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	12/31/2024

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** 34151 Based on interview, and record review, the facility failed to develop a care plan for one of two sampled residents (Resident 1) when Resident 1's care needs for alcohol withdrawal and elopement prevention were not addressed on admission. This deficient practice resulted in Resident 1 ' s elopement from the facility on 12/6/24 and 12/13/24. Findings: Review of Resident 1 ' s ADMISSION RECORD, indicated Resident 1 was admitted to the facility from Acute Hospital 1 on 12/4/24 with diagnoses including but not limited to alcohol use with intoxication, discitis (an inflammation of the intervertebral discs, convulsion (a sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles), and chronic obstructive pulmonary disease (a chronic lung disease that causes breathing problems and restricted airflow). Review of Resident 1 ' s Physician Progress Note from Acute Hospital 1 dated 11/27/24, indicated Resident 1 was admitted to the hospital for generalized pain. Resident 1 had a past medical history of alcohol abuse disorder (an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences), and alcohol withdrawal seizures (a sudden, uncontrolled electrical disturbance in the brain that can cause temporary changes in behavior, consciousness, and body movements). Review of Resident 1 ' s Physician Progress Note from Acute Hospital 1 dated 11/28/24, indicated Resident 1 .had left AMA [Against Medical Advice] yesterday and today come back after he drank alcohol . It also indicated Resident 1 .left AMA multiple times in the ER [emergency room] and during previous admissions . Review of Resident 1 ' s Nursing - Clinical Admission Evaluation, in the Elopement Risk section, with a signed date of 12/04/24, indicated a yes was checked for Question 5 Is the wandering behavior a pattern, goal-directed (i.e. specific destination in mind, going home etc.)? (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1 ' s Progress Note (Nurses Note), dated 12/6/24, indicated, .During shift report, it was noted that resident [Resident 1] was unable to be located within the facility. Last observed at 1410 [2:10 p.m.] A comprehensive search was conducted with staff performing a triple check of all rooms and areas within the facility .Attempts to reach the emergency contact were unsuccessful .At 1650 [4:50 p.m.], resident returned to the facility .MD [medical doctor] notified and ordered to send resident to ER for further evaluation . Review of Resident 1 ' s Progress Note (Note Text: HISTORY & PHYSICAL), with a date of service of 12/7/24, indicated, HPI [History of Present Illness]: Patient .presented to Acute care hospital 1 due to alcohol withdrawal. He elopement [sic] from the ER but returned with profound weakness and dizziness. Patient would drink 750 ml [milliliter- unit of volume] to 1 L [liter- unit of volume] of hard liquor on a daily basis. He is now in this facility for PT/OT [Physical Therapy/Occupational Therapy] . Review of Resident 1 ' s Progress Note (Note Text: Nurses Note), with an Effective Date of 12/13/24, indicated, .At approximately 4:15 p.m. the resident was observed smoking in the designated smoking area by a CNA. During rounds at 5:00 p.m., the nurse could not locate the resident .Despite these efforts, the resident could not be located. DON [Director of Nursing] and administrator were notified .The police were notified .It was emphasized to the officers that the resident left AMA without signing out, and the presence of a PICC [peripherally inserted central catheter- access device to large vein] line made it crucial to locate the resident promptly . During a concurrent interview and record review on 12/17/24, at 9:40 a.m., with the Director of Nursing (DON), the DON stated Resident 1 had two episodes of elopement from the facility since his admission to the facility on [DATE]; one occurred on 12/6/24 and the second elopement occurred on 12/13/24. The DON further stated the interventions after Resident 1 ' s elopement on 12/6/24 should have included education and monitoring. During a concurrent interview and record review on 12/31/24, at 8:30 a.m., with Licensed Nurse (LN) 1, LN 1 acknowledged that there was only one elopement assessment completed (on 12/4/24) throughout Resident 1 ' s stay in the facility from 12/4/24 thru 12/13/24. LN 1 further acknowledged there was no care plan developed for Resident 1 to address his alcohol withdrawal and elopement risk. During a concurrent interview and record review on 12/31/24, at 10:15 a.m., with LN 2, LN 2 acknowledged there was no elopement precaution/monitoring or withdrawal behavior precaution/monitoring placed on Resident 1. LN 2 stated, We keep a white binder where we have listed all the residents on any special monitoring, i.e. fall, elopement precaution. He [Resident 1] was listed on IV [Intravenous therapy] monitoring only. Review of a facility policy titled, Wandering and Elopement, with a revised date of March 2019, indicated, . The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents .If identified as at risk for wandering, elopement, or other safety issues, the resident ' s care plan will include strategies and interventions to maintain the resident ' s safety .