STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555355	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Faire Nursing & Rehabilitation Center	3620 B Dale Rd. Modesto, CA 95356

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50925 Based on interview, and record review, the facility failed to maintain the hydration status for 1 of 4 sampled residents (Resident 1) when Resident 1's fluid intake was not monitored and documented accurately. This failure resulted in Resident 1 being hospitalized for dehydration (a condition that occurs when the body loses too much water and other fluids that it needs to work properly) and an electrolyte imbalance (the body's mineral levels are too high or too low). Findings: A review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility with diagnoses including cerebral infarction (disrupted blood flow to the brain), dysphagia (difficulty swallowing), acute kidney failure (sudden loss of kidney function) and hyperkalemia (high potassium level in the blood). A review of Resident 1's care plan titled, Altered nutrition and hydration risk ., revised on 2/25/24, indicated, . Labs as per MD order .RD [registered dietician] evaluation as needed . A review of Resident 1's care plan titled, Resident is incontinent of Bowl/ Bladder, revised on 5/17/23, indicated, .Monitor and record bowel and bladder patterns each shift . A review of Resident 1's Nutritional Risk Assessment, dated 5/18/24, indicated, .Estimated fluid needs in ml: [milliliter- unit of measurement for volume] 1ML/KCAL [kilocalorie- unit of energy] OR PER MD [physician] . po [oral] intake varies 25-50% .Will continue to monitor wt [weight] trends and po intake .and hydration status . A review of Resident 1's electronic health record (EHR) titled, General Note, dated 6/13/24, at 1:17 p.m., indicated, .[Resident 1] being transferred D/T [due to] decline in cognition for baseline, decline in oral intake . A review of Resident 1's EHR titled, General Note, dated 6/13/24, at 6:12 p.m., indicated, .Spoke with ER [emergency room] nurse .PT [patient] being admitted with dx [diagnosis] of hyperkalemia, hypernatremia [high sodium level in the blood], acute renal insufficiency [sudden loss of kidney function], and uremia [a buildup of waste products in the blood due to impaired kidney function] . (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's hospital record titled, Discharge Summary, dated 6/16/24, indicated, XXX[AGE] year-old female history of prior CVA [cerebral vascular accident] left sided weakness who was brought to ER from rehab 6/13/2024 due to worsening shortness of breath desaturation [low blood oxygen], severe dehydration and hyperkalemia with AKI [acute kidney injury] . During an interview on 2/11/25, at 1:24 p.m., Certified Nurse Assistant (CNA) 1 stated fluid intake was checked if there was an order in the resident's chart. CNA 1 further stated generally there was no charting of fluid intake. During an interview on 2/11/25, at 1:55 p.m., Licensed Nurse (LN) 1 stated there would be an order in the resident's chart if a resident's intake and output (I&O) needed monitoring. During a concurrent interview and record review on 2/11/25, at 2:27 p.m., LN 2 confirmed Resident 1 did not have a physician order to monitor her intake and output. LN 2 stated Resident 1 was at risk of dehydration due to her refusal to eat or drink. LN 2 further stated she was not sure how intake and output was monitored for residents at the facility who had no order in place. LN 2 explained that monitoring I&O's would be a preventative measure and helpful for nurses to monitor for dehydration. During a concurrent interview and record review on 2/11/25, at 4:27 p.m., LN 3 confirmed Resident 1 was not on a fluid restriction. LN 3 stated only residents with a fluid restriction had their I&O monitored. LN 3 further stated there was no standard for monitoring I&O in the facility. During an interview on 2/12/25, at 1:12 p.m., the Medical Records (MR) stated the feature to monitor a resident's I&O used to be part of the facility's electronic health record system but was no longer available due to a corporate change. The MR further stated staff would only monitor the I&O if there was specific order for it. The MR stated she was not sure how a resident's input and output was monitored. During a concurrent interview and record review on 2/20/25, at 10:58 a.m., with LN 4, Resident 1's EHR was reviewed. LN 4 confirmed Resident 1 was not being monitored for I&O. LN 4 stated it was possible for Resident 1 to get dehydrated due to her behavior of refusing her meals. LN 4 further stated not monitoring I&O's was a risk for dehydration. LN 4 further confirmed Resident 1's reason for admission to the hospital on 6/13/24 meant Resident 1 was dehydrated. LN 4 stated Resident 1's dehydration could have been prevented with close I&O monitoring. During a concurrent interview and record review on 2/20/25, 3:51 p.m., with the Director of Nursing (DON), Resident 1's EHR was reviewed. The DON confirmed Resident 1 was at risk for dehydration. The DON further confirmed only meal percentages were documented, and no fluids were measured for Resident 1's fluid intake. The DON explained the RD's calculated recommendation for Resident 1's fluid intake was not followed because Resident's fluid intake was not monitored. The DON stated the amount of fluid Resident 1 drank in the facility could not be determined because fluid intake was not monitored. The DON further stated she expected the RD to review the resident's meal intakes, refusals, and medical history to determine if I&O's needed to be monitored for Resident 1. The DON confirmed no labs were ordered for Resident 1. The DON stated the MD should have ordered labs due to Resident 1's poor oral intake. The DON further stated the risk for not monitoring I&O's included patient safety, decline, and being transferred to the hospital. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 2/21/25, at 9:28 a.m., the RD stated fluid intake was not monitored for the residents. The RD further stated the overall percentage for the total meal documented by staff included the fluids a resident drank with meals. The RD stated the risk for not monitoring fluid intake would be dehydration and a decline in health. The RD further stated that the MD was the one to determine if a resident needed their I&O's monitored. During a phone interview on 2/21/25, at 3:48 p.m., the Medical Doctor (MD) 1 stated Resident 1 was at risk for dehydration due to her history of refusing to eat or drink. MD 1 further stated I&O monitoring should be routinely monitored as protocol at nursing homes. MD 1 explained the LN or CNA should document the amount a resident ate or drank in the facility. MD 1 stated the elderly could get dehydrated right away. MD 1 further stated the facility could do a better job in documenting the fluid intake for residents.