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	03/14/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50925 Based on interview and record review, the facility failed to ensure one of twenty sampled residents (Resident 39) had their rights related to treatment choices known and protected when, a copy of Resident 39's Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) was not available in the medical record. This failure had the potential to result in Resident 39's preferences for treatment to not be followed. Findings: A review of Resident 39's ADMISSION RECORD, indicated that Resident 39 was admitted to the facility in the fall of 2023 with diagnoses that included Alzheimer's (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and cognitive communication deficit (communication problem that stems from difficulties with thinking and processing information). A review of Resident 39's medical record titled, Physician Orders for Life-Sustaining Treatment [POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life], dated 9/13/23, indicated Section D (area on the POLST form about Advance Directives) was not filled out and was left blank. A review of Resident 39's Electronic Health Record (EHR - information stored in the facility's computer system), indicated that Resident 39's Advance Directive was not uploaded in Resident 39's EHR. (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

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	03/14/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/13/25, at 11:13 a.m., with the Social Services Director (SSD), Resident 39's EHR was reviewed. The SSD confirmed section D of Resident 39's POLST form not filled out. The SSD stated she recalled Resident 39's Responsible Party (RP) - telling her that Resident 39 had an Advance Directive and sent photos via email to the SSD. The SSD further stated the photos were not clear and was not uploaded in Resident 39's EHR. The SSD confirmed that there was no documentation found for notes regarding her conversation about the Advance Directive with Resident 39's RP. The SSD stated Resident 39's POLST form and Advance Directive should have been reviewed and checked. The SSD further stated it was her expectation to have the Advance Directive on file because the facility would not be able to honor Resident 39's wishes. The SSD explained that Resident 39's RP should have been contacted to obtain the copy of Resident 39's Advance Directive. The SSD stated the risk of not having a copy of the Advance Directive was for Resident 39's wishes to not be honored if something happened. During an interview on 3/13/25, at 4:04 p.m., with Resident 39's RP, the RP stated she had power of attorney (a legal document that allows someone else to act on your behalf) and had provided a copy of Resident 39's Advance Directive to the facility and the SSD was aware. The RP further stated that the copy of Resident 39's Advance Directive was sent via email to the facility on [DATE]. During an interview on 3/13/25, at 5:12 PM, with the Director of Nursing (DON), the DON stated the POLST form contained the resident's code status (the type of emergency treatment a person would or would not receive if their heart or breathing stops). The DON stated it was her expectation for the POLST form to be completed by the admitting nurse during the admission process. The DON further stated the admitting nurse and the Interdisciplinary team (IDT - a group of healthcare professionals who work together to provide comprehensive care, focusing on the individual needs of each resident) would also review the completion of the Advance Directive. The DON acknowledged Resident 39's POLST form section D was not completed. The DON stated the risk of not having the Advance Directive available in the chart was that the resident's wishes might not be implemented or followed. A review of the facility's document titled, Advance Directives, revised 9/22, indicated, .Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated .Determining Existence of Advance Directive 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives .If the Resident Does not have an Advance Directive .2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff .If the Resident Has an Advance Directive .7. The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record .

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	03/14/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50716 Based on observation and interview, the facility failed to ensure a clean, comfortable homelike environment for a census of 91 when: 1. room [ROOM NUMBER], occupied by three residents, had patched wall work done unevenly in white spackle (a compound used to fill cracks and holes in walls) that did not match the paint on the wall, and several spots of different colored paint; and, 2. A Shared [NAME] and [NAME] (shared bathroom between two rooms that have an entrance from each room) style bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] had a sink pulling out from the wall with cracked caulking (a waterproof filler and sealant), a large circular area on the wall near the handrail had missing paint, and a broken raised toilet seat; and, 3. room [ROOM NUMBER], occupied by three residents, had white caulked patches over dark spots on a tan door frame, uneven white spackle was not painted to match the tan wall, tan and brown stains on the wall, a large area of the wall next to bed C had uneven spackle, and a soiled privacy curtain between bed B and bed C; 4. A Shared [NAME] and [NAME] style bathroom between room [ROOM NUMBER] and room [ROOM NUMBER] had damaged walls, mismatched and chipped paint, damage to wall near sink, damage to wall near soap and paper towel dispensers, cracked paint, and damage to wall around the toilet; and 5. room [ROOM NUMBER], occupied by three residents, had tan, gray and yellow paint that covered holes in a wall that was painted that was white, white spackled marks on the wall with deep gouges, damaged and uneven spackle to the inside door frame, a large patch of damaged wall with missing paint, damage to the wall behind bed A, and damaged baseboards pulling away from the walls. These deficient practice can have negative impact on residents' comfort and well being. Findings: 1. During a concurrent observation and interview with Resident 12 on 3/11/25 at 11:58 AM, in room [ROOM NUMBER], there was a large oval area of damage to the wall near bed C. The damage had been patched unevenly with spackle. Surrounding the uneven spackle were varying spots of peeled paint, exposed dry wall and different colored paint under the white paint on the walls. Resident 12 stated the walls should not be like that, and they should be fixed to match. (continued on next page)

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	03/14/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on 3/11/25 at 12:03 PM of the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER], the bathroom door facing room [ROOM NUMBER] had 3 white uneven spackle spots with dent marks and chipped paint. The white spackled spots did not match the light brown painted door. Inside the bathroom, the crooked sink was slightly pulled away from the wall, with cracked caulking. A large gash in the wall below the sink had exposed dry wall. Chipped and missing paint was observed around the tank of the toilet, and uneven spackle with differing textures was observed around the soap dispenser. A melon sized circular peeled paint area near the handrail was observed above the toilet paper dispenser. A large, raised, over-the-toilet commode (a portable toilet seat that was raised for different sized people to make it safer to transfer on and off the toilet) seat had broken pieces. 3. During an observation on 3/11/25 at 10:51 AM, of room [ROOM NUMBER], the wall next to bed C had a large area that was unevenly spackled with missing paint, and another area of tannish pink stains on the wall. The wall at the head of the bed by bed A had holes with white uneven spackle and was not smooth or painted the same color as the rest of the wall. The privacy curtain between bed B and bed C had an orange stain. The doorframe leading to the hallway was damaged, dented, and had missing paint, and was unevenly spackled. 4. During an observation 3/11/25 at 10:53 AM, the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER], had a large amount of uneven caulking and had cracks, the wall near the sink had two large white spackled repairs that did not match the paint of the bathroom, paint was chipping near the sink, the soap dispenser had exposed dry wall, and the area surrounding the toilet tank had chipped paint and dented walls. 5. During a concurrent observation and interview on 3/13/25 at 9:08 AM, in room [ROOM NUMBER], Licensed Nurse (LN) 5, confirmed dented, damaged walls, mismatched paint, unfinished dry wall repairs, uneven spackle, and the damaged torn baseboards near bed A. LN 5 stated it was not a home like environment. Resident 299 stated he did not feel like his room (room [ROOM NUMBER]) was in good shape and it did not look professional. Resident 299 stated if he had the tools and paint, he would do the work himself. Resident 299 stated the damage to the wall near his bed with the baseboards pulled away from the wall should not be that way. Resident 299 also pointed out to LN 5 damage to the wall near the bathroom with deep scratches, and the foil butterfly decorations on the wall by the television which were partially worn off. During a concurrent observation and interview on 3/13/25 at 10:06 AM, the maintenance director (MATD) confirmed the damages, mismatched paint, uneven spackle, cracked caulking, damaged baseboards, and dirty privacy curtains in the rooms and bathrooms. The MATD stated he was the only maintenance person and shared a map of each wing. The MATD further explained repairs to each wing would begin in late Spring of this year. The MATD stated the status of these rooms and other rooms in the building did not contribute to a homelike environment. During an interview on 3/13/25 at 2:41 PM, the Administrator (ADM) stated it was his expectation that the resident's bedrooms and bathrooms were in good repair. The ADM further stated the damage did not match his expectation or the facility policy for a homelike environment. (continued on next page)

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	03/14/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility provided policy and procedure titled, Safe and Homelike Environment, undated, indicated, .the facility will provide a safe, clean, comfortable and homelike environment .maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment .

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	03/14/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50925 Based on interview and record review, the facility failed to resubmit the Pre-Admission Screening and Resident Review (PASRR - a required assessment for individuals with mental illness, intellectual or developmental disabilities, or related conditions, so that a determination of need, appropriate setting, and a set of recommendations for services to be included in the individual's plan of care is provided) for one of twenty sampled residents (Resident 71) when, Resident 71's PASRR was not submitted by the facility on the 31st day after admission to the facility. This failure had the potential for Resident 71 to not receive the necessary services to meet their mental and psychosocial (the link between social factors and individual thought and behavior) needs. Findings: A review of Resident 71's ADMISSION RECORD, indicated that Resident 71 was admitted to the facility in early 2024 with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 71's medical record, from the transferring hospital, titled, Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 3/28/24, indicated .Result of Level 1 Screening: Level 1 - Negative .Reason Code: 30-Day Exempted Hospital Discharge . A review of Resident 71's letter from the State of California - Health and Human Services Agency Department of Health Care Services (DHCS), dated 3/28/24, indicated .Negative Level 1 Screening indicates a Level II Mental Health Evaluation is Not Required .Result: Negative .Reason: Exempted Hospital Discharge .Level II Mental Health Evaluation Referral: Not Required .If the individual remains in the NF [Nursing Facility] longer than 30 days, the facility should resubmit a new Level I screening as a Resident Review on the 31st day . During a concurrent interview and record review on 3/12/25, at 10:14 a.m., with the Social Services Director (SSD), the SSD stated Resident 71 had the mental disorder diagnosis of schizophrenia. The SSD confirmed that Resident 71 had a PASSR Level 1 assessment done at the hospital on 3/28/24 on the day that he left the hospital. The SSD stated that Resident 71's PASSR level 1 assessment was good for 30 days. The SSD confirmed that Resident 71 had a PASSR Level II screening done on 7/8/24 and was completed late. The SSD further stated the facility should have resubmitted Resident 71's PASSR Level I assessment within the 30-day timeframe of the first one done by the hospital. The SSD stated that the facility should have done another PASSR Level I assessment after the expiration of the first PASSR Level I completed from the hospital if the resident stayed at the facility after the initial 30 days from admission. The SSD stated she checked the DHCS online portal and did not see a PASSR Level I screening completed for Resident 71 during the 30-day window from the initial screening done at the hospital. The SSD stated that the risk of not submitting the PASSR Level I screening would be the potential for Resident 71's needs to be unmet based on the assessment determination results. (continued on next page)

