

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: 056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled appropriately and correctly when:1. Loose pills, non-medication items, bisacodyl suppositories (a stimulant laxative), and a tube of triamcinolone cream (topical corticosteroid for itching, redness or swelling) were found in the 400 Even medication cart,2. Bisacodyl suppository and brownish residue were found in the 600 Hall medication cart,3. Expired over-the-counter (OTC) medications were found in medication room [ROOM NUMBER], and;4. Two medications found at Resident 1's bedside table. These failures had the potential for medication misuse, drug diversion, and diminish medication effectiveness.Findings: 1.During an inspection of medication cart 400 Even with Licensed Nurse (LN) 5 on 12/3/25 at 1:31 p.m., LN 5 verified that there had been five loose pills, a bisacodyl suppository stored with oral medications; a tube of triamcinolone cream; an oxygen nasal cannula; two dignity bags for a Foley catheter; and one Stat Lock (adhesive stabilizer) for Foley catheter in the medication cart. 2. During an inspection of medication cart 600 hall with LN 6 on 12/3/25 at 2:07 p.m., LN 6 verified that there was a box of Bisacodyl suppository stored with oral medications. It was also observed that there was a brownish residue on the first drawer of the medication cart. During an interview on 12/4/25 at 9:20 a.m. with Director of Nursing (DON), DON stated the expectation for the medication cart was that it should contain only medications. DON stated non-medication items were not to be stored in the cart, and the cart was to be kept clean and free of loose pills to prevent contamination and reduce the risk of infection. 3. During an inspection of Medication room [ROOM NUMBER] on 12/4/25 at 10:38 a.m. with Assistant Director of Nursing (ADON), ADON verified that the following medications were expired: one bottle of antacid (medication that neutralizes stomach acid) liquid (medication that neutralizes stomach acid), one bottle of diphenhydramine (antihistamine-treats allergy symptoms), one bottle of probiotic acidophilus (a dietary supplement that improves digestion), 1 bottle of antacid tablets, one bottle of guaifenesin (medication to relieve chest congestion), two bottles of senna (stimulant laxative), and two bottles of nasal saline spray. (moisturizes dry passages and loosens mucus). During a telephone interview with Pharmacy Consultant (PC), PC stated that bisacodyl suppositories should not be stored with oral medications to prevent accidental oral administration and cross contamination. The PC stated that medications carts should be kept clean at all times to prevent infection; that loose pills should not be left on the cart to avoid accidental administration; and that expired medications should be discarded to prevent them from being mistakenly given to residents. (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

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 12/05/2025
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled Storage of Medications, revised 11/20; the P&P indicated, .nursing staff is responsible for maintaining storage and preparation areas in a clean, safe and sanitary manner. discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 4.A review of Resident 1's admission record (AR), indicated, she was admitted 11/24 with diagnosis of acute and chronic respiratory failure with hypoxia (hypoxia - a condition where the body or a part of it does not get enough oxygen). Resident 1's Minimum Data set (MDS- a federally mandated resident assessment tool), dated, 11/26/25 indicated, she had no memory impairment. During a review of Resident 1's medication administration record dated 12/1/25 to 12/3/25 (MAR- a daily documentation record used by licensed nurse to document medications and treatments given to a resident), the MAR indicated, [brand name for calcium carbonate] oral tablet. give 2 tablets by mouth every 8 hours as needed for heartburn. Fluticasone Propionate Nasal Suspension 1 spray in each nostril one time a day for nasal congestion. During a review of Resident 1's medical records, there was no documented evidence of care plan and of physician's order for self-administration of medication at bedside. During a concurrent observation and interview on 12/2/25 at 11:05 a.m. in Resident 1's room, there were 2 round tablet medications with color yellow and pink in a medication cup. Resident 1 confirmed and stated, That's my [brand name of calcium carbonate]. There was a bottle of fluticasone nasal spray seen at Resident 1's kidney basin on her table. Resident 1 stated, That's for my allergies. The two medications found at the bedside did not have Resident 1's name and did not have any labels and were not in their original packaging. During a concurrent interview and record review on 12/2/25 with Licensed Nurse (LN) 3, Resident 1's MAR was reviewed. LN 3 confirmed there were no orders for Resident 1 to self-administer medications at bedside. LN 3 confirmed there should be orders for residents to keep medications at the bedside. LN 3 stated and confirmed Resident 1's medication found at bedside was not labeled or in their original packaging and acknowledged he left the medications at Resident 1's bedside.		

