

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 05/29/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>49823</p> <p>Based on interview and record review, the facility failed to protect one of three sampled resident's (Resident 1) right to be free from physical abuse by facility staff, when Resident 1 was grabbed and was hit in the face by Certified Nursing Assistant (CNA) 1.</p> <p>This failure resulted in Resident 1 crying and sustaining bleeding and discoloration to her lip.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, dated September 2023, the Admission Record indicated Resident 1's diagnoses included Dementia, (an impairment of brain function including loss of memory and judgment); and Alzheimer's disease, (the most common cause of dementia -a gradual decline in memory, thinking, behavior, and social skills which causes the brain to shrink and brain cells to eventually die).</p> <p>During a review of Resident 1's clinical record, Progress Notes, dated 5/8/24 at 9:55 p.m., the note indicated, .Resident noted lip bleeding, first aid rendered .</p> <p>During a review of Resident 1's clinical record, IDT-Interdisciplinary Post Event Note [IDT-an interdisciplinary team consists of staff from different backgrounds], dated 5/8/24, at 10:01 p.m., the note indicated, .At approx. 1730 [5:30 p.m.], resident attempting to leave dementia unit, CNA redirected resident into dining room when resident became combative towards CNA kicking and striking at her yelling out let me go CNA responded by striking resident in the face with her hand. Resident noted lip bleeding, first aid rendered .</p> <p>During a review of Resident 1's clinical record, IDT-Interdisciplinary Post Event Note, dated 5/9/24, at 9:38 a. m., the note indicated, .IDT team met to discuss COC [change of condition] that occurred on 5/8/24 .Witness saw CNA strike resident. Resident noted with discoloration on lip .</p> <p>During a review of Resident 1's Physician Orders, dated 5/9/24, at 9:46 a.m., the orders indicated, . TREATMENT: Lower Lip Tear: cleanse with NS [normal saline-used to clean a wound] then pat dry with gauze, leave open to air. Daily and as needed .MONITOR: Lower Lip Tear: monitor for signs and symptoms of infection and report to MD .</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's clinical record, Progress Notes, dated 5/10/24, at 10:44 a.m., the note indicated, .denies pain to left upper lip, discoloration still visible .staff will continue with plan of care .</p> <p>During a review of Resident 1's clinical record, Progress Notes, dated 5/11/24, at 2:36 p.m., the note indicated, .noted left upper lip has bruise with blue and purple color .c/o [complaint of] slight pain. Will continue to monitor .</p> <p>During a review of Resident 1's clinical record, Progress Notes, dated 5/12/24, at 7:38 a.m., the note indicated, .Discoloration still noted to the resident's left lower arm .Lips monitored for injury .no active bleeding noted. No c/o pain or distress noted .</p> <p>During a review of Resident 1's clinical record, Care Plan, dated 5/13/24, the care plan indicated, [Resident 1] .focus: is at risk for potential signs and symptoms of depression or anxiety related to recent alleged abuse . goal: [Resident 1] will not experience any increased signs and symptoms of depression or anxiety . interventions: allow [Resident 1] time to verbalize feelings and concerns, assess for signs and symptoms of depression and anxiety .</p> <p>During a phone interview on 5/28/24, at 11:13 a.m. with CNA 6, CNA 6 stated that a commotion was heard between the dining area and the hallway on the South Unit. Resident 1 was angry and crying. CNA 6 stated Resident 1 had a cut on her lip and stated Resident 1 said CNA 1 hit her.</p> <p>During a phone interview on 5/28/24 at 12:45 p.m. with Resident 1's family member (FM) 1, FM 1 stated, I was in Los Angeles working when I was notified. I had to return the next day to come and see about my mother. FM 1 stated, The staff stated that the nurse hit my mother in the face. FM 1 stated, When I saw my mother, her lip was busted, and she had a bruise on her hand.</p> <p>During an interview on 5/28/24 at 2:30 p.m. with Licensed Nurse (LN) 2, LN 2 stated, [Resident 1] has a tendency of walking out of the unit .[CNA1] tried to direct [Resident 1] back to the room. Then [Resident 1] became combative .then [CNA1] hit [Resident 1] in the face.</p> <p>During an interview on 5/28/24 at 4:40 p.m. with the facility Operations Manager (OPM), and the facility Administrator (Admin) in the Business Office, the OPM and the Admin stated the injury to Resident 1 was preventable.</p> <p>During an interview on 5/29/24 at 11:08 a.m. with the Social Services Director (SSD), the SSD stated she spoke with Resident 1 and FM 1 regarding the incident. SSD stated FM 1 was upset about the alleged abuse incident.</p> <p>During an interview on 5/29/24 at 11:14 a.m. with the Director of Nursing (DON), the DON stated the facility was a safe environment for Resident 1. The DON stated CNA 1's behavior toward Resident 1 was not acceptable.</p> <p>During an interview on 5/29/24 at 11:37 a.m. with the OPM and Admin., the OPM and the Admin stated CNA 1's behavior with Resident 1 was not acceptable.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 5/29/24 at 12:00 p.m. with the facility Medical Director (MD), the MD stated the facility was a safe environment for residents. The MD stated, I believe this was an isolated incident. The MD stated CNA 1's behavior toward Resident 1 was never acceptable.</p> <p>During a review of the facility ' s policy and procedure titled, Abuse, Neglect and Exploitation, dated 2023, the policy indicated, .Definitions: ' Abuse ' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse . ' Physical Abuse ' includes, but is not limited to, hitting, slapping, punching, biting, and kicking .The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written . Prevention of Abuse, Neglect and Exploitation . Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors .Protection of Resident: the facility will make efforts to ensure all residents are protected from physical and psychosocial harm .</p>		