STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555263	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Manor Nursing & Rehabilitation Center	541 V Avenue National City, CA 91950

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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on interview and record review, the facility failed to ensure licensed nurse (LN) 1 performed a complete assessment (a process that evaluates a resident's health by gathering and analyzing information) and notified the physician for one of three residents (Resident 1), when Resident 1 experienced a sudden decrease in oxygen level and blood pressure. As a result, Resident 1 was found with cold, pale skin and without pulse approximately four hours after the decreased blood pressure (Measurement of the force exerted by blood against the walls of the arteries as the heart pumps) and oxygen level was first identified. An hour later, Resident 1 was pronounced dead. Findings: On [DATE] at 1:15 P.M., an unannounced onsite visit at the facility was conducted for a complaint investigation. A review of Resident 1's medical record was conducted on [DATE]. Per the Admission Record, Resident 1 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (infection in the system of organs that makes urine). A review of Resident 1 ' s Nursing Progress Notes, documented by LN 1, indicated the following events: On [DATE] at 11:30 P.M., Resident 1 requested for water and rested. No labored breathing or distress. No discoloration from lack of oxygen or changes noticed in skin color. On [DATE] at 12:30 A.M., Resident 1 was seen resting with eyes closed. No labored breathing or distress. No discoloration from lack of oxygen or changes noticed in skin color. On [DATE] at 2:09 A.M., Resident 1's vital sign (measurements to show how well the body functions) were BP (blood pressure) ,d+[DATE] mmHg (millimeters of mercury), HR (heart rate) 71 bpm (beats per minute), and the O2 sat (oxygen saturation - measure of how well the body is oxygenating the blood with normal range of ,d+[DATE]%) was 87 %. LN 1 applied four liters of oxygen via nasal (nose) cannula (thin plastic tube) to Resident 1. LN 1 gave Resident 1 water, and Resident 1 drank 240 milliliters. LN 1 left the pulse oximeter (an electronic device measuring oxygen saturation) on Resident 1's finger. (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
	555263	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Manor Nursing & Rehabilitation Center	541 V Avenue National City, CA 91950

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 - Actual harm Residents Affected - Few	On [DATE] at 2:33 A.M., Resident 1's vital sign was assessed. BP was ,d+[DATE] mmHg, HR 67 bpm, and O2 sat of 90%. On [DATE] at 2:37 A.M., Resident 1's BP was rechecked and was ,d+[DATE] mmHg. On [DATE] at 3 A.M., a Certified Nursing Assistant (CNA) checked Resident 1, and the O2 sat was 90%. On [DATE] at 3:30 A.M., LN 1 checked on Resident 1 and offered fluids, but Resident 1 refused. On [DATE] at 4 A.M., a CNA notified LN 1 that Resident 1's O2 sat was 95%. Resident 1 had no discoloration from lack of oxygen or changes noticed in skin color. On [DATE] at 4:30 A.M., LN 1 checked Resident 1. Resident 1 was resting. No labored breathing or distress. No discoloration from lack of oxygen or changes noticed in skin color. On [DATE] at 4:45 A.M., a CNA checked on Resident 1, and there was no labored breathing or distress. No discoloration from lack of oxygen or changes noticed in skin color. On [DATE] at 5 A.M., LN 1 checked Resident 1, and the O2 sat was 93% with oxygen at four lpm of oxygen. On [DATE] at 5:15 A.M., a CNA checked on Resident 1, and there was no labored breathing or distress. No discoloration from lack of oxygen or changes noticed in skin color. On [DATE] at 5:30 A.M., LN 1 checked Resident 1, and the pulse oximeter read that O2 saturation was stable . No labored breathing or distress. No discoloration from lack of oxygen or changes noticed in skin color. On [DATE] at 6:05 A.M., a CNA checked Resident 1. Resident 1 was resting. No labored breathing or distress. No discoloration from lack of oxygen or changes noticed in skin color. On [DATE] at 6:15 A.M., LN 1 checked Resident 1. Resident 1's skin was pale, and the body was cold. LN 1 instructed CNA to call 911 (emergency responder). Resident 1 had no pulse, and CPR (Cardiopulmonary Resuscitation- life-saving procedure) was performed. The emergency responder came to the facility and provided CPR. Resident 1 was pronounced dead at 7 A.M. A review of Resident 1's Weights and Vitals Summary log was conducted. Resident 1 had the following BP readings and HR during the night shift: [DATE] at 12:21 A.M., ,d+[DATE] and 88 bpm [DATE] at 2:47 A.M., ,d+[DATE] and 81 bpm [DATE] at 5:35 A.M., ,d+[DATE] and 63 bpm (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555263	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Manor Nursing & Rehabilitation Center	541 V Avenue National City, CA 91950