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: 056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure that food was stored in accordance with professional standards for food service for a census of 161 residents when food items in freezer #1 were expired or not properly sealed. These failures had the potential to cause food borne illness. Findings: During an observation and interview on 12/2/25 at 9:09 a.m. with the Dietary Manager (DM), the following was found in kitchen Freezer #1: 2 small plastic containers of ice cream with no open or use by date, a bag of unsealed donut holes with a preparation date (prep date) of 10/30/29 and use by date of 11/30/25, a lemon cake with a prep date of 10/30/25 and use by date of 11/30/25 and a bag of flour tortillas that were in an unsealed and undated bag. The DM confirmed the above findings and said her expectation would be for expired food to be thrown out and that food should be properly sealed. DM stated that not sealing freezer foods could cause freezer burns and affect the taste of the food. Review of policy and procedure (P&P), titled, Food Storage: Cold Foods, revised 2/2023, the P&P indicated, all foods will be stored in wrapped or in covered containers, labeled and dated .		

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 12/05/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure six of 32 sampled residents (Resident 1, Resident 81, Resident 67, Resident 68, Resident 114 and Resident 122) residents' rights were respected when: 1. Resident 1, Resident 81, Resident 67, and Resident 122 were not informed ahead of time of the construction plan and the significant noise associated with it and, 2. The facility threw away food brought in by the Resident 68 and Resident 114's family. These failures caused anxiety among the residents and resulted in residents not getting enough rest and had the potential to result in the residents not attaining their highest practicable physical, psychosocial, and emotional well-being. Findings: A review of Resident 1's admission record (AR), indicated, she was admitted 11/24 with diagnosis of acute and chronic respiratory failure with hypoxia (hypoxia - a condition where the body or a part of it does not get enough oxygen.) Resident 1's Minimum Data set (MDS- a federally mandated resident assessment tool), dated, 11/26/25 indicated, she had no memory impairment. A review of Resident 81's AR, indicated, she was admitted 1/25 with diagnosis of acute and chronic respiratory failure with hypoxia. Resident 81's MDS, dated [DATE] indicated, she had no memory impairment. A review of Resident 67's AR, indicated she was admitted 2/20 with diagnosis of Diabetes Mellitus Type 2 (DM 2- a chronic condition where the body either doesn't make enough insulin [hormone that turns food into energy and manages blood sugar level] leading to high blood sugar levels. Resident 67's MDS, dated [DATE] indicated, she had no memory impairment. A review of Resident 122's AR indicated, she was admitted 7/21 with diagnosis of DM 2. Resident 122's MDS, dated , 2/16/25, indicated, severe cognitive impairment. During a concurrent observation and interview on 12/2/25 at 11:05 a.m. with Resident 1 in her room, Resident 1 was observed flushed and restless. Resident 1 stated, the constant noise from the roof construction triggered her anxiety. Resident 1 stated she was not informed ahead of time of the early construction and loud noise. Resident 1 also stated, the banging noise started before 8 a.m. daily for over two weeks. Resident 1 further stated, if she was informed ahead of time, she'll be more understanding and will help alleviate her anxiety. During an interview on 12/2/25 at 11:40 a.m. with Resident 81, Resident 81 stated, no one has informed her about the roof construction and the noise ahead of time. Resident 81 stated that the banging noise was very loud and affected her. Resident 81 also stated she cannot get some rest or get naps. Resident 81 further stated, If I am informed ahead of time, it will make me feel valuable and respected and would understand that the construction and noise were expected and necessary. During an interview on 12/2/25 at 11:44 a.m. with Resident 122, Resident 122 stated, it's hard for her to sleep at night, and she wakes up early because of the banging on the roof. Further stated, . don't know what's going on up there. During an observation on 12/3/25, at 7:45 a.m., in the conference room, there were construction workers on the roof, and the banging noise was loud. (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 