

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Sharp Chula Vista Med Ctr Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 751 Medical Center Court Chula Vista, CA 91911	
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 - Some	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. Based on interview and record review, the facility failed to document that residents were informed of their right to formulate advance directives and failed to document provision of advance-directive information in the medical record for 9 of 18 sampled residents reviewed. (Residents #17, 95, 11, 38, 6, 52, 60, and 42). Failure to ensure documentation of advance-directive education has the potential to affect residents' ability to exercise their right to make informed healthcare decisions. Findings On 2/24/26 at 8:43 A.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 11. LN11 reviewed the medical record for Resident #17 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the resident or resident's representative in the medical record and there should have been. LN11 reviewed the medical record for Resident #95 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the resident or resident's representative in the medical record and there should have been. On 2/24/26 at 9:12 A.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 3. LN3 reviewed the medical record for Resident #11 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the resident or resident's representative in the medical record and there should have been. LN3 reviewed the medical record for Resident #38 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the resident or resident's representative in the medical record and there should have been. LN3 reviewed the medical record for Resident #6 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the resident or resident's representative in the medical record and there should have been. LN3 reviewed the medical record for Resident #52 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the resident or resident's representative in the medical record and there should have been. On 2/24/26 at 2:06 P.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 2. LN2 reviewed the medical record for resident #60 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the resident or resident's representative in the medical record and there should have been. LN2 reviewed the medical record for resident #42 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the resident or resident's representative in the medical record and there should have been. LN2 reviewed the medical record for Resident #32 and stated there was no documentation regarding advance directive discussion or that advance directive information had been provided to the Resident or Resident's representative in the medical record and there should have been. On 2/25/26 at 11:08 A.M., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated that the admitting staff did not document in the medical record when advance directive information was provided to the Resident or the Resident's representative, and it should have been. The DON stated this is a failure in the admission process. On 2/25/26 at 1:48 P.M., a (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
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concurrent interview and record review was conducted with the Admissions Counselor (AC). The AC stated that admitting staff did not document Advance Directive information was provided to all Residents or Resident Representatives during the admitting process and her expectation was that it should have been. A review of the facility's policy titled Advanced Directives and Physician Orders for Life Sustaining Treatment (POLST), 0122156.99 approved 3/5/25, does not address provisions requiring documentation that advance directive information was provided to residents or resident representatives upon admission.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility's QAA/QAPI (Quality Assessment and Assurance/ Quality Assessment Program Improvement) committee failed to identify, develop, and implement action plans related to advance directives (cross reference F 578). This failure had the potential for residents not to be informed of their right to formulate advance directives and make informed decision regarding their medical care and treatment preferences. FINDINGS On 2/26/26 at 2:05 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that the admissions staff missed the opportunity to document advance directives information was provided to all residents. The DON stated his expectation was that the documentation should have been completed. The DON stated the facility's QAPI committee looked into facility issues that affected a high number of residents. The DON stated advance directives should have been identified as a project for the QAPI committee. A review of the facility's policy titled Quality Assurance and Performance Improvement (QAPI) Plan and Adverse Events Policy, 160003.00 revision date 3/21/25 indicated II. Authority and Responsibility .2. A. performance improvements to reduce the risk of failure. improve the reliability of systems, processes. 