

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 04/11/2025
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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52181</p> <p>Based on observation, interview and record review the facility failed to ensure assessments were completed accurately for 2 or 27 sampled residents (Resident 25 and Resident 28), when:</p> <ol style="list-style-type: none"> 1. Resident 25's and Resident 28's weekly nursing evaluations were not completed accurately for the presence of pain and pressure ulcers (localized damage to the skin and underlying soft tissue, usually over a bony prominence, caused by prolonged or severe pressure); and 2. Resident 28's change of condition evaluation did not accurately reflect the location and/or description of the pressure ulcer located on the left thumb. <p>These failures had the potential for Resident 25 to have inadequate pain relief and emotional distress and for Resident 28 to have delayed wound healing.</p> <p>Findings:</p> <p>1a. Review of ADMISSION RECORD indicated Resident 25 was admitted to the facility with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (the right side of the brain has been damaged, leading to one-sided weakness or paralysis on the left side of the body), and secondary malignant neoplasm of bone (also known as secondary bone cancer or bone metastasis, refers to cancer that has spread to the bone from a primary tumor located elsewhere in the body).</p> <p>During a concurrent interview and record review on 4/10/25 at 4:04 PM, Licensed Nurse (LN) 2 confirmed that Resident 25 was able to communicate and rate his pain level using a verbal 1-10 pain scale (a tool used to measure the intensity of pain, 0-3 mild pain, 4-6 moderate pain and 7/10 severe pain). LN 2 confirmed that Resident 25 had reported pain from 4/1-4/7/25 for the day, evening and night shifts as follows:</p> <p>4/1/25 0.5.7</p> <p>4/2/25 0.5.0</p> <p>4/3/25 0.0.0</p> <p>4/4/25 0.7.7</p> <p>(continued on next page)</p>

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/5/25 7.7.0</p> <p>4/6/25 7.0.0</p> <p>4/7/25 0.0.0</p> <p>LN 2 confirmed that the weekly nurse's evaluation dated 4/8/25 indicated that Resident 25 reported no pain during the look back of period of 4/1/25-4/7/25. LN 2 confirmed Resident 25's weekly evaluation dated 4/8/25 was inaccurate based on the Resident's reported pain levels documented in the Medication Administration Record from 4/1/25 to 4/7/25.</p> <p>Review of an undated facility policy and procedure titled Pain Management indicated .The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences . Recognition: 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: .b. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments .</p> <p>1b. Review of Resident 28's ADMISSION RECORD indicated he was admitted to the facility with multiple diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of muscle of the right and left lower legs and contracture of muscle of the left upper arm.</p> <p>During wound care observation with LN 5 on 4/10/25 at 10:18 am, Resident 28's left thumb was noted to have an unstageable pressure ulcer (a type of pressure ulcer where the wound bed is obscured by slough [a type of dead tissue that appears as yellow or white material in the wound bed] or eschar [a hardened, dry, dark dead tissue that forms a scab-like covering over deep wounds] making it impossible to determine the true depth of the ulcer) to the top of the left thumb that was covered in dry, black eschar.</p> <p>A record review of Resident 28's nurses progress note dated 3/29/2025 indicated, Patient has pressure ulcer on his left hand. It is located between the left thumb and index finger .</p> <p>A record review of Resident 28's weekly nursing assessment dated [DATE] and titled N Adv - Long Term Care Evaluation the skin section indicated: .1. skin warm & dry, skin color WNL [Within Normal Limit] and turgor [skin's elasticity or ability to return to its original shape after being pinched or pulled] is normal . Resident 28's weekly nursing assessment failed to indicate that Resident 28 had a pressure ulcer to the left thumb.</p> <p>During a concurrent interview and record review on 4/10/25 at 10:02 AM, LN 5 confirmed that Resident 28's weekly nursing assessment dated [DATE] was inaccurate since the pressure ulcer to the left thumb was not indicated.</p> <p>During an interview on 4/10/25 at 4:27 PM, the DON stated that her expectation was that the LN should accurately assess and document the overall picture of the resident on the weekly evaluation, including reported pain levels and skin condition.