12/05/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/3/25 at 2:30 p.m. with Resident 67, Resident 67 stated, she was not informed ahead of time about the roof construction and the loud noise. Resident 67 stated, she was restless since they started the roof work. Resident 67 further stated, They start so early, and we are not even awake yet. Resident 67 further stated, It will make me feel important and cared better if my voice was heard and can agree with a better start time. During an observation on 12/4/25 at 11:15 a.m. at the Resident Council meeting, residents in attendance were grimacing and frowning because of the loud noise. The residents had to speak very loudly to be heard. Resident 58 was mouthing the words, I can't hear, too loud. During an interview on 12/4/25 at 4:20 p.m. with the Director of Nursing (DON), DON confirmed that the residents have the right to be fully informed including advance notice of changes affecting daily life, including disruptive construction due to noise. During a review of the facility's policy and procedure titled, Resident Rights, revised, December 2021, indicated, .Federal and state laws guarantee certain basic rights to all residents. These rights include the resident's right to be treated with respect, kindness, and dignity. right to be informed of. and participate in his or her care. During a review of the facility's policy and procedure titled, Noise Control, revised April 2014, indicated, .The facility strives to maintain comfortable sound levels that enhance privacy. and that do not interfere with resident's hearing. resident care and services should be provided in a manner that promotes calm, organized, and comfortable levels. 2. During a review of Resident 68's admission record, the admission record indicated Resident 68 was admitted to the facility March 2025 with multiple diagnosis including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 114's admission record, the admission record indicated Resident 114 was admitted to the facility August 2022 with multiple diagnosis including Chronic Kidney Disease (CKD - a gradual loss of kidney function over time). During an interview on 12/2/25 at 11:01 a.m. with Resident 114, Resident 114 stated his wife brought ham, black eyed peas, macaroni and cheese, and soda to the facility for Thanksgiving dinner on 11/27/25. Resident 114 further stated he gave the food to facility staff to label and date. Resident 114 further stated he watched facility staff place the labeled food in the resident refrigerator on 11/27/25. Resident 114 further stated on the morning of 11/28/25, the food that his wife brought in on 11/27/25 was thrown away by facility staff. Resident 114 further stated the incident was upsetting and affected his dignity. During an interview on 12/2/25 at 11:09 a.m. with Resident 68. Resident 68 stated on 11/27/25 he gave a plate of leftover food to Licensed Nurse (LN) 7 to label and put in the resident refrigerator. Resident 68 further stated the food was thrown away on 11/28/25 by facility staff. Resident 68 further stated this upset him because he was looking forward to enjoying his leftover Thanksgiving dinner. During an interview on 12/2/25 at 11:17 a.m. with LN 7, LN 7 verified she labeled and dated Resident 68's food on 11/27/25 before placing it in the resident refrigerator. LN 7 further stated the policy is for resident food to be kept at least 2 days before being thrown away. (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 12/05/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/2/25 at 11:23 a.m. with Assistant Director of Nursing (ADON), ADON confirmed the resident refrigerator was emptied before 10 a.m. on 11/28/25. ADON acknowledged policy and procedure for resident food was not followed and this affected residents' dignity. During an interview on 12/2/25 at 12:24 p.m. with Administrator (ADM), ADM confirmed Resident 114's food was thrown away on 11/28/25. ADM further stated Resident 114 should have been consulted or notified before his food was thrown away. During an interview on 12/5/25 at 9:33 a.m. with Director Nursing (DON), DON confirmed the facility did not follow policy when residents' food was thrown out before 48 hours. DON acknowledged the incident affected residents' dignity. During a review of the facility's policy and procedure (P&P) titled Food Brought by Family/Visitors, revised 3/28/24, the P&P indicated, .When food items are intended for later consumption, the responsible staff member will.Label the foods with resident's name, and the current date and use by date.Items will be thrown out after 48 hours.		

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 12/05/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure infection prevention measures were implemented for a census of 161 when:1. Resident 156's nebulizer mask was unbagged and undated on the bedside dresser,2. Resident 93's foley bag was on the floor,3. Resident 20, Resident 170 and Resident 163's catheter tubing was on the floor,4. Resident 47's distilled water for CPAP (continuous positive airway pressure-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in) was not labeled with a date and stored on the floor,5. Resident 47's oxygen tubing was not labeled with a date, and;6. Resident 81's nasal cannula was wrapped around the side rail and not securely stored in an oxygen tubing storage bag. These failures had the potential to cause the spread of infection among a vulnerable resident population.Findings: 1. During Review of Resident 156's admission Record (AR), AR indicated, Resident 156 was admitted to the facility in March of 2022, with diagnosis including chronic obstructive airway disease (COPD-a disease that can cause difficulty in breathing). During a review of Resident 156's Minimum Data Set (MDS-A federally mandated resident assessment tool), dated 9/22/25, indicated Resident 156 had moderate cognitive impairment. During a review of Resident 156's Order summary Report (OSR) dated 12/5/25, OSR indicated order for Albuterol Sulfate Nebulizer Solution (a medication given via mask that makes it easier to breathe) 3 ml (milliliter-a unit of measurement) inhale orally via nebulizer (a machine that turns liquid medication into a mist) every four hours for shortness of breath. During a concurrent observation and interview on 12/2/25 at 3:14 p.m. in Resident 156's room with Licensed Nurse (LN) 4, a nebulizer mask (a face mask used to deliver medication) was found on the bedside dresser unbagged and undated. LN 4 stated that it should be in a plastic bag and have a date on it. LN 4 stated that having the mask left out of the bag would be an infection control issue. During an interview on 12/3/25 at 9:40 a.m. with Infection Preventionist (IP), the IP stated that her expectation would be that Resident 156's nebulizer mask should be in a dated plastic bag. The IP added that improper storage of the nebulizer mask could expose his roommates to respiratory bacteria and increase the risk of infection. During a review of the facility's Policy and Procedure (P&P) titled, Departmental (Respiratory Therapy)-Prevention of Infection, dated November 2011, indicated, related to Medication Nebulizer.store the circuit in plastic bag, marked with date and resident's name, between uses. 2. During a review of Resident 93's (AR), indicated, Resident 93 was admitted to the facility in December 2022 with diagnoses including chronic kidney disease and neuromuscular dysfunction of bladder (a condition where nerve damage disrupts signals between the brain and the bladder, leading to problems emptying the bladder). A review of Resident 93's MDS dated [DATE] indicated, Resident 93 had severe cognitive impairment. A review of Resident 93's OSR dated 12/5/25 indicated an order for Indwelling Catheter (a flexible tube inserted into the bladder used to drain urine). (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 12/05/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/2/25 at 2:37 p.m. with Certified Nurse Assistant (CNA) 3, Resident 93's foley bag (a urine collection bag) was found lying on the floor. CNA 3 confirmed the foley bag was on the floor and stated it should not be on the floor. During an interview on 12/3/25 at 9:32 a.m. with the IP, IP stated her expectation was that Resident 93's foley bag should be off the floor and in a plastic basin. The IP further stated that improper storage of the foley bag could expose Resident 93 to bacteria, increasing the risk of illness. A facility policy and procedure was requested and not provided. 3. During a review of Resident 20's AR, the AR indicated, Resident 20 was re-admitted on [DATE] with diagnoses which included benign prostatic hyperplasia (enlarged prostate gland), hydronephrosis (swelling of one or both kidneys due to urine not draining properly), hydroureter (swelling of the ureter-thin tube that carries urine from kidney to bladder) and retention of urine. During a review of Resident 20's OSR, the OSR indicated that Resident 20 had an order to have the Foley catheter (a type of urine catheter) and drainage bag changed on the first day of every month. During a review of Resident 170's AR, the AR indicated Resident 170 was admitted on [DATE] with diagnoses which included urinary tract infection (UTI- an infection in the bladder/urinary tract), neuromuscular dysfunction of bladder (the nerves and muscles controlling the bladder is not communicating well) and retention of urine. During a review of Resident 170's OSR, the OSR indicated that Resident 170 had an order for Foley catheter for neuromuscular dysfunction of the bladder. During a review of Resident 163's AR, the AR indicated, Resident 163 was admitted on [DATE] with diagnoses which included UTI and retention of urine. During a concurrent observation and interview on 12/2/25 at 10:38 a.m. with Licensed Nurse (LN) 2 in Resident 20's room, Resident 20's catheter tubing was observed lying on the floor. LN 2 stated that the tubing was touching the floor and stated that catheter tubing should not be kinked or in contact with the floor. During an interview on 12/2/25 at 10:40 a.m. with IP, IP stated that catheter tubing should not touch the floor because there was a risk for transmission of bacteria or infection if it came into contact with the floor. During a concurrent observation and interview on 12/2/25 at 10:47 a.m. with Resident 170 in Resident 170's room, Resident 170 was seated in a wheelchair and stated he had just gone to an appointment that day and that his foley catheter had been changed. It was observed that the catheter tubing was lying on the floor and the Foley bag with the dignity bag was also on the floor. During a concurrent observation and interview on 12/2/25 at 11:04 a.m. with IP in Resident 163's room, Resident 163's catheter tubing was observed lying on the floor, and the catheter bag, which was inside a dignity bag, was on the floormat (a cushioned floor pad designed to help prevent injury should a person fall). This was confirmed by the IP. The IP stated that even when a catheter bag is placed inside a dignity bag, it should not be touching the floor because of the risk for infection. (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 12/05/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy and procedure for the prevention of infection for indwelling urinary catheters was requested but was not provided. 4. During a review of Resident 47's AR, Resident 47 was admitted to the facility May 2025 with multiple diagnosis including asthma (a chronic lung disease that inflames and narrows airways, causing symptoms like wheezing, coughing, chest tightness, and shortness of breath). During a review of Resident 47's Physician's Orders, the Physician's Orders indicated Resident 47 had a CPAP. During a concurrent observation and interview on 12/2/25 at 12:21 p.m. in Resident 47's room, an open bottle of distilled water was on the floor. The bottle was not dated with an open or use by date. Resident 47 stated she used the distilled water with her CPAP. Resident 47 further stated she was not sure how long the opened bottle had been there. LN 7 confirmed the bottle of distilled water should have been labeled and not stored on the floor. During an interview on 12/5/25 at 9:29 a.m. with Director of Nursing (DON), DON stated the expectation was for open bottles of distilled water to be stored on a clean surface and labeled with open and use by dates. DON acknowledged risk for infection when distilled water was not stored on the floor and not labeled. During a review of the facility's P&P titled Departmental (Respiratory Therapy) & Prevention of Infection, revised November 2011, the P&P indicated, .distilled water used in respiratory therapy must be dated and initialed when opened, and discarded after twenty-four (24) hours. During a review of the facility's P&P titled Policies and Practices & Infection Control, revised October 2018, the P&P indicated, .maintain a safe, sanitary.environment for.residents. 5. During a review of Resident 47's Physician's Orders, the Physician's Orders indicated Resident 47 had oxygen. During a concurrent observation and interview on 12/2/25 at 12:21 p.m. in Resident 47's room, LN 7 administered oxygen to Resident 47 by connecting unlabeled oxygen tubing to a portable tank on Resident 47's wheelchair. LN 7 acknowledged the oxygen tubing should have been labeled with a date. During an interview on 12/5/25 at 9:29 a.m. with DON, DON stated the expectation was for oxygen tubing to be labeled with a date and there was a risk for infection when this was not done. During a review of the facility's P&P titled, Departmental (Respiratory Therapy) & Prevention of Infection, Revised November 2011, the P&P indicated, .change the oxygen.tubing every seven (7) days. Findings: A review of Resident 81's AR, indicated, she was admitted [DATE] with diagnosis of acute and chronic respiratory failure with hypoxia (the body or a part of it is not getting enough oxygen to work right) A review of Resident 81's MDS, dated [DATE] indicated, she had no memory impairment. (continued on next page)		

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: 056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/2/25 at 11:40 a.m., in Resident 81's room, Resident 81 had an oxygen concentrator (a machine that takes normal air, filters out the nitrogen[invisible, odorless gas that makes up most of the air we breathe] and delivers concentrated purer oxygen at bedside. Resident 81's oxygen tubing was wrapped around her side rail and was not placed in a secured storage bag when not in use. During an interview with Infection Prevention (IP) nurse on 12/3/25 at 3:40 p.m., the IP stated, oxygen tubing must be placed in a secured storage bag when not in use to prevent contamination. A review of the facility's policy and procedure titled, Receipt and Storage of Supplies and Equipment, revised November 2009, indicated, .all supplies and equipment must be stored in accordance with the manufacturer's recommendations. No Policy and Procedure were provided related to Infection Prevention using nasal cannula or face masks when requested.		

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 12/05/2025
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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement an effective pest control program for 20 out of 32 sampled residents (Resident 37, Resident 133, Resident 97, Resident 98, Resident 22, Resident 91, Resident 135, Resident 31, Resident 111, Resident 16, Resident 129, Resident 30, Resident 1, Resident 67, Resident 29, Resident 63, Resident 83, Resident 81, Resident 142, and Resident 9) when gnats (tiny flying insects) and flies were observed in their rooms. This deficient practice had the potential to create unsanitary conditions for the residents, staff, and visitors. Findings: During an observation on 12/2/25, the following were observed:- At 10:48 a.m., room [ROOM NUMBER] was observed with gnats flying around back and forth.- At 10:54 a.m., room [ROOM NUMBER] was observed with gnats flying back and forth.- At 11a.m., room [ROOM NUMBER] was observed with gnats flying.- At 11:30 a.m., room [ROOM NUMBER] was observed with gnats flying around.- At 12: 34 p.m., room [ROOM NUMBER] was observed with gnats flying.- At 3:14 p.m., room [ROOM NUMBER] was observed to have flies and gnats in the room During an observation on 12/3/25, the following were observed.- At 8:30 a.m., room [ROOM NUMBER] was observed with gnats flying around.- At 8:40 a.m., room [ROOM NUMBER] was observed with gnats flying around.- At 3:04 p.m., room [ROOM NUMBER] was observed with gnats flying around. During an interview on 12/2/25 at 10:45 a.m. with Certified Nurse Assistant (CNA)1, CNA 1 stated, Gnats are everywhere. During an interview on 12/2/25 at 10:56 a.m. with CNA 2, CNA 2 stated, .gnats are everywhere in this place; they are also in other rooms and other hallways too. During an interview on 12/2/25 at 10:58 a.m. with Resident 63, Resident 63 stated, I see them (gnats) all the time, not only in my room, also in the hallway. They are everywhere. During an interview on 12/2/25 at 11:05 a.m. with Resident 1, Resident 1 stated, Gnats are everywhere. During an interview on 12/2/25 at 11:40 a.m. with Resident 81, Resident 81 stated, Gnats are here every day flying around. It is nasty because it lands in your food or water. During a concurrent observation and interview on 12/2/25 at 3:04 p.m. with CNA 4, observed four to five gnats flying above Resident 9's head of bed. CNA 4 confirmed this finding and stated it is a problem in the building. During an interview on 12/3/25 at 8:15 a.m. with Maintenance Supervisor (MS), the MS stated, pest control treatment was performed at hallway 600 where there were reported gnats/pests. MS stated and confirmed Pest Control company did not provide any pest control treatments on other hallways. MS stated, gnats could be a problem for residents because they could get on their food and make the residents sick. During an interview on 12/3/25 at 2:27 p.m. with the Infection Preventionist (IP), the IP stated that Gnats have been an issue in the building for three to four months. During an interview with Director of Nursing (DON) on 12/4/25 at 4:20 p.m., the DON stated, the maintenance should inspect all rooms and hallways to evaluate pest situation. Pests must be treated right away to protect the residents living in the facility. During a review of the facility's policy and procedure titled. Pest Control, revised May 2008, indicated, . Our facility shall maintain an effective pest control program. this facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.		

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 12/05/2025
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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on interview and record review, the facility failed to provide treatment and services to maintain mobility and prevent further decrease in range of motion for one of 32 sampled residents (Resident 134), when Resident 134 did not receive restorative nursing assistant (RNA, exercises to improve or maintain resident's functional abilities) services per her care plan interventions. This failure placed Resident 134 at risk for further complications and decline in their physical functioning and mobility. Findings: During a review of Resident 134's admission record, the admission record indicated Resident 134 was admitted to the facility July 2024 with multiple diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the right side. During a review of Resident 134's Care Plan initiated 7/15/25, the care plan indicated, .Interventions. Restorative Nursing Program: Active Range of Motion - Right Upper Extremity. RNA will assist resident with AROM [Active Range of Motion] to Right Upper Extremities, 3 times a week. During an interview on 12/4/25 at 8:55 a.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 confirmed Resident 134 should have received RNA services three times a week for right upper hand range of motion. RNA 1 further stated she did not provide RNA services to Resident 134 that week. RNA 1 also stated she was not sure if Resident 134 received RNA services from another RNA because there was no documentation available. During a review of Resident 134's medical record, there was no documented evidence that Resident 134 was offered RNA services from 7/15/25 through 12/4/25. During an interview on 12/4/25 at 12 p.m. with Assistant Director of Nursing (ADON), ADON confirmed there was no documentation indicating Resident 134 received RNA services per care plan. During an interview on 12/5/25 at 9:34 a.m. with Director of Nursing (DON), DON stated the expectation was for care plan interventions to be followed and documented. DON acknowledged Resident 134 had a risk for decrease in mobility and activities of daily living when RNA services were not provided or documented. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plan, dated 8/25/2021, the P&P indicated, .the facility's Interdisciplinary Team must develop and implement a comprehensive person-centered care plan to meet resident's physical needs. During a review of the facility's P&P titled, Nursing Documentation, dated 6/27/2023, the P&P indicated, .Purpose. To communicate patient's status and provide, complete, comprehensive, and accessible accounting of care and monitoring provided. Documentation includes interventions. timely entry of documentation must occur as soon as possible after the provision of care.		

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 12/05/2025
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to ensure an environment free from accident hazards for one resident (Resident 93) when two beds in the room were situated side by side and put together, for a census of 161. This failure increased the risk of Resident 39 getting caught between beds risking injury and had the potential to cause blocked access for the staff when providing resident care. Findings: Review of Resident 93's admission Record, indicated Resident 93 was admitted to the facility in December 2022, with several diagnoses including, aphasia (a disorder that makes it difficult to speak) following a cerebral infarction (a condition that causes decreased blood flow to part of the brain), monoplegia (paralysis restricted to one limb) of upper limb affecting right dominant side, need for assistance with personal care, and muscle weakness (generalized). Review of Resident 93's MDS (Minimum Data Set-A federally mandated resident assessment tool), dated 9/20/25 indicated Resident 93 had severe cognitive impairment. Review of Resident 93's care plan dated 5/18/24, indicated, . Behaviors . Sliding down or crawling to the floor from her low bed. The resident needs a safe environment . During a concurrent observation and interview on 12/4/25 at 9:18 a.m. with Licensed Nurse (LN) 1, in Resident 93's room, LN 1 confirmed that bed A and B were situated side by side put together. During a concurrent observation and interview on 12/4/25 at 11:00 a.m. with the Director of Nursing (DON), in Resident 93's room, the DON stated that Resident 93's family did not sign consent for the beds to be together. Resident 93's bed was not locked. The DON confirmed Resident 93's bed was not locked. During an interview on 12/5/25 at 12:10 p.m. with Regional Consultant (RC), the RC that acknowledged Resident 93 could be at risk of entrapment with the current bed arrangement. Review of the policy and procedure (P & P) titled, Safety and Supervision dated July 2017, the P & P indicated, Our facility strives to make the environment as free from accident hazards as possible. these risk factors and environmental hazards include the following: Bed safety.		

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 12/05/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that pharmacy services were maintained when:1. Controlled drug (medication that may be abused or cause addiction) record form for Resident 63 was not signed immediately after medication administration, and;2. LN did not follow the correct dilution protocol for the intravenous (IV antibiotic for Resident 61). These failures resulted in Resident 61 not receiving the correct dose of IV antibiotic and had the potential to result in diversion of the resident's medication.Findings:1. During an inspection of medication cart 400 Even with Licensed Nurse (LN) 5 on 12/3/25 at 1:31 p.m., a controlled drug count for Resident 63's hydrocodone acetaminophen (pain medication) 5/325 milligram (mg-unit of measurement) was not accurate. There were five tablets of hydrocodone acetaminophen 5/325 mg in the medication bubble pack and the controlled drug log indicated there should be six. LN 5 stated she had administered the hydrocodone acetaminophen 5/325 mg at 11:34 a.m. and forgot to sign after giving it.During an interview on 12/4/25 at 2:22 p.m. with Director of Nursing (DON), DON stated for narcotics, nurses were expected to sign the narcotic count record immediately after removing the medication from the bubble pack.During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines: Controlled Medications, dated 4/08, the P&P indicated, .medications are obtained from the locked cabinet. when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record.1. Date and time of administration 2. Amount administered 3. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply.2. During a review of Resident 61's admission Record (AR), the AR indicated, Resident 61 was admitted on [DATE] with diagnoses which included endocarditis (infection of the heart's inner lining, chambers or valves) and severe sepsis (a life-threatening blood infection)During a review of Resident 61's Order Summary Report (OSR), the OSR indicated Resident 61 had an order for ceftriaxone sodium (an antibiotic) 2 gm (gram-a unit of measurement) reconstituted IV solution every 12 hours from 11/17/25 to 11/26/25, and a separate one-time order for ceftriaxone sodium 1 gm reconstituted IV solution on 11/21/25.During a telephone interview on 12/5/25 at 10:38 a.m. with LN 8, LN 8 stated that on 11/21/25 she had not taken the ceftriaxone sodium vial from the emergency kit. Instead, another nurse had provided her with a 2 gm vial of ceftriaxone for administration. LN 8 stated upon reviewing the Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), she saw that the order was for 1 gm but confirmed she had not replaced the vial with a 1 gm vial. LN 8 stated she had reconstituted the 2 gm vial by injecting 10 mL (milliliters-unit of measurement) of normal saline into it, withdrew 5 mL from the vial and discarded it, then injected the remaining 5 mL into the IV bag. LN 8 stated she had administered the IV bag after this preparation.During an interview on 12/5/25 at 10:52 a.m. with DON, DON stated if there were no instructions on how to prepare an IV antibiotic, the LN was expected to contact the pharmacist for guidance.During a telephone interview on 12/5/25 at 11:19 a.m. with IV Department Pharmacist (IVDP) of the facility's pharmacy vendor, the IVDP stated, they have never used a 2 gm vial of ceftriaxone sodium to administer a 1 gm dose, as the emergency kit typically contained 1 gm vials, which was their standard protocol. The IVDP stated that, based on the information available to her, to prepare a 1 gm dose from a 2 gm vial, the 2 gm vial should be reconstituted with 19.2 mL of normal saline, and then 10 mL should be withdrawn and injected into a 50 mL normal saline bag for administration. The IVDP confirmed that LN 8 did not administer the accurate 1 gm dose because the reconstitution process was done incorrectly.During a review of the facility's P&P titled, Admixing Medications, dated 03/23, the P&P indicated, .the appropriate diluent is to be used when admixing medications. for powdered drug reconstitution from a medication vial: 1. (continued on next page)		

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: 056238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inspect medication and diluent for integrity, expiration date, and strength. Notify pharmacy if any question.		