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	04/16/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview, and record review, the facility failed to implement its abuse prevention policy for two out of ten sampled residents, when Resident 1 and Resident 2 were continued to be roomed together after Licensed Nurse (LN 1) witnessed Resident 2 touching Resident 1 in his bed and Resident 1 had a left eye injury with bleeding that was not previously observed. This failure had the potential safety risk for Resident 1 and increased the likelihood of resident-to-resident abuse. Findings: During a review of Resident 1's admission Record (AR), dated 4/15/26 (print date), the AR indicated Resident 1 was admitted to the facility in December of 2025 with diagnoses which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and mild cognitive impairment (a condition causing noticeable memory or thinking problems greater than normal aging). During a review of Resident 1's Progress Note (PN) dated 4/11/26, the PN written by LN 1 indicated, During routine rounds at approximately 1830 [6:30 p.m.], [LN 1] observed [Resident 2] squatting beside [Resident 1] bed. [Resident 2] was noted holding both arms of [Resident 1]. Staff immediately intervened and separated both residents. [Resident 1] was assessed immediately after the incident. Assessment revealed redness to the left sclera [white area of the eye] with scant bleeding estimated at approximately 0.5mL [milliliters unit of volume]. An abrasion measuring approximately 0.5 cm [centimeter, unit of measurement] was noted on the left cheek, with no active bleeding at the time of assessment. No other visible signs of physical injury were observed. Left eye noted to have vision impairment per assessment.Resident complained of severe pain in the left eye, rated 10/10 on pain scale [highest pain] .new orders were received to transfer resident to the emergency department for further evaluation and management. During a review of Resident 1's Care Plan (CP) initiated on 4/13/26, the CP indicated, Risk for further injury related to exposure to other resident with behavioral dysregulation, as evidenced by incident on 4/11/2026 resulting in minor facial abrasion, corneal [eye surface] abrasion, and subconjunctival hemorrhage [bleeding in the white area of the eye]. During a review of Resident 2's AR, dated 4/15/26 (print date), the AR indicated, Resident 2 was admitted to the facility in April of 2026 with diagnoses which included dementia (a progressive state of decline in mental abilities), disorientation, and anxiety. During a review of Resident 2's PN dated 4/12/16, the PN indicated, Upon routine rounds, resident [Resident 2] noted to have increased confusion and restlessness. LN [licensed nurse] saw resident standing up from bed and aggressively tried to attack [Resident 1] of the same room, LN immediately intervened hold resident's arm and tried to re-orient him calmly. But resident refused to settle and tried to attack LN with his right hand. LN called for help but resident tried to hit staffs who responded. Resident throws water at CNA [Certified Nurse Assistant], and tried to swing.Called Physician, advised to call 911 and send patient to ED [Emergency Department] for further evaluation. Resident able to calm down but still confused and tried to stand, walk to rooms and hit residents. During a review of Resident 2's CP initiated on 4/9/26, the CP indicated, Resident is at risk for behavioral dysregulation with potential for unintended physical contact with others.resulting in impaired impulse control, poor safety awareness, and decreased ability to interpret environment.Risk (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for further injury related to exposure to other resident with behavioral dysregulation, as evidenced by incident on 4/11/2026 resulting in minor facial abrasion, corneal [eye surface] abrasion. During an interview on 4/15/26 at 2:44 p.m. with LN 1, LN 1 stated that on 4/11/26 at around 6:30 p.m., she walked into Resident 1's and Resident 2's [roommates] room and saw how Resident 2 was kneeling over Resident 1's bed and holding Resident 1's hands. Resident 1 had left eye redness and scant bleeding that was not seen earlier that day [new injury]. LN 1 stated that Resident 2 was taken out to the nurse's station and Resident 1 was sent out to the emergency department (ED) for evaluation and returned later on the same day. LN 1 confirmed that Resident 1 and Resident 2 were not separated in different rooms upon Resident 1's return from the ED. During an interview on 4/16/26 at 3:48 p.m. with the Director of Nursing (DON), the DON confirmed that Resident 1 and Resident 2 were not put into separate rooms after the reported injury incident on 4/11/26. The DON expected residents to be separated and housed in different rooms because keeping them together constituted continued exposure of the victim to the potential abuser. The DON stated that she was unable to provide documentation that two residents were continually monitored by staff in the room after the incident on 4/11/26. During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition, revised 10/25/24, the P&P indicated, Health Care Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms. The Center will implement an abuse prohibition program through the