

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/30/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure a medication was administered as prescribed for one of three sampled residents (Resident 1), when the physician orders for that medication was not transcribed (copying a doctor's medication order into a residents medication administration record or electronic health record), by the licensed nurse. This failure resulted in Resident 1 missing a cycle of her breast cancer medication for approximately 25 days. Findings: During a review of Resident 1's Face Sheet (demographics), dated 6/30/2026, the face sheet indicated, Resident 1 had a diagnosis of malignant neoplasm (abnormal growth of tissue) of the nipple and areola of the right female breast (breast cancer). During a review of Resident 1's Medication Administration Record (MAR), for the months of May 2026 and June 2026, the MAR indicated Resident 1 was receiving letrozole (a breast cancer medication), 2.5 mg (milligrams), tablet daily. Review of the MAR indicated Resident 1 was receiving Kisqali (also known as ribociclib, a breast cancer medication), 400 mg, tablets daily for malignant neoplasm of the nipple and areola of the right female breast. Further review of the MAR indicated Resident 1 did not receive the medication Kisqali for 25 days from 5/15/2026 to 6/4/2026 and from 6/12/2026 to 6/15/2026. During a review of Resident 1's Clinical Note, dated 5/5/2026 at 2:27 p.m., by the Registered Nurse (RN 1), the note indicated Resident 1 returned from the oncology appointment with a treatment prescribed for the medication Kisqali 400 mg, by mouth daily for 21 days (starting on 5/15/2026 to 6/4/2026) and off 7 days (from 6/5/2026 to 6/11/2026), and repeat the cycle (repeating pattern). During a review of Resident 1's Clinical Note, dated 6/16/2026 at 4:11 p.m., by the Supervising Registered Nurse (SRN 1), the note indicated Resident 1 returned from the oncology appointment with a treatment prescribed for the medication Kisqali 400 mg, by mouth daily as previously ordered. The note further indicated that last month's appointment on 5/5/2026, the medication order for Kisqali was not re-entered and there was no record that it was given to Resident 1. During a concurrent interview and record review on 6/30/2026 at 12:01 p.m., with SRN 1, Resident 1's Physician's Orders, for the months of March 2026, April 2026, May 2026 and June 2026 and the Specialty Services Consultation and Tracking Form, dated 3/3/2026, 5/5/2026, and 6/16/2026 were reviewed. Review of the specialty services consultation and tracking form dated 5/5/2026, indicated, Treatment Prescribed: To continue Kisqali, 400 mg, PO (by mouth), daily x 21 days (5/15/2026 to 6/4/2026), then 7 days off (6/5/2026 to 6/11/2026) and to repeat the cycle. Review of the physician orders for the month of May 2026, indicated there was no physician order for the medication Kisqali prescribed on 5/5/2026. SRN 1 stated this was a medication error and Resident 1 missed a cycle (from 5/15/2026 to 6/4/2026) of the medication Kisqali for the month of May 2026. During a concurrent interview and record review on 6/30/2026 at 2:17 p.m., with the Director of Nursing (DON) and SRN 1, the following medical records for Resident 1 were reviewed: -The MARs for the months of March 2026, April 2026, and May 2026. -The Specialty Services Consultation and Tracking Form dated 3/3/2026, 5/5/2026, and 6/16/2026. -The physician's orders for letrozole and Kisqali dated 3/3/2026, 4/16/2026 and 6/16/2026. The DON stated on 4/16/2026, Resident 1 had a physician's order for a cycle of Kisqali 400 mg daily for 21 days (until 5/7/2026) and then off for 7 days (from 5/8/2026 to 5/14/2026). The DON stated on 5/5/2026, Resident 1 had a follow up oncology (the study of cancer) appointment and (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 was prescribed to continue Kisqali 400 mg daily for 21 days (starting on 5/15/2026 to 6/4/2026), then 7 days off (from 6/5/2026 to 6/11/2026) and to repeat the cycle. The DON further stated on 6/16/2026, Resident 1 had another follow up oncology appointment and Resident 1 was prescribed to continue Kisqali 400 mg daily for another 21 days. The DON stated per RN 1, they acknowledged Resident 1's prescription on 5/5/2026 to continue the Kisqali 400 mg, daily for 21 days (starting on 5/15/2026 to 6/4/2026), then 7 days off (from 6/5/2026 to 6/11/2026), however, RN 1 did not transcribe the physician's order for Resident 1's medication. The DON stated RN 1 should have written an order for Resident 1's Kisqali medication on 5/5/2026 to have it restarted on 5/15/2026, but since the physician order was not transcribed, Resident 1 did not receive the medication from 5/15/2026 through 6/4/2026 (for 21 days). During an interview on 6/30/2026 at 2:17 p.m., with SRN 1, SRN 1 stated on 6/16/2026, after reviewing Resident 1's MAR, it was discovered that there was no physician's order transcribed on 5/5/2026 for the medication Kisqali 400 mg daily. During an interview on 6/30/2026 at 3:12 p.m., with Resident 1, Resident 1 stated she recalled the facility staff informing her that she had missed taking her cancer drug. Resident 1 stated she was not happy about not taking her cancer drug, stating the facility was careless about it. During an interview on 7/1/2026 at 8:59 a.m., with RN 1, RN 1 stated she signed the Specialty Services Consultation and Tracking Form and acknowledged Resident 1's prescribed medication treatment of Kisqali 400 mg on 5/5/2026. RN 1 stated she thought the order would automatically continue. RN 1 stated she should have written the new order on 5/5/2026 for the medication Kisqali. During an interview on 7/1/2026 at 9:50 a.m., with the physician (Physician 1), Physician 1 stated he expressed his frustration to the facility's supervisor when he was notified that Resident 1 missed doses of the Kisqali medication. Physician 1 stated it was a mistake, and it was not okay for Resident 1 to have missed a cycle of Kisqali. Physician 1 stated missing cycles of Kisqali could impact the trajectory of care for Resident 1 and may have changed the progression of Resident 1's metastatic cancer. During a review of the facility's policy and procedures (P&P) titled, Skilled Nursing Facility Outside Medical Referrals, dated 6/15/2026, the P&P indicated, 1. Consultations. E. Nurse receiving paperwork on return of Resident will: 1. Review consultation. 2. Inform physician of consultation report and/or recommendation 3. G. Nurse will note and carry out orders. During a review of the facility's policy and procedures (P&P) titled, Transcribing Physician Orders, dated 12/26/2025, the P&P indicated, The facility will ensure that all orders .shall be noted and carried out promptly. Nursing staff will: Note orders in the Electronic Health Record.		