STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056238	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solano Post Acute	2200 Tuolumne Street Vallejo, CA 94589

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to report an alleged abuse within the prescribed time frame within two hours for one of four residents (Resident 1), when the resident's allegations of inappropriate touching by another resident and a staff member was not reported to the state agency after the charge nurse was notified.This failure resulted to the delayed investigation of the allegation and had the potential to result in Resident 1's emotional and psychological distress.Resident 1 was admitted to the facility in the summer of 2025 with multiple diagnoses which included left and right hemiplegia (left and right-side paralysis) and dysarthria (difficulty speaking).During a review of the Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/29/25, the MDS indicated Resident 1 had no memory impairment.During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation) Communication Form and Progress Notes (PN), dated 8/5/25, the SBAR and PN indicated that on 8/3/25, Resident 1 reported that a male resident allegedly kissed her forehead while she was asleep and also alleged that an X-ray tech touched her inappropriately in her shoulder, forehead and breast and called her beautiful.During a review of the SOC 341 (Report of Suspected Dependent Adult/Elder Abuse) which involved Resident 1 as the victim, the SOC 341 indicated that the report was received on 8/5/25 at 11:20 p.m.During a review of the SOC 341 which involved Resident 1 as the victim, dated 8/5/25, the SOC 341 indicated that the faxed report was received by the state agency on 8/5/25 at 12:47 p.m.During a review of the 5-day investigation letter received from the facility, dated 8/11/25, the letter indicated that on 8/3/25, Resident 1 reported to the charge nurse that another resident kissed her forehead while she was asleep.During an interview on 8/15/25 at 11:20 a.m. with the Administrator (ADM), the ADM confirmed that Resident 1 reported on 8/3/25 that another resident inappropriately kissed her forehead while she was asleep and a staff member inappropriately touched her shoulder and breast. The ADM confirmed that all staff can report any form of abuse or abuse allegations according to policy and procedures.During an interview on 8/15/25 at 11:45 a.m. with Resident 1, Resident 1 indicated that she notified the nurse on 8/3/25 about being inappropriately touched on her arm, forehead, and breast, and indicated she felt uncomfortable and felt ignored and stated she was disappointed in the facility's lack of urgency.During an interview on 8/15/25 at 1:30 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that all abuse allegations, witnessed or unwitnessed, should be reported according to the facility's protocol, and stated, I witnessed [Resident 1] her crying in her room after the incident.During an interview on 8/15/24 at 3:07 p.m. with Registered Nurse 1 (RN 1), RN 1 stated that if she observed abuse or received a report from a resident, she would immediately report the incident to her supervisor within two hours.During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, dated 2017, the P&P indicated that Reporting: 1. All alleged violations involving abuse.mistreatment.will be reported by the facility administrator or their designee, to the following persons or agencies: a. The State Licensing/certification agency responsible for surveying/licensing the facility. 2. All alleged violations of abuse. will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse. twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious.injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, interview and record review, the facility failed to timely investigate and report the results of investigation of abuse allegations within five days for one of four sampled residents (Resident 1), when Resident 1 complained of being inappropriately touched by another resident and by a staff member. This failure resulted to the delayed investigation of the allegation and had the potential to result in Resident 1's emotional and psychological distress and further abuse. Resident 1 was admitted to the facility in the summer of 2025 with multiple diagnoses which included left and right hemiplegia (left and right-side paralysis) and dysarthria (difficulty speaking).During a review of the Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/29/25, the MDS indicated Resident 1 had no memory impairment.During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation) Communication Form and Progress Notes (PN), dated 8/5/25, the SBAR and PN indicated that on 8/3/25, Resident 1 reported that a male resident allegedly kissed her forehead while she was asleep and also alleged that an X-ray tech touched her inappropriately in her shoulder, forehead and breast and called her beautiful.During a review of the 5-Day Investigation Letter in which Resident 1 was involved as the victim, dated 8/11/25, the letter indicated, On 8/3/25, Resident 1 reported to the charge nurse that a [staff name]. touched her arm and her breast.During a review of the Staff to Resident 5-Day investigation Letter in which Resident 1 was involved as the victim, the letter indicated the report was received on 8/11/25 at 4:04 p.m., eight days after the Resident 1's allegation.During a review of the Resident-to-Resident 5-Day Investigation Letter which Resident 1 was involved as the victim, the letter indicated the report was received on 8/11/25 at 4:15 p.m., eight days after the Resident 1's allegation.During an interview on 8/15/25 at 11:20 a.m. with the Administrator (ADM), the ADM confirmed Resident 1 reported the allegations of inappropriate touching by another resident to the nurse and the inappropriate touching by a staff member on 8/3/25. The ADM confirmed he was the primary investigator and was expected to follow facility investigation policy. The ADM indicated the investigation was not done in a timely manner.During an interview on 8/15/25 at 11:45 a.m. with Resident 1, Resident 1 indicated that she notified the nurse on 8/3/25 about being inappropriately touched on her arm, forehead, and breast, and indicated she felt uncomfortable and felt ignored, and stated she was disappointed in the facility's lack of urgency.During an interview on 8/15/25 at 1:30 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that all abuse allegations, witnessed or unwitnessed, should be reported according to the facility's protocol and documented, and stated, I witnessed [Resident 1] her crying in her room after the incident.During an interview on 8/15/24 at 3:07 p.m. with Registered Nurse 1 (RN 1), RN 1 stated that if she observed abuse or received a report from a resident, she would immediately report the incident to her supervisor within two hours.During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting dated 2017, the P&P indicated, Reporting: .5. The Administrator, or their designee, will provide the appropriate agencies.with a written report of the finding of the investigation within five (5) working days of the occurrence of the incident.