3.d. Monitoring and improving compliance with all state and national regulatory, accreditation, and certification standards.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure that one out of five sampled residents (Resident 52) was free from unnecessary psychotropic (affecting brain activities associated with mental processes and behavior) medication when Resident 52 was prescribed a psychotropic medication as needed for more than 14 days. This failure had the potential for Resident 52 to receive an unnecessary psychotropic medication which can lead to side effects, such as sedation, falls, and headaches. Findings: A review of Resident 52's medical records indicated an active order for hydroxyzine (a medication used for various conditions, including anxiety, a condition characterized by excessive worrying), 25 milligram (mg, unit of measure) tablet every six hours prn (as needed) for anxiety, dated 1/10/26. The order was noted to have a duration of 54 days and was prescribed by a physician. During an interview with the Director of Nursing (DON) on 2/26/26 at 1:25 P.M., the DON acknowledged hydroxyzine for anxiety meant that hydroxyzine was being used as a psychotropic medication. During a concurrent interview and record review of Resident 52's hydroxyzine order with the DON and pharmacist (RPH) on 2/26/26 at 1:56 P.M., the DON and RPH were asked for documentation for the prescriber's rationale for exceeding a 14-day treatment duration of a prn psychotropic. During a concurrent interview and record review of Resident 52's Nurse Practitioner (NP) Psychiatry Consult Note, dated 1/23/2026 (13 days after hydralazine was prescribed), with the DON on 2/26/26 at 2:36 P.M., the DON stated the following paragraph was justification for prescribing hydroxyzine prn beyond 14 days: She [Resident 52] does note that breakthrough anxiety appears to be addressed with as needed medication, although appears to be taking it on a somewhat regular basis. Discussed adjustment of medications with patient at bedside. Patient is agreeable to an adjustment of medications to address her ongoing depressive symptoms [sic] A review of the NP Psychiatry Consult Note indicated hydroxyzine therapy was not addressed. A review of the facility's policies and procedures (P&P) titled, Assessment of Psychotropic Medications, 39130, revised 5/4/23, indicated, 1. PURPOSE Residents who receive psychotropic medication are assessed to determine the need or continued need of the medication for the ordered indication as mandated by State and Federal Law.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of transfer to the Long-Term Care Ombudsman for three of four sampled residents. (Resident #7, 89 and 91). This failure had the potential for the Ombudsmen to not be aware of the residents' transfers. Findings On 2/25/26 at 8:29 A.M., a concurrent interview and record review was conducted with Licensed Nurse (LN) 3. LN3 reviewed the medical record for Resident #7 and stated that Resident #7 was admitted to the facility on [DATE] with a past history of DVT (deep vein thrombosis- a blood clot (thrombus) in one or more of the deep veins in the body, usually in the legs). LN3 stated on 12/10/25, Resident #7 was assessed to have dark discoloration to right foot with severe pain and was transferred to the hospital. LN3 stated a written notification to the Ombudsmen was not documented. Resident #7 returned to the facility on [DATE]. LN3 stated on 12/13/25, Resident #7 was assessed to have abdominal distension and pain and was transferred to the hospital. LN3 stated a written notification to the Ombudsmen was not documented. On 2/25/26 at 9:19 A.M., a concurrent interview and closed record review was conducted with Licensed Nurse (LN) 3. LN3 reviewed the medical record for Resident #89 and stated Resident #89 was admitted to the facility on [DATE] with a diagnosis of generalized weakness and hypertension (HTN-high blood pressure). LN3 stated on 12/21/25, Resident #89 was assessed for poor appetite and dehydration and was transferred to the hospital. LN3 stated a written notification to the Ombudsmen was not documented. On 2/26/26 at 8:20 A.M., an interview and record review was done with the Director of Nursing (DON). The DON reviewed Resident #7's medical record and stated that the written notification to the Ombudsman of the resident's transfer to the hospital was not done and it should have been. The DON also stated that the Ombudsman was not notified of Residents' 89 and #91 transfer to the hospital and should have been. The DON stated it was important that the Ombudsman be notified and written notice should have been done so the Ombudsman was aware of the Resident's status and that resident was transferred to the hospital. On 2/26/26 at 10:17 A.M., a concurrent interview and closed record review was conducted with LN11 for Resident #91. Resident #91 was admitted on [DATE] and left the facility against medical advice on 1/11/26. LN11 stated there was no documentation of notification to Ombudsman. A review of the facility's policy titled Admission, Transfer and Discharge Guidelines (Short Term Sub Acute - SNF/TCU/LTC - Custodial), 3940 last revised 8/22/23 does not indicate the facility must send a copy of the notice of transfer or discharge to the representative or the Office of the State Long-Term Care (LTC) Ombudsman.