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	08/14/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview, and record review, the facility failed to ensure that the Medical Director (MD) was notified and made aware of potential health changes for one of two sampled residents (Resident 1) when Resident 1 refused to eat, take his medications, and exhibited aggressive behavior.This deficient practice resulted in the MD not being able to assess Resident 1's health status with the potential delay in treatment. Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in the summer of 2025 with diagnoses including: need for assistance with personal care, unspecified dementia/ unspecified severity with other behavioral disturbance (an umbrella term for a decline in mental abilities severe enough to interfere with daily life. It affects memory, thinking, and behavior, and is not a normal part of aging), and suicidal ideations.During a review of Resident 1's Progress Notes, dated 7/16/25, the Progress Notes, indicated, .Resident has done nothing except lay facing the wall in his bed. Refused to eat. Refused Covid booster. Refused all medications. Will continue to monitor. Call light in reach.During a review of Resident 1's Progress Notes, dated 7/17/25, the Progress Notes, indicated, .Resident noted very aggressive behavior. He took the medicine from the nurse and pretending he is going to take while he tried to sit on the edge of the bed. He lead forward and throw away all his medicine under the night stand and under the bed. Re-direct the resident. Will continue to monitor.During an interview on 8/14/25, at 1:07 PM, with Licensed Nurse (LN) 2, LN 2 stated that Resident 1's behavior on 7/17/25 was very aggressive as she carefully entered the room to check and was able to validate the actions of Resident 1. LN 2 confirmed that she did not notify the MD and that she should have done so. LN 2 stated that informing the MD could have led to a further evaluation of Resident 1, including the ordering of possible laboratory tests. During a concurrent interview and record review on 8/14/25, at 11:11 AM, with the Director of Nursing (DON), Resident 1's Progress Notes, were reviewed. The DON confirmed that Resident 1 was exhibiting aggressive behaviors, was refusing his medications, and was also refusing to eat. The DON stated that the LNs should have notified the MD if there were behavioral changes occurring for Resident 1. The DON further stated that if Resident 1 was refusing to eat or take his medications, that those were other reasons to inform the MD. The DON explained that notifying the MD would have provided guidance on what actions to take with Resident 1. During an interview on 8/14/25, at 1:38 PM, with the MD, the MD stated that he could not recall any LNs notifying him about Resident 1's refusal to eat, refusal to take medications, or his aggressive behaviors. The MD further stated that he was available 24 hours a day and 7 days a week. The MD stated that he would have liked the facility to have notified him about Resident 1 so he could have discussed some medical options with him.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised on 4/2025, the P&P indicated, .The nurse will notify the resident's Attending Physician/Physician On-Call/Nurse Practitioner when there has been a(an).significant change in the resident's condition.need to alter the resident's medical treatment significantly.specific instruction to notify the Physician/Nurse Practitioner of changes in the resident's condition .

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that a safe discharge plan was in place for one of two sampled residents (Resident 1) when:1. The facility did not notify and document that the Ombudsman (acts as an independent and impartial resource to help individuals and groups resolve issues and complaints, often within a larger organization or government agency), Adult Protective Services (APS-programs that promote the safety, independence, and quality-of-life for vulnerable adults who are, or are in danger of, being abused, neglected by self or others, or financially exploited, and who are unable to protect themselves), the police department, and Resident 1's Responsible Party (RP) were contacted upon his Discharge Against Medical Advice ([NAME]- when a patient leaves a hospital or healthcare facility before their doctor recommends they be discharged) from the facility.2. The Medical Director (MD) did not receive notification from the facility that Resident 1 was attempting to leave the facility.3. The MD was not made aware of potential changes in behavior during Resident 1's stay in the facility.4. An elopement care plan (a proactive strategy to prevent residents in care facilities from leaving unsupervised, especially those with dementia or other cognitive impairments) was not created after Resident 1 was readmitted to the facility; when he had a history of leaving the facility during his initial admission on [DATE].These deficient practices had the potential to result in poor continuity of care and could lead to adverse health outcomes for Resident 1.Findings:1. A review of Resident 1's admission RECORD, indicated Resident 1 was initially admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including: need for assistance with personal care, unspecified dementia/ unspecified severity with other behavioral disturbance (an umbrella term for a decline in mental abilities severe enough to interfere with daily life. It affects memory, thinking, and behavior, and is not a normal part of aging), and suicidal ideations.During a review of Resident 1's clinical record titled, Nurses Notes, dated 7/11/25, at 9:37 PM, indicated, .[Resident 1] arrived via ambulance with 2 attendants .Resident is alert and oriented .he doesn't understand the situation .Resident started questioning me on whether or not the doors were locked and if he could go outside. Stated to resident that its getting dark .When resident saw EMT's [sic] he started yelling take me with you .resident became irate for some reason and stated he was leaving. Headed for the door. Didn't try to physically stop him as he was getting very aggressive in language and posture. Followed him out door, trying to convince resident to come back inside .Told my CNA [certified nursing assistant] to back off and let him go, it wasn't worth getting hurt. Came inside and called 911 .Received call our from maintenance supervisor that he is following the resident he saw leave the facility grounds. Maintenance stated policespotted [sic] them and started questioning resident . Police came to facility and told me that they were putting him [Resident 1] on a hold .During a review of Resident 1's clinical record titled, Nurses' Progress Note, dated 7/15/25, at 3:36 PM, indicated, .admission Note: Resident arrived from [local hospital] .Resident is alert and oriented .with episodes of confusion . Elopement Evaluation Score .High Risk .During a review of Resident 1's clinical record titled, [facility name] History and Physical, dated 7/16/25, the record indicated, .This is a medically complex patient, he has a baseline cognitive impairment and dementia, he is a poor historian.he is at high risk for decline and worsening due to his poor functional status as well as his cognitive impairment.Psychiatry exam indicated that Resident 1 has a baseline cognitive impairment and is unable to participate in the exam.During a review of Resident 1's clinical record titled, Social Service Assessment - Admission/Readmission, dated 7/17/25, the record indicated, .Resident 1 and Resident Representative/Family will participate in discharge planning. Safety concerns with Resident 1 preferred discharge plan indicated Resident 1 would need HH (Home Health), DME (Durable Medical Equipment) and caregiver for a successful discharge.During a review of Resident 1's clinical record titled, Nurses Note, dated 7/17/2025, the record indicated, .Resident 1 packed his belongings, put them in his walker, walked to the desk to tell staff that he is leaving. Licensed Nurse stated to Resident 1 to wait a moment to sign the [NAME] form. Resident 1 signed and Licensed Nurse pointed him to the door.During a phone interview on 7/29/25, at 1:49 PM, with Resident 1's RP, the RP stated that the facility did not notify her when Resident 1 left the facility. The RP further stated Resident 1 needed to be at the facility due to his severe dementia. The RP stated that a representative from a hospital contacted her on 7/18/25 to inform her that Resident 1 was no longer residing at the facility and had been admitted to the hospital. The RP further stated how upset she was that the facility did not notify her of Resident 1's [NAME] and was concerned that Resident 1 was left homeless overnight from 7/17/25 to 7/18/25 During a phone