

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER Vintage Faire Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to report to the Department an injury of unknown source in accordance with the facility's abuse policy and procedure (P&P) for one of four sampled residents (Resident 4) when on 10/30/25, Resident 4 was found with an unexplainable bruise and bump to the left side of her forehead. This failure denied the Department the ability to conduct a timely investigation and placed Resident 4 at risk for abuse. In addition, the facility failed to comply with state and federal reporting regulations. Findings: A review of Resident 4's, admission RECORD, indicated Resident 4 was admitted to the facility with diagnoses which included but not limited to: Hemiplegia (paralysis of one side of the body) and hemiparesis (a condition characterized by partial weakness on one side of the body) following cerebral infarction (a type of stroke caused by a blockage in an artery that supplies blood to the brain) affecting left non-dominant side, Dysphagia (difficulty swallowing), and anxiety disorder (a mental health condition described to have excessive and persistent fear, worry or dread that interferes with daily life). A review of Resident 4's, electronic medical record (EMR - a digital version of a patient's chart that contains their medical history, information including treatments, progress and plan) a progress note (a document that records a patient's condition, treatment, and progress over time) dated 10/30/25, written by Licensed Nurse (LN 1), indicated, .CNA [Certified Nursing Assistant] informed this writer [LN 1] that [Resident 4] has a bruise to left forehead. This writer completed a skin assessment. Pt [patient -Resident 4] does have a bruise to left forehead .This writer [LN 1] then asked [Resident 4] how injury occurred and pt [patient -Resident 4] stated, I don't know. Informed Treatment nurse, and informed MD [medical doctor] and RP [Resident 4's responsible party -Family member] .During a phone interview on 11/13/25 at 12:28 PM with Resident 4's responsible party/family member (FM) 1, FM 1 stated Resident 4 was currently out of the facility, in a hospital and very ill. FM 1 added, Resident 4 was very difficult to understand due to her medical condition, she was with Resident 4, relayed interview questions, and spoke on her behalf. FM 1 confirmed on 10/30/25, she received a call from LN 1 who explained a bruise was found on Resident 4's forehead. FM 1 further stated it was common for the facility to call her and update her of any changes in her condition. FM 1 asked Resident 4 how the injury to her forehead occurred and Resident 4 replied she did not know. FM 1 explained the facility called her in the past when Resident 4 was anxious and had scratched her arm, chest, and stomach. During an interview on 11/18/25 at 2:14 PM, LN 1 confirmed she was working on 10/30/25 when she was told by a Certified Nursing Assistant (CNA) that a new bruise was observed on Resident 4's left forehead. LN 1 stated she went and assessed Resident 4 and observed a bruise and bump on Resident 4's left forehead. LN 1 stated she asked Resident 4 how it happened, and Resident 4 told LN 1 she did not know. LN 1 further stated she documented the findings in Resident 4's medical record, notified the treatment nurse (a nurse specializing in direct patient care for wounds and other skin conditions), notified the doctor, and notified Resident 4's RP. LN 1 stated she believed she had met her obligation of reporting the injury because Resident 4 had a history of hitting herself and believed it was self-inflicted. LN 1 confirmed she did not witness Resident 4 injure herself, and the other staff working with Resident 4 did not witness the injury either. During a concurrent interview and record review on 11/13/25 at 4 PM, Resident 4's EHR progress note dated 10/30/25 regarding Resident 4's bruise to her left forehead was reviewed with the Director of Nursing (DON). The DON stated the facility completed their own investigation into how the injury had occurred. The DON further stated their investigation revealed there were no witnesses to the injury and Resident 4 could not explain how the injury occurred. The DON explained the facility did not report the injury to the Department because they assumed the injury was self-inflicted by Resident 4. The DON further explained Resident 4 had a history of scratching her arm and chest as well as hitting herself. The DON reviewed Resident 4's medical record and was unable to provide documentation of Resident 4's history of hitting herself. The DON stated they were just guessing that was how the injury occurred since it was not explainable by Resident 4 or observed by staff. The DON further stated it was important to notify the Department of an injury of unknown source to the face and head for the safety of the residents. The DON further stated the purpose of the notification was so an injury to a resident could be investigated to rule out the possibility of abuse. During a follow-up interview on 11/18/25 at 8:06 AM, FM 1 confirmed the facility did call and notify her when Resident 4 would scratch or pick at her arm and chest. FM 1 added the facility was good about calling anytime there was a change in Resident 4's behavior or scratching herself. FM 1 further added she had never observed Resident 4 hitting herself in the head or face and stated the facility had never notified her of that behavior</p>		