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	04/10/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received necessary assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves), including turning and repositioning and timely incontinence care, for two out of seven sampled residents (Resident 1 and Resident 2) when:Resident 1 was not repositioned and provided incontinence care in accordance with the care plan, as evidence by a prolonged gap without repositioning and toileting care, andResident 2 did not receive any assistance with repositioning, comfort, or incontinence care during the observation period, as no such care was observed.These failures has the potential to cause pressure on skin and prolonged exposure to moisture, putting both residents at higher risk for skin breakdown and discomfort.Findings:During a review of Resident 1's admission Record (AR), AR indicated, Resident 1 was initially admitted on [DATE] with diagnoses which included Diabetes Mellitus Type 2 (DM 2- a disorder characterized by difficulty in blood sugar control and poor wound healing), Muscle weakness (Generalized), Morbid [Severe] Obesity (a chronic condition defined by a Body Mass Index, BMI - simple screening tool that uses the height and weight to estimate if a person is in a healthy weight range of 40 or higher with serious obesity-related health conditions).During a review of Minimum data Set (MDS- a federally mandated resident assessment tool), dated 3/18/26, indicated, Resident 1 has intact cognition. MDS indicated Resident 1 requires maximal assistance (Helper performing more than half of the effort) for turning and repositioning.During a review of Resident 1 Care Plan (CP), initiated, 11/2/21, the CP indicated, .Resident has high risk or at risk for pressure ulcer development.related to bladder and bowel impairment, impaired mobility.obesity with interventions which indicated, .resident needs to turn/reposition at least every 2-4 hours,.more often as needed.During a review of Resident 2's AR, the AR indicated, Resident 2 was initially admitted on [DATE] with diagnoses including Urinary Tract infection (UTI-an infection in the part of the body that makes and carries urine, usually caused by bacteria.), Need assistance with personal care, Unspecified Dementia (Dementia- a condition where a person's memory, thinking, and ability to do everyday tasks slowly get worse over time.)During a review of MDS dated [DATE] indicated, Resident 2 has severe cognitive impairment. Resident 2's self-care assessment indicated, Resident 2 was dependent (Helper does all the effort, total dependence) on her care related to toilet hygiene, and repositioning.During a review of Resident 2's care plan revised 2/23/26 indicated, there was no evidence of a person-centered care plan related to Resident 2's toilet hygiene and repositioning.During an observation on 4/10/26, at 10:35 a.m., 11 a.m., 12 p.m., and 1:30 p.m. respectively, Resident 1 was observed head of bed up, positioned on her back with no staff observed offering assistance for repositioning and or incontinence care.During an observation on 4/10/26, at 10:30 a.m., 11 a.m., 12 noon, 1:30 p.m., respectively, Resident 2 was observed lying flat on her back, no incontinence care and repositioning assistance was observed and was provided during these times.During an observation on 4/10/26 at 1:40 p.m., a Certified Nurse Assistant (CNA 1) entered Resident 1's room and performed incontinence care. Following completion of care, at 1:51 p.m., Resident 1 remained in the same supine position (on her back) with her head up at 60 degrees, with no repositioning (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance observed.During an observation on 4/10/26 at 2 p.m., Resident 2 was observed lying flat on her back, no incontinence care and repositioning assistance was observed during this time.During an interview on 4/10/26 at 1:51 p.m. with Resident 1, Resident 1 stated that the last incontinence care and repositioning provided prior to 1:40 p.m. occurred approximately at 2 a.m. Resident 1 confirmed she has not been changed or repositioned since that time. Resident 1 further stated, .they never turn me, not even every 4 hours.If I don't call for assistance, they will not come to help me. Resident 1 stated, it was not her preference to be changed once a shift, but because she was a big and heavy-set person, she just sometimes had to wait. An attempt was made to interview CNA 1 to confirm the allegation, however, the CNA was no longer in the facility. The facility was asked to provide contact information, but no information was provided. During an interview on 4/10/26 at 2:15 p.m. with CNA 2, CNA 2 stated, residents must be changed and repositioned every 2 hours, to keep them clean, dry, comfortable.During an interview on 4/10/26 at 2:39 p.m. with LN 1 stated, the