

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Solano Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure one of ten sampled residents (Resident 2) was free from physical abuse when Resident 1 hit Resident 2 in the face with a plastic basin. This failure had the potential for Resident 2 to feel unsafe in the facility resulting in a decreased quality of life. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in July 2026 with multiple diagnoses including cellulitis (bacterial skin infection) of left leg, sepsis (body's extreme response to infection causing tissue damage and organ failure) psychosis (mental state where person loses touch with reality), and schizophrenia (mental illness marked by hallucinations, delusions, and disorganized thinking). A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 7/9/26, indicated Resident 1 was rarely or never understood and had long and short-term memory problems. A review of Resident 1's Progress Notes, dated 7/8/26 at 4:54 p.m., indicated .Resident was admitted to C bed this shift. Shortly after admission, the resident in B bed and the resident's spouse notified nursing that the newly admitted resident was repeatedly opening and closing the bedside privacy curtains . A review of Resident 1's Progress Notes, dated 7/9/26 at 10:08 a.m., indicated .Around 1250AM [12:50 a.m.], resident was interviewed regarding the report made by the resident roommate in B bed. Resident was unable to provide information regarding the reported event and did not appear to understand what was being discussed . A review of Resident 1's Interdisciplinary Care Conference, dated 7/9/26 at 12:32 p.m., indicated .The IDT [Interdisciplinary Team] completed a comprehensive review following the reported room safety event to evaluate contributing factors, assess the resident's clinical and behavioral status .The IDT recognized that the resident's documented history of schizophrenia, unspecified psychosis, impaired cognition, and impaired judgment may significantly affect his ability to accurately perceive, process, and respond to his surroundings .the reported behaviors appear consistent with the resident's underlying cognitive and psychiatric conditions . A review of Resident 1's Progress Notes, Admit Visit Note by provider, dated 7/9/26 at 7:37 p.m., indicated .Pt [patient] had an incident with another resident in his room this am with foul language, threatening behaviors, and physical aggression . A review of Resident 1's Progress Notes, dated 7/9/26 at 12:57 p.m., indicated .Monitor for episodes of throwing objects, intrusive behavior . A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in July 2026 with multiple diagnoses including psoas muscle abscess (collection of pus in psoas muscle of the spine), sepsis, diabetes (too much sugar in the blood), and heart failure (heart does not pump blood as efficiently as it should). A review of Resident 2's MDS, Cognitive Patterns, dated 7/12/26, indicated Resident 2 had Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident was cognitively intact. A review of Resident 2's Progress Notes, dated 7/8/26 at 4:57 p.m., indicated . Resident and spouse reported concern that the newly admitted (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056238	Facility ID: 056238
		If continuation sheet Page 1 of 10

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident in C bed was repeatedly opening and closing the bedside privacy curtain .Staff were instructed to conduct frequent safety rounds and ongoing monitoring of both residents, with CNA [Certified Nursing Assistant] and licensed nurse providing routine observation and reporting any changes . A review of Resident 2's Progress Notes, dated 7/9/26 at 9:54 a.m. indicated .Around 1250 am, resident in B bed reported that the resident in C bed attempted to take his phone. Resident in B bed stated that the phone belonged to him and that he retrieved it from the resident in C bed . A review of Resident 2's Progress Notes, dated 7/9/26 at 11:17 a.m., indicated .Addendum: At around 12:50AM During the initial interview, resident in B bed also reported that resident in C bed had been randomly throwing objects in the room. Resident stated that one of the objects, identified as a basin, made contact with him during this behavior .No visible injuries . A review of Resident 2's Progress Notes, dated 7/9/26 at 11:55 a.m., indicated .Resident -to- resident occurred. The incident was reported to local law enforcement . Resident will continue to be monitored . A review of Resident 2's Interdisciplinary Care Conference, dated 7/9/26 at 12:55 p.m., indicated .The IDT completed a comprehensive review of the reported room safety event to evaluate contributing factors .The