosis Frequent falls .Urinary tract infection . page 5 indicated, Follow -up Instructions: .Report: CT C spine . continued to page 6, . IMPRESSION: Nondisplaced fracture through right C3 transverse process extending to the transverse foramen . During an interview on 5/20/24, at 3:37 PM, the Director of Staff Development (DSD) stated the ED paperwork indicated diagnoses of frequent falls and UTI on the first page of the discharge instructions and that was the information LN 5 relied on. The DSD further stated another nurse reviewed the discharge notes on 4/26/24 and discovered the documentation about the fracture. The DSD stated the medical provider was informed of the CT results on 4/26/24 and new orders were received. The DSD stated Resident 7 was at risk for potential worsening of her condition due to the delay in treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 7's Progress Notes, dated 4/26/24, at 8:36 PM, indicated, NP [Nurse Practitioner] . made a rounds today and order, cervical MRI [magnetic resonance imaging, uses magnets and radio waves to make detailed pictures of the body's organs, muscles, soft tissues, and structures], refer to ortho, neck brace, and u/s [ultrasound] to soft tissue neck, refer to ENT [ear, nose and throat physician] . A review of Resident 7's Progress Notes, dated 4/26/24, at 8:30 PM, indicated .Resident is on monitoring day 1 for nondisplaced fracture through the right c3 transverse . During an interview on 5/20/24, at 4:10 PM, the Director of Nurses (DON) stated it was her expectation that all discharge instructions would be reviewed when a resident returned from the hospital. The DON further stated the delay in treatment put Resident 7 at potential risk of improper healing and of more severe injury if she sustained another fall. A review of a facility policy titled, Incidents and Accidents, dated 2023, indicated, .Any injuries will be assessed by the licensed nurse or practitioner .The nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated . A review of a facility policy titled, Provision of Quality Care, dated 2023, indicated, .Qualified persons will provide the care and treatment in accordance with professional standards of practice .