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	04/15/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, and record review, the facility failed to maintain an accurate medical record for two of three sampled residents (Resident 2 and Resident 3) when:Wound care treatments were not documented daily as ordered by the physician for Resident 2 in February 2026 and March 2026; and,Wound care treatments, skin assessments, and skin treatments were not documented daily as ordered by the physician for Resident 3 in February 2026 and March 2026.These failures resulted in an inaccurate representation of the residents' progress in their plan of care and had the potential to result in a decreased well-being for Resident 2 and Resident 3.Findings:1. A review of Resident 2's admission RECORD, indicated that Resident 2 was admitted to the facility in 2023 with diagnoses which included paraplegia (paralysis of the legs and lower body making it impossible to stand or walk), amputation of left and right legs above the knee (surgical removal of both legs), and hypertension (a condition in which the force of the blood pushing against the blood vessel walls is consistently too high which causes the heart to work harder to pump blood).A review pf Resident 2's Physician Order Summary, indicated, .Treatment: Stage 4 pressure ulcer [A localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or a pressure in combination with friction] to left ischium [A bone in the pelvis]: cleanse with NS [A mix of salt and water used to cleanse wounds], apply silver alginate [An absorbent wound dressing that inhibits the growth of germs], and cover with dry dressing [Bandage].every day shift.Start Date.11/18/2025 0830. D/C [Discontinue] Date.03/05/2026 1916.A review of Resident 2's Physician Order Summary, indicated, .TX [Treatment]: Monitor skin tear [A traumatic wound caused when the skin is pulled or stretched] to left posterior thigh; notify MD [medical doctor] for any significant changes.every shift.Start Date.10/07/2025 0630.A review of Resident 2's Physician Order Summary, indicated, .Treatment: Stage 4 pressure ulcer to left ischium: cleanse with NS, apply skin prep [A skin protectant that prepares skin for tapes and adhesive bandages] to peri wound [the skin surrounding the wound], apply silver alginate to wound bed, and cover with dry dressing.every day shift.Start Date.02/21/2026 0630.D/C Date.03/05/2026 1916.A review of Resident 2's TAR February 2026, indicated that the treatment order to monitor Resident 2's skin tear to the left posterior thigh was not documented every shift per the physician order.A review of Resident 2's TAR February 2026, indicated that the treatment order for wound care to Resident 2's left ischium Stage 4 pressure ulcer was not documented every shift per the physician order.A review of Resident 2's TAR March 2026, indicated that the treatment order for wound care to Resident 2's left ischium Stage 4 pressure ulcer was not documented every shift per the physician order.During an interview on 4/15/26, at 9:50 a.m., with Licensed Nurse (LN) 1, LN 1 stated that if a resident refused treatment, she would tell the resident that she would come back later and then return to see if the resident changed their mind. LN 1 further stated that if the resident still refused treatment, she would again leave and return to the resident's room at a later time. LN 1 stated that if the resident still refused she would provide teaching to the resident on the risks of refusing the treatment, she would notify the charge nurse and the resident's physician, and document the refusal in the resident's electronic medical record (EMR) on the Treatment Administration Record (TAR, a list of prescribed treatments), in the progress notes, (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and in the care plan.During an interview on 4/15/26, at 9:55 a.m., with LN 2, LN 2 stated that she documented resident refusals of treatments and education provided in the medical record on the TAR, in the progress notes, and in the care plan. LN 2 further stated that the facility Administrator, Director of Nursing, and the resident's physician were also notified whenever residents refused treatments. During a concurrent interview and record review on 4/15/26, at 12:16 p.m., with the Director of Nursing (DON), Resident 2's February 2026 TAR, and March 2026 TAR, were reviewed. The DON stated that her expectation was that staff documented wound treatments and wound and skin assessments per the physician orders in the TAR, and documented any refusals by the residents in the TAR and in the progress notes. The DON confirmed that facility staff did not document monitoring of Resident 2's skin tear for twelve days and did not document wound care to Resident 2's Stage 4 pressure ulcer for two days in February 2026. The DON further confirmed that facility staff did not document wound care to Resident 2's Stage 4 pressure ulcer for three days. The DON stated that Resident 2 had a history of refusing care. The DON further stated that when residents refused wound care and/or treatments, facility staff should have not left blanks on the TAR but needed to document a chart code that indicated refused and document the refusal in the resident's progress notes. The DON confirmed that there was no refusal codes documented in Resident 2's TARs and confirmed by a review of Resident 2's Progress Notes, that there was no documentation that Resident 2 refused wound treatments in February 2026 and in March 2026. The DON stated that the risk of not documenting wound care, treatments, and assessments per the physician orders was that staff reviewing the record would not have a clear picture of Resident 2's wound healing status. The DON acknowledged that the facility policy was not followed.2. A review of Resident 3's admission RECORD, indicated that Resident 3 was admitted to the facility in 2025 with diagnoses which included type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), blepharitis (a condition that causes swelling, itching, and other irritation of the eyelids), and amputation of right leg below the knee (surgical removal of right lower leg).A review pf Resident 3's Physician Order Summary, indicated, .Blepharitis [inflammation of the eyelids] Both eyes: Eyelid Scrub-cleanse with 50:50 [half and half] H20 [water] and baby shampoo, clean eyelash margins [the edge of the eyelids where the eyelashes grow] QHS [hour of sleep] at bedtime for Blepharitis.Start Date.02/25/2026 2100.A review pf Resident 3's Physician Order Summary, indicated, .TX [treatment]: skin tear [a traumatic wound caused when the skin is pulled or stretched] to Left first knuckle [the joint at the base of the finger where the hand bone meets the finger bone]: cleanse with normal saline [NS, mix of salt and water used to cleanse wounds], pat dry, apply triple antibiotic ointment [a product