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	03/19/2025

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) had a safe discharge plan in place when Resident 1 expressed wanting to leave the facility against medical advice (AMA - a situation where a resident left a facility without following the physician's recommendation for treatment). This failure resulted in Resident 1 leaving the facility AMA when he was not equipped to meet his healthcare needs and was found lying in an unknown person ' s front yard 3.4 miles from the facility confused and gravely disabled (a person who was unable to provide for their basic needs [food, clothing, shelter, gravely disabled personal safety, or necessary medical care]). Findings: A review of Resident 1 ' s clinical record from [ACUTE CARE HOSPTIAL NAME], titled, History and Physical Reports, dated 2/9/25, by Physician (PHYS) 1, indicated upon entrance to the Emergency Department (ED), Resident 1 was restless and only able to identify his name (not place, time, or event). Resident 1 had fallen and hit his head on 2/8/25 and had acute encephalopathy (new onset of brain dysfunction or damage, causing confusion) and imaging of the head indicated Resident 1 had a brain bleed. A review of Resident 1 ' s clinical record from [ACUTE CARE HOSPTIAL NAME], titled, Discharge Summary, dated 2/13/25, by PHYS 2, indicated Resident 1 was discharged from the hospital to the facility and ordered to have Physical Therapy (PT - (exercises to help Resident 1 improve movement, manage pain, and regain function), Occupational Therapy (exercises to help Resident 1 improve or maintain skills needed for daily living), and a nutritional consult. Resident 1 was on fall precautions (measures taken to prevent falls). A review of Resident 1 ' s clinical record (at the facility) titled, History and Physical, dated 2/13/25, by the Medical Director (MD), indicated Resident 1 was recently transferred from [ACUTE CARE HOSPITAL NAME] to the facility and had a history of atrial fibrillation (irregular heartbeat), heart failure, and kidney disease. Upon admission to the facility, Resident 1 demonstrated cognitive impairment (confusion) and was oriented to person but not to place, time, or event. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/19/25 at 11:22 a.m., with Licensed Nurse (LN) 1, Resident 1 ' s document titled, Progress Notes, dated 2/16/25, was reviewed. The record indicated, Resident [Resident 1] was . restless, wandering around the facility claiming he 'needed to leave'. During AM [morning] medication pass, resident began to pack his belongings and when asked where he was going, he would state ' to go with my wife ' (wife not on scene) .Resident .does have intermittent episodes of forgetfulness and is a poor historian .resident left the facility with his bag (no medications discharged with patient) . LN 1 stated Resident 1 verbalized that he wanted to leave the facility for approximately two hours before he left AMA. LN 1 stated she texted MD 1 that Resident 1 wanted to leave the facility, but she never received a text back. LN 1 stated there was not a follow up phone call to MD 1 until after Resident 1 left the facility. LN 1 stated Resident 1 did not have a walker (used to provide support and stability while walking) when he left the facility. LN 1 stated she did not notify the ombudsman (an independent official that attempted to resolve conflicts or concerns raised by a resident), the facility social services director (SSD), or Adult Protective Services (APS - an agency that assisted elders, and dependent adults who are disables when the adults are unable to meet their own needs) that Resident 1 wanted to leave the facility AMA. LN 1 acknowelged she did not document in Resident 1 ' s clinical record specific alternatives to AMA that were offered to Resident 1. LN 1 stated it was her first time she had a resident leave AMA, and she was unsure whom she was supposed to notify. LN 1 stated Social Services would have been a great support to Resident 1 and could have possibly provided Resident 1 safe transportation from the facility to his home. LN 1 stated the Ombudsman could have provided Resident 1 with some community resources. LN 1 stated she was unaware if she should have called APS. A review of the document titled, Incident Report [CITY NAME 2] Police Department, dated 2/23/25, at 9:53 a. m., by Deputy Officer (DO) 1, indicated at approximately 10:00 a.m. on 2/16/25, Resident 1 left the facility AMA and was last seen walking on foot in an unknown direction away front the facility. At 12:32 p.m., DO 1 was alerted that Resident 1 ' s family member (FM) had filed a missing person ' s report. DO 1 called FM and FM stated he had gone to the facility to visit Resident 1, and the facility staff had advised him that Resident 1 had left the facility earlier that morning. Upon hearing this, FM drove around [CITY NAME 2] and looked for Resident 1 because FM was not sure if Resident 1 could get home independently. On 2/16/25, at approximately 4:47 p.m., DO 2 and DO 3 were sent on a call that a man (Resident 1) was