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a plan of care plan was developed for anticoagulant medications (medication to prevent blood clots) for 2 of 5 sampled residents. This failure had the potential to result in inadequate monitoring for complications of anticoagulant medications for residents (60, 95). Findings: 1. On 2/25/26 at 8:33 A.M., a concurrent interview and clinical record review was conducted with a Licensed Nurse (LN 11). Resident 95 was admitted to the facility on [DATE] according to the facility Face Sheet. Physician order dated 2/19/26, Xarelto (anticoagulant) tablet 20 milligrams daily with evening meal. Resident 95's clinical record did not have a care plan in place to monitor for complications of anticoagulant medication. LN 11 stated a care plan should have been developed to monitor for complications of anticoagulant medication. On 2/26/26 at 9:43 A.M., the Director of Nursing (DON) was interviewed. The DON stated care plans should have been developed for any residents on anticoagulant medications. 2. A review of Resident 60's Face Sheet, indicated the resident was admitted to the facility on [DATE] with a diagnosis that included Atrial Fibrillation (an irregular, often rapid, heart rate). On 2/24/26 at 3:09 P.M., an interview and record review was conducted with Licensed Nurse (LN) 1. LN 1 reviewed Resident 60's physician's order. Physician's order indicated, Eliquis tablet 5 milligrams (mg) one tablet by mouth twice a day for Afib. LN 1 stated there was no specific care plan for monitoring the negative side effects of the blood thinner for Resident 60 and there should have been. LN 1 stated it was important to monitor negative side such as blood stools, bruising, bleeding gums. On 2/26/26 at 9:43 A.M., the Director of Nursing (DON) was interviewed. The DON stated care plans should have been developed for any residents on anticoagulant medications. A review of facility policy titled Care Plan/interdisciplinary Care Conference. Revised 2/19/25, indicated .1. Develop and implement by IDT. A review of Apixaban ([NAME]-Drugs) dated 2/18/26 provided by facility indicated side effects .vomiting blood or vomit that looks like coffee grounds. blood in urine, black, red or tarry stools, bleeding gums.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide medication therapy in accordance with professional standards of practice for one of six sampled residents (Resident 1) when Licensed Nurse (LN) 14 did not flush (push water through) Resident 1's feeding tube (a device used to administer food and medications to individuals with difficulty swallowing) in between medication administration. This failure had the potential for Resident 1 not to get the full therapeutic benefit of his medications or to experience complications from his medications clogging in the feeding tube. Findings: During a concurrent medication administration observation and interview on 2/23/26 at 12:04 P.M., LN 14 was observed preparing and administering a total of 11 medications for Resident 1. LN 14 flushed the feeding tube with 30 milliliters (mL, unit of measure) of water before starting the medication administration. LN 14 administered each medication separately. Flushing was not observed in between the administration of the 11 medications. After administering all the medications, LN 14 flushed the feeding tube with water. LN 14 stated she flushed only before and after the medication administration and not between each of the medications. During an interview with the Director of Nursing (DON) on 2/25/26 at 1:41 P.M., the DON stated nursing staff were expected to flush with 10 mL of water in between each medication, in addition to flushing with 30 mL of water before and with 30 mL of water after medication administration. A review of the facility's policy and procedure (P&P) titled, Enteral Tube - Medication Administration, 39102.99, revised 5/4/2023, indicated, .L. Flush the feeding tube with 30 mls [milliliters] of water prior to medication administration. M. Tube is flushed between individual liquids and solids with a minimum of 10 mls of water. N. Flush tube with 30 mls. [sic] of water following medication administration.		