IDT [Interdisciplinary Team] identified multiple contributing factors, including the shared room environment and the roommates documented cognitive impairment and behavioral symptoms . A review of Resident 2's Progress Notes, dated 7/9/26 at 1:02 p.m., indicated .At approximately 12:20 PM today, officer from the [Law Enforcement Agency] spoke with residents . During an interview on 7/23/26 at 11:46 a.m. with the Director of Nursing (DON), reviewed resident-to-resident altercation between Resident 1 and Resident 2 on 7/9/26. The DON stated Resident 1 had schizophrenia and was discharged from the facility on 7/9/26 due to escalating aggressive behaviors. The DON stated the incident was documented in the electronic record. The DON stated when a resident-to-resident altercation occurs residents are separated and assessed for injuries. During an interview on 7/23/26 at 1:46 p.m. with the DON, the DON stated Resident 1 had a prior diagnosis of psychosis but had not been taking his medications. The DON stated Resident 2 reported the incident to staff and talked to the police. The DON stated Resident 1 was placed on 1:1 (one to one) supervision. During an interview on 7/23/26 at 2:43 p.m. with CNA 1, CNA 1 stated it was reported to her that Resident 1 had thrown a plastic water pitcher at Resident 2 and that Resident 1 was naked and trying to get up. During an interview on 7/23/26 at 2:49 p.m. with Resident 2, Resident 2 answered questions appropriately and was able to converse effectively. Resident 2 stated Resident 1 attacked him on 7/9/26 around 1 a.m. Resident 2 stated Resident 1 came to his bed and tried to steal his cell phone. Resident 2 stated Resident 1 picked up a small plastic basin, swung, and hit him on the lower lip and then went back to his own bed. Resident 2 stated he had a cut below his lower right lip. Observed small scab on face right below lower right lip. Resident 2 stated a few minutes later, Resident 1 came back and tried to grab his cell phone again and was throwing around stuff in the room. Resident 2 stated Resident 1 climbed on him, was naked, and smacked him on the left side of his face with an open hand. Resident 2 stated he yelled for help at that point and Resident 1 was moved to another room. Resident 2 stated the police came and he told them he wanted to file charges. During an interview on 7/23/26 at 3:05 p.m. with Licensed Nurse (LN) 2, LN 2 stated Resident 2 was asleep, and Resident 1 stood up and began throwing things out of the drawer. Resident 1 threw a plastic basin at Resident 2 and hit him with the basin. LN 2 stated residents were separated, and Resident 1 was moved to another room. Resident 2 was assessed for injury, and incident was reported to police and the ombudsman.During an interview on 7/23/26 at 3:57 p.m. with the DON, the DON acknowledged that Resident 2 had been hit with basin by Resident 1. The DON stated that no bleeding or injury was identified on Resident 2 at the time. When asked what could have been done to prevent altercation, the DON stated when (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors were identified 1:1 supervision was implemented. The DON stated Resident 1's behaviors escalated and he was transferred to the hospital on 7/9/26. During a telephone interview on 7/28/26 at 8:46 a.m. with LN 4, LN 4 had received report at beginning of shift that Resident 1 had some behavior problems including pulling the privacy curtains and getting up. LN 4 stated while she was doing her rounds, Resident 1 kept trying to get up and was taking his brief off and throwing it. LN 4 stated Resident 1 was only wearing a brief and was naked without the brief. LN 4 stated at approximately 1 a.m. Resident 2 called and reported Resident 1 had grabbed his phone but he was able to get it back. A concurrent review of Resident 2's progress note dated 7/9/26 and timed at 11:17 a.m. indicated Resident 2 reported Resident 1 hit him with a small basin. LN 4 stated she had observed the basin on the bed. LN 4 stated she assessed Resident 2 for injuries but did not see any. LN 4 stated she reported the incident to the DON in the morning on 7/9/26. A review of the facility's Policy & Procedure (P&P) titled Abuse Prohibition, revised 10/25/24, indicated .Health Care Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. Physical abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment. Purpose: To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse. 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. The Center will provide adequate supervision when the risk of resident-to-resident altercation is suspected. The Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit behaviors that make them more likely to be involved in an altercation.		