expectation is for the resident to be turned and repositioned every 2 hours, and incontinent care is provided whenever the resident needs to be changed.During an interview with Director of Nursing (DON), on 4/10/26 at 3:30 p.m., DON stated, turning, repositioning and incontinence care must be performed every 2-3 hours, and as directed by the care plan.During a review of the facility's policy and procedure titled, Care Plan Comprehensive dated, 8/25/21 indicated, .the facility's interdisciplinary team, in coordination with the resident and or her/his family or representative, must develop and implement a comprehensive person-centered care plan for each resident.that includes measurable objectives, and timeframes.that are identified in the comprehensive assessment.During a review of the facility's policy and procedure titled, Turning a Resident on His/her Side Away from You, revised,10/2010 indicated, .the purpose of this procedure is to provide comfort to the resident, to prevent skin irritation and breakdown.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure three of 7 sampled residents (Resident 2, Resident 7 and Resident 5) was offered and had access to sufficient fluids to maintain hydration when:Resident 2 was observed with dry lips and a dry tongue, with a dry cup present on the bedside table, and no fluids available. During the observation period, no staff were observed offering or providing fluids to the resident,Resident 7's water pitcher was not within reach, and;Resident 5's water pitcher was not refilled in a timely manner.These failures had the potential to result in inadequate fluid intake and negatively affect the residents' hydration status. 1.During a review of Resident 2's AR, the AR indicated, Resident 2 was initially admitted on [DATE] with diagnoses including Urinary Tract infection (UTI-an infection in the part of the body that makes and carries urine, usually caused by bacteria.), Need assistance with personal care, Unspecified Dementia (Dementia- a condition where a person's memory, thinking, and ability to do everyday tasks slowly get worse over time.) During a review of MDS dated [DATE] indicated, Resident 2 has severe cognitive impairment. Resident 2's self-care assessment indicated Resident 2 was dependent (Helper does all the effort) for eating. During a review of Resident 2's care plan, revised 4/9/26, indicated, .Resident 2 is at nutritional risk and has risk for dehydration. interventions listed includes, .encourage po (oral) intake based on resident cues and desire.offer fluids of choice.monitor signs/symptoms of dehydration (dry mucous membranes, mental status changes. During an observation on 4/10/26, at 10:30 a.m., 11 a.m., 11 a.m., 12 noon, 1:30 p.m., and 1:50 p.m., respectively, Resident 2 was observed lying flat on her back, eyes closed, lips and tongue were very dry. There was an empty dry drinking cup on the table. Did not observe any staff assisting her with hydration during those observation times. During an interview on 4/10/26 at 2:53 p.m. with Licensed Nurse (LN) 2, LN 2 stated, his expectation is for the Certified Nurse Assistants (CNA) to offer fluids and supplements to their residents whenever they round every 2 hours. LN 2 further stated, depending on residents' fluid restriction, and dietary restrictions, fluids can still be offered, and the amount needs to be documented. 2. During a review of Resident 7's admission Record (AR), the AR indicated, Resident 7 was admitted on [DATE] with diagnoses which included End Stage Renal Disease (ESRD-irreversible kidney failure), muscle weakness and calculus of kidney (kidney stone). During a concurrent observation and interview on 4/10/26 at 10:23 a.m., in Resident 7's room, Resident 7's water pitcher was on the overbed table, which was pushed against the window behind him. Resident 7 stated he was unable to reach the water pitcher and was thirsty. 3. During a review of Resident 5's AR, the AR indicated, Resident 5 was re-admitted on [DATE] with diagnoses which included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), need for assistance with personal care, chronic kidney disease (kidneys are damaged gradually), and anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/10/26 at 10:35 a.m., Resident 5 was heard from the hallway calling out loudly, Agua, Agua (water). At 10:47 a.m., upon entering Resident 5's room, Resident 5 stated Agua para [NAME] (water to drink), please. An empty water pitcher was observed on the overbed table. At 10:51 a.m., Resident 5 continued calling out, stating, Agua, I need water, his pitcher still empty. During an interview on 4/10/26 at 11:28 a.m., with Director of Staff Development (DSD), DSD stated that water pitchers should be accessible to residents and refilled as soon as possible when needed. The DSD stated it was important to provide water to maintain hydration