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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** Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services when: A bag containing three inhaler (a device used to deliver medications to the lungs) mouthpieces for Resident 85 was found in one of two sampled active Medication Carts with the top part of the label missing. This failure had the potential for residents to receive the wrong inhaler or wrong dose, which could result in adverse resident outcomes and medication errors. An expired inhaler mouthpiece for Resident 85 was found in one of two sampled Medication Carts, and an expired tube of white petrolatum was found in one of two sampled Treatment Carts. These failures had the potential to negatively alter the drugs' stability, physical properties (such as consistency) and effectiveness, which could result in adverse resident outcomes. Findings: During a concurrent observation and interview on [DATE] at 10:58 A.M. with Licensed Nurse (LN) 10, an inspection of East Wing Medication Cart 2 was conducted. A bag was found missing the top portion of the prescription label. The remaining portion of the prescription label did not have the resident's name, the drug name or part of the directions for how to use the medication. The bag contained three albuterol (a breathing treatment for respiratory conditions) inhaler mouthpieces for Resident 85. LN 10 stated the outside bag should have had a label on it in addition to the individual labels on each inhaler. The labels on the individual inhalers were observed to only have the names of the resident and medication, not the directions for use. A review of Resident 85's medical record indicated an active order for albuterol 90 mcg (micrograms, unit of measure) - 1 puff every 4 hours PRN (as needed) for wheezing (high pitched sound due to inflamed or narrowed airways), dated [DATE]. During an interview with the Director of Nursing (DON) on [DATE] at 1:41 P.M., the DON stated both the outer bag and the devices inside were labeled for medications, such as inhalers. A review of the facility's policy and procedure (P&P) titled, Labeling of Medications, 43021.99, revised [DATE], indicated, III. POLICY All drug labels must be legible and in compliance with State and Federal requirements. Containers with worn, illegible, or missing labels shall be returned to the pharmacy for proper disposition. During a concurrent observation and interview on [DATE] at 10:58 A.M. with LN 10, an inspection of East Wing Medication Cart 2 was conducted. An expired Breo Ellipta (a medication for asthma or chronic obstructive pulmonary disease [COPD], respiratory conditions that affect breathing) inhaler mouthpiece for Resident 85 was observed. The medication had a sticker on the inhaler and on the outer bag. Both stickers read, .EXPIRES 15 [DATE]. LN 10 read the sticker and stated the medication was expired. A review of Resident 85's medical record indicated she had an active order for Breo Ellipta 200/25 mcg (microgram, unit of measure) inhaler 1 puff daily, originally ordered [DATE]. During an interview with the DON on [DATE] at 1:41 P.M., the DON stated the expired Breo Ellipta should not have been in the Medication Cart. The DON stated the expired medication should have been disposed of or returned to the pharmacy. During a concurrent observation and interview on [DATE] at 11:32 A.M. with LN 10, an inspection of the East Wing Treatment Cart 2 was conducted. A tube of white petrolatum was observed in the treatment cart with an expiration date of 10/23. LN 10 confirmed the tube was expired. During an interview with the DON on [DATE] at 1:41 P.M., the DON stated the tube should have been disposed of prior to the expiration date. A review of the facility's P&P titled, Medication Storage in the Long Term Care Facility, 39129, revised [DATE], indicated, .L. Outdated medications are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exists.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's medication error rate was 11.43% when four medication errors occurred out of 35 opportunities during the medication administration for three of six randomly observed residents (Residents 92, 94 and 1). These failures had the potential for the residents not to get the full therapeutic benefit of their medications or to experience negative health outcomes, such as harm from exposure to medication errors. Findings: During a medication administration observation on 2/23/25 at 8:28 A.M., Licensed Nurse (LN) 14 was observed preparing and administering 13 medications for Resident 92. The medications included the following: doxycycline (an antibiotic in the tetracycline class) 100 milligram (mg, unit of measurement) tablet, magnesium oxide (supplement for low magnesium levels) 400 mg tablet, and levothyroxine (used to treat hypothyroidism, underactive thyroid) 50 microgram (mcg, unit of measurement) tablet. During an interview on 2/23/25 at 8:28 A.M., Resident 92 was asked about breakfast. Resident 92 stated she had just eaten breakfast. During a concurrent interview and record review of Resident 92's medical record with LN 14 on 2/24/26 at 11:08 A.M., LN 14 stated levothyroxine was scheduled to be administered daily at 9 A.M. The pharmacist (RPH) joined the interview at 11:11 A.M. The RPH stated the facility did not administer levothyroxine at 6 A.M., but administered the medication at the same time daily at 9 A.M. LN 14 was shown the prescription label