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 - Actual harm Residents Affected - Few	[DATE] at 1:27 A.M., ,d+[DATE] and 63 bpm [DATE] at 4:01 A.M., ,d+[DATE] and 82 bpm [DATE] at 2:09 A.M., ,d+[DATE] and 71 bpm [DATE] at 2:33 A.M., ,d+[DATE] and 67 bpm [DATE] at 2:37 A.M., ,d+[DATE] On [DATE] at 2:29 P.M., LN 1 was interviewed. LN 1 stated Resident 1 had low BP readings ranging from , d+[DATE] mmHg to ,d+[DATE] mmHg on [DATE]. LN 1 stated he offered Resident 1 fluids, elevated the resident ' s head of the bed, provided oxygen, and elevated Resident 1's feet. LN 1 stated Resident 1's vital sign on [DATE] were not within Resident 1's normal range. LN 1 stated Resident 1 experienced a change of condition. LN 1 stated he should have immediately notified Resident 1 ' s physician regarding the resident ' s change of condition. On [DATE] at 4 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated LN 1 should have assessed Resident 1 thoroughly when the resident ' s oxygen level and blood pressure suddenly went down. The DON also stated that LN 1 should have immediately notified Resident 1 ' s physician when the resident experienced a change of condition. On [DATE] at 1:45 P.M., an interview was conducted with Resident 1 ' s physician (PH). The PH stated he expected the nurses to inform him when a resident experience a change of condition. The PH stated the license nurse should have notified him when Resident 1 experienced a change of condition. A review of the facility ' s policy and procedure, titled Change in a Resident's Condition or Status, dated , d+[DATE], was conducted. The policy indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555263	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Manor Nursing & Rehabilitation Center	541 V Avenue National City, CA 91950

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** 36471 Based on interview and record review, the facility failed to ensure license nurse (LN) 3 transcribed a medication accurately for one of three residents (Resident 1) reviewed for pharmacy services, when Resident 1 ' s Carvedilol (a medication used to treat heart failure and high blood pressure) 3.125 milligrams (mg) order was incorrectly documented as Carvedilol 25 mg. As a result, Resident 1 was given a higher dose of Carvedilol than what was ordered by the physician which may cause for the resident ' s blood pressure to decrease. Finding: Resident 1 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection, per the Admission Record. A review of Resident 1's medical record was conducted. Per the Hospital Discharge Order List, dated 12/27/24, the hospital physician ordered Carvedilol 3.125 milligrams twice daily. Per the facility's Order Summary, dated 12/27/24, Resident 1 had a physician order for Carvedilol 25 milligrams twice daily. Further review of Resident 1's medical record was conducted. There was no evidence of medication reconciliation of the Hospital discharge order and facility admission order for the Carvedilol medication. Licensed Nurse (LN) 3 was not available for an interview. On 2/4/25 at 4 P.M., a joint interview and record review was conducted with the Director of Nursing (DON). The DON stated LN 3 should ensure the orders from the hospital matched the facility ' s admission order. The DON stated that LN 3 did not transcribe the Carvedilol order correctly. On 2/29/25 at 2:52 P.M., an interview was conducted with the Pharmacy Consultant (PC). The PC stated LN 3 transcribed the order incorrectly, it was supposed to be Carvedilol 3.125 mg, and LN 3 wrote Carvedilol 25 mg. The computer system did not alert the nursing staff because the Carvedilol can be given up to 50 mg daily. The PC stated the pharmacy sent the dosage of what was ordered by the physician, which was Carvedilol 25 mg. Per the facility's policy and procedure, dated 7/17, titled Reconciliation of Medications on Admission, The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosage upon admission or readmission to the facility .