following: .Prevention of occurrences.Investigation of incidents and allegations; Protection of patients during investigations. If the suspected abuse is resident-to-resident, the resident who has in any way threatened or attacked another will be removed from the setting or situation and an investigation will be completed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely report abuse-related incident for two out of ten sampled residents (Resident 1 and Resident 2), when Licensed Nurse (LN 1) witnessed Resident 2 touching Resident 1 in his bed, and Resident 1 had a left eye injury with bleeding that was not previously observed. This failure delayed the investigation by the Department and increased the likelihood of abuse for Resident 1.Findings: During a review of Resident 1's admission Record (AR), dated 4/15/26 (print date), the AR indicated, Resident 1 was admitted to the facility in December of 2025 with diagnoses which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and mild cognitive impairment (a condition causing noticeable memory or thinking problems greater than normal aging). During a review of Resident 1's Progress Note (PN) dated 4/11/26, the PN written by LN 1 indicated, During routine rounds at approximately 1830 [6:30 p.m.], [LN 1] observed [Resident 2] squatting beside [Resident 1] bed. [Resident 2] was noted holding both arms of [Resident 1]. Staff immediately intervened and separated both residents. [Resident 1] was assessed immediately after the incident. Assessment revealed redness to the left sclera [white area of the eye] with scant bleeding estimated at approximately 0.5mL [milliliters unit of volume]. An abrasion measuring approximately 0.5 cm [centimeter, unit of measurement] was noted on the left cheek, with no active bleeding at the time of assessment. No other visible signs of physical injury were observed. Left eye noted to have vision impairment per assessment.Resident complained of severe pain in the left eye, rated 10/10 on pain scale [highest pain] .new orders were received to transfer resident to the emergency department for further evaluation and management. During a review of Resident 1's Care Plan (CP) initiated on 4/13/26, the CP indicated, Risk for further injury related to exposure to other resident with behavioral dysregulation, as evidenced by incident on 4/11/2026 resulting in minor facial abrasion, corneal [eye surface] abrasion, and subconjunctival hemorrhage [bleeding in the white area of the eye]. During a review of Resident 2's AR, dated 4/15/26 (print date), the AR indicated, Resident 2 was admitted to the facility in April of 2026 with diagnoses which included dementia (a progressive state of decline in mental abilities), disorientation, and anxiety. During a review of Resident 2's PN dated 4/12/16, the PN indicated, Upon routine rounds, resident [Resident 2] noted to have increased confusion and restlessness. LN [licensed nurse] saw resident standing up from bed and aggressively tried to attack [Resident 1] of the same room, LN immediately intervened hold resident's arm and tried to re-orient him calmly. But resident refused to settle and tried to attack LN with his right hand. LN called for help but resident tried to hit staffs who responded. Resident throws water at CNA [Certified Nurse Assistant], and tried to swing.Called Physician, advised to call 911 and send patient to ED [Emergency Department] for further evaluation. Resident able to calm down but still confused and tried to stand, walk to rooms and hit residents. During a review of Resident 2's CP initiated on 4/9/26, the CP indicated, Resident is at risk for behavioral dysregulation with potential for unintended physical contact with others.resulting in impaired impulse control, poor safety awareness, and decreased ability to interpret environment.Risk for further injury related to exposure to other resident with behavioral dysregulation, as evidenced by incident on 4/11/2026 resulting in minor facial abrasion, corneal [eye surface] abrasion. During an interview on 4/15/26 at 2:44 p.m. with LN 1, LN 1 stated that on 4/11/26 at around 6:30 p.m. she walked into Resident 1's and Resident 2's [roommates] room and saw how Resident 2 was kneeling over Resident 1's bed and holding Resident 1's hands. Resident 1 had left eye redness and scant bleeding that was not seen earlier that day [New injury]. LN 1 stated that Resident 2 was taken out to the nurse's station and Resident 1 was sent out to the emergency department (ED) for evaluation and returned later on the same day. LN 1 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that Resident 1 and Resident 2 were not separated in different rooms upon Resident 1's return from the ED. During an interview on 4/16/26 with the Administrator (Admin), the Admin confirmed that the incident between Resident 1 and Resident 2 with an eye injury to Resident 1 was documented on 4/11/26 and was reported on 4/13/26. Admin confirmed that the incident should have been reported within 2 hours. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating, dated September 2022, the P&P indicated, .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. Immediately is defined as: a. Within two hours of an allegation involving abuse or result in serious bodily injury; or b. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.