on the doxycycline pill bottle. The prescription label indicated, Do not give milk, iron products, or antacids containing aluminum, calcium or magnesium within 2 hours before or at least 4 hours after dose. LN 14 stated that doxycycline and magnesium should not have been given together. A review of Resident 92's medical record indicated orders for medications, including the following: doxycycline 100 milligrams two times daily, started 2/19/26. magnesium oxide 400 mg daily, started 2/19/26. levothyroxine daily, started 2/20/26. During an interview with the Director of Nursing (DON) on 2/25/26 at 1:41 P.M., the DON stated nursing should have followed the directions on the doxycycline order because it could impact the dose. A drug review of doxycycline from [NAME]-Drugs (a nationally renowned drug information resource, which the facility uses), provided by the facility, undated, indicated, .Drug interactions. magnesium salts: May decrease absorption of Tetracyclines. Only applicable to oral [by mouth] preparations of each agent. Management: Avoid coadministration of oral magnesium salts and oral tetracyclines. If coadministration cannot be avoided, administer oral magnesium at least 2 hours before or 4 hours after oral tetracyclines. Monitor for decreased tetracycline therapeutic effects. Risk D: Consider Therapy Modification. A drug review of magnesium oxide from [NAME]-Drugs, provided by the facility, undated, indicated, Tetracyclines: Magnesium Salts may decrease absorption of Tetracyclines. Only applicable to oral preparations of each agent. Management: Avoid coadministration of oral magnesium salts and oral tetracyclines. If coadministration cannot be avoided, administer oral magnesium at least 2 hours before, or 4 hours after, oral tetracyclines. Monitor for decreased tetracycline therapeutic effects. Risk D: Consider Therapy Modification. During a medication administration observation on 2/23/26 at 9:16 A.M., LN 12 was observed preparing and administering six medications to Resident 94. One of the medications was a levothyroxine 75 mcg tablet. During an interview with LN 12 on 2/24/26 at 10:45 A.M., LN 12 stated that levothyroxine had been given on an empty stomach in the morning around 6:30 A.M., but all levothyroxine orders were changed to be administered at 9 A.M. LN 12 stated all residents on levothyroxine received a dose at 9 A.M., unless they requested to take levothyroxine at 6 A.M. A review of Resident 94's medical record indicated an order for levothyroxine 75 mcg tablet daily, started on 2/17/26. During an interview with the Director of Nursing (DON) on 2/25/26 at 1:41 P.M., the DON stated levothyroxine orders were changed within the past six months from being given before breakfast to a 9 A.M. administration for patient satisfaction. During an interview with the Lead Clinical Nurse (LCN) 13 on 2/25/26 at 3:11 P.M., LCN 13 stated breakfast at the facility was at 7 A.M. A (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 94's medical record indicated she consumed 100% of her breakfast on 2/23/26 at 8 A.M.A review of the levothyroxine tablet package insert (PI, document from the drug manufacturer on how to safely and effectively use medications), provided by the facility, revised 8/24, indicated, .Administer levothyroxine.tablets as a single daily dose, on an empty stomach, one-half to one hour before breakfast.A drug review of levothyroxine from [NAME]-Drugs, provided by the facility, undated, indicated, .Administer consistently in the morning on an empty stomach, at least 30 to 60 minutes.before food. Alternatively, may consistently administer at night 3 to 4 hours after the last meal.A review of the patient medication information from the facility's organization on levothyroxine, provided by the facility, indicated, .Levothyroxine.usually is taken once a day on an empty stomach, 30 minutes to 1 hour before breakfast.During a concurrent interview and record review of levothyroxine drug information with the RPH on 2/26/26 at 7:57 A.M., the RPH acknowledged drug information on [NAME]-Drug and the drug manufacturer specified administering levothyroxine at least 30 minutes before the first meal of the day. The RPH stated the specification was a [AGE] year-old recommendation. The RPH stated the facility followed guidelines from the American Thyroid Association. The RPH had previously provided a document from the American Thyroid Association, copyrighted 2012, titled, Thyroid Hormone Treatment. The RPH highlighted a part of the two-page document, .the most important thing is to be consistent, and take your thyroid hormone at the same time, and in the same way, every day. The RPH stated the document was a guideline from the American Thyroid Association and underscored a consistent medication administration.A review the American Thyroid Association Task Force on Thyroid Hormone Replacement publication titled, Guidelines for the Treatment of Hypothyroidism, dated 2014, indicated, .RECOMMENDATION Because co-administration of food and levothyroxine is likely to impair levothyroxine absorption, we recommend that, if possible, levothyroxine be consistently taken either 60 minutes before breakfast or at bedtime (3 or more hours after evening meal) for optimal, consistent absorption. During a concurrent medication administration observation and interview on 2/23/26 at 12:04 P.M., LN 14 was observed preparing and administering 11 medications for Resident 1 through the resident's feeding tube (a device used