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. A review of Resident 28's change of condition report titled SBAR-Physical Injury Report of Incident initiated on 3/29/25, indicated it was inaccurate and incomplete when entries for dates of 3/29/25, 3/20/25, 3/31/25, and 4/1/25 did not include a correct site or description of the pressure ulcer to the left thumb. Further review of the report indicated that the interdisciplinary team's (IDT - group of professionals from different disciplines or fields who work together on a project or task, leveraging their unique expertise to achieve a common goal) did not complete an assessment of Resident 28's newly developed pressure ulcer to the left thumb.</p> <p>During a concurrent interview and record review on 4/10/25 at 10:02 AM, LN 5 stated when a LN found a pressure ulcer, then they were supposed to assess the wound and complete the form titled SBAR-Physical Injury Report of Incident every shift for 72 hours. LN 5 confirmed that Resident 28's SBAR-Physical Injury Report of Incident was inaccurate and incomplete as it did not include accurate information on the pressure ulcer location or description and IDT assessment. LN 5 confirmed that the risk of evaluation not being completed accurately placed Resident 28 at risk for not being assessed correctly for needed interventions by the IDT.</p> <p>During a concurrent interview and record review on 4/10/25 at 10:28 AM, the Director of Nursing (DON) stated that LN and IDT are expected to complete all sections of a change of condition report accurately. The DON further stated that the risk of the LN and/or IDT not completing the evaluation accurately and, in its entirety, placed Resident 28 at risk for a delay in treatment and interventions being put into place to help resolve Resident 28's pressure ulcer.</p> <p>Review of an undated facility policy and procedure titled Resident Assessment (comprehensive assessment) indicated complete all areas on the assessment forms(s) . do not leave any blank areas on any forms .</p> <p>Review of an undated facility provided policy and procedure titled Conducting an Accurate Resident Assessment indicated . Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems . 2. Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161</p> <p>Based on interview and record review, the facility failed to accurately complete a Pre-Admission Screening and Resident Review (PASRR, a required assessment for individuals with mental illness, intellectual or developmental disabilities, or related conditions, so that a determination of need, appropriate setting, and a set of recommendations for services to be included in the individual's plan of care is provided) for one of twenty-seven sampled residents (Resident 46) when, Resident 46's level I PASRR did not reflect his diagnosis of bipolar (a mental disorder characterized by periods of extreme mood swings, and causes shifts in mood, energy, activity levels, and concentration) and diagnosis of lack of expected normal psychological development in childhood (refers to a developmental delay in one or more areas such as a way a person thinks, interacts with and communicates with others and persists into adulthood).</p> <p>This failure resulted in a level II PASRR (a mental health screening for additional services) never being completed with the potential to affect the provision of appropriate treatment and specialized services for Resident 46 and increased his risk of having unmet behavioral health needs.</p> <p>Findings:</p> <p>Review of Resident 46's ADMISSION RECORD, indicated Resident 46 was originally admitted to the facility in summer of 2021, with a diagnosis including but not limited to, lack of expected normal physiological development in childhood, encounter for screening for other developmental delays, and bipolar disorder (a mental disorder characterized by periods of extreme mood swings, and causes shifts in mood, energy, activity levels, and concentration).</p> <p>Review of Resident 46's [name redacted, Discharging Hospital A] Discharge Summary, dated 5/7/21, indicated, .This a [AGE] year-old male with a past medical history of developmental delay who was brought to the hospital by his brother due to declining health .Patient is unable to provide any useful history .</p> <p>During a concurrent interview and observation on 4/8/25, at 10:49 a.m., Resident 46 was observed in a private room with the door shut, sitting on the edge of his bed. Resident 46 stated his food was not served to him correctly on the food tray and as he was speaking it was observed Resident 46 was getting agitated. Resident 46's voice was raising, and Resident 46 stated the sugar packets were being placed in the dirt and served to him dirty and contaminated.