laying on a homeowner ' s front yard (approximately 3.4 miles from the facility). Resident 1 stated he was lying on the yard because he had fallen. Upon arrival, DO 2 and DO 3 determined Resident 1 was unable to properly care for himself and considered Resident 1 gravely disabled. Resident 1 lived in [CITY NAME 1] approximately 21 miles from the facility. APS was notified, and Resident 1 was placed on a 72-hour evaluation hold (temporary involuntary detention for evaluation and treatment when a person was deemed a danger to themselves, others, or are gravely disabled) and sent to [ACUTE CARE HOSPITAL NAME]. A review of Resident 1's clinical record (from the Hospital Emergency Department), titled, [ACUTE CARE HOSPITAL NAME] Discharge Summary, dated 2/21/25, indicated Resident 1 remained disoriented while at the hospital and was later discharged home with a bedside commode (portable toilet), front wheeled walker, and a shower chair. A review of Resident 1 ' s clinical record titled, Malnutrition, dated 2/13/25, by MD, indicated Resident 1 had a diagnosis of malnutrition. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s clinical record titled, Fall Risk Assessment, dated 2/13/25, at 2:25 p.m., indicated Resident 1 was a high fall risk related to 1 to 2 falls in the past three months, required use of an assistive device (i.e. cane, w/c walker, furniture), took three or more medications that could have contributed to falls, had a recent change in medication in the past five days, and had 1 to 2 predisposing diseases that could have contributed to falls. A review of Resident 1 ' s clinical record titled, Care Plan Report (a document that contained Resident 1 ' s problems, goals and interventions), dated 2/14/25, indicated Resident 1 had declined in functional mobility, had decreased leg strength and coordination, and had increased falls. Resident 1 required moderate to maximum assist with Activities of Daily Living (ADL - brushed hair, brushed teeth, toileted) and moderate assist with mobility skills and safety activity tolerance. A review of Resident 1 ' s clinical record titled, Section GG - Function Abilities (a portion of a comprehensive assessment conducted at Skilled Nursing Facilities), dated 2/16/25, indicated Resident 1 required partial to moderate assistance (helper did less than half the effort) with toileting hygiene, upper body dressing, chair to bed transfer, toilet transfers, rolling to the left and to the right while in bed, and assistance when Resident 1 walked 10 feet in a room or 50 feet with two turns in a room. Resident 1 required substantial to maximum assistance (helper did more than half the effort) with lower body dressing and when he put on and took off socks. A review of Resident 1's clinical record titled, Evaluation Summary, dated 2/14/25, at 12:01 p.m., by the Social Services Director (SSD), indicated prior to admission, Resident 1 lived on the second floor of an apartment building and required home health and durable medical equipment (DME - medically necessary devices and supplies) prior to discharge from the facility. During a phone interview on 3/18/24 at 11:19 a.m., with the Ombudsman (OMB), the OMB stated the facility had not contacted him when Resident 1 had expressed the desire to leave the facility AMA. The OMB stated if he would have been notified, he would have provided AMA instructions to the facility. During a phone interview on 3/18/25, at 2:34 p.m., with APS employee (APS) 1, APS 1 stated when Resident 1 left the facility AMA, it was considered self-neglect (not caring for oneself) and an unsafe discharge. APS stated it was her expectation to be notified when Resident 1 left the facility AMA. APS 1 stated the failure of the facility to notify APS when Resident 1 left the facility AMA delayed the process of locating Resident 1 and delayed arranging services to assist Resident 1 with ADL assistance and medical care. During a concurrent interview and record review on 3/19/25, at 10:50 a.m., with LN 2, Resident 1 ' s Electronic Health Record (EHR) at the facility was reviewed. LN 2 stated Resident 1 was a high fall risk. LN 2 stated there were not any progress notes in the record that indicated that staff attempted to provide other options to Resident 1 prior to leaving AMA. LN 2 stated there was no documentation as to the time Resident 1 left AMA or the destination address. LN 2 stated the Ombudsman and APS should have been notified when Resident 1 left AMA but was unsure as to what the OMB and APS would have done to help. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/19/25, at 12:10 p.m., with LN 3, LN 3 stated the LN on duty should have notified the MD at the first sign that Resident 1 wanted to leave AMA and documented the notification in the EHR. LN 3 stated if the LN was unable to reach the MD, the LN should have attempted to notify the Nurse Practitioner (NP). LN 3 acknowelged the times the LN attempted to reach the MD were not documented in Resident 1 ' s clinical record. LN 3 stated Resident 1 was not safe to leave the facility AMA because he was a high fall risk. LN 3 stated the ombudsman, and APS should have been notified when Resident 1 left AMA because Resident 1 was at risk for injuries. During an interview on 3/19/25, at 12:25 p.m., with the SSD, the SSD stated she would have liked to have been notified when Resident 1 expressed he wanted to leave the facility AMA. The SSD stated she would have attempted to create a safer plan (such as home health-medical care provided in a person's home) upon leaving AMA. SSD stated she would have asked Resident 1 to wait until the MD could assess Resident 1 ' s ability to safety leave the facility. SSD stated Resident 1 had lived in an apartment approximately 21 miles from the facility and the staff had not formulated a plan on how Resident 1 was going to get home. The SSD stated she would have expected the LN to document all attempts that were made to have Resident 1 agree to remain at the facility until a safe discharge plan could have been arranged. During a phone interview on 3/19/25, at 2:10 p.m., with the MD, the MD stated when he assessed Resident 1 upon admission Resident 1 had intermittent confusion. The MD stated he was not aware Resident 1 had left AMA until after Resident 1 had already left the facility. The MD stated if he would have been made aware of Resident 1 ' s desire to leave AMA, he would have attempted to have a conversation with Resident 1 to ascertain (conclude) why Resident 1 was eager to leave. The MD stated he would have tried to convince Resident 1 to stay at the facility until he was deemed safe to discharge home. The MD stated the facility could have provided transportation to his home and/or followed up with Resident 1 to ensure he had arrived safely at home. During a joint phone interview with the Director of Nursing (DON) and the Administrator (ADM), the DON and ADM acknowelged Resident 1 had cognitive impairment and his orientation waxed and waned (stronger than weaker). The DON and ADM acknowelged it was not documented in Resident 1 ' s clinical record that alternative options (other than Resident 1 leaving AMA) were presented to Resident 1. The ADM stated APS should be called when a resident has left AMA and had mobility issues. The DON acknowelged Resident 1 was admitted with decreased mobility and needed PT and assistance with ADL care. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint concurrent phone interview and record reviews on 3/20/25, at 3:35 p.m., a review of the facility ' s Policy and Procedure (P&P) titled, Transfer and Discharge (including AMA [Against Medical Advice]), dated 2025, and Discharge Planning Process, dated 2025, was reviewed. The P&P titled, Transfer and Discharge (including AMA [Against Medical Advice]), indicated, .Discharge Against Medial Advice (AMA) .the physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. Documentation of this notification should be entered in the nurses ' notes .The social service designee should document any discussions held with the resident/family in the social service progress notes .Notify Adult Protection Services other entity as appropriate, if self-neglect is suspected. Document accordingly . The P&P titled, Discharge Planning Process, indicated, .In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care: a. Discuss with the resident .and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location. b. Offer other, more suitable, options of locations that are equipped to meet the needs of the resident. Document any discussions related to the options presented. c. Document refusals of other options that could meet the resident ' s needs. d. At time of discharge, follow policies regarding discharged Against Medical Advice, and refer to Adult Protective Services . The DON and ADM acknowelged Resident 1 had had two recent falls and had been diagnosed with a brain bleed following the fall. The DON and ADM acknowelged Resident 1 had intermittent confusion. The ADM stated the staff should have asked Resident 1 his plan to get home from the facility and documented the plan. The DON and ADM stated the AMA process had room for improvement and there was a lack of documentation by the LN on the steps that were taken prior to Resident 1 leaving the facility AMA. The DON and ADM stated from here on forward, APS would be called with AMAs to ensure the safety of a resident when the resident was not appropriate to leave the facility. During a joint concurrent phone interview and record review on 3/20/25, at 3:33 p.m., with the ADM and DON, a review of the facility ' s Policy and Procedure (P&P) titled, Accidents and Supervision, dated 2024 was reviewed. The P&P indicated, . The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents .A. All staff .are to be involved in observing and identifying potential hazards in the environment .The facility should make a reasonable effort to identify the hazards and risk factors for each resident . The ADM and DON acknowelged Resident 1 was a high risk for falls, had had a recent brain bleed, and there was not a plan in place as to how Resident 1 would get from the facility to his home when he left the facility AMA. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) had a safe discharge plan in place when Resident 1 expressed wanting to leave the facility against medical advice (AMA - a situation where a resident left a facility without following the physician's recommendation for treatment). This failure resulted in Resident 1 leaving the facility AMA when he was not equipped to meet his healthcare needs and was found lying in an unknown person's front yard 3.4 miles from the facility confused and gravely disabled (a person who was unable to provide for their basic needs [food, clothing, shelter, gravely disabled personal safety, or necessary medical care]). Findings: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's clinical record from [ACUTE CARE HOSPTIAL NAME], titled, History and Physical Reports , dated 2/9/25, by Physician (PHYS) 1, indicated upon entrance to the Emergency Department (ED), Resident 1 was restless and only able to identify his name (not place, time, or event). Resident 1 had fallen and hit his head on 2/8/25 and had acute encephalopathy (new onset of brain dysfunction or damage, causing confusion) and imaging of the head indicated Resident 1 had a brain bleed. A review of Resident 1's clinical record from [ACUTE CARE HOSPTIAL NAME], titled, Discharge Summary , dated 2/13/25, by PHYS 2, indicated Resident 1 was discharged from the hospital to the facility and ordered to have Physical Therapy (PT - (exercises to help Resident 1 improve movement, manage pain, and regain function), Occupational Therapy (exercises to help Resident 1 improve or maintain skills needed for daily living), and a nutritional consult. Resident 1 was on fall precautions (measures taken to prevent falls). A review of Resident 1's clinical record (at the facility) titled, History and Physical , dated 2/13/25, by the Medical Director (MD), indicated Resident 1 was recently transferred from [ACUTE CARE HOSPITAL NAME] to the facility and had a history of atrial fibrillation (irregular heartbeat), heart failure, and kidney disease. Upon admission to the facility, Resident 1 demonstrated cognitive impairment (confusion) and was oriented to person but not to place, time, or event. During a concurrent interview and record review on 3/19/25 at 11:22 a.m., with Licensed Nurse (LN) 1, Resident 1's document titled, Progress Notes , dated 2/16/25, was reviewed. The record indicated, Resident [Resident 1] was . restless, wandering around the facility claiming he 'needed to leave'. During AM [morning] medication pass, resident began to pack his belongings and when asked where he was going, he would state ' to go with my wife' (wife not on scene) .Resident .does have intermittent episodes of forgetfulness and is a poor historian .resident left the facility with his bag (no medications discharged with patient) . . LN 1 stated Resident 1 verbalized that he wanted to leave the facility for approximately two hours before he left AMA. LN 1 stated she texted MD 1 that Resident 1 wanted to leave the facility, but she never received a text back. LN 1 stated there was not a follow up phone call to MD 1 until after Resident 1 left the facility. LN 1 stated Resident 1 did not have a walker (used to provide support and stability while walking) when he left the facility. LN 1 stated she did not notify the ombudsman (an independent official that attempted to resolve conflicts or concerns raised by a resident), the facility social services director (SSD), or Adult Protective Services (APS - an agency that assisted elders, and dependent adults who are disables when the adults are unable to meet their own needs) that Resident 1 wanted to leave the facility AMA. LN 1 acknowelged she did not document in Resident 1's clinical record specific alternatives to AMA that were offered to Resident 1. LN 1 stated it was her first time she had a resident leave AMA, and she was unsure whom she was supposed to notify. LN 1 stated Social Services would have been a great support to Resident 1 and could have possibly provided Resident 1 safe transportation from the facility to his home. LN 1 stated the Ombudsman could have provided Resident 1 with some community resources. LN 1 stated she was unaware if she should have called APS. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the document titled, Incident Report [CITY NAME 2] Police Department , dated 2/23/25, at 9:53 a.m., by Deputy Officer (DO) 1, indicated at approximately 10:00 a.m. on 2/16/25, Resident 1 left the facility AMA and was last seen walking on foot in an unknown direction away front the facility. At 12:32 p.m., DO 1 was alerted that Resident 1's family member (FM) had filed a missing person's report. DO 1 called FM and FM stated he had gone to the facility to visit Resident 1, and the facility staff had advised him that Resident 1 had left the facility earlier that morning. Upon hearing this, FM drove around [CITY NAME 2] and looked for Resident 1 because FM was not sure if Resident 1 could get home independently. On 2/16/25, at approximately 4:47 p.m., DO 2 and DO 3 were sent on a call that a man (Resident 1) was laying on a homeowner's