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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. Based on interview and record review, the facility failed to report an allegation of physical abuse to The Department within the regulatory time frame and to provide a 5-day investigative report to The Department when two of ten sampled residents (Resident 1 and Resident 2) were involved in an altercation. This failure resulted in The Department not being aware of the incident with the potential for further abuse to occur. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in July 2026 with multiple diagnoses including cellulitis (bacterial skin infection) of left leg, sepsis (body's extreme response to infection causing tissue damage and organ failure) psychosis (mental state where person loses touch with reality), and schizophrenia (mental illness marked by hallucinations, delusions, and disorganized thinking). A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 7/9/26, indicated Resident 1 was rarely or never understood and had long and short-term memory problems. A review of Resident 1's Progress Notes, dated 7/9/26 at 10:08 a.m., indicated .Around 1250AM, resident was interviewed regarding the report made by the resident roommate in B bed. Resident was unable to provide information regarding the reported event and did not appear to understand what was being discussed . A review of Resident 1's Interdisciplinary Care Conference, dated 7/9/26 at 12:32 p.m., indicated .The IDT [Interdisciplinary Team] completed a comprehensive review following the reported room safety event to evaluate contributing factors, assess the resident's clinical and behavioral status .The IDT recognized that the resident's documented history of schizophrenia, unspecified psychosis, impaired cognition, and impaired judgment may significantly affect his ability to accurately perceive, process, and respond to his surroundings .the reported behaviors appear consistent with the resident's underlying cognitive and psychiatric conditions . A review of Resident 1's Progress Notes, Admit Visit Note by provider, dated 7/9/26 at 7:37 p.m., indicated .Pt [patient] had an incident with another resident in his room this am with foul language, threatening behaviors, and physical aggression . A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in July 2026 with multiple diagnoses including psoas muscle abscess (collection of pus in psoas muscle of the spine), sepsis, diabetes (too much sugar in the blood), and heart failure (heart does not pump blood as efficiently as it should). A review of Resident 2's MDS, Cognitive Patterns, dated 7/12/26, indicated Resident 2 had Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident was cognitively intact. A review of Resident 2's Progress Notes, dated 7/9/26 at 9:54 a.m. indicated .Around 1250 am, resident in B bed reported that the resident in C bed attempted to take his phone. Resident in B bed stated that the phone belonged to him and that he retrieved it from the resident in C bed . A review of Resident 2's Progress Notes, dated 7/9/26 at 11:17 a.m., indicated .Addendum: At around 12:50AM During the initial interview, resident in B bed also reported that resident in C bed had been randomly throwing objects in the room. Resident stated that one of the objects, identified as a basin, made contact with him during this behavior .No visible injuries . A review of Resident 2's Progress Notes, dated 7/9/26 at 11:55 a.m., indicated .Resident -to- resident occurred. The incident was reported to local law enforcement . The attending physician (MD) was notified and made aware of the incident. The resident's responsible party was notified and informed of the incident in accordance with facility policy. Resident will continue to be monitored . A review of Resident 2's Interdisciplinary Care Conference, dated 7/9/26 at 12:55 p.m., indicated .The IDT completed a comprehensive review of the reported room safety event to evaluate contributing factors .The IDT [Interdisciplinary Team] (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified multiple contributing factors, including the shared room environment and the roommates documented cognitive impairment and behavioral symptoms . A review of Resident 2's Progress Notes, dated 7/9/26 at 1:02 p.m., indicated .At approximately 12:20 PM today, officer from the [Law Enforcement Agency] spoke with residents . A review of a flowsheet titled Mandated Reporter provided by Director of Nursing (DON) indicated .Observes, has knowledge of, or reasonably suspects abuse in a Long-Term Care Facility .Physical Abuse .Caused by Resident Diagnosed with Dementia by Physician No Serious Bodily Injury . directed to contact LTC ombudsman (long term care ombudsman is person who protects residents in nursing homes) or Law Enforcement immediately and within 24 hours provide SOC 341 (Report of Suspected Dependent Adult/Elder Abuse- used by mandated reporters to report suspected abuse) written report to LTC ombudsman or Law Enforcement . During an interview on 7/23/26 at 11:46 a.m. with the DON, reviewed complaint intake involving resident to resident altercation between Resident 1 and Resident 2 on 7/9/26. The DON stated was not aware of the incident, but it should have been reported to the LTC ombudsman and law enforcement. The DON stated Resident 1 had schizophrenia and was discharged from the facility on 7/9/26 due to escalating aggressive behaviors. The DON stated the incident was documented in the electronic