to administer food and medications in individuals with difficulty swallowing). LN 14 was asked if this was part of the midday medication administration. LN 14 stated that this was part of the 9 A.M. morning medication administration, but there was a delay. One of the medications was levothyroxine 88 mcg tablet. LN 14 flushed (push water through) the feeding tube with 30 mL (milliliters, unit of measure) of water before and after the medication administration, but did not flush in between the medications. LN 14 confirmed she flushed before and after the medication administration, but did not flush in between each medication.During an interview with the Director of Nursing (DON) on 2/25/26 at 1:41 P.M., the DON stated nursing staff were expected to flush with 10 mL of water in between each medication, in addition to flushing with 30 mL of water before and after medication administration.A review of Resident 1's medical record indicated he had an active order for levothyroxine 88 mcg daily, started 2/19/26, and scheduled for 9 A.M.A drug review of levothyroxine from [NAME]-Drugs, provided by the facility, undated, indicated, .Flush feeding tube with an appropriate volume of purified water (eg, 15 mL) before administration.Following administration, rinse container used for preparation with purified water; draw up rinse and administer contents to ensure delivery of entire dose.Flush feeding tube with an appropriate volume of purified water (eg, 15 mL).During an interview with the RPH on 2/26/26 at 7:57 A.M., the RPH was asked about levothyroxine administration through a feeding-tube. The RPH stated consistent timing was important, but the time itself did not matter. A review of the facility's policy and procedure (P&P) titled, Provider Pharmacy - Responsibilities, 39123, revised 10/24/24, indicated, .5. New medication orders are reviewed for accuracy and appropriateness including: a. The right drug, for the right resident, at the right dose, at the right time, the right route. [sic] and the right rationale.A review of the facility's policy and procedure (P&P) titled, Enteral Tube - Medication Administration, 39102.99, revised 5/4/2023, indicated, .L. Flush the feeding tube with 30 mls [milliliters] of water prior to medication (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Sharp Chula Vista Med Ctr Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 751 Medical Center Court Chula Vista, CA 91911	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration. M.Tube is flushed between individual liquids and solids with a minimum of 10 mls of water.N. Flush tube with 30 mls. [sic] of water following medication administration.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to implement proper infection control practices when Licensed Nurse (LN) 14 did not perform hand hygiene after touching a potentially contaminated surface during medication administration through a feeding tube (a surgically placed tube used to administer food and medications in individuals who have trouble swallowing) for Resident 1. This failure had the potential to put residents, staff and visitors at risk for infections due to cross-contamination. Findings: During a concurrent medication administration observation and interview with LN 14 on 2/23/26 at 12:04 P.M., LN 14 was observed preparing and administering 11 medications through Resident 1's feeding tube. Resident 1 had a sign outside his door that read .Enhanced Barrier Precautions [EBP, infection control strategies used in nursing homes to prevent the spread of multidrug resistant organisms [MDROs, bacteria that cannot be killed by antibiotics]. LN 14 wore a gown and gloves shortly before entering Resident 1's room for medication administration. LN 14 elevated Resident 1's head of the bed while wearing gloves and then proceeded to administer Resident 1's medications through the resident's feeding tube while wearing the same pair of gloves. LN 14 acknowledged she used the same gloves to adjust Resident 1's bed and for medication administration. LN 14 stated she may have missed performing hand hygiene after adjusting Resident 1's bed. During an interview with the Infection Preventionist (IP) on 2/24/26 at 10:31 A.M., the IP stated the facility followed guidance from the Centers for Disease Control and Prevention (CDC, a national agency that provides instruction on public health issues) for EBP. The IP stated nursing staff were to give medications immediately after performing hand hygiene and donning gloves. The IP stated touching the resident's surroundings, such as the bed, could harbor microorganisms (microscopic living things, such as bacteria) and defeated the purpose of EBP. A review of the CDC's resource on EBP, titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated, .PPE .refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. A review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions in the Skilled Nursing Units, 05662, revised 8/24, indicated, .The use of gown and gloves for high-contact resident care activities is indicated. for residents with. c. Feeding tube. 3. Examples of high-contact resident care activities requiring gown and gloves for use for EBP include. g. Device care (.feeding tube.). A review of the facility's P&P titled, Hand Hygiene, 05704.99, revised 6/24, indicated, .Hand hygiene must be performed with either soap and water, ABHR [alcohol-based hand rub]. 6. After contact with inanimate objects in the immediate vicinity of the patient.		