and accommodate resident preferences, such as temperature. During a review of the facility's policy and procedure (P&P) titled, Encouraging and Restricting Fluids, revised 10/10, the P&P indicated, .be supportive of the resident's fluid intake.take the fluid container to the resident's room.encourage the resident to drink the fluid. During a review of the facility's P&P titled, Resident Hydration and Prevention of Dehydration, revised 3/25, the P&P indicated, .Nurses' Aide will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the call light (a device that allows residents to communicate with nursing staff when they need assistance) was within reach for three of 7 sampled residents (Resident 7, Resident 5 and Resident 4).This deficient practice had the potential to result in Resident 7, Resident 5 and Resident 4 to not be able to call facility staff for help or assistance.Findings:During a review of Resident 7's admission Record (AR), the AR indicated, Resident 7 was admitted on [DATE] with diagnoses which included End Stage Renal Disease (ESRD-irreversible kidney failure), muscle weakness and abnormalities in gait and mobility.During a review of Resident 7's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 2/19/26, the MDS indicated Resident 7 had moderate cognitive impairment. The MDS also indicated Resident 7 needed assistance with eating, oral hygiene, toileting hygiene, personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear.During a review of Resident 7's Care Plan (CP), initiated on 10/2/24 and revised on 6/17/25, the CP indicated Resident 7 was at risk for falls and intervention included placing the call light within reach while in bed or at close proximity to the bed.During a review of Resident 5's AR, the AR indicated, Resident 5 was re-admitted on [DATE] with diagnoses which included abnormalities of gait and mobility, need for assistance with personal care, dementia (a progressive state of decline in mental abilities) and anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities).During a review of Resident 5's MDS dated [DATE], MDS indicated Resident 5 had severe cognitive impairment. The MDS also indicated Resident 5 needed assistance with eating, oral hygiene, toileting hygiene, personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear.During a review of Resident 4's AR, the AR indicated, Resident 4 was re-admitted on [DATE] with diagnoses that included osteomyelitis of right ankle and foot, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscular weakness or partial paralysis) of left non-dominant side, need assistance with personal care and muscle weakness.During a review of Resident 4's MDS dated [DATE], MDS indicated Resident 4 had moderate cognitive impairment. The MDS also indicated Resident 4 needed assistance with eating and was dependent on a helper for oral hygiene, toileting hygiene, shower, upper and lower body dressing and putting on/taking off footwear.During a review of Resident 4's CP, initiated on 9/19/25 and revised on 9/30/25, the CP indicated Resident 4 was at risk for falls and intervention included placing the call light within reach while in bed or at close proximity to the bed.During a concurrent observation and interview on 4/10/26 at 10:23 a.m. in Resident 7's room, Resident 7 stated he did not call for assistance because he did not have a call light button. It was observed the call light button was tied to the side rail of the bed next to him.During an interview on 4/10/26 at 10:33 a.m. with Licensed Nurse (LN) 3, LN 3 confirmed the call light tied to the side rail of the bed next to Resident 7 belonged to Resident 7.During a concurrent observation and interview on 4/10/26 at 11:02 a.m. with Director of Staff Development (DSD) in Resident 5's room, DSD confirmed Resident 5's call light button was on the floor by the bedside table. The DSD stated call lights should be kept within reach of the resident.During an interview on 4/10/26 at 11:28 a.m. with DSD, DSD stated it was important for call light button to be within reach and accessible for resident safety and allow residents to call for assistance.During a concurrent observation and interview on 4/10/26 at 2:44 p.m. in Resident 4's room, Resident 4 was in bed with the head of the bed elevated in a sitting position. Resident 4 stated he had a call light button for when he needed assistance but could not find it at that time. The call light button was on top of the bedside table. At 3:10 p.m., the call light remained on the bedside table, and Resident 4 stated he still could not find it and that no one had checked on him to provide him with the call light button.During a review of the facility's policy and procedures (P&P) titled, Answering Call Light, revised 10/24, the P&P indicated, . 5. Ensure that the call light is (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.