record. The DON stated they followed the guidelines for reporting as on the Mandated Reporter flowsheet provided by the Administrator. The DON stated the facility did not contact The Department because the flowsheet indicated if resident had dementia to contact ombudsman and/or law enforcement. The flowsheet did not indicate to notify The Department. The DON stated if the altercation caused no serious bodily injury and caused by resident with dementia there was no need to contact The Department. The DON stated this Mandated Reporter flowsheet was provided by the Administrator and was implemented for the first time for this incident. The DON stated prior to this incident and receiving this flowsheet, The Department would have been notified of this allegation of abuse. Requested the investigation report. The DON stated she does not have access to it but will try and obtain from Administrator. During an interview on 7/23/26 at 1:03 p.m. with the Social Services Director (SSD), the SSD stated she was notified to call the LTC ombudsman regarding altercation between Resident 1 and Resident 2. The SSD stated she was not aware of any notification sent to The Department. The SSD stated prior to this incident, if an allegation of abuse occurred, the process was to notify law enforcement, ombudsman, and The Department. The SSD stated that since the new flowsheet was implemented for this incident there was a different criteria for reporting to The Department. The SSD stated the process now was to call only law enforcement and the ombudsman if there was no injury and resident was confused. During an interview on 7/23/26 at 1:10 p.m. with the Director of Staff Development (DSD), the DSD stated if there is an allegation of abuse or a resident-to-resident altercation it should be reported to The Department, the ombudsman, and law enforcement within 2 hours. The DSD stated if resident has dementia, per Mandated Reporter flowsheet only needs to be reported to ombudsman and law enforcement. Reviewed with the DSD that reporting policy does not distinguish if resident has dementia. The DSD acknowledged that the Mandated Reporter guidelines does not correspond to the facility reporting policy. The DSD stated she does not know if an investigation report was completed for this incident. During an interview on 7/23/26 at 1:46 p.m. with the DON, the DON stated she had not located the investigation report yet. During an interview on 7/23/26 at 2:43 p.m. with CNA 1, CNA 1 stated it was reported to her by staff that Resident 1 had thrown a plastic water pitcher at Resident 2 and that Resident 1 was naked and trying to get up. CNA 1 stated if there is an allegation of abuse it is reported to The Department, ombudsman, and Administrator as soon as it happened. When asked if the reporting criteria was different if resident is confused, CNA 1 stated, No, have to report everything. During an interview on 7/23/26 at 2:49 p.m. with Resident 2, Resident 2 answered (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	questions appropriately and was able to converse effectively. Resident 2 stated Resident 1 attacked him on 7/9/26 around 1 a.m. Resident 2 stated Resident 1 came to his bed and tried to steal his cell phone. Resident 2 stated Resident 1 picked up a small plastic basin, swung, and hit him on the lower lip and then went back to his own bed. Resident 2 stated he had a cut below his lower right lip. Observed small scab on face right below lower right lip. Resident 2 stated a few minutes later, Resident 1 came back and tried to grab his cell phone again and was throwing around stuff in the room. Resident 2 stated Resident 1 climbed on him, was naked, and smacked him on the left side of his face with an open hand. Resident 2 stated he yelled for help at that point and Resident 1 was moved to another room. Resident 2 stated the police came and he told them he wanted to file charges. During an interview on 7/23/26 at 3:05 p.m. with Licensed Nurse (LN) 2, LN 2 stated Resident 2 was asleep, and Resident 1 stood up and began throwing things out of the drawer. Resident 1 threw a plastic basin at Resident 2 and hit him with the basin. LN 2 stated incident was reported to police and ombudsman. LN 2 stated abuse should be reported to the DON, The Department, ombudsman, and police within 2 hours. During an interview on 7/23/26 at 3:42 p.m. with LN 3, LN 3 stated if there is an allegation of abuse they reported it to The Department, ombudsman and the police within 2 hours. When asked if reporting criteria was different if resident had dementia, LN 3 stated there is no difference in reporting allegations. During an interview on 7/23/26 at 5:15 p.m. with the DON, the DON acknowledged that The Department had not been notified of the abuse allegation between Resident 1 and Resident 2 because they were following the Mandated Reporter flowsheet implemented by the Administrator. The DON stated she was not able to provide an investigation report that included staff and resident interviews. The DON stated a 5-day investigation report was not sent to The Department. During a telephone interview on 7/28/26 at 8:46 a.m. with LN 4, LN 4 had received report at beginning of shift that Resident 1 had some behavior problems. LN 4 stated at approximately 1 a.m. Resident 2 called and reported Resident 1 had grabbed his phone but he was able to get it back. A review of Resident 2's progress note dated 7/9/26 at 11:17 a.m. indicated Resident 2 reported Resident 1 hit him with a small basin. LN 4 stated she