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	03/05/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to ensure dignity was maintained for one of five sampled residents (Resident 1) when personal hygiene items (attends - single-use, highly absorbent garments designed to manage, contain, and absorb urine and fecal leaks for individuals with loss of bladder or bowel control, and personal hygiene wipes - pre-moistened, disposable cloths designed for gentle, effective cleaning of the sensitive genital and anal areas) were left on Resident 1 small 3 drawer dresser in public view.This failure had the potential to negatively effect Resident 1's right to maintain a dignified existence, negatively affecting Resident 1's psychosocial well-being.Findings:A review of Resident 1 clinical document titled, admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life).During an observation on 3/5/26 at 9:12 AM, in Resident 1's room, Resident 1 was in bed. Resident 1's small bedside 3 drawer dresser had a full open packet of attends and a packet of personal hygiene wipes on top of the dresser.During a concurrent interview and observation on 3/5/26 at 10:55 AM with the Infection Preventionist (IP), the IP confirmed the packet of attends and personal hygiene wipes were stored on top of Resident 1's small 3 drawer dresser. The IP stated the attends and personal hygiene wipes should not have been stored on top of the small 3 drawer dresser. The IP explained it was a dignity issue for Resident 1. The IP further stated Resident 1 would not want everyone to know she was wearing attends.A review of the facility policy titled, Resident Rights, revised 2/21, indicated, . Employees shall treat all residents with kindness, respect, and dignity . rights include . a dignified existence .

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure one of two sampled resident (Resident 4) whom received enteral (a method of delivering liquid nutrition directly into the stomach or small intestine using a tube) feedings was positioned correctly during enteral feeding when, Resident 4's head of bed position was at approximately 20 to 25 degree angle while receiving nutrition via an enteral feeding.This failure had the potential to negatively effect Resident 4's health and well-being by placing Resident 4 at risk for aspirating (breathing in) her enteral feeding potentially resulting in aspiration pneumonia (a lung infection that occurs when food, liquid, saliva, or vomit is accidentally breathed into the airways and lungs).Findings:A review of Resident 4's clinical document titled, admission RECORD, indicated Resident 4 was admitted to the facility with diagnoses which included a gastrostomy tube (a soft, flexible tube inserted through the skin of the abdomen directly into the stomach to deliver nutrition, fluids, and medication).A review of Resident 4's clinical document titled, Care Plan Report, dated 9/22/25, indicated, . Requires tube feeding [enteral feeding] .HOB [head of bed] elevated 45 degrees during and thirty minutes after tube feed .A review of Resident 4's physician's orders indicated, . every shift for nutrition Administer [brand name enteral feeding] VIA an Enteral Pump and Infuse at 50 ml/hr . Order Date . 2/9/2026 .During a concurrent interview and observation on 3/5/26 at 10:08 AM with the Infection Preventionist (IP), Resident 4's enteral feeding was observed being administered via an enteral feeding pump at 50 ml/hr (milliliters a unit of measure/hour the time to administer a given volume over the specified hour). Resident 4's position in bed for the enteral feeding was approximately 20-25 degrees. The IP confirmed Resident 4's position of 20-25 degrees. The IP stated Resident 4's position should be at 35 or 45 degrees.During an interview on 3/5/26 at 10:21 AM with the Director of Nursing (DON), the DON stated residents should be positioned at least 30 degrees when enteral feedings are being administered. The DON explained Resident 4 was placed at a high risk for aspiration pneumonia if the bed was not at least at a 30 degree angle or greater.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure one of five sampled resident (Resident 2) received appropriate respiratory care as needed when, Resident 2 was receiving oxygen at 3 liters per minute (LPM - a unit of measurement for the rate of flow of oxygen) via a nasal canula (NC - a lightweight, flexible tube with two small prongs that sit inside the nostrils to deliver supplemental oxygen) and there was no physician's order for oxygen use in place. This failure had the potential to negatively affect Resident 2's health and well-being with negative health consequences such as lung and brain damage related to receiving unordered, unmonitored oxygen therapy. Findings:A review of Resident 2's clinical document titled, admission RECORD, printed 3/5/26, indicated Resident 2 was admitted to the facility with diagnoses which included heart failure (a chronic, manageable condition where the heart muscle becomes too weak or stiff to pump blood efficiently, failing to meet the body's needs for oxygen) and sleep apnea (a common, serious disorder where breathing repeatedly stops and starts during sleep).During an observation on 3/5/26 at 9:42 AM, in Resident 2's room, Resident 2 was observed lying in bed. Resident 2 was wearing a NC with the oxygen flow rate set at 3 LPM.During a record review of Resident 2's physician's orders, an order for oxygen via NC at 3 LPM was not found.During an interview on 3/5/26 at 11:40 AM, with licensed nurse (LN) 1, LN 1 stated he did not see an oxygen order for Resident 2. LN 1 confirmed there was not an order for Resident 2's oxygen. LN 1 explained there needs to be an order for oxygen and LN 1 was stated he was going to call the physician for clarification.During an interview on 3/5/26 at 12:43 PM, with the Director of Nursing (DON), the DON stated a PRN (as needed) oxygen order had been added on 3/5/26 for Resident 2. The DON explained she had asked staff why Resident 2 had a NC. The DON further explained Resident 2 had asked a staff member on 2/28/26 for oxygen therapy via a NC and the staff member provided it to Resident 2 without obtaining a physician's order.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation and interview, the facility to ensure food was stored safely for one of five sampled residents (Resident 5) when, Resident 5 had nine single serve [brand name] yogurts stored on Resident 5's overbed table for three days.This failure had the potential to cause foodborne illness, with a potential to negatively effect Resident 5's health and well-being if consumed.Findings:During a concurrent observation and interview on 3/5/26 at 9:28 AM, with Resident 5, in Resident 5's room, Resident 5 stated her friend had brought her the [brand name] yogurt 3 days prior. During an interview on 3/5/26 at 10:45 AM with the Infection Preventionist (IP), the IP confirmed there were nine [brand name], single serve yogurts on Resident 3's overbed table. The IP stated the nine [brand name], single serve yogurts should have been refrigerated. The IP explained staff should have informed Resident 5 that the single serve yogurts required refrigeration. The IP further explained the single serve yogurts could cause foodborne illness when left at room temperature. The IP stated the single serve yogurts could make Resident 5 sick.A review of the facility policy titled, Resident Personal Food Storage, revised 4/25, indicated, . Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal/resident refrigeration units will be monitored by designated facility staff for food safety . Outside foods brought in to residents by visitors will be stored in . facility refrigerator designated for resident use .