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	03/14/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/13/25, at 5:03 p.m., with the Director of Nursing (DON), the DON stated the hospital will start the PASSR Level I screening prior to sending the resident to the facility and after 30 days needs to be reevaluated. The DON stated that the SSD is in charge to make sure that PASSR assessments were completed. The DON confirmed that Resident 71's PASSR level I was not resubmitted timely, and it was months later when it was resubmitted on 7/8/24. The DON stated that it was her expectation for the PASSR Level I to have been completed within the first 30 days of Resident 71's admission at the facility. The DON further stated it was Social Services mainly reviewing PASSR assessments but should have also been reviewed during care conferences with the Interdisciplinary Team (IDT) as well. The DON stated the risk of not completing the PASSR Level I screening was the potential for Resident 71 not receiving appropriate care since he may need specific recommendations based on the assessment determination. A review of Resident 71's letter received from the State of California - Health and Human Services Agency DHCS, dated 7/8/24, indicated .A SERIOUS MENTAL ILLNESS (SMI) LEVEL II MENTAL HEALTH EVALUATION IS REQUIRED .Your Level I Screening indicates that a SMI Level II Mental Health Evaluation is required and an ID (intellectual disability)/DD (developmental disability)/RC (related conditions) Level II Mental Health Evaluation is not required .Result: Positive for SMI; Negative for ID/DD/RC .Level II Mental Health Evaluation Referral: Required for SMI; Not Required for ID/DD/RC . A review of Resident 71's letter received from the State of California - Health and Human Services Agency DHCS, dated 7/8/24, indicated .SUBJECT: NOTICE OF LEVEL II CATEGORICAL DETERMINATION .Your Level I Screening was conducted at [name of skilled nursing facility], followed by a Categorical Review on 07/09/2024, by a PASSR Level II SMI evaluator. The results of this Categorical Review are provided in the PASSR Categorical Determination Report attached to this letter . A review of the facility's undated document titled, Resident Assessment - Coordination with PASARR Program, indicated .Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs .Policy Explanation and Compliance Guidelines: .5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID, or a related condition to the appropriate state-designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission .

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	03/14/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission as required to address resident-specific care needs for one of twenty sampled residents (Resident 249) when, Resident 249's admission document identified a communication need that was not addressed on his baseline care plan. This failure had the potential for Resident 249 to not receive person-centered care. Findings: A review of Resident 249's ADMISSION RECORD indicated that Resident 249 was admitted in 2/28/25 with diagnoses which included dementia (a decline in memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily living). A review of Resident 249's Social Services Assessment-Admission/Re-Admission, dated 3/5/25, indicated that Resident 249's primary language was [NAME], and further indicated that Resident 249 could not communicate in English. During an observation on 3/12/25, at 12:29 p.m., of Resident 249 in his room, Resident 249 spoke [NAME] in response to all questions asked in English. During an interview on 3/13/25, at 11:30 a.m., with the Respiratory Therapist (RT), the RT confirmed that Resident 249 did not speak English. The RT stated that he believed staff used an interpreter to communicate with Resident 249. During an interview on 3/13/25, at 11:35 a.m., with Licensed Nurse (LN) 2, LN 2 stated that Resident 249 did not speak English. LN 2 stated that Resident 249 spoke [NAME]. LN 2 stated that the facility included at least one staff member who spoke [NAME] on the schedule each shift. LN 2 stated that Resident 249's inability to speak English should be on his care plan. During an interview and concurrent record review on 3/14/25, at 10:15 a.m., Resident 249's care plans were reviewed with the Director of Nursing (DON). The DON stated that when a resident was admitted whose primary language was not English, facility administration worked to identify if anyone on staff spoke the same dialect, or if the resident's Responsible Party (RP, the person designated to direct the care of a loved one admitted into a nursing facility) was able to translate for the resident. The DON stated that a communication board was also used to help with communication with residents as needed. The DON stated that a care plan was developed that listed the types of communication used with the resident. The DON stated that the risk of not developing a care plan was that staff would not know how to assist the resident with communication/translation needs. The DON confirmed that Resident 249 did not have a care plan that addressed his communication needs. The DON acknowledged that the facility policy was not followed. (continued on next page)

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	03/14/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an undated facility policy and procedure (P&P) titled, Culturally Competent Care, the P&P indicated, .Policy: It is the policy of this facility to provide culturally competent care in accordance with professional standards of practice. The facility has established a culture that treats each resident with respect and dignity as an individual, and addresses, supports and/or enhances his/her feelings of self-worth including personal control over choices and cultural preference . Language Assistance Services is defined as language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. This may include oral interpretation, written language translation, or both .Policy Explanation and Compliance Guidelines: 1. The facility will use the Facility Assessment to identify resident populations having unique cultural characteristics, such as language .2. Each resident will be assessed upon admission .3. The facility will provide sufficient guidance for staff, including temporary staff, on how to communicate and deliver care for the resident .4. The facility social worker or designee will meet with the resident .5. If the resident is non-English speaking, the facility will identify how communication will occur with the resident .The care plan will identify the language spoken and tools used to communicate .

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	03/14/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49823 Based on interview and record review the facility failed to develop and implement a resident-specific care plan intervention for 1 of 20 sampled residents (Resident 66) when, Resident 66 had no care plan addressing his anticoagulant care needs. This failure placed Resident 66 at risk for a decline in their health and well-being. Findings: A review of Resident 66's ADMISSION RECORD indicated that Resident 66 was admitted to the facility with diagnoses which included amputation of both legs below the knees (surgical procedure to remove the lower legs below the knees when they were severely damaged or diseased), and amputation of fingers on right and left hand due to frostbite (surgical procedures to remove fingers of both hands when they were severely damaged due to frostbite (injury caused by freezing of the skin and underlying tissue)). A review of Resident 66's Physician Order Summary, indicated, .Apixaban Oral Tablet [anticoagulant (medication used to prevent or reduce blood clots)] 5 MG [unit of measure] .Give 1 tablet by mouth two times a day for treat and prevent blood clot (clumps that occur when blood hardens from a liquid to a solid). Monitor for s/s [signs/symptoms] of bleeding [loss of blood]/bruising [skin discoloration from damaged, leaking blood vessels under the resident's skin]; monitor for s/s thromboembolism [a blood clot that travels in a vein and blocks blood flow to a part of the resident's body] .order date 2/9/2025 . A review of Resident 66's Physician Order Summary, indicated, .Aspirin 81 Oral Tablet [medication used to prevent blood clots] Chewable .Give 1 tablet by mouth one time a day for Prevention of blood clot. Monitor for s/s of bleeding/bruising; monitor for s/s thromboembolism .order date 2/9/2025 . During a concurrent interview and record review of Resident 66's care plans with the Director of Nursing (DON) on 3/12/25, at 4:25 p.m., the DON stated her expectation was that residents who were prescribed anticoagulant medication had a care plan for monitoring signs and symptoms of bleeding while taking the anticoagulant. The DON stated that Licensed Nurses (LNs) monitored residents on anticoagulant medications for signs and symptoms of bleeding. The DON stated that LNs documented that they monitored residents for signs and symptoms of bleeding on the resident's Medication Administration Record (MAR, a document listing medications and monitoring parameters). The DON stated that the risk of not having a care plan for residents on an anticoagulant was missing the signs and symptoms of bleeding. The DON confirmed that Resident 66 did not have a care plan for anticoagulant use. The DON acknowledged that the facility policy was not followed. (continued on next page)

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	03/14/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/25, at 9:28 a.m., LN 7 stated that residents who were on anticoagulants were monitored for signs and symptoms of bleeding. LN 7 stated that LNs documented monitoring for signs and symptoms of bleeding in the progress notes and on the MAR. LN 7 stated that when the physician ordered the anticoagulant, the monitoring parameters were on the MAR. LN 7 stated that a care plan was developed for residents who were on anticoagulants. LN 7 stated that the risk of not having the care plan and the monitoring on the MAR for anticoagulants was that the staff would not know which residents had a risk for bleeding. A review of a facility policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/22, indicated, .Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .Policy Interpretation and Implementation .7. The comprehensive, person-centered care plan: .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: .e. reflects currently recognized standards of practice for problem areas and conditions .

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	03/14/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 52230 Based on interview and record review, the facility failed to conduct an IDT (Interdisciplinary Team: group of healthcare professionals from various disciplines that works together to develop and implement individualized resident care plans) meetings for one of twenty sampled residents (Resident 31), when Resident 31 ' s quarterly IDT care conferences were not conducted as scheduled for April 2024 and October 2024. This failure had potential to result in Resident 31's changing care needs not being accurately reflected in the care plan and the current care interventions not being readily available to implement and evaluate for their effectiveness and relevance. Findings: Review of Resident 31's ADMISSION RECORD indicated Resident 31 was admitted to the facility with multiple diagnoses including diabetes (abnormal blood sugar levels) and hyperlipidemia (elevated levels of lipids (fats) in the blood). During a concurrent interview and record review on 3/13/25, at 10 a.m., Resident 31's electronic medical record (EHR) was reviewed with the Social Services Director (SSD). The SSD stated resident IDT care conferences were conducted quarterly. The SSD stated IDT care conferences were done to allow a resident and/or resident representative to discuss the residents plan of care. The SSD stated that there should have been a care conference meetings conducted for Resident 31 in April 2024 and October 2024. The SSD stated Resident 31's quarterly IDT care conferences were not conducted in April 2024 and October 2024 as scheduled due to change in social services staffing. During a concurrent interview and record review on 3/14/25 at 10 a.m., Resident 31's EHR was reviewed with the Director of Nursing (DON). The DON stated IDT care conferences for Resident 31 should be done quarterly. The DON confirmed Resident 31's quarterly care conferences for April 2024 and October 2024 were missed. The DON stated that there was a change in the social services staffing during the time frame of Resident 31's missed care conference meetings, which resulted in the care conferences not being conducted for Resident 31 in April 2024 and October 2024. The DON stated care conferences were meant to review plans of care for residents and was a way to communicate with family regarding medication. The DON added, when quarterly IDT care conferences were not conducted, resident's care plans were not reviewed and care plan interventions could be missed. Review of the facility policy titled, Care Planning-Resident Participation, dated 2024, indicated, .This facility supports the resident's right to be informed of and participate in, his or her care planning and treatment . The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility will make an effort to schedule the conference at the best time of the day for the resident/resident representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan .

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	03/14/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50925 Based on observation, interview, and record review, the facility failed to ensure adequate treatment and services were provided for one of twenty sampled residents (Resident 96) when Resident 96's STAT order (should be prioritized first as it is needed urgently) left hand x-ray was delayed and the delay in the order being carried out was not reported to the physician in a timely manner. This failure placed Resident 96's at risk of worsening and prolonged pain while awaiting for diagnosis of the left hand injury. Findings: A review of Resident 96's medical record titled, ADMISSION RECORD, indicated that Resident 96 was admitted to the facility in early 2025 with diagnoses that included encephalopathy (a disturbance of brain function) and cognitive communication deficit (communication problem that stems from difficulties with thinking and processing information). During an observation and interview on 3/11/25, at 11:36 a.m., with Resident 96, Resident 96 was noted to have bruising on the back part of his left hand. Resident 96 stated that he got the bruising from somewhere but does not recall how. A review of Resident 96's Electronic Health Record (EHR - information stored in the facility's computer system), indicated Resident 96's had an order, dated 3/8/25, for .STAT: xray to left hand one time only for fracture rule out for 3 days . During a concurrent interview and record review on 3/11/25, at 12:18 p.m., with Licensed Nurse (LN) 9, LN 9 stated Resident 96 had left hand bruising and a skin tear. LN 9 confirmed Resident 96 had an order for a STAT x-ray to the left hand and a treatment order that was initiated on 3/8/25. LN 9 stated there was a change in Resident 96's condition for the left hand skin tear on 3/8/25. LN 9 further stated the notes showed that Resident 96 had a verbal altercation with another resident and Resident 96 slammed the activity room door to his own left hand. LN 9 stated the doctor ordered for a STAT left hand x-ray on 3/8/25 and the x-ray was done on 3/10/25. LN 9 stated usually if there was an order for a STAT x-ray, the x-ray company would come on the same day. During a concurrent interview and record review on 3/12/25, at 9:53 a.m., with LN 10, LN 10 confirmed Resident 96's STAT left hand x-ray was ordered on 3/8/25. LN 10 stated she contacted the x-ray company and was advised that they called the facility to notify staff that they could not come right away and would send someone as soon as they had an x-ray tech available. LN 10 stated the x-ray was done on 3/10/25 at 11:52 a.m. and reported result were received at 12:41 p.m. on the same day. LN 10 further stated per the x-ray company, STAT x-rays should be done within 1 to 5 hours and if they could not make it within that window, then they would call the facility right away. LN 10 stated the expectation for staff who received a call from the x-ray company about not having the tech come on time should have documented that information in Resident 96's chart for tracking. LN 10 stated the facility only used one company for x-rays for the residents. (continued on next page)

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	03/14/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/25, at 11:29 a.m., with the Director of Nursing (DON), the DON stated she reached out to the nurse who worked the evening of 3/8/25 with Resident 96. The DON stated according to the nurse, she received a call from the x-ray company stating that they did not have a tech so there would be a delay. The DON confirmed the STAT order should have been done right away, but the company notified the facility that there would be a delay. The DON stated it was her expectation for the x-ray company to have the x-ray tech be sent right away for STAT orders. A review of Resident 96's medical record titled View Progress Note, dated 3/8/25, indicated .Effective Date: 3/8/2025 .Created Date: 3/11/2025 .I received a call from [x-ray company] stating that the left-hand X-ray of the resident would be delayed. The MD was made aware of the delay . During a concurrent interview and record review on 3/13/25, at 4:14 p.m., with LN 8, LN 8 stated she received the call from the x-ray company on 3/8/25. LN 8 stated the company told her there was a delay that night because there was no tech available and did not specify how long the delay was for. LN 9 confirmed the x-ray company was aware that the order for the left hand was a STAT order. LN 9 stated her documentation of x-ray company's call was late due to having two codes that night. LN 9 stated she expected for the company to have come in by the next morning and that the nurses should have also followed up. LN 9 confirmed she received that call from the x-ray company on 3/8/25, but was not able to notify the MD about the delay until 3/11/25 when she did the late documentation on Resident 96's chart. During an interview on 3/13/25, at 5:27 p.m., with the DON, the DON stated it was her expectation for the nurses who worked the next shift to have followed up about the x-ray especially with a STAT order. The DON added the MD should have been notified of any delay. The DON stated the risk of having a delay in STAT orders would be the delay in treatment for Resident 69. A review of the facility's undated policy document titled, Provision of Physician Ordered Services, indicated . Policy Explanation and Compliance Guidelines: 1. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders .4. Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record .5. In instances where diagnostic testing or consultations are not available to be performed on-site OR the physician has requested that the services be performed at an off-site facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments .

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	03/14/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50716 Based on observation, interview, and record review, the facility failed to provide a safe environment for 1 of 20 sampled residents (Resident 65) when, Resident 65's footboard (part of the bed frame located at the foot of the bed) was broken and splintered. This failure had the potential to cause harm to Resident 65. Findings: During a concurrent observation and interview on 3/11/25, at 11:53 AM, in Resident 65's room, it was observed that Resident 65 had a broken footboard that had exposed splinters and sharp edges on the side that faced Resident 65. Upon further observation it was noted that there was a thick black tape placed around the broken part of the footboard; however, it did not cover the sharp and splintered part facing Resident 65. Resident 65 stated it had been taped for a while, but could not recall who taped it, or when it was taped. Resident 65 further stated she could hurt herself on it and the footboard should be fixed. During a concurrent observation and interview on 3/11/25, at 12:24 PM, in Resident 65's room, Licensed Nurse (LN) 1 confirmed the footboard was broken. LN 1 further stated it was a risk of harm to Resident 65 when the resident got into or out of bed or moved a foot across it while in bed. During an interview on 3/13/25, at 10:06 AM, the Maintenance Director (MATD) stated he was not sure why the footboard was taped. The MATD confirmed the broken exposed part of the footboard was a hazard. The MATD further stated the broken footboard was sharp, and Resident 65 was at risk to be injured. During an interview on 3/13/25, at 2:21 PM, the Administrator (ADM) stated the footboard was a priority to be replaced and should not have been taped. The ADM further stated the risk to Resident 65 was an injury if touched. The ADM explained his expectation was no harm was done to the residents. A review of an undated facility provided policy and procedure titled, Accidents and Supervision, indicated, . The resident environment will remain free of accident hazards as is possible .Identifying hazard(s) and risk(s) .Implementing interventions to reduce hazard(s) and risk(s) .Hazards refers to elements of the resident environment that have the potential to cause injury .All staff .are to be involved in observing and identifying potential hazards in the environment .

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	03/14/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on interview and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs for two of twenty sampled residents (Resident 66 and Resident 300) when: 1. Resident 66's antibiotic (a medication that kills germs) doses were not documented accurately in the medical record; and, 2. Resident 300's nicotine patch (a nicotine medicated patch worn on the skin to help reduce cravings of cigarettes) was not available for use for 6 days. These failures had the potential for Resident 66's infection (invasion and growth of germs in the body) to not be fully treated, resulting in a decline of his health and well-being and, resulted in Resident 300 feeling anxious without the nicotine patch and did not allow Resident 300 to achieve his highest practicable physical, mental, and psychosocial well-being. Findings: 1. A review of Resident 66's ADMISSION RECORD indicated that Resident 66 was admitted to the facility in 2025 with diagnoses which included Methicillin Resistant Staphylococcus Aureus Infection (MRSA, presence of germs in the body that do not respond to commonly used medications used to kill them), osteomyelitis (presence of germs in a bone), amputation of both legs below the knees (surgical procedure to remove the lower legs below the knees when they were severely damaged or diseased), and amputation of fingers on right and left hand due to frostbite (surgical procedures to remove fingers of both hands when they were severely damaged due to frostbite [injury caused by freezing of the skin and underlying tissue]). A review of Resident 66's Physician Order Summary, indicated, .DAPTOmycin [antibiotic medication used to kill germs that cause infection] Intravenous Solution [I.V., medication and/or fluids placed into a vein using a needle or catheter] Reconstituted [adding a liquid to a dry ingredient to make a specific concentration of liquid] .Give 500 mg [unit of measure] intravenously one time a day for Osteomyelitis of multiple sites until 03/10/2025 .start date-02/06/2025 . During a review of Resident 66's Medication Administration Record, (MAR, a document listing medications and monitoring parameters) for March of 2025, Resident 66's MAR indicated that doses of Daptomycin were not documented as given to Resident 66 on 3/4/25, 3/5/25, and 3/7/25. A review of Resident 66's Progress Notes indicated no entries for missed or refused doses of antibiotics on 3/4/25, 3/5/25, and 3/7/25. During a concurrent interview and record review of Resident 66's MAR, dated 3/25, with Licensed Nurse (LN) 2 on 3/12/25, at 10:25 a.m., LN 2 confirmed there was no documentation on the MAR for doses of Resident 66's Daptomycin on 3/4/25, 3/5/25, and 3/7/25. (continued on next page)

