

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 03/25/2026
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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff did not leave medication unattended on the bedside for one of two sampled residents (Resident 1). This failure had the potential to compromise the health and safety of Resident 1. Findings: During a review of Resident 1's Face Sheet (demographics), dated 3/25/2026, the face sheet indicated Resident 1 has a diagnosis of nicotine dependence (an addiction to tobacco products caused by the drug nicotine). During a review of Resident 1's Physician Orders, dated 3/18/2026, the physician order indicated Resident 1 had a medication order for nicotine 2 milligrams (mg), lozenge (small tablet that dissolves in the mouth and helps you quit smoking), give one (1) as needed every 2 hours. During a concurrent observation and interview on 3/20/2026 at 11:31 a.m., in Resident 1's room with Resident 1, Resident 1 was lying in bed. On top of a bedside drawer next to Resident 1's bed was a clear plastic medication cup with one white circular tablet in it. There was no nursing staff in Resident 1's room. Resident 1 stated the white circular tablet inside the clear medication cup was his nicotine wafer and the nurse left it there. Resident 1 took the white circular tablet and stated he hoped it was the nicotine lozenge. During an interview on 3/20/2026 at 11:40 a.m., with the Registered Nurse (RN 1), RN 1 stated Resident 1 had an order for nicotine lozenges every 4 hours as needed. RN 1 stated she gave Resident 1 two nicotine lozenges earlier. RN 1 stated she only saw Resident 1 take one of the two nicotine lozenges. RN 1 further stated since the nicotine lozenges were ordered as needed, she did not have to see Resident 1 take the nicotine lozenges. During a review of Resident 1's Medication Administration Record (MAR), dated for the month of March 2026, the MAR indicated, documentation by the Registered Nurse (RN 1), that Resident 1 was given nicotine 2 mg, (1) lozenge on 3/20/2026 at 10:34 a.m. During an interview on 3/20/2026 at 11:53 a.m., with the Supervising Registered Nurse (SRN 1), SRN 1 stated the nursing staff should not have left the medication unattended at Resident 1's bedside. During a concurrent interview and record review on 3/20/2026 at 4:31 p.m., with SRN 1, Resident 1's nursing assessments, were reviewed. SRN 1 stated Resident 1 did not have an evaluation to self-administer medication. During an interview on 3/25/2026 at 3:07 p.m., with RN 2, RN 2 stated Resident 1 did not have a physician order to self-administer medication. During a review of the facility's policy and procedure (P&P) titled Medication and Treatment Administration, dated 6/23/2025, the P&P indicated, Medications and treatments will be administered as prescribed, in accordance with good nursing principles and practices. The complete act of administration involves removing an individual dose from a previously dispensed, properly labeled container, verifying the dose with the transcriber's orders and promptly giving the individual dose to the proper Resident.</p>

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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