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	04/03/2026

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. Based on interview and record review the facility failed to protect one of three sampled residents (Resident 2) from physical abuse by another resident when Resident 1 allegedly pushed his wheelchair into Resident 2's knees on 3/17/26 and punched her in the abdomen on 3/19/26. This failure resulted in Resident 2 being physically assaulted by Resident 1 on two occasions and had the potential to negatively affect her psychosocial well-being.Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included dementia (a condition that causes a decline in cognitive abilities such as memory, thinking, reasoning, and problem solving) and psychosis (a mental disorder characterized by disconnection from reality). During a review of Resident 1's clinical document titled, Brief Interview for Mental Status (BIMS [a tool used to screen for cognitive impairment]), the document indicated a score of 4 which suggested severe cognitive impairment. During a review of Resident 1's clinical document titled, Care Plan Report, dated 9/12/25, the document indicated, .Focus.Risk for Violence r/t [related to] impaired impulse control.as evidenced by escalating agitation and irritability and physical restlessness.Goal.Resident will not harm self or others.Interventions/Tasks.Maintain safety: place resident in calm low stimulus environment. Remove objects that could be used as weapons to prevents [sic] harm to patient, staff and others. A review of Resident 2's admission RECORD, indicated she was admitted to the facility with diagnoses which included osteoarthritis (disease that causes joint pain and stiffness) and depression (mental health condition that causes a persistent feeling of sadness). During a review of Resident 2's clinical document titled, Brief Interview for Mental Status (BIMS), the document indicated a score of 15 which suggested that cognition was intact. During an interview on 4/3/26 at 8:59 AM with Resident 2, Resident 2 stated she woke up in her bed on 3/17/26 and Resident 1 was in her room. Resident 2 stated she told Resident 1 to leave and he did not move. Resident 2 further stated Resident 1 had a cart with blankets on it, and he hit her left knee with it. Resident 2 stated she told staff and they did nothing, so she called the police. Resident 2 further stated, she should not be subjected to perverts like that. Resident 2 stated she and Resident 1 had an altercation in the past. During an interview on 4/3/26 at 9:55 AM, with Licensed Nurse (LN) 1, LN 1 stated Resident 1 went in and out of other patient rooms frequently and was redirected by staff. LN 1 stated Resident 1 could become angry and agitated at times. LN 1 stated she was not aware of the incident that occurred on 3/17/26 until the police showed up around 10 AM. During a review of Resident 1's progress notes titled, Nurse Notes, dated 3/17/26 at 3:32 PM, the note indicated, .At approximately 10:25am [AM].Police department came into facility asking to speak to [Resident 1].other resident reported that [Resident 1] allegedly, 'went into her room at approximately 4:00am and was looking through her closet. When she woke up and told him to get out, he then went over to her with his wheelchair and rammed her knees/legs 4 times and walked out' . During a telephone interview on 4/6/26 at 7:56 AM with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 1 frequently went into other residents' rooms, and the residents told him to get out. CNA 3 further stated during her shift on 3/17/26 she observed Resident 1 in the doorway of Resident 2's room. CNA 3 stated Resident 2 was awake and yelling at Resident 1 to leave the room. CNA 3 (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 - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 2 told her Resident 1 pushed something and hit her leg. CNA 3 stated she did not report it to her supervisor because she was not sure if it happened that day or on another day. During a review of Resident 2's progress notes titled Nurse Notes, dated 3/19/26 at 11:19 PM, the note indicated, .Resident -to- resident altercation occurred in the hallway near medication cart. [Resident 2] was seated in a wheelchair awaiting medication administration. [Resident 1] exited the dining room with an angry affect [sic] and visible agitation. [Resident 1] was moving to the medication area.Verbal redirection was attempted; however, resident remained escalated. [Resident 2] verbally engaged [Resident 1], stating, Don't come nearme! [sic] despite no prior direct interaction. Following [Resident 2's] statement, [Resident 1] redirected attention toward [Resident 2] and advanced in her direction [Resident 1] then made physical contact with [Resident 2] striking her in the stomach with a closed fist. A review of Resident 2's progress notes titled, Social Services Progress Note, dated 3/20/26 at 5:31 PM, indicated .Pt. [Resident 2] stated, I just want him to stay away from me. I don't care if he doesn't realize what he is doing. During an interview on 4/3/26 at 12:55 PM with the Director of Nurses (DON), the DON stated Resident 1 had been monitored every 30 minutes by staff after the incident on 3/17/26 and the monitoring increased to every 15 minutes after the incident on 3/19/26. The DON stated the facility was doing the best they could to continually monitor Resident 1's behaviors and adjust his medications to decrease his anxiety and agitation. During a review of a facility policy titled, Abuse, Neglect and Exploitation, dated 2025, the policy 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, neglect, exploitation and misappropriation of resident property.Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.Responding immediately to protect the alleged victim and the integrity of the investigation.Examining the alleged victim for any sign of injury.Increased supervision of alleged victim and residents.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to ensure an allegation of potential abuse was reported in a timely manner for one of three sampled residents (Resident 2). This failure resulted in a delay in the abuse investigation and decreased the facility's potential to protect residents from physical and psychosocial harm. Findings: A review of Resident 2's admission RECORD, indicated she was admitted to the facility with diagnoses which included osteoarthritis (disease that causes joint pain and stiffness) and depression (mental health condition that causes a persistent feeling of sadness). During a review of Resident 2's clinical document titled, Brief Interview for Mental Status (BIMS), (a tool used to screen for cognitive impairment), the document indicated a score of 15 which suggested that cognition was intact. A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included dementia (condition that causes a decline in cognitive abilities such as memory, thinking, reasoning, and problem solving) and psychosis (a mental disorder characterized by disconnection from reality). During an interview on 4/3/26 at 8:59 AM with Resident 2, Resident 2 stated she woke up in her bed on 3/17/26 and Resident 1 was in her room. Resident 2 stated she told Resident 1 to leave and he did not move. Resident 2 further stated Resident 1 had a cart with blankets on it, and he hit her left knee with it. Resident 2 stated she told staff and they did nothing, so she called the police. Resident 2 further stated, she should not be subjected to perverts like that. During an interview on 4/3/26 at 9:55 AM with Licensed Nurse (LN) 1, LN 1 stated Resident 1 went in and out of other patient rooms frequently and was redirected by staff. LN 1 stated Resident 1 could become angry and agitated at times. LN 1 stated she became aware of the incident that occurred between Resident 1 and Resident 2 when the police showed up around 10 AM on 3/17/26. During a review of Resident 1's progress notes titled, Nurse Notes, dated 3/17/26 at 3:32 PM, the notes indicated, .At approximately 10:25am .Police department came into facility asking to speak to [Resident 1].other resident reported that [Resident 1] allegedly, 'went into her room at approximately 4:00am and was looking through her closet. When she woke up and told him to get out, he then went over to her with his wheelchair and rammed her knees/legs 4 times and walked out' . During a telephone interview on 4/6/26 at 7:56 AM with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 1 frequently went into other residents' rooms, and the residents told him to get out. CNA 3 further stated during her shift on 3/17/26 she observed Resident 1 in the doorway of Resident 2's room. CNA 3 further stated Resident 2 was awake and hollering at Resident 1 to leave her room. CNA 3 stated Resident 2 told her Resident 1 pushed something and hit her leg. CNA 3 stated she did not report it to her supervisor because she was not sure if it happened that day or on another day. During an interview on 4/14/26 at 12:38 PM with the Director of Nurses (DON), the DON stated CNA 3 should have reported the incident to her supervisor on 3/17/26 after Resident 2 reported it to her. The DON stated it was important to report the allegation of abuse in order for the facility to follow up and put interventions in place to prevent further incidents. During an review of the facility's policy titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, dated 2025, the policy indicated, .It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment.immediately to the Administrator of the facility and to other appropriate agencies.When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur.The Licensed Nurse will.Respond to the needs of the resident and protect him/her from further incident. During a review of a facility policy titled, Abuse, Neglect and Exploitation, dated 2025, the policy 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, neglect, exploitation and misappropriation of resident property.Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the investigation.Responding immediately to protect the alleged victim and the integrity of the investigation.Examining the alleged victim for any sign of injury.Increased supervision of alleged victim and residents.Reporting of all alleged violations to the Administrator, state agency.and all other required agencies within specified time frames.