prescribed to apply to skin containing three medications that work together to kill germs], cover with dry dressing [bandage].one time a day.Start Date.02/10/2026 0900.D/C [Discontinue] Date.03/20/2026 1010.A review pf Resident 3's Physician Order Summary, indicated, .Cleanse with Normal Saline, apply triple antibiotic and cover with a dry dressing two times a day for open area to Lateral aspect near left great toe [outer side of big toe facing toward the second toe].Start Date.02/08/2026 0900.D/C Date.02/15/2026 0900.A review pf Resident 3's Physician Order Summary, indicated, .TX: Diabetic Ulcer [a slow-healing wound on the foot of a person with Diabetes] to Left, Medial, Anterior Foot [the side of the left foot near the ankle]: cleanse with NS, apply silver alginate [an absorbent wound dressing that inhibits the growth of germs], and cover with dry dressing two times a day.Start Date.02/15/2026 0900.D/C Date.03/24/2026 0915.A review pf Resident 3's Physician Order Summary, indicated, .Treatment: Monitor Callous [a thickening of skin in response to prolonged rubbing] to the Left Heel, notify MD [medical doctor] for any changes.every shift for treatment monitoring.Start Date.12/02/2025 2230.D/C Date.03/24/2026 0915.A review pf Resident 3's Physician Order Summary, indicated, .TX Monitoring: Monitor for Skin tear to the Left Knuckle, Notify MD for any s/sx [signs/symptoms] of infection [presence of germs] or any significant changes.every shift for TX monitoring.Start Date.02/17/2026 2200.D/C Date.03/20/2026 1010.During a concurrent interview and record review on 4/15/26, at 12:16 p.m., with the DON, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3's February 2026 TAR, and March 2026 TAR, were reviewed. The DON stated that her expectation was that staff documented wound care and assessments per the physician orders in the TAR and documented any refusals by the residents in the TAR and in the progress notes. The DON acknowledged that for Resident 3's February 2026 TAR, the eyelid scrub for both eyes was not documented for three days, the skin care for the left knuckle skin tear care was not documented for ten days, the left great toe dressing changes were not documented for three days, and the monitoring of a callous to the left heel was not documented every shift as ordered for fourteen days. The DON further acknowledged that for Resident 3's March 2026 TAR, the eyelid scrub for both eyelids was not documented for 20 days, the skin care for the left knuckle was not documented for four days, the diabetic foot ulcer care to the left foot was not documented for 17 days, the monitoring of the callous to the left heel was not documented for 19 days, and the monitoring for the skin tear to the left knuckle every shift was not documented for 17 days. The DON stated that the risk of not documenting wound assessments and treatments per the physician order was that the staff would not know Resident 3's status if it was not documented. The DON further stated that the treatments should have been documented in the TAR and the progress notes. The DON acknowledged that the facility policy was not followed.A review of an undated facility policy and procedure (P&P) titled, Documentation In Medical Record, indicated, .Policy.Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Policy Explanation and Compliance Guidelines.1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record.2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care.occurred.4. Principles of documentation include, but are not limited to.b. Documentation shall be accurate, relevant, and complete.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure safe infection prevention practices were used for a census of 96 when a staff member changed bed linens in the room of a resident on Enhanced Barrier Precautions (EBP, infection control interventions designed to reduce the spread of multidrug resistant organisms [MDRO, germs that are more difficult to kill with antibiotics] in nursing homes) on 4/15/26.This failed practice could contribute to the spread of infection by cross-contamination (physical movement or transfer of harmful germs from one person, object, or place to another) in the facility.Findings:A review of Resident 3's admission RECORD, indicated that Resident 3 was admitted to the facility in 2025 with diagnoses which included type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), blepharitis (a condition that causes swelling, itching, and other irritation of the eyelids), and amputation of right leg below the knee (surgical removal of right lower leg).A review of Resident 3's Physician Order Summary, indicated, .Enhanced Barrier Precautions per MD [medical doctor] order.Order Status.Active.Order Date.12/05/2025.During an observation on 4/15/26, at 11:57 a.m., outside of Resident 3's room, an EBP sign was posted outside the door. Certified Nursing Assistant (CNA) 2 changed bed linens in Resident 3's room without wearing a gown and gloves (Personal Protective Equipment [PPE], gowns, gloves, eye protection, facemasks or respirators used to prevent the spread of germs).During a concurrent observation and interview on 4/15/26, at 11:57 a.m., with CNA 2 outside of Resident 3's room, the EBP sign posted on the door was observed. CNA 2 acknowledged that the EBP sign indicated that PPE was required to be worn during bed linen changes. CNA 2 confirmed that she was not wearing PPE when she changed the bed linens in Resident 3's room. CNA 2 stated that the risk of not wearing PPE while changing the bed linen was infection (to affect or contaminate with disease-producing germs).During an interview on 4/15/26, at 12:16 p.m., with the Director of Nursing (DON), the DON stated that her expectation was that facility staff would wear the appropriate PPE provided when caring for residents in EBP. The DON further stated that the risk of not wearing the appropriate PPE as indicated was the spread of infection. The DON acknowledged that the facility policy was not followed.During a review of an undated facility policy and procedure (P&P) titled, Enhanced Barrier Precautions, the P&P indicated, .Policy.It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Definitions.'Enhanced Barrier Precautions' (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.Policy Explanation and Compliance Guidelines.2. Initiation of Enhanced Barrier Precautions.b. An order for enhanced barrier precautions will be obtained for residents with any of the following.Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers).even if the resident is not known to be infected or colonized with a MDRO.3. Implementation of Enhanced Barrier Precautions.a. Make gowns and gloves available immediately near or outside of the resident's room.4. High-contact resident care activities include.e. Changing linens.10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound.that placed them at higher risk.