observed the basin on the bed. LN 4 stated she assessed Resident 2 for injuries but did not see any. LN 4 stated she reported the incident to the DON in the morning on 7/9/26. LN 4 stated she did not report incident as abuse as she thought it sounded like a misunderstanding and did not think it was abuse. LN 4 stated if she had recognized it as abuse, she would have called ombudsman, The Department, police and filled out the SOC 341 within 2 hours. LN 4 stated if residents are confused, they still reported as usual and do all the steps. A review of the facility's Policy and Procedure (P&P) titled Abuse Prohibition, revised 10/25/24, indicated .Physical abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment .If the suspected abuse is resident-to-resident, the resident .an investigation will be completed .Upon receiving information concerning a report of suspected or alleged abuse, mistreatment .will perform the following .Report allegations involving abuse not later than two (2) hours after the allegation is made .Notify local law enforcement, Ombudsman, Licensing District Office, Licensing Boards, Registries and other agencies as required .Provide subsequent reports to the Department as often as necessary to inform the Department of significant changes in the status of affected individuals or changes in material facts originally reported .Initiate an investigation within 2 hours of an allegation of abuse that focuses on .whether abuse or neglect occurred and to what extent .The investigation will be thoroughly documented. Ensure that documentation of witnessed interviews is included .Conduct interviews using the Interview Record and Witness Interview Record .Report findings of all completed investigations within five (5) working days to the Licensing District Office .A review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation-Reporting (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Investigating, revised 9/22, indicated .All reports of resident abuse .are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management .If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other official according to state law .The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies .The state licensing/certification agency responsible for surveying/licensing the facility .Immediately is defined as .within two hours of an allegation involving abuse or results in serious bodily injury; or .Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury .All allegations are to be thoroughly investigated .Within five (5) business days of the incident, the administrator will provide a follow-up investigation report .		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to investigate an allegation of abuse for two of ten sampled residents (Resident 1 and Resident 2), when Resident 1 hit Resident 2 in the face with a plastic basin. This failure had the potential for abuse to continue if causes are not identified and interventions not implemented. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in July 2026 with multiple diagnoses including cellulitis (bacterial skin infection) of left leg, sepsis (body's extreme response to infection causing tissue damage and organ failure) psychosis (mental state where person loses touch with reality), and schizophrenia (mental illness marked by hallucinations, delusions, and disorganized thinking). A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 7/9/26, indicated Resident 1 was rarely or never understood and had long and short-term memory problems. A review of Resident 1's Progress Notes, dated 7/9/26 at 10:08 a.m., indicated .Around 1250AM, resident was interviewed regarding the report made by the resident roommate in B bed. Resident was unable to provide information regarding the reported event and did not appear to understand what was being discussed . A review of Resident 1's Interdisciplinary Care Conference, dated 7/9/26 at 12:32 p.m., indicated .The IDT [Interdisciplinary Team] completed a comprehensive review following the reported room safety event to evaluate contributing factors, assess the resident's clinical and behavioral status .The IDT recognized that the resident's documented history of schizophrenia, unspecified psychosis, impaired cognition, and impaired judgment may significantly affect his ability to accurately perceive, process, and respond to his surroundings .the reported behaviors appear consistent with the resident's underlying cognitive and psychiatric conditions . A review of Resident 1's Progress Notes, Admit Visit Note by provider, dated 7/9/26 at 7:37 p.m., indicated .Pt [patient] had an incident with another resident in his room this am with foul language, threatening behaviors, and physical aggression . A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in July 2026 with multiple diagnoses including psoas muscle abscess (collection of pus in psoas muscle of the spine), sepsis, diabetes (too much sugar in the blood), and heart failure (heart does not pump blood as efficiently as it should). A review of Resident 2's MDS, Cognitive Patterns, dated 7/12/26, indicated Resident 2 had Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident was cognitively intact. A review of Resident 2's Progress Notes, dated 7/9/26 at 9:54 a.m., indicated . Around 1250 am, resident in B bed reported that the resident in C bed attempted to take his phone. Resident in B bed stated that the phone belonged to him and that he retrieved it from the resident in C bed . A review of Resident 2's Progress Notes, dated 7/9/26 at 11:17 a.m., indicated .Addendum: At around 12:50AM During the initial interview, resident in B bed also reported that resident in C bed had been randomly throwing objects in the room. Resident stated that one of the objects, identified as a basin, made contact with him during this behavior .No visible injuries . A review of Resident 2's Progress Notes, dated 7/9/26 at 11:55 a.m., indicated .Resident -to- resident occurred. The incident was reported to local law enforcement . The attending physician (MD) was notified and made aware of the incident. The resident's responsible party was notified and informed of the incident in accordance with facility policy. Resident will continue to be monitored . A review of Resident 2's Interdisciplinary Care Conference, dated 7/9/26 at 12:55 p.m., indicated .The IDT completed a comprehensive review of the reported room safety event to evaluate contributing factors .The IDT [Interdisciplinary Team] identified multiple contributing factors, including the shared room environment and the roommates documented cognitive impairment and behavioral symptoms . A review of Resident 2's Progress (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Solano Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notes, dated 7/9/26 at 1:02 p.m., indicated .At approximately 12:20 PM today, officer from the [Law Enforcement Agency] spoke with residents . During an interview on 7/23/26 at 11:46 a.m. with the DON, reviewed complaint intake involving resident to resident altercation between Resident 1 and Resident 2 on 7/9/26. The DON stated was not aware of the incident, but it should have been reported to the LTC ombudsman and law enforcement. The DON stated Resident 1 had schizophrenia and was discharged from the facility on 7/9/26 due to escalating aggressive behaviors. The DON stated the incident was documented in the electronic record. The DON stated the investigation was documented in the IDT Care Conference notes. Requested the investigation report. The DON stated she does not have access to it but will try and obtain from Administrator. The DON stated she did not know if had been sent to The Department. During an interview on 7/23/26 at 1:10 p.m. with the Director of Staff Development (DSD), the DSD stated she did not know if an investigation report was completed for this incident. During an interview on 7/23/26 at 1:46 p.m. with the DON, the DON stated had not located the investigation report yet. During an interview on 7/23/26 at 2:49 p.m. with Resident 2, Resident 2 answered questions appropriately and was able to converse effectively. Resident 2 stated Resident 1 attacked him on 7/9/26 around 1 a.m. Resident 2 stated Resident 1 came to his bed and tried to steal his cell phone. Resident 2 stated Resident 1 picked up a small plastic basin, swung, and hit him on the lower lip and then went back to his own bed. Resident 2 stated he had a cut below his lower right lip. Observed small scab on face right below lower right lip. Resident 2 stated a few minutes later, Resident 1 came back and tried to grab the cell phone again and was throwing around stuff in the room. Resident 2 stated Resident 1 climbed on him, was naked, and smacked him on the left side of his face with an open hand. Resident 2 stated he yelled for help at that point and Resident 1 was moved to another room. Resident 2 stated the police came and he told them he wanted to file charges. During an interview on 7/23/26 at 5:15 p.m. with the DON, the DON acknowledged that The Department had not been notified of the abuse allegation between Resident 1 and Resident 2 because they were following the Mandated Reporter flowsheet implemented by the Administrator. The DON stated she was not able to provide an investigation report that included staff and resident interviews with the outcome of the investigation. The DON stated the police department made a report. The DON stated a 5-day investigation report was not sent to The Department. A review of the facility's Policy and Procedure (P&P) titled Abuse Prohibition, revised 10/25/24, indicated .Physical abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment .If the suspected abuse is resident-to-resident, the resident .an investigation will be completed .Upon receiving information concerning a report of suspected or alleged abuse, mistreatment .will perform the following .Provide subsequent reports to the Department as often as necessary to inform the Department of significant changes in the status of affected individuals or changes in material facts originally reported .Initiate an investigation within 2 hours of an allegation of abuse that focuses on .whether abuse or neglect occurred and to what extent .The investigation will be thoroughly documented. Ensure that documentation of witnessed interviews is included .Conduct interviews using the Interview Record and Witness Interview Record .Report findings of all completed investigations within five (5) working days to the Licensing District Office .A review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 9/22, indicated .All reports of resident abuse .are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management .All allegations are to be thoroughly investigated. The administrator initiates the investigations . The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation .The Individual conducting the investigation as a minimum .reviews the documentation (continued on next page)		

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