

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555795	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Veterans Home of California - Chula Vista		STREET ADDRESS, CITY, STATE, ZIP CODE 700 East Naples 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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. (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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<p>F 0620</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary treatment for one of three sampled residents (Resident 1), when the facility accepted Resident 1 for readmission with an order of intravenous (IV, into a vein) antibiotic and the facility was unable to provide this treatment after admission. This failure resulted in delayed medication treatment and Resident 1 being transferred to a different facility that could provide the necessary treatment. Findings:During a phone interview on 11/13/2025 at 8:55 a.m., with the hospital Social Worker (SW), the SW stated a hospital discharge referral was provided to the facility for Resident 1 to be transferred to them on 11/8/2025 with Resident 1 requiring IV Zosyn (also known as piperacillin-tazobactam, an antibiotic). The SW stated when Resident 1 arrived at the facility on 11/8/2025, the facility stated their pharmacy was closed and they could not get the IV Zosyn that Resident 1 required. The SW further stated, Resident 1 had to be transferred to another facility that had the IV Zosyn available for Resident 1. During a review of the email correspondence from the Registered Nurse Case Manager (RNCM), dated 11/7/2025 at 5:13 p.m. and at 5:17 p.m., addressed to the staff, the email correspondence indicated Resident 1 was admitted to the hospital on [DATE] and the plan was for Resident 1 to return to the facility on [DATE] with IV Zosyn.During a review of the hospital's After Visit Summary, dated 11/8/2025, the after visit summary indicated, start taking Zosyn to infuse 3.375-gram (unit of measurement) into a venous catheter (a thin, flexible tube inserted into a large vein), every 8 (eight) hours for infection within the abdomen. Further review of the after visit summary indicated, Zosyn was last given to Resident 1 in the hospital on [DATE] at 8:37 a.m.During a review of Resident 1's Physician Orders, dated 11/8/2025, the physician orders indicated an order for Zosyn, infuse 3.375 grams into a venous catheter, every 8 hours for infection within the abdomen. Further review of the physician orders indicated at 5:50 p.m., Resident 1 was transfer from the hospital and readmitted to the facility with diagnosis of acute appendicitis with appendiceal abscess (a ruptured appendix causes an infection to form a pocket of pus in the abdomen). A 11:05 p.m., Resident 1 was transfer to another facility.During a review of Resident 1's Nursing Notes, dated 11/9/2025 at 12:52 a.m., by Supervising Registered Nurse (SRN 1), the nursing notes indicated, IV Zosyn was not available at the facility, and the in-house pharmacy was closed on the weekends and after hours. Further review of the nursing notes indicated, the after-hours IV pharmacy was called and the operator stated it was the weekend hours, and no one was in the pharmacy. During an interview on 11/19/2025 at 11:06 a.m., with RNCM and SRN 2, RNCM stated she spoke with the hospital's case manager on 11/7/2025, the plan was for Resident 1 to return to the facility on [DATE] and that Resident 1 will be on IV Zosyn. RNCM stated she communicated via email with the staff including the director of nursing and the supervising registered nurses, that Resident 1 will possibly be returning to the facility on [DATE] with IV Zosyn. RNCM further stated she replied yes to the hospital on accepting Resident 1 back at the facility because they can administer the IV Zosyn. SRN 2 stated when the facility gets referrals for a new admission or readmission, the process was to review the referral to determine whether the facility could take that resident. During an interview on 11/19/2025 at 11:55 a.m., with the Director of Nursing (DON), the DON stated the facility was notified on 11/7/2025 that Resident 1 will be on IV Zosyn upon admission. The DON further stated SRN 1 called their contracted after-hours IV pharmacy and was informed that no one could process the IV antibiotic request. During a concurrent interview and record review on 11/19/2025 at 1:25 p.m., with the Pharmacy Manager (PM), the facility's after-hours IV Pharmacy Contract, dated 12/30/2022 was reviewed. The PM stated the after-hours IV pharmacy was not frequently used and did not seem like they were open 24/7. During a follow up interview on 11/19/2025 at 2:47 p.m., with the DON, the DON stated Resident 1 previously lived at the facility and so Resident 1 was accepted to be readmitted to the facility on [DATE]. The DON stated the facility did not ensure that they had the antibiotic available to administer and the after-hours IV pharmacy was called, but the nurse was told no one was there to process the order. The DON stated the assumption was that the hospital would provide the antibiotic when Resident 1 was transferred to the facility. The DON further stated the facility thought the after-hours IV pharmacy was open 24/7.During a follow up interview on 11/19/2025 at 3:33 p.m., with RNCM, RNCM stated on 11/7/2025, she did not check if the facility had IV Zosyn available because their in-house pharmacy was closed already.During a follow up interview on 11/19/2025 at 3:48 p.m., with PM, the PM stated she was not made aware that Resident 1 would be on IV Zosyn During a phone interview on 11/21/2025 at 6:10 p.m. with SRN 1, SRN 1 stated the last</p>		