front yard (approximately 3.4 miles from the facility). Resident 1 stated he was lying on the yard because he had fallen. Upon arrival, DO 2 and DO 3 determined Resident 1 was unable to properly care for himself and considered Resident 1 gravely disabled. Resident 1 lived in [CITY NAME 1] approximately 21 miles from the facility. APS was notified, and Resident 1 was placed on a 72-hour evaluation hold (temporary involuntary detention for evaluation and treatment when a person was deemed a danger to themselves, others, or are gravely disabled) and sent to [ACUTE CARE HOSPITAL NAME]. A review of Resident 1's clinical record (from the Hospital Emergency Department), titled, [ACUTE CARE HOSPITAL NAME] Discharge Summary, dated 2/21/25, indicated Resident 1 remained disoriented while at the hospital and was later discharged home with a bedside commode (portable toilet), front wheeled walker, and a shower chair. A review of Resident 1's clinical record titled, Malnutrition , dated 2/13/25, by MD, indicated Resident 1 had a diagnosis of malnutrition. A review of Resident 1's clinical record titled, Fall Risk Assessment , dated 2/13/25, at 2:25 p.m., indicated Resident 1 was a high fall risk related to 1 to 2 falls in the past three months, required use of an assistive device (i.e. cane, w/c walker, furniture), took three or more medications that could have contributed to falls, had a recent change in medication in the past five days, and had 1 to 2 predisposing diseases that could have contributed to falls. A review of Resident 1's clinical record titled, Care Plan Report (a document that contained Resident 1's problems, goals and interventions), dated 2/14/25, indicated Resident 1 had declined in functional mobility, had decreased leg strength and coordination, and had increased falls. Resident 1 required moderate to maximum assist with Activities of Daily Living (ADL - brushed hair, brushed teeth, toileted) and moderate assist with mobility skills and safety activity tolerance. A review of Resident 1's clinical record titled, Section GG - Function Abilities (a portion of a comprehensive assessment conducted at Skilled Nursing Facilities), dated 2/16/25, indicated Resident 1 required partial to moderate assistance (helper did less than half the effort) with toileting hygiene, upper body dressing, chair to bed transfer, toilet transfers, rolling to the left and to the right while in bed, and assistance when Resident 1 walked 10 feet in a room or 50 feet with two turns in a room. Resident 1 required substantial to maximum assistance (helper did more than half the effort) with lower body dressing and when he put on and took off socks. A review of Resident 1's clinical record titled, Evaluation Summary , dated 2/14/25, at 12:01 p.m., by the Social Services Director (SSD), indicated prior to admission, Resident 1 lived on the second floor of an apartment building and required home health and durable medical equipment (DME - medically necessary devices and supplies) prior to discharge from the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 3/18/24 at 11:19 a.m., with the Ombudsman (OMB), the OMB stated the facility had not contacted him when Resident 1 had expressed the desire to leave the facility AMA. The OMB stated if he would have been notified, he would have provided AMA instructions to the facility. During a phone interview on 3/18/25, at 2:34 p.m., with APS employee (APS) 1, APS 1 stated when Resident 1 left the facility AMA, it was considered self-neglect (not caring for oneself) and an unsafe discharge. APS stated it was her expectation to be notified when Resident 1 left the facility AMA. APS 1 stated the failure of the facility to notify APS when Resident 1 left the facility AMA delayed the process of locating Resident 1 and delayed arranging services to assist Resident 1 with ADL assistance and medical care. During a concurrent interview and record review on 3/19/25, at 10:50 a.m., with LN 2, Resident 1's Electronic Health Record (EHR) at the facility was reviewed. LN 2 stated Resident 1 was a high fall risk. LN 2 stated there were not any progress notes in the record that indicated that staff attempted to provide other options to Resident 1 prior to leaving AMA. LN 2 stated there was no documentation as to the time Resident 1 left AMA or the destination address. LN 2 stated the Ombudsman and APS should have been notified when Resident 1 left AMA but was unsure as to what the OMB and APS would have done to help. During a concurrent interview and record review on 3/19/25, at 12:10 p.m., with LN 3, LN 3 stated the LN on duty should have notified the MD at the first sign that Resident 1 wanted to leave AMA and documented the notification in the EHR. LN 3 stated if the LN was unable to reach the MD, the LN should have attempted to notify the Nurse Practitioner (NP). LN 3 acknowelged the times the LN attempted to reach the MD were not documented in Resident 1's clinical record. LN 3 stated Resident 1 was not safe to leave the facility AMA because he was a high fall risk. LN 3 stated the ombudsman, and APS should have been notified