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	03/14/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/25, at 10:40 a.m., LN 5 stated that if a dose of medication was missing, was given late, or was refused by the resident, LNs documented the reason that the medication was not given or was late on the MAR and documented a note in the resident's progress notes. During a concurrent interview and record review on 3/12/25 at 4:25 p.m.,Resident 66's MAR, dated 3/25, and Resident 66's Progress Notes were reviewed with the Director of Nursing (DON). The DON stated that her expectation was that medications were administered as ordered by the physician per the scheduled administration times following the rights of medication administration. The DON stated that when I.V. medications were delivered to the facility, the courier took the medications to the nurses' station, the LNs verified the medications on the invoice, signed the invoice, and placed the medications in the medication cart and/or medication storage room. The DON stated that she expected the LNs to document missed medication dosages in the MAR with the reason the medication was missed. The DON stated that the LNs also called the physician when medications were missed and/or refused. The DON stated that the LNs documented the physician notifications in the progress notes of the residents' electronic medical record (EMR). The DON stated that the risk of missed doses of antibiotic was the potential delay in resolving an infection. The DON confirmed that doses of Resident 66's Daptomycin were not documented as given on 3/4/25, 3/5/25, and 3/7/25, with no physician notifications in 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, Medication Administration, indicated, . Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .Policy Explanation and Compliance Guidelines: .20. Sign MAR after administered .23. Correct any discrepancies and report to nurse manager . 50716 2. During a concurrent observation, interview, and record review, on 3/13/25 at 9:10 AM, Licensed Nurse (LN) 5 prepared Resident 300's medications for administration. LN 5 stated Resident 300 had an order for a Nicotine patch 21mg (milligrams -a unit a measure) to be given once daily, with the first dose to be given 3/7/25. LN 5 stated she would have to follow-up with the pharmacy because it had not been available since it was ordered by the physician on 3/6/25. LN 5 reviewed Resident 300's medication administration record (MAR), dated 3/25, and confirmed the nicotine patch had not been given on 3/7/25, 3/8/25, 3/9/25, 3/10/25, 3/11/25, and 3/12/25, with the explanation given as, Medication not available. LN 5 stated she was unable to locate any progress notes that indicated the pharmacy had been called for follow-up, or the physician had been notified that Resident 300 had missed doses of the medication. LN 5 stated the facility policy when a medication was unavailable was to call the pharmacy to check the status of the medication and notify the physician of any missed medication. LN 5 explained the risk to Resident 300 for missing the medication was increased anxiety and cravings (of nicotine). During an interview on 3/13/25 at 9:22 AM, in Resident 300's room, Resident 300 stated he still wanted the nicotine patch and felt anxious without it. (continued on next page)

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	03/14/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/25, at 9:58 AM, with the Director of Nursing (DON), the DON stated the process of ordering the medication from the pharmacy included notifying the pharmacy of the medication orders from the physician. The DON stated the pharmacy's delivery time was usually no later than 24 hours and normally received on the same day. The DON further stated on 3/7/25 when the nurse noticed the medication was not available the nurse should have called the pharmacy to follow-up on the status of delivery. The DON further explained it was facility policy to notify the physician if Resident 300 missed doses of the medication. During a telephone interview on 3/14/25 at 8:46 AM, with a pharmacy representative (PR), the PR stated the pharmacy received the order for the medication on 3/6/25. The PR explained on 3/6/25 at 5:18 PM, the pharmacy sent the order back to the facility via fax for the signature and approval of the DON. The PR further explained since the medication was over the counter (OTC - medications you can buy without a prescription from a doctor) it required a signature from the DON. The PR further stated a second request was sent to the facility on [DATE] at 2:59 PM requesting a signature from the DON for the medication. During an interview on 3/14/25, at 11:30 AM, the DON stated she had not received the fax requests from the pharmacy. The DON further stated they now have the medication because the facility went out to a local pharmacy and purchased it on 3/13/25, so Resident 300 would not miss anymore doses. The DON explained the physician was notified on 3/13/25 Resident 300 missed 6 doses of the medication. A review of the facility provided policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy Provider, dated 1/23, indicated, .Medications and related products are received from the provider pharmacy on a timely basis. The nursing care center maintains accurate records of medication order and receipt .Timely delivery of new orders is required so that medication administration is not delayed . A review of an undated facility P&P titled, Medication Administration, indicated, .Review MAR to identify medication to be administered .Correct any discrepancies and report to nurse manager .

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	03/14/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47369 Based on interview and record review, the facility failed to ensure one of six sampled patients (Patient 68) was free from unnecessary medication when Patient 68 was receiving antidepressant medication with no monitoring for side effects or behavior manifestations of depression and the pharmacist's recommendation for a review of the medication use was not acknowledged by the physician in a timely manner. These failures had the potential for Patient 68 to receive unnecessary medication and the potential for medication side effects to go unnoticed, negatively impacting Patient 68's health and well - being. Findings: A review of Patient 68's ADMISSION RECORD, indicated, she was admitted to the facility in early 2024, with diagnoses which included depression. A review of Patient 68's Order Details, dated 6/12/24, indicated, .Selegiline HCL [hydrochloride] [medication prescribed to treat depression] .one time a day for m/b [manifested behavior] verbalization of sadness related to DEPRESSION . A review of an online document, accessed on 3/21/25, published by the National Library of Medicine (NLM) DAILYMED, titled, SELEGILINE HYDROCHLORIDE capsule, revised 10/1/24, indicated, .ADVERSE REACTIONS .Nausea, Dizziness/Lightheaded/fainting, abdominal pain, Confusion, Hallucinations, Dry mouth, Vivid dreams, Dyskinesia [involuntary, repetitive, and abnormal movements], Headache . https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1924db3d-6a16-4496-cfd0-6903be146925 During a concurrent interview and record review on 3/13/25, at 10:09 AM, Licensed Nurse (LN) 2 confirmed there was no documentation in Patient 68's electronic health record (EHR) to indicate staff were monitoring her for side effects of the antidepressant medication or monitoring for verbalizations of sadness related to depression. LN 2 stated there should be monitoring in place to determine if the medication was working correctly and to determine if the medication dose needed to be increased or decreased. LN 2 further stated Resident 68 should be monitored closely to ensure she did not experience side effects of her medication. During a concurrent interview and record review on 3/13/25, at 10:19 AM, the Director of Nurses (DON) confirmed there was no documentation in Patient 68's EHR to indicate staff were monitoring for side effects of the antidepressant medication or for depressive behaviors. The DON stated monitoring was important to ensure staff could intervene when side effects were observed and to modify interventions as needed. The DON further stated the monitoring would provide data to inform the physician if there was a need for adjustments in the medication dosage. (continued on next page)

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	03/14/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Patient 68's pharmacy document titled, Consultant Pharmacist's Medication Regimen Review Recommendations Pending a Final Response' dated 1/31/25, indicated, .Recommendation: .patient has been taking the antidepressant Selegiline 5mg [milligrams] since 1/6/24. Please evaluate the current dose and consider a dose reduction . Recommendation Status .Pending . A review of Resident 68's pharmacy document titled NURSING RECOMMENDATIONS, Dated 2/28/25, indicated, .Routing: Physician .patient has been taking antidepressant Selegiline 5 mg since 1/6/24. Please evaluate the current dose and consider a dose reduction .Follow-Through .Note written to physician . During a concurrent interview and record review on 3/14/25, at 12:40 PM, the DON confirmed the consultant pharmacist's recommendation for the physician to consider a reduction in Resident 68's antidepressant medication was not responded to in a timely manner. The DON stated there was no documentation in Patient 68's EHR to indicate the physician reviewed the recommendation. The DON further stated recommendations from the pharmacist should be responded to right away. The DON stated behavior monitoring and pharmacist reviews were important to ensure Resident 68 was receiving the right medication at the right dose. A review of a facility policy titled, Use of Psychotropic Medication[medications that affect the mind, emotions, and behavior], dated 2024, indicated, .Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) .Psychotropic drugs include, but are not limited to the following categories . antidepressants .The resident's response to the medications(s), including progress towards goals and the presence/absence of adverse consequences, shall be documented in the resident's medical record . A review of a facility policy titled Medication Regimen Review, dated 2024, indicated, The drug regimen of each resident is reviewed at least once a month .Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication .

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	03/14/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 50778 Based on interview and record review, the facility failed to ensure safe monitoring and assessment of blood pressure (BP-the force of your blood pushing against the walls of your arteries as your heart pumps blood and was measured as two numbers: systolic (when the heart beats) and diastolic (when the heart rests between beats)) and heart rate (HR-frequency of your heart beats per minute) for medications to treat high (hypertension (HTN)) and low (hypotension) BP for 1 of 20 sampled residents (Resident 35) when: 1. Resident 35's physician's prescribed hold parameters (a set of numbers that guide the nursing staff when to not give medication for safety reasons) for midodrine (medication used to treat low BP) was not followed; 2. Resident 35's physician's prescribed hold parameters for labetalol (a medication used to treat HTN) were not followed; 3. Resident 35's BP and HR readings used to determine hold parameters for administering BP medications were used for more than one dose of medication at different times on the same day for both midodrine and labetalol; and, 4. Licensed Nurses (LN) documented administering both midodrine and labetalol at the same time on the Medication Administration Records (MAR) over a two month period (1/25 and 2/25). These failed practices could put Resident 35 at risk of adverse drug effects including hypotension and HTN which increased Resident 35's chance of having a severe medical emergency. Findings: During an interview on 3/13/25, at 11:40 AM, with LN 5, LN 5 stated, midodrine was given to raise a low BP, and labetalol was given to lower BP. LN 5 stated she would need to know Resident 35's BP and HR to administer these medications at the time doses were due. LN 5 stated these two medications should never be given at the same time and the risk to the resident would be a BP that fluctuated (rise and fall irregularly). LN 5 stated LNs should never use the same vital signs to administer doses of medication scheduled for different times of the day and would always need to obtain the most recent vital signs right before administration of a BP medication. (continued on next page)

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	03/14/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/13/25, at 2:22 PM, with the Director of Nursing (DON), Resident 35's Medication Administration Record (MAR) for 1/2025 was reviewed. The DON confirmed the MAR for 1/2025 indicated, four occurrences midodrine was administered without a documented BP reading and six occurrences it was given outside the hold parameters. The DON confirmed labetalol was administered three times outside of the hold parameters and on six occurrences the same BP reading was used to give the 7 AM dose of labetalol was also used to give the 1 PM dose of labetalol. The DON verified both midodrine and labetalol were documented as given on the same days and times one to two hours apart 14 times. The DON also confirmed the LN used the same BP readings to administer midodrine as was used to administer labetalol even though the two medications were ordered to be given at different times on the same day. The DON stated the risk for Resident 35 was fluctuating BP and HR. During a concurrent interview and record review on 3/13/25 at 2:22 PM with the DON, Resident 35's MAR for 2/2025 was reviewed. The DON confirmed the 2/2025 MAR indicated, there were six occurrences midodrine was given outside of the hold parameters and labetalol was given three times outside of the hold parameters. The DON confirmed the same BP readings were used for doses of midodrine and labetalol given at different times on the same day ten times, and both medications were administered within one to two hours apart 18 times. The DON confirmed the risk for Resident 35 of giving both midodrine and labetalol too close together would be fluctuating BP and HR. During a phone interview on 3/14/25, at 9:20 AM, with the Pharmacist Consultant (PC), the PC stated the purpose of labetalol was to lower the BP and the purpose of midodrine was to raise the BP. The PC stated the onset of action (the time it takes for a drug to start producing its therapeutic effects after it is given) for labetalol was twenty minutes to two hours and the duration (the length of time the medication produces its desired therapeutic effect) was eight to twelve hours. The PC stated for midodrine the onset of action was about one hour and the duration was two to three hours. The PC confirmed these medications should not be given together. The PC confirmed if BP medication was given, the BP and HR must be checked prior to giving the dose and if BP medications were given at different times the LN would need to recheck the BP again at the time of each medication administration. The PC further confirmed if LNs were not heeding to the hold parameters it could cause hypotension or HTN and the risk to Resident 35 could result in kidney injury (a condition where the kidneys suddenly lose their ability to function properly) and could cause a severe medical emergency. During a review of the facility's undated policy and procedure (P&P) titled, Medication Administration, the P&P indicated, .Medications are administered by licensed nurses .in accordance with professional standards of practice .Obtain and record vital signs, when applicable or per physician's orders .when applicable, hold medication for those vital signs outside the physician's prescribed parameters .Refer to drug reference material if unfamiliar with the medication, including its mechanism of action [processes by which a drug or substance produces its effect in the body] or common side effects .Medication requiring vital signs prior to administration .anti-hypertensives [drugs used to treat and prevent hypertension by lowering blood pressure] . During a review of the facility's undated policy and procedure (P&P) titled, Vital Signs, the P&P indicated, . Vital signs will be obtained by the nurse .when administering certain medications .Certain cardiac drugs are given only when a resident's pulse or blood pressure is within a certain range .

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	03/14/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50716 Based on observation, interview, and record review, the facility failed to ensure safe medication storage for a census of 91 when: 1. Two over-the-counter (medication that can be obtained without a doctors order) medication bottles were stored in open view on the bedside table of Resident 90, in a multi-resident room; 2. An Emergency Kit (E-kit -a locked and secure box containing an available collection of medications and supplies designed to address immediate needs when the pharmacy is unavailable) was opened and a medication was used without the proper documentation per facility policy; and, 3. An opened and used multi-dose vial of Heparin (an injectable medication given to prevent blood clots) was not dated with an opened or use by date per standards of practice. These failures may pose unsafe medication use in the facility. Findings: 1. During a concurrent observation and interview, on [DATE], at 12:20 PM, in Resident 90's room with Licensed Nurse (LN) 1, LN 1 confirmed Resident 90 had one bottle of Fish oil which expired on ,d+[DATE], and one bottle of Centrum Multi-Vitamin tablets sitting in open view on Resident 90's bedside table. LN 1 stated the facility does not permit residents to keep medications at bedside unless they were assessed for self-administration and had a physician order. LN 1 stated Resident 90 did not have an order, or an assessment, and the medications are not on Resident 90's medication list. LN 1 explained Resident 90 had been told previously that medications could not be kept at bedside. LN 1 stated the risk for the medications being at bedside was other residents could take them, and Resident 90 could take more than prescribed. LN 1 further explained Fish oil could interact with the Resident 90's anticoagulant medication (to prevent blood from clotting). During an interview on [DATE], at 10 AM, with the Director of Nursing (DON), the DON stated medications should never be kept at the bedside. The DON stated the risk to the resident was not being able to monitor for drug interactions and the risk that other residents could take the medication. A review of a facility provided policy and procedure (P&P) titled, Medication Storage, undated, indicated, .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms .to ensure proper sanitation, temperature .security . A review of a facility provided P&P titled, Storage of Medication-(Nursing Care Center Pharmacy Policy & Procedure [NAME] -2007 PharMerica Corp) dated ,d+[DATE], indicated, .Medications and biologicals are stored properly .to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . (continued on next page)

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	03/14/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent interview and observation on [DATE], at 4:11 PM, in the facility's medication room located behind the North Nurses Station, with LN 2, an Intravenous (a thin tube placed inside a vein to received medication) E-kit labeled #80 was confirmed to have been opened. LN 2 stated the E-kit contained a blue lock tag which meant someone had opened the E-kit. LN 2 explained when an E-kit was opened, a paper slip was placed inside the E-kit, and a copy was placed in a binder and written in a log at the nurse's station. LN 2 checked the binder and was unable to locate documentation on the log, or the paper slip indicating who opened the E-kit, and what medication or supply was used. LN 2 opened the E-kit to check the paper slip inside, LN 2 confirmed no paper slip was located inside the E-kit. LN 2 further explained the paper slip was supposed to be filled out with the date, time, what item was used, and who used the item. LN 2 checked the E-kit to find the missing contents and stated one 10-millimeter (mL -a unit of measure) syringe of Normal Saline (NS - 0.9% sodium chloride solution used in or as medication) was missing, as there were only 9 and there was supposed to be 10, according to the contents sheet. During an interview on [DATE], at 11:35 AM, the DON stated they investigated and were unable to find who accessed the E-kit. The DON further stated they were unable to find a paper slip or fax confirmation to the pharmacy of the item used, and none of their nurses stated they used it. The DON explained their policy was to leave a completed paper slip inside the E-kit once opened and fax the other paper slip to the pharmacy so they could replace the E-kit. The DON confirmed their policy was not followed. The DON stated the risk for the policy not being followed was diversion (theft or illegal transfer) of the medications or supplies in the E-kit. A review of a facility provided P&P titled, Emergency Pharmacy Services and Emergency Kits (E-Kits) (Nursing Care Center Pharmacy Policy & Procedure Manual -2007 PharMerica Corp) dated ,d+[DATE], indicated, .7. Emergency medications are only administered with a valid prescribed order .8. Upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy or replaced within the resealed emergency kit .The hard copy will be retained by the nursing care center. Items to be documented on the log include .residents name, medication name .date and time of medication removal .prescribers name .date and time pharmacy notified .signature of nurse removing the administered dose . 3. During a concurrent observation and interview on [DATE], at 10:36 AM, on the [NAME] Medication Cart, an opened and used multi-dose vial of Heparin was observed without an opened or a use-by-date. LN 4 confirmed the vial was not labeled and stated the vial should have been labeled with a use-by-date for 28 days after it was opened. LN 4 stated the risk to the resident if used was it may not be strong enough. During an interview on [DATE], at 11:30 AM, the DON stated it was her expectation anytime a multi-dose bottle was opened it should labeled with the date of opening and the use by date, so it was not used beyond the manufacturers recommended use-by-date. The DON further stated the risk to the residents was less effective medication. A review of the Heparin package instructions indicated, .After opening, heparin vials may be kept for 28 days at 25 degrees C, after which they should be discarded . (continued on next page)

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	03/14/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Center for Disease Control (CDC) publication titled, Preventing Unsafe Injection Practices, dated [DATE], indicated, .Once a multi-dose vial is opened .the vial should be dated and discarded within 28 days unless the manufacturer states another date for that opened vial . (https://www.cdc.gov/injection-safety/hcp/clinical-safety/?CDC_AAref_Val=https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html)

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	03/14/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51285 Based on observation, interview, and record review, the facility failed to ensure standardized recipes were utilized for food preparation to ensure foods were prepared by methods that conserve nutritive value and flavor when vegetables were placed into the steam table approximately three hours before meal service, and measurement tools were not used during meal preparation for the 87 residents receiving kitchen prepared meals. These deficient practices placed residents at an increased risk for nutritional impairment. Findings: During an observation on 3/12/25, at 8:29 a.m., [NAME] 1 (CK 1) added a green scoop of butter to vegetables in a pot on the stove. The [NAME] was unsure of the amount in the scoop. During an observation on 3/12/25, at 8:32 a.m., CK 1 set a pot of water on stove to make noodles and added an unmeasured amount of oil. During an observation on 3/12/25, at 9 a.m., CK 1 transferred vegetables from the steamer to a steam table pan and added a handful of salt, a plastic spoon of black pepper, 3 spoonfuls of garlic powder, and an unmeasured amount of butter. After having mixed in the seasonings, CK, 1 tasted the vegetables then added another handful of salt, and placed vegetables into steam table at 9:04 a.m. During an interview on 3/12/25, at 11:42 a.m., CK 1 stated she cooked for food to taste good and not necessarily by the recipe. During an interview on 3/13/25, at 8:56 a.m., with the Registered Dietitian (RD). The RD stated that recipes should have been followed to ensure nutritive value was consistent and served in accordance with the planned menu that was designed to meet the recommended dietary allowances. The RD stated dietary staff needed to measure ingredients and follow recipes, as well as utilize proper scoop sizes to ensure residents are receiving accurate amount of nutrients. During an interview on 3/14/25, at 10:12 a.m., with the Certified Dietary Manager (CDM), the CDM stated cooks should prepare foods according to what menu items take the longest amount of time. The CDM stated she would expect them to prepare the protein item first. The CDM explained that the starch and vegetable should cook last to ensure texture and nutrient content were not affected. The CDM stated these practices had the potential to diminish nutritive value of food that could lead to increased risk for nutritional impairment for residents in the facility. Review of the facility provided recipe titled, RECIPE: STIR FRY VEGETABLES, dated 2024, indicated, . Serves 96 .Ingredients .20 lbs. [pounds- unit of measurement] Assorted vegetables such as: cauliflower, broccoli, squash, onions, zucchini, carrots (fresh or frozen vegetable), 1 1/2 cup [cup- unit of measurement] Margarine (9 oz [ounces- unit of measurement]), 1 1/2 tsp [teaspoon] of Garlic, powdered, 1 Tbsp [tablespoon] of Salt .

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	03/14/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 41838 Based on observation, interview, and record review, the facility failed to ensure that the alternative meal option of a grilled cheese sandwich had a similar protein content to the main entree for the 87 residents receiving kitchen prepared meals. This had the potential of leading to inadequate protein intake/malnutrition for those residents choosing the sandwich in place of the main entree. Findings: During an observation of the facility menu posted outside of the kitchen on 3/11/25, at 10:50 a.m., the alternative choices menu was observed. The choices on the Spring 2025 menu included a Grilled Cheese Sandwich without any additional items listed. Review of a facility provided recipe titled, Grilled Two-Cheese Sandwich, indicated that each sandwich was made with 2 ounces [unit of measurement] of cheese, the equivalent of 2 ounces of protein or 14 grams [unit of measurement] of protein. Review of the Cook's Spreadsheet for the lunch meal served on 3/12/25, indicated that the serving size for the Sweet and Sour Chicken was 1/2 cup (4 ounces) for the small portion, and 3/4 cup (6 ounces) for the regular and large portions. Review of the facility provided document titled, Nutritional Breakdown, dated 2025, indicated that the regular diet provided 100 grams of protein per day. During an interview on 3/13/25, at 8:56 a.m., with the Registered Dietitian (RD), the RD confirmed that the grilled cheese sandwich was not equivalent in protein content to the main entree.

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	03/14/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 41838 Based on observation, interview, and record review, the facility failed to ensure residents receiving pureed chicken and pureed noodles received the appropriate nutritive content as prescribed by a physician when serving sizes were smaller than ordered for the 14 residents receiving a Pureed (soft, pudding-like consistency) diet, and the 10 residents receiving the pureed meat on the Dysphagia Mechanical diet (texture-modified diet designed to make foods easier to chew and swallow). This failure had the potential of leading to malnutrition and weight loss for the 14 residents receiving a Pureed diet, and the 10 residents receiving the pureed meat on the Dysphagia Mechanical diet. Findings: During an observation of the lunch meal on 3/12/25, at 11:42 a.m., the service utensils were noted for the various foods. The pureed sweet and sour chicken was noted to have a green handled scoop (equivalent to 2 2/3 ounces {unit of measurement}) in the pan, which was the only scoop used during the lunch meal service. The pureed noodles also had a green handled scoop (2 2/3 ounces) placed in the pan and was the only scoop used during the meal plating. Both items were given as one scoop on the meal plates receiving these items. Review of an undated facility provided cook's spread sheet indicated the serving amounts for the pureed sweet and sour chicken (for both the pureed and dysphagia mechanical meals) was a 3/4 cup (unit of measurement) serving, the equivalent of 6 ounces. The spread sheet also indicated the portion size for the pureed noodles was a number 8 (gray handle) scoop or 4 ounces. Review of an undated facility provided document titled, Portion Control Chart, had the following scoops portions indicated the following: Green color=#12 scoop which held 2 2/3 ounces or 1/3rd of a cup Gray color=#8 scoop which held 4 ounces or 1/2 of a cup Blue color=#16 scoop which held 2 ounces or 1/4 of a cup During an interview on 3/13/25, at 8:56 a.m., with the Registered Dietitian (RD), the RD stated it was important that staff measure accurately to ensure the proper nutrient content of the meals was provided to residents as ordered by the physician. During an interview on 3/14/25, at 10:12 a.m., with the Certified Dietary Manager (CDM), the CDM concurred that the scoops were incorrect to meet the portions of the menu. The CDM stated that the pureed chicken would have needed a gray scoop (4 ounces) combined with a blue scoop (2 ounces) to meet the 6-ounce serving, and the pureed noodle serving should have been a gray scoop The CDM further stated that the green scoop was not large enough and would lead to a decrease in amount of nutrients provided with residents receiving an improper nutrient amount.

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	03/14/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51285 Based on observation, interview, and record review, the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 87 residents who ate facility prepared meals when: 1. Two food labels were unreadable, two labels did not include the year, and several bottles of seasoning did not have a use by date; 2. Dry storage walls were not smooth and cleanable, floor of the dry storage was uneven, the refrigerator door appeared discolored, and the kitchen floor had missing and cracked tiles; 3. One container of baking powder was left open and unsealed; 4. Dry storage floor was discolored and sticky, oven doors, microwave, and toaster had food residue on surfaces, and the shelf under the dishwashing machine appeared discolored and rough to the touch; 5. Two containers of sugar and flour were stored directly on kitchen floor, as well as a box of juices in the emergency food closet; 6. Kitchen had worn food preparation equipment such as a rusty strainer, one pot had food residue on the surface, two pans and one pot had discoloration on the surfaces, the can opener tip was missing metal, five syrup container tops were discolored, and eleven black bowls lacked glaze and had scratches on the eating surface; and, 7. Five steam table pans were stored in the ready to use area but were wet and stacked together. These facility failures had the potential of leading to food borne illness and the growth of microorganisms. Findings: 1. During a concurrent observation and interview of the initial tour of the kitchen on 3/11/25, at 8:12 a.m., with the Certified Dietary Manager (CDM), in the kitchen's walk-in refrigerator, the following items were noted: a. A container of vanilla low fat yogurt in the walk-in refrigerator was labeled with an open date of 2/5/25 but had an unreadable used by date. During a subsequent concurrent observation and interview on 3/11/25, at 8:20 a.m., the CDM confirmed that the label was unreadable and stated, When in doubt, throw it out. b. A bag of shaved parmesan cheese was dated 3/9 without a year. (continued on next page)

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	03/14/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a subsequent concurrent observation and interview on 3/11/25, at 8:21 a.m., the CDM stated she expected the year labeled with the date and threw it out. c. Three seasoning containers (onion powder with an open date of 2/26/25, tarragon with an open date of 3/5/25, and poultry seasoning with an open date of 3/5/25) were noted without use-by dates. During an interview on 3/13/25, at 8:56 a.m., with the Registered Dietitian (RD), the RD stated the container labels were important for the rotation of food products to use food in order of delivery. During an interview on 3/14/25, at 10:12 a.m., with the CDM, the CDM stated products should have a use by date, as well as a received date, and an open date to ensure the food is still safe to eat since seasonings were good for 1 year after opening. Review of the facility provided document titled, REFRIGERATED STORAGE GUIDE, dated 2019, indicated, . Cream, yogurt, cottage cheese, cream cheese, follow expiration date or 7 days after opening, whichever comes first . Review of the US Food and Drug Administration, Food Code 2022, section 3-501.17 on Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, indicated, .(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . 2. During a concurrent observation and interview of the initial tour of the kitchen on 3/11/25, at 8:12 a.m., with the CDM, the following items were noted: a. Walls of the dry storage had a textured area that was a different color. During an interview on 3/11/25 at 10:12 a.m., Maintenance Director (MATD) stated he had recently patched the holes, and still needed to sand down and paint. b. The door to the walk-in refrigerator was noted to be silver with a discoloration of areas that were white as well as black. During a concurrent observation and interview on 3/11/25 at 10:12 a.m., the CDM stated the door to the walk-in refrigerator had white as well as black discolorations. The CDM further stated it should be replaced or repaired as it was old due to the possibility of cross contamination potentially leading to residents' illness. c. The dry storage floor had a slope and appeared with darkened areas. (continued on next page)

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	03/14/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/11/25, at 10:12 a.m., the CDM acknowledged that the slope had been there since she started working in the facility and added it was a hazard for staff safety. d. The kitchen floor under the dish washing area had missing and cracked tiles. During a concurrent observation and interview on 3/11/25, at 10:12 a.m., the MATD confirmed that the kitchen floor had missing and cracked tiles. The MATD stated the kitchen floor should be replaced as it was old and hard to clean. Review of the US Food and Drug Administration, Food Code 2022, section 4-202.11 on Food-Contact Surfaces, indicated, .The purpose of the requirements for multi-use food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts . Review of the US Food and Drug Administration, Food Code 2022, section 4-202.16 on Nonfood-Contact Surfaces, indicated, .NonFOOD-CONTACT SURFACES shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance . Hard-to-clean areas could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms. Well-designed equipment enhances the ability to keep nonfood-contact surfaces clean . 3. During a concurrent observation and interview of the initial tour of the kitchen on 3/11/25, at 8:12 a.m., with the CDM, one opened box of baking soda was observed with the top not sealed and open to the environment. During an interview on 3/13/25, at 8:56 a.m., the RD stated that the container closure was important to prevent contamination. During an interview on 3/14/25, at 10:12 a.m., the CDM stated that baking soda being left open could lead to the product becoming hard as well as allow bacteria and dust into the product. The CDM stated if left open it should be tossed in 3 days. Review of the facility's policy and procedure (P&P) titled, .STORAGE OF FOOD AND SUPPLIES, dated 2020, indicated, POLICY: Food and supplies will be stored properly and in a safe manner .9. Dry food items which have been opened .will be tightly closed . 4. During a concurrent observation and interview of the initial tour of the kitchen on 3/11/25, at 8:12 a.m., with the CDM, the following was noted: a. The dry storage floor was observed to be discolored with black and gray areas and sticky to touch. b. The microwave oven, toaster, and two oven doors had food residue on surfaces. (continued on next page)

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	03/14/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a subsequent observation on 3/12/25 at 9:43 a.m., the microwave oven, toaster, and two oven doors was noted with food residue on surfaces. c. The shelf under the dishwashing machine appeared with white, brown, and black discolorations and was rough to touch. During an interview on 3/14/25, at 10:12 a.m., the CDM stated the expectation was for all food contact and non-food contact surfaces to be cleaned to prevent cross contamination. Review of the facility's P&P titled, .SANITATION, dated 2018, indicated, .PROCEDURE .9. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks and chipped areas . Review of the US Food and Drug Administration, Food Code 2022, section 4-601.11 on Equipment, Food-Contact Surfaces, and Nonfood-Contact Surfaces, and Utensils, indicated, .(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris .The objective of cleaning focuses on the need to remove organic matter from food contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted . 5. During a concurrent observation and interview of the initial tour of the kitchen on 3/11/25, at 8:12 a.m., with the CDM, two plastic containers of sugar and flour were stored directly on the kitchen floor, as well as a box of juices in the emergency food closet. During an interview on 3/14/25, at 10:12 a.m., the CDM stated the expectation was for containers not to be stored directly on the floor. The CDM stated there was a risk for contamination and a possibility of bugs that could get easily into the containers which could lead to a resident's illness. Review of the facility's P&P titled, .STORAGE OF FOOD AND SUPPLIES, dated 2020, indicated, .POLICY: Food and supplies will be stored properly and in a safe manner. PROCEDURES FOR DRY STORAGE .4 .All food and food containers are to be stored 6 [inches- unit of measurement] off the floor and on clean surfaces in a manner that protects it from contamination . 6. During a concurrent observation and interview of the initial tour of the kitchen on 3/11/25, at 8:12 a.m., with the CDM, the kitchen was noted with worn food preparation equipment such as: a. One pot had food residue on the surface in the ready to use area; b. Two oven pans and one pot had yellow, brown, and black discolorations on the surfaces in the ready to use area; c. One strainer had rust on the surface the in ready to use area; d. A can opener tip was missing metal; (continued on next page)

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	03/14/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Five syrup container tops had white discoloration on food-contacting surfaces; and, f. Eleven black bowls were observed with a lack of glaze and had scratches on the eating surface. During a concurrent observation and interview on 3/11/25, at 9:43 a.m., the CDM confirmed that the metal tip of the can opener was chipped. The CDM further stated that there was a concern that chips of metal could be dropped into the food and the can opener should be replaced. During an interview on 3/14/25, at 10:12 a.m., the CDM stated the expectation was for food preparation equipment to be clean, in good condition, and free of rust to prevent cross contamination that could lead to resident's illness. The CDM further stated items that had rust and or, the lack of glaze on the surfaces should be discarded. Review of the facility's P&P titled, .SANITATION, dated 2018, indicated .PROCEDURE .10. Plastic ware, china, and glassware that becomes unsightly, unsanitary or hazardous because of chip, cracks or loss of glaze shall be discarded . Review of the US Food and Drug Administration, Food Code 2022, section 4-501.11 on Good Repair and Proper Adjustment, indicated, .(A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened . 7. During a concurrent observation and interview of the initial tour of the kitchen on 3/11/25, at 8:12 a.m., with the CDM, five steam table pans were stored in the ready to use area, but were wet and stacked together. During an interview on 3/14/25, at 10:12 a.m., the CDM stated the expectation was for wet pans to be air dried before stacking and storing. The CDM further stated it could lead to rust and contamination (e.g. mold), possibly leading to a resident's illness. Review of the facility's P&P titled, .DISH WASHING, dated 2018, indicated .PROCEDURE .5. Dishes are to be air dried in racks before stacking and storing . Review of the US Food and Drug Administration, Food Code 2022, section 4-901.11 on Equipment and Utensils, Air-Drying Required, indicated, .Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils .

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	03/14/2025

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 51285 Based on observation, interview, and record review, the facility failed to provide a clean and safe environment for residents when two of two garbage dumpsters located outside the kitchen service entrance did not have the lids down to cover the trash. This failure had the potential for an unsafe environment for the residents due to possible insect and rodent infestation and spread of disease in the facility. Findings: During observations on 3/12/25 at 8:12 a.m., and again at 9:30 a.m., two garbage dumpsters were located outside the kitchen service entrance in the facility's parking lot, that were locked behind a gate with open lids. During a concurrent observation and interview on 3/12/25 at 9:30 a.m., with the Certified Dietary Manager (CDM). The CDM stated that leaving the lids open was normal and the dumpsters had always been uncovered since she started working in the facility. The CDM further stated that this practice had the potential to lead to insect and rodent infestation. A review of an undated facility policy and procedure (P&P) titled, Disposal of Garbage and Refuse, indicated, .The facility shall properly dispose of kitchen garbage and refuse .7. Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered .that accumulation of debris and insect/rodent attractions are minimized . Review of the US Food and Drug Administration Food Code 2022, under section 5-501.15, indicated that .(A) receptacles and waste handling units REFUSE, recyclable, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. (B) Receptacles and waste handling units for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit .

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	03/14/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49823 Based on interview and record review, the facility failed to maintain the confidentiality of 1 of 20 sampled residents (Resident 31) when portions of Resident 31's medical records were discovered in Resident 98's medical record during a closed record review (examining a residents medical records after their care has concluded (for example; discharge, death). This failure had the potential for exposure of Resident 31's private and confidential information to unauthorized individuals. Findings: During a closed record review of Resident 98's paper medical record file on 3/14/25, at 8:12 a.m., Resident 98's paper medical record file contained paper medical record documents belonging to Resident 31. During an interview and concurrent record review on 3/14/25, at 9:05 a.m., Resident 98's paper medical record file was reviewed with the Medical Records Clerk (MR). The MR confirmed that there were medical record documents in Resident 98's medical record file that belonged to Resident 31. The MR stated that the risk of placing another resident's records in the wrong file was a violation of the Health Insurance Portability and Accountability Act (HIPAA, The Health Insurance Portability and Accountability Act of 1996 establishes federal standards protecting sensitive health information from disclosure without a patient's consent). During an interview with the facility Director of Nursing (DON) on 3/14/25, at 10:15 a.m. the DON stated that her expectation was that the residents' medical records files would be placed in a folder with the residents' identifiers (ex. Name, date of birth, medical record number or other unique identifier) and stored securely for record review. The DON stated that the risk of not putting the resident's medical record information in the correct file was that the information of one resident may not be found if the document was misplaced in another resident's medical record file.

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	03/14/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 47369 Based on interview and record review, the facility's Quality Assessment Performance Improvement (QAPI, a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes) committee failed to develop and implement action plans, for a problem identified in June 2024, when three of eight sampled employee files (Certified Nurse Assistant (CNA) 1, CNA 2, and Licensed Nurse (LN) 8) did not contain background checks until 22-24 months after their hire dates. These failures had the potential to expose residents to physical and psychosocial harm. Findings: During an interview and record review on 3/11/25, at 12:09 PM, CNA 1's employee file was reviewed with the Director of Staff Development (DSD). The DSD confirmed Certified Nurse Assistant (CNA) 1 was hired on 4/26/23, and the background check (a screening for a history of fraud, abuse, and criminal offenses) in her file was completed on 2/11/25. The DSD confirmed the background check was not completed until 22 months after the hire date. The DSD stated the importance of background checks was to make sure staff did not have a history of criminal activity that would affect their job description. The DSD further stated the residents would be at risk of possible injury or abuse if background checks were not completed. During an interview and record review on 3/11/25, at 12:44 PM, CNA 2's employee file was reviewed with the DSD. The DSD confirmed CNA 2 was hired on 2/14/23, and the background check in her file was completed on 2/9/25. During an interview and record review on 3/12/25, at 10:51 AM, LN 8's employee file was reviewed with the DSD. The DSD confirmed LN 8 was hired on 2/8/23, and the background check in her file was completed on 2/8/25. During an interview on 3/12/25, at 3:07 PM, the Director of Nurses (DON) stated the facility was performing audits but had not initiated a QAPI for the delayed background checks. The DON further stated the issue was identified in June of 2024. The DON stated the importance of a QAPI for background checks was to ensure there were no issues that would prevent staff from working with residents. The DON further stated not having background checks completed for newly hired staff put the residents at risk of potential abuse. During an interview on 3/12/25, at 3:17 PM, the DON stated QAPI was important to identify a specific problem, ensure the problem was reviewed and re- audited, to monitor for improvement, and if the interventions were not working to look for new ways to improve the system. (continued on next page)

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	03/14/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility policy titled, Quality Assurance and Performance Improvement (QAPI), dated 2024, indicated, .It is the policy of this facility to develop, implement, and maintain an effective, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides .Develop and implement appropriate plans of action to correct identified quality deficiencies .All identified problems will be addressed and prioritized .

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	03/14/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50716 Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 91 when: 1. Licensed Nurse (LN) 1 did not clean, sanitize, and disinfect the glucometer (a device that measures blood sugar levels) per manufacturer's guidelines; and 2. A partially full urinal was sitting on the bedside table with Resident 300's water. These failures had the potential to spread infection and cause health problems to the residents for a census of 91. Findings: 1. During a concurrent observation and interview on 3/11/25, at 12:24 PM, in front of room [ROOM NUMBER], LN 1 was observed cleaning a glucometer after use. LN 1 took one (name brand pre-moistened disinfectant wipe) and cleansed the glucometer for a few seconds and then placed the glucometer on a tray on her medication cart. LN 1 stated she cleaned the glucometer for approximately 15 seconds and could not remember how long the recommended wet-contact time was (how long a disinfectant needs to stay wet on a surface to be effective) was. LN 1 stated the policy was to clean the glucometers with the (name brand pre-moistened disinfectant wipe). A review of the back of the wipes with LN 1 indicated, .Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes . During an interview on 3/13/25, at 9:58 AM, the Director of Nursing (DON) stated it was the policy of the facility to follow the manufacturer's guidelines when the glucometers were cleaned and should have a wet contact time of 2-4 minutes. The DON stated the risk to the residents was the spread of infection and bloodborne pathogens (small viruses or bacteria that are present in blood and can cause disease). A review of an undated facility provided policy and procedure (P&P) titled, Glucometer Disinfection, indicated, .facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions .Retrieve (2) disinfectant wipes from the container. Using first wipe, clean first to remove heavy soil .use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following manufacturer's instructions . A review of the glucometer's manufacturer's cleaning instructions, titled, Cleaning and Disinfecting the Assure Prism multi Blood Glucose Monitoring System (BGMS), revised 9/24, indicated, .Each time the cleaning and disinfecting procedure is performed, two wipes are needed; one wipe to clean the meter and a second wipe to disinfect the meter .Meter surfaces must remain wet according to the contact times listed in the wipe manufacturer's instructions . (https://arkrayusa.com/diabetes-management/professional-healthcare-products/assure/assure-prism-multi/) (continued on next page)

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	03/14/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on 3/13/25, at 9:17 AM, with LN 5 and Resident 300, in Resident 300's room, LN 5 confirmed a urinal half full of urine was sitting on the bedside table with Resident 300's drinking water. Resident 300 stated he asked for it to be emptied earlier in the morning, but it still had not. LN 5 stated it should have been emptied and placed in a blue holder that hangs from the side of the bed. LN 5 was unable to locate the blue hanging holder at Resident 300's bedside. LN 5 explained the risk to the resident was infection or accidentally mistaking the urinal for his drinking water. LN 5 confirmed it should have been emptied when he asked earlier. LN 5 did not empty the urinal, and it was left on the bedside table while she administered his medications. During an interview on 3/13/25, at 9:58 AM, the Director of Nursing (DON) stated Resident 300 should have had the bedside holder for his urinal, so it was not placed on the table over his bed. The DON further stated the urinal should have been emptied immediately when it was brought to the nurse's attention. The DON stated the urine sitting on the bedside table was an infection control risk. A review of an undated facility P&P titled, Disinfection of Bedpans and Urinals, indicated, .urinals are handled in a manner to prevent the spread of infection through personal equipment .place urinals in the Urinal Holds as per facility policy .do not allow placement on the floor or on a bedside table that is used for eating or drinking .

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	03/14/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 50778 Based on interview and record review, the facility failed to ensure the Antibiotic Stewardship Program (ASP- a federally mandated program with goals of monitoring, optimizing antibiotic use, and reducing misuse of antibiotics) was followed for one of two residents on antibiotics (Resident 90) in a sample of 20 based on facility policy and national standards when: 1. McGeer Criteria (a set of guidelines for identifying infections in long-term care facilities) was not followed for prescribing antibiotics as indicated in the facility policy and procedure for Resident 90; and, 2. An antibiotic time-out (an active reassessment of an antibiotic prescription 48-72 hours after the medication's first dose) for Resident 90 was done within 24 hours and did not follow the facility's policy and procedure of the ASP; and, 3. The facility did not order a diagnostic urine Culture (a test to find germs, such as bacteria, that can cause an infection) and Sensitivity ([C&S]- a sensitivity test checks to see what kind of medicine such as an antibiotic that will work best to treat an infection) test for Resident 90. These failures had the potential to contribute to unsafe antibiotic use and monitoring in the facility for a census of 91 and placed Resident 90 at higher risk of antibiotic resistance (when bacteria/germs change in some way that reduces or eliminates the effectiveness of drugs, chemicals, or other agents designed to cure or prevent infections). Findings: During a concurrent interview and record review on 03/14/25 at 10:53 AM with the Infection Preventionist (IP), the facility's Infection Control Log dated 2/2025 was reviewed. The IP stated the Infection Control Log indicated, Resident 90 had a diagnosis of a Urinary Tract Infection (UTI-an infection that affects any part of the urinary system, commonly caused by bacteria) but did not have culture (a biological sample sent to a laboratory to determine the type of germ causing an infection) results under the heading Culture (pathogens-[a microorganism that causes, or can cause, disease]). The IP confirmed the C&S was not done for Resident 90. The IP confirmed on the Infection Control Log under the column heading criteria met? indicated, Yes. The IP could not explain how Resident 90 could meet the UTI surveillance definition without a positive result of C&S which was an essential criteria in McGeer guidelines as referenced in facility policies and procedures. During a concurrent interview and record review on 03/14/25 at 10:53 AM with the IP, the facility's Antibiotic Time Out document for Resident 90 was reviewed. The Antibiotic Time Out indicated, .Diagnostic Testing Ordered .Other .Other laboratory tests .Resident concern regarding too much voiding [urinating] and she is using 3 incontinent brief [designed to absorb and contain urine or stool] each time . The IP confirmed documentation indicated Resident 90 started antibiotics on 2/26/25 and the Antibiotic Time Out was completed and signed on 2/27/25. The IP verified the antibiotic time out was done one day after Resident 90 started on antibiotics and not within the 48-72 hours as specified in the McGeer Criteria guidelines and the facility's policies and procedures. (continued on next page)

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	03/14/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 03/14/25 at 10:53 AM with the IP, the facility's undated policy and procedure (P&P) titled, Antibiotic Stewardship Program was reviewed. The P&P indicated, . Nursing will monitor the initiation of antibiotics on residents and conduct an 'antibiotic timeout' within 48-72 [hours] of antibiotic therapy to monitor response to the antibiotic and review laboratory results .New or changed orders for antibiotics based on the antibiotic time out recommendations will be obtained from the practitioner . The IP confirmed this P&P was not followed. During a concurrent interview and record review on 3/14/25 at 12:27 AM with the Director of Nursing (DON), Resident 90's medical record and the Infection Control Log, dated 2/2025 were reviewed. Resident 90's medical record indicated, an antibiotic was started on 2/26/25 and the antibiotic time out was done on 2/27/25. The [NAME] stated an antibiotic time out should have been done 48-72 hours after the start of the antibiotics. The DON confirmed (the antibiotic time out) did not meet the criteria of 48-72 hours. The DON stated the purpose of an antibiotic time out is to check for any adverse reactions (unwanted or undesirable effects related to a medication) and to make sure the correct antibiotic was prescribed. The DON verified a urine C&S was not done for Resident 90. The DON stated if the wrong antibiotic was prescribed the risk to Resident 90 was the infection may not resolve or may worsen, and Resident 90 could develop resistance to the antibiotic causing multi-drug resistant organisms. Review of the facility's undated policy and procedure titled, Infection Surveillance indicated, .CDC's [Centers for Disease Control] National Healthcare Safety Network (NHSN) Long Term Care Criteria, Updated McGeer criteria .will be used to define infections .Data to be used in the surveillance activities .Lab reports . Review of the facility's undated policy and procedure titled, Antibiotic Stewardship Program indicated, .policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program .The program includes antibiotic use protocols and a system to monitor antibiotic use .Antibiotic use protocol .Laboratory testing shall be in accordance with current standards of practice .facility uses the .CDC's NHSN Surveillance Definitions, updated McGeer criteria .to define infections .Monitor response to antibiotics .to determine if the antibiotic is still indicated or adjustments should be made (e.g. antibiotic time-out) .

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	03/14/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50925 Based on observation, interview, and record review, the facility failed to ensure shared resident bedrooms measured at least 80 square feet (sq. ft.) per resident in a total of thirty-three resident rooms. This failure had the potential for an inadequacy of space for provision of care and to limit space for residents' personal belongings. Findings: During a concurrent observation and interview on 3/14/25, at 8:42 a.m., with the Maintenance Director (MATD), the MATD measured rooms 9, 29 and 31 with the Department to ensure accuracy of the measurements. The MATD provided the following documented room measurements for rooms not meeting the space requirement of 80 sq. ft. per resident in a shared bedroom: Room Number Occupancy Required/Actual Sq. Ft. Sq. ft per Resident 1 3 residents 240/220.71 73.57 2 3 residents 240/220.71 73.57 3 3 residents 240/220.71 73.57 4 3 residents 240/220.71 73.57 5 3 residents 240/220.71 73.57 6 3 residents 240/220.71 73.57 7 3 residents 240/220.71 73.57 8 3 residents 240/220.71 73.57 9 3 residents 240/220.71 73.57 10 3 residents 240/220.71 73.57 11 3 residents 240/220.71 73.57 12 3 residents 240/219.99 73.33 14 3 residents 240/219.99 73.33 15 3 residents 240/219.99 73.33 (continued on next page)

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	03/14/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	16 3 residents 240/219.99 73.33 17 3 residents 240/231.99 77.33 19 3 residents 240/231.99 77.33 21 3 residents 240/231.99 77.33 22 3 residents 240/219.45 73.15 23 3 residents 240/219.45 73.15 24 3 residents 240/219.45 73.15 25 2 residents 160/143.14 71.57 26 2 residents 160/143.14 71.57 29 3 residents 240/228.99 76.33 30 3 residents 240/231.99 77.33 31 3 residents 240/228.99 76.33 32 3 residents 240/231.99 77.33 33 3 residents 240/231.99 77.33 34 3 residents 240/231.99 77.33 35 3 residents 240/231.99 77.33 36 3 residents 240/231.99 77.33 During an interview on 3/14/25, at 8:39 a.m., with the housekeeper (HK), the HK stated that she was assigned to clean rooms 22 to 28. The HK stated that she had no issues with cleaning and moving around the rooms during cleanup and had no concerns with the size of the rooms. The HK stated that it was easy for her to move stuff around and did not feel that the rooms were tight or too small. During an interview in room [ROOM NUMBER], on 3/14/25, at 9:31 a.m., Resident 31 stated that the room size was okay and had enough space. Resident 31 stated that she had no problems with the room size. During a resident council meeting held with the Department on 3/12/25, at 9:30 a.m., there were no complaints about the room size reported by the residents in attendance. (continued on next page)

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	03/14/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Based on the findings during the Recertification Survey, the Department recommends granting continuation of the Room Waiver, contingent upon compliance with federal regulations at Resident Rights (481.10) and Physical Environment (483.90).