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	12/09/2025

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 - 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. (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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from physical abuse for one of two sampled residents (Resident 1) when the facility did not address Resident 2's escalating behaviors and noncompliance of his medications which resulted in Resident 2 hitting Resident 1 multiple times in the face on 12/4/25.This failure resulted in Resident 1 sustaining multiple injuries to his face and required him to be transferred to an acute care hospital on [DATE] for immediate treatment. This failure also has the potential for psychosocial harm to Resident 1.Findings: A review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with a diagnosis of, but not limited to dementia (a range of conditions involving a significant loss of mental abilities such as memory, thinking, and reasoning skills severe enough to interfere with a person's daily life and activities), schizophrenia (a serious brain condition that affects how a person thinks, feels, and behaves, making it difficult for them to tell what was real and what was not), noncompliance with other medical treatment and regimen, and history of traumatic brain injury (a brain injury that is caused by an outside force).A review of Resident 2's clinical record titled, [Name of Hospital] Discharge Summary Final Report, dated 11/18/25, indicated, .Final Diagnosis.History of traumatic brain injury with added progressive dementia.Personal history of noncompliance with medical treatment.Poor short-term memory .can be impulsive .A review of Resident 2's clinical record titled, Psychiatric Visit Progress Report, dated 11/20/25, indicated, .Initial NP [nurse practitioner] Psychiatric Evaluation.History of schizophrenia, depression (a serious mood disorder causing persistent sadness and loss of interest in activities), insomnia (difficulty falling asleep), and angry outburst.[Resident 2] was in bed, disorganized, bizarre.Staff report that the [Resident 2] recently threw his breakfast, has difficulty following directions.A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with a diagnosis of, but not limited to encephalopathy (a condition affecting the brain's function causing confusion, memory loss, personality changes, and trouble concentrating), major depressive disorder (a condition characterized by persistent feelings of sadness and loss of interest in activities which interfere with daily life), and psychosis (a mental health condition when a person experiences a significant break from reality). A review of Resident 1's clinical record titled, [Name of facility] History and Physical, dated 2/12/25, indicated, .ASSESSMENT AND PLAN.Agitation and violent behavior.Depression.consider mental health evaluation if needed.A review of Resident 1's clinical record titled, Psychiatric Visit Progress Report, dated 11/21/25, indicated, .[Resident 1].was seen and evaluated for a follow up assessment of psychiatric symptoms and to make recommendations to assist with person-centered treatment planning.Objective: [Resident 1] is seen in his bed, irritable, irritable, and poorly cooperative.Staff reported aggressive behavior toward others. A review of Resident 1's Nurses Note, dated 12/4/25, indicated, .Around 0450 [4:50 AM] . [Resident 1] walked out of room with a bloody face .Claiming roommate [Resident 2] punched him repeatedly in the face and chest 25 times .Has wounds to right head laceration [deep cut], [NAME] [sic] to right forehead, wound to right lip, bleeding from right ear, nd [and] skin tear to right hand. Victim [Resident 1] and assaulter [Resident 2] separated immediately, 911 called. Around 0510 [5:10 AM] Cops arrived and [paramedics] arrived .took [Resident 1] to [acute care hospital] .A review of Resident 1's Nurses Note, dated 12/4/25, at 5:20 AM, indicated, .[Resident 1] face covered in blood, resident stated my roommate attacked me, he punched me 25 times, all over in my face, bump noted to right eyebrow with laceration, skin tear to left brow, bleeding from his mouth, bleeding from his right ear, and a skin tear to his right hand .[Resident 1] stated, look at what he did to my ear, while pointing at his ear with his right hand.A review of Resident 1's clinical record titled, Emergency Documentation, dated 12/4/25, indicated, .[Resident 1] is a [AGE] year old male presenting from nursing home for assault.[Resident 1] per report was assaulted in his sleep by another nursing home resident. He was hit multiple times in the face with a fist.[Resident 1] has lacerations to the face and scalp as well as bleeding from the right ear lobe. [Resident 1] is complaining of generalized pain mostly across the head.Presentation is consistent with a closed head injury and soft tissue trauma.A review of Resident 1's Nurses Note, dated 12/4/25, at 12:45 PM, indicated, .[Resident 1] back in facility.[Resident 1] noted with stitches to middle left eyebrow, laceration to right earlobe and scattered bruising to the face.A review of Resident 1's Nurses Note, dated 12/4/25, at 9:36 PM, indicated, .[Resident 1] is on day 1 s/p [status post] hospitalization d/t [due to] resident [Resident 1] to resident [Resident 2] altercation.Noted resident [Resident 1] with laceration to forehead with stitches and some dry blood of resident (Resident 1)