when Resident 1 left AMA because Resident 1 was at risk for injuries. During an interview on 3/19/25, at 12:25 p.m., with the SSD, the SSD stated she would have liked to have been notified when Resident 1 expressed he wanted to leave the facility AMA. The SSD stated she would have attempted to create a safer plan (such as home health-medical care provided in a person's home) upon leaving AMA. SSD stated she would have asked Resident 1 to wait until the MD could assess Resident 1's ability to safety leave the facility. SSD stated Resident 1 had lived in an apartment approximately 21 miles from the facility and the staff had not formulated a plan on how Resident 1 was going to get home. The SSD stated she would have expected the LN to document all attempts that were made to have Resident 1 agree to remain at the facility until a safe discharge plan could have been arranged. During a phone interview on 3/19/25, at 2:10 p.m., with the MD, the MD stated when he assessed Resident 1 upon admission Resident 1 had intermittent confusion. The MD stated he was not aware Resident 1 had left AMA until after Resident 1 had already left the facility. The MD stated if he would have been made aware of Resident 1's desire to leave AMA, he would have attempted to have a conversation with Resident 1 to ascertain (conclude) why Resident 1 was eager to leave. The MD stated he would have tried to convince Resident 1 to stay at the facility until he was deemed safe to discharge home. The MD stated the facility could have provided transportation to his home and/or followed up with Resident 1 to ensure he had arrived safely at home. (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	03/19/2025

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint phone interview with the Director of Nursing (DON) and the Administrator (ADM), the DON and ADM acknowelged Resident 1 had cognitive impairment and his orientation waxed and waned (stronger than weaker). The DON and ADM acknowelged it was not documented in Resident 1's clinical record that alternative options (other than Resident 1 leaving AMA) were presented to Resident 1. The ADM stated APS should be called when a resident has left AMA and had mobility issues. The DON acknowelged Resident 1 was admitted with decreased mobility and needed PT and assistance with ADL care. During a joint concurrent phone interview and record reviews on 3/20/25, at 3:35 p.m., a review of the facility's Policy and Procedure (P&P) titled, Transfer and Discharge (including AMA [Against Medical Advice]), dated 2025, and Discharge Planning Process , dated 2025, was reviewed. The P&P titled, Transfer and Discharge (including AMA [Against Medical Advice]) , indicated, .Discharge Against Medial Advice (AMA) .the physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. Documentation of this notification should be entered in the nurses' notes .The social service designee should document any discussions held with the resident/family in the social service progress notes .Notify Adult Protection Services other entity as appropriate, if self-neglect is suspected. Document accordingly . . The P&P titled, Discharge Planning Process , indicated, .In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care: a. Discuss with the resident .and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location. b. Offer other, more suitable, options of locations that are equipped to meet the needs of the resident. Document any discussions related to the options presented. c. Document refusals of other options that could meet the resident's needs. d. At time of discharge, follow policies regarding discharged Against Medical Advice, and refer to Adult Protective Services . . The DON and ADM acknowelged Resident 1 had had two recent falls and had been diagnosed with a brain bleed following the fall. The DON and ADM acknowelged Resident 1 had intermittent confusion. The ADM stated the staff should have asked Resident 1 his plan to get home from the facility and documented the plan. The DON and ADM stated the AMA process had room for improvement and there was a lack of documentation by the LN on the steps that were taken prior to Resident 1 leaving the facility AMA. The DON and ADM stated from here on forward, APS would be called with AMAs to ensure the safety of a resident when the resident was not appropriate to leave the facility. During a joint concurrent phone interview and record review on 3/20/25, at 3:33 p.m., with the ADM and DON, a review of the facility's Policy and Procedure (P&P) titled, Accidents and Supervision , dated 2024 was reviewed. The P&P indicated, . The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents .A. All staff .are to be involved in observing and identifying potential hazards in the environment .The facility should make a reasonable effort to identify the hazards and risk factors for each resident . . The ADM and DON acknowelged Resident 1 was a high risk for falls, had had a recent brain bleed, and there was not a plan in place as to how Resident 1 would get from the facility to his home when he left the facility AMA.