

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/10/2026
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)		
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to report the findings of two of three abuse allegation investigations to the State Survey Agency (the Department), within 5 working days of the incident occurring, when: 1. The results of the investigation into the alleged allegation of abuse that occurred on 4/11/26 between Resident 64 and Resident 8 was not reported to the Department; and 2. The results of the investigation into the alleged allegation of abuse that occurred on 5/31/26 between Resident 79 and Resident 92 was not reported to the Department. These failures had the potential to compromise the facility's ability to ensure that appropriate corrective actions were taken as a result of the investigations and could have compromised Resident 64, Resident 8, Resident 79, and Resident 92's safety. Findings: 1. A review of Resident 64's admission RECORD, indicated that Resident 64 was admitted to the facility in the winter of 2022 with diagnoses including adult failure to thrive (a syndrome of progressive physical, cognitive, and functional decline), unspecified dementia (a clinical diagnosis used when a patient shows clear signs of cognitive decline or memory loss, but the exact underlying cause or specific type [like Alzheimer's or vascular dementia] cannot be definitively determined), and major depressive disorder (a serious mental health condition characterized by a persistent low mood and a loss of interest in activities). A review of Resident 8's admission RECORD, indicated that Resident 8 was admitted to the facility in the spring of 2026 with diagnoses including unspecified dementia, major depressive disorder, and generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday issues). During a concurrent interview and record review on 7/9/26 at 4:04 PM with the Administrator (ADM), the facility reported incident folder between Resident 64 and Resident 8 was reviewed. The ADM confirmed that an altercation between Resident 64 and Resident 8 occurred on 4/11/26 and that there was no follow-up report that was submitted to the Department. The ADM stated that it was his expectation for all reports of abuse to be investigated and submitted to the Department within five days of an incident occurring. The ADM also stated that it was important for investigations to be done to help support the residents and prevent further harm from occurring. The ADM further stated that the due diligence of an investigation should be done to ensure the residents safety. During an interview on 7/10/26 at 12:01 PM with Assistant Director of Nursing (ADON), the ADON stated that it was her expectation for all abuse investigations to be submitted to the Department and other relevant agencies within a five-day timeframe. The ADON also stated that if the results of the investigation were not submitted, there could be a delay in making sure the residents are safe. The ADON further stated that it was important for proper investigations to be conducted to ensure that it would not happen to others residing in the facility. 2. A review of Resident 79's admission RECORD, indicated that Resident 79 was admitted to the facility in the fall of 2025 with diagnoses including generalized anxiety disorder, unspecified dementia, and adult failure to thrive. A review of Resident 92's admission RECORD, indicated that Resident 92 was admitted to the facility in the fall of 2025 with (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555105	Facility ID: 555105 If continuation sheet Page 1 of 2

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses including unspecified dementia, adult failure to thrive, Alzheimer's disease (a progressive, irreversible brain disorder that accounts for 60% to 80% of dementia cases), restlessness, and agitation. During a concurrent interview and record review on 7/9/26 at 4:06 PM with the ADM, the facility reported incident folder between Resident 79 and Resident 92 was reviewed. The ADM confirmed that an altercation between Resident 79 and Resident 92 occurred on 5/31/26 and that there was no follow-up report that was submitted to the Department. The ADM acknowledged that a report should have been submitted to the Department within five days of the incident. During a review of the facility's undated policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, the P&P 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 . The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies .		