

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 11/19/2025
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure three of three (3) current sampled residents (Resident 1, Resident 4, and Resident 5), had person-centered care plans (a personalized document outlining a resident's health, support, and personal needs) when:1. Resident 1 did not have a care plan developed and implemented for diagnoses of hypertension (HTN, High blood pressure-the force of blood against your artery walls is consistently too high, making your heart work harder), medication for depression (feelings of sadness), and medication for prevention of blood clots (pooling of blood).2. Resident 4 did not have a care plan developed and implemented for diagnoses of HTN, chest pain, and a stroke (blood flow to the brain is suddenly interrupted, causing brain cells to die due to lack of oxygen). 3. Resident 5 did not have a care plan developed and implemented for diagnoses of diabetes (the body can't properly use sugar for energy, leading to high blood sugar levels because the body does not make enough insulin). These failures had the potential for Resident 1, Resident 4, and Resident 5's health care needs to go unrecognized, negatively affecting all three residents; Resident 1 (increased risk for stroke and depression), Resident 4 (increased risk for stroke), and Resident 5 (increased risk for uncontrolled blood sugar which could lead to fatigue, blurred vision, and in severe cases, seizures [a sudden surge of abnormal electrical activity in the brain]). Findings: 1. A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included high blood pressure.A review of Resident 1's Order Summary Report, (contains the physician's orders) dated 11/19/25, indicated the following physician orders:-Amlodipine (medication used to treat [HTN] high blood pressure) one time a day for HTN-Lisinopril (medication used to treat HTN) one time a day for HTN-Metoprolol (medication used to treat HTN) three times a day for HTN-Sertraline (medication used to treat depression) one time a day for depression-Clopidogrel (antiplatelet medication to prevent blood clots) give 1 time a day for CVA (cerebral [brain] vascular accident - a stroke caused by a blood clot)A review of Resident 1's care plans did not contain care plans for Resident 1's HTN, depression, and anticoagulant therapy (medication to prevent blood clots).During a concurrent interview and record review on 11/19/25 at 1:35 PM with licensed nurse (LN) 1, LN 1 confirmed Resident 1 did not have care plans in place for HTN, depression, and anticoagulant therapy. LN 1 stated the care plans should have been in place. LN 1 explained the importance of the care plans was to guide the care of Resident 1 and to have given interventions for health conditions. LN 1 explained that without care plans in place for HTN, depression, and anticoagulant therapy, Resident 1's basic needs may not be met.2. A review of Resident 4's admission RECORD, indicated Resident 4 was admitted to the facility with diagnoses which included HTN, and a stroke. A review of Resident 4's care plans did not contain care plans related to Resident 4's diagnosis of HTN, stroke, and chest pain.A review of Resident 4's Order Summary Report, dated 11/19/25, indicated the following physician orders:-Aspirin one time a day for stroke prevention-Clopidogrel one time a day for stroke prevention-Hydralazine (medication for HTN) one tablet every six hours as needed for HTN-Losartan (medication for HTN) one time a day for HTN-Nitroglycerin 1 tablet every 5 minutes as needed for chest painDuring a concurrent interview and record review on 11/19/25 at 3:34 PM with the Minimum Data Set Assistant (the MDSA works with the MDS nurse who handles clinical assessments known as the Minimum Data Set), Resident 4's care plans were reviewed. The MDSA confirmed Resident 4 did not have care plans in place for stroke prevention, HTN, and chest pain. The MDSA explained there should have been care plans in place, but due to a transition in ownership of the facility on 8/1/25, more than three months prior, the facility had not caught up on all their care plans, stating it was a work in progress.During an interview with the Director of Nursing (DON) on 11/19/25 at 4:18 PM, the DON stated resident's care plans should have reflected their current health status. The DON stated it was important to have care plans in place that directed the care the resident received by having focus goals and interventions for that specific health condition. The DON further explained if the care plans were not in place there could be a delay care.During a follow-up interview with the DON on 12/24/25 at 12:19 PM, the DON confirmed Resident 4 did not have care plans in place for stoke prevention, HTN, and chest pain. The DON explained it was important to have active care plans in Resident 4's electronic health record (EHR) so the staff would have a visualization of Resident 4's ongoing plan of care.3. A review of Resident 5's admission RECORD, indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included diabetes.A review of Resident 5's Order Summary Report dated 11/19/25 indicated Resident 5 was on the following medications for diabetes:-Metformin</p>		