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 4/9/25, at 9:18 a.m., Responsible Party (RP) 1 stated he was Resident 46's health care decision maker and family member and prior to coming to the facility four years ago, Resident 46 had lived at home but was not independent and had a caretaker. RP 1 stated Resident 46 was bipolar and had grown up as a child with a developmental delay. RP 1 stated a nurse had called him from the facility two days ago regarding Resident 46 refusal of taking his medications and was not allowing staff to address the swelling in his feet. RP 1 stated Resident 46 was refusing care and had become aggressive with staff in the last few months because the facility had changed his psychiatric medications. RP 1 stated in the last two years there had been issues regarding Resident 46's mental health and Resident 46 was exhibiting escalating behaviors. RP 1 explained he was concerned regarding Resident 46's refusal of medications and nursing care. RP 1 stated staff have told him they cannot control Resident 46. RP 1 stated Resident 46 was angry, easily agitated, and was verbally lashing out at people. RP 1 stated Resident 46 initially was able to tolerate a roommate but due to his behaviors he was not able to be housed with other residents.</p> <p>During an interview on 4/9/25, at 11:53 a.m., Certified Nursing Assistant (CNA) 4 stated Resident 46 used to have a roommate, but they had to isolate him because he was talking about the roommate having the devil in him. CNA 4 stated Resident 46 now stayed mostly in his room and did not want to participate in activities.</p> <p>During an interview on 4/9/25, at 12:39 p.m., LN 9 stated Resident 46 was verbally aggressive towards staff and was kind of scary. LN 9 stated he had a lot of odd behaviors. LN 9 stated Resident 46 had a psychiatrist see him one time via telehealth. LN 9 stated Resident 46 used to take all the medications but about a month ago he stopped taking his medications and he now only wanted to take the white pills. LN 9 stated he sometimes refused to take those too. LN 9 stated he will also refuse the water staff offer him because Resident 46 thought staff was poisoning him.</p> <p>During an interview on 4/9/25, at 3:00 p.m., LN 11 stated Resident 46 was sharing a room with another resident and but had to be moved to a private room. LN 11 stated Resident 46 refuses his medication and only wants to take specific medications. LN 11 stated Resident 46 does not want to talk to anyone and wants his room door shut. LN 11 stated he did not believe Resident 46 was currently receiving mental health therapies. LN 11 stated he though Resident 46 would benefit from mental health interventions including counseling.</p> <p>During an interview on 4/9/25, at 3:59 p.m., LN 8 stated Resident 46 refuses a lot of medications and will have outbursts where he gets upset and yells at people. LN 8 stated Resident 46 often thinks things are missing and get very upset about the missing items.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 46's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 6/21/23, indicated under the section .Intellectual or Developmental Disability (ID /(DD) or Related Condition . the answer was marked Yes to the question. Under the question Specify type/Diagnosis was written . Unspecified lack of expected normal physiological development in childhood . To the question .The individual has a history of substantial disability prior to the age of 22 . the answer was marked Unknown. Upon review of the document, all questions pertaining to additional services received for Resident 46, including Regional Center (RC, agency contacted with the state and coordinated services and supports for individuals with developmental disabilities and their families) services, all questions were marked No, indicating the resident was never referred to the RC or had received RC services in the past. Under the question .Because of ID/DD the individual experiences functional limitations. Examples of functional limitations include .self-care, self-direction, learning/understanding/using language, capacity for living independently . the answer was marked No.</p> <p>A Review of Resident 46's Department of Developmental Services [DDS] Letter, dated 6/22/23, indicated, .In compliance .nursing homes .refer residents suspected of having intellectual disability or a condition similar to intellectual disability to DDS for Level II assessments .This document does not identify criteria for developmental disability in the named individual .A level II PASRR assessment will not be conducted by the regional center .Should you have any questions about this letter, please contact the DDS PASSR team [redacted contact information] .</p> <p>During a concurrent interview and record review on 4/10/25, at 10:22 a.m., with MDS Coordinator (MDS, Minimum Data Set represents a standardized assessment tool used in nursing homes and helps facilitate health care management for residents) 1 and MDS 2, MDS 2 stated she had been completing the PASSR's for the last six months while the Director of Nursing (DON) was on leave. MDS 2 stated PASSR's were completed every 18 months for all residents. MDS 2 stated Resident 46 had a lot of behavioral issues, will get paranoid, and yells at staff. During a record