

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

Printed: 07/18/2026
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 01/16/2026
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to maintain a safe, comfortable, and sanitary environment when: 1. One of the shower rooms, Room A729, was found with broken tiles and an exposed wall cavity. This failure had the potential to result in exposing residents to pests and contaminants, compromising the hygiene and safety of a medically vulnerable population of 107 residents. 2. The shared bathroom for one of 24 sampled resident's (Resident 39) and one unsampled resident (Resident 34), had a large, unsealed hole located directly above the toilet. This failure resulted in Resident 39 and Resident 34 feeling stress and discomfort with the disrepair (poor condition of a building) and had the potential to result in injuries or infections from dust, insulation, or debris falling from an unsealed ceiling. Findings: 1. During a concurrent observation and interview on 1/15/2026 at 11:20 a.m. with the Charge Nurse (CN), in shower room A729, there were broken tiles and an exposed wall cavity. The CN stated shower room A729 was one of two in the whole facility used by residents. The CN stated the broken tiles should have been reported for repair to plant operations. During a concurrent interview and record review on 1/15/2026 at 11:57 a.m. with the Staff Service Manager (SS), the documents' titled, Environmental Rounds, dated February 2025 to January 2026 were reviewed. The Environmental Rounds indicated broken tiles were noted and recommended for repair and replacement on the following dates: 2/12/2025, 4/23/2025, 7/3/2025, 10/22/2025, and 1/9/2026. The SS stated the broken tiles were unsafe and should have been repaired. During a review of a Work Order, #24_094880, dated 10/23/2024, the work order indicated tile repair was needed in the shower room A729 for broken tiles. Further review of the work order indicated the work order was created back on 10/23/2024 and was left opened with no repair date and no completion date. During an interview on 1/15/2026 at 12:30 p.m. with the Building Maintenance Worker (BMW), the BMW stated it was not safe for the shower disrepair to be left like that. During a follow up interview on 1/15/2026 at 4:38 p.m. with the SS, the SS stated the broken tiles and an exposed wall cavity measured at 5.5 inches by 16 inches (unit of measurement). During a review of the facility's policy and procedure (P&P) titled, Environment of Care Rounds, dated 10/9/2025, the P&P indicated, Any safety issues will require that immediate action be taken to prevent harm to resident, staff, or visitors. During a review of the facility's policy and procedure (P&P) titled, General Maintenance, dated 5/1/2025, the P&P indicated, All building, fixtures, equipment, and spaces will be maintained in operable conditions. Maintenance of [the facility], including the grounds, in a clean and sanitary condition and in good repair at all times was to ensure the safety and well-being of residents, staff, and visitors. 2. During a concurrent observation and interview on 1/15/2026 at 11:46 a.m. with Resident 39, in the resident's room, there was a large, unsealed hole observed in the bathroom ceiling located directly above the toilet. Resident 39 stated, I don't like the hole; it feels like the devil would come out. During an interview on 1/15/2026 at 12:30 p.m. with the Building Maintenance Worker (BMW), the BMW stated it was not safe for the unsealed hole to be left like that and it should have been covered up. During a follow up interview on 1/15/2026 at 3:00 p.m. with the BMW, the BMW stated a maintenance worker was supposed to do the dry wall and cover the hole but did not. During an interview on 1/15/2026 at 4:38 p.m. with the Staff Service Manager (SS), the SS stated the (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unsealed hole in the ceiling was measured at 33 inches by 19 inches (unit of measurement). During an interview on 1/16/2026 at 8:15 a.m. with Resident 34, Resident 34 stated, the hole on the bathroom ceiling bothers me. During a review of the facility's policy and procedure (P&P) titled, General Maintenance, dated 5/1/2025, the P&P indicated, All building, fixtures, equipment, and spaces will be maintained in operable conditions. Maintenance of [the facility], including the grounds, in a clean and sanitary condition and in good repair at all times was to ensure the safety and well-being of residents, staff, and visitors.		

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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 identified building damage that remained consistent during the public safety committee meeting reports from 4/23/2024 to 10/23/2025, and the facility's Quality Assurance and Performance Improvement failed to address a plan of repair to correct the issue. This failure had the potential to adversely affect the health of residents. Cross-reference F584 Findings: During a review of the facility's Health and Safety Committee Meetings Records, from 4/23/2024 to 10/23/2025, the meeting records indicated that the walls have holes, scrapes, and paint damage, and this remains consistent. During an interview on 1/15/2025 at 4:16 p.m. with the Staff Services Manager (SS), SS stated he keeps track of all damage found during Environment of Care (EOC-area in building where residents are cared for) rounds. SS confirmed, there is building damage that remained unaddressed for over a year. During an interview on 1/16/2025 at 8:27 a.m. with the Skilled Nursing Facility Administrator (SA), the Standards and Compliance Coordinator (SCC) and the Quality Assurance Registered Nurse (QA), the SA stated they attend the Health and Safety Meetings, and were aware of the building damage reported. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program, dated 4/30/2025, the P&P indicated, Reports will be evaluated to determine further quality issues, plan solutions, implement actions, and ensure follow-up as well as consistent monitoring or results over a specified time frame.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure the garbage was disposed properly, when one of the garbage compactor's (a machine that reduces the volume of trash by compacting it) had no top cover and was not closed when not in use. This failure had the potential to attract pests and rodents. Findings: During a concurrent observation and interview on 1/14/2026 at 2:04 p.m. with the Food Service Manager (FSM), in the garbage disposal area, the blue garbage compactor door was opened, no staff around and missing a lid cover. The FSM stated the garbage compactor should have been covered from all sides when not in use to prevent odor and to prevent attracting pests. During a follow up concurrent observation and interview on 1/15/2026 at 10 a.m. with the FSM, in the garbage disposal area, the blue garbage compactor door was opened, no staff around and missing a lid cover. The FSM stated she didn't know why it was like this yesterday and today. The FSM further stated this was not okay and will attract pest and rodents. During an interview on 1/15/2026 at 2:36 p.m. with the Plant Operations Supervisor (POS), the POS stated the garbage compactor had to be a closed container to prevent odor and harborage of pests. During an interview on 1/15/2026 at 3:10 p.m. with the Infection Preventionist (IP), the IP stated the garbage compactor should have been covered in all directions so it reduces the risk of bringing infection to our residents. During a review of the facility's policy and procedure (P&P) titled, Waste Management Program, dated 5/1/2025, the P&P indicated, All containers will have tight fitting covers in good repair, external handles, and be leak proof and rodent proof and will meet the following requirements: 1. Have a tight fitting covers, closed when not being loaded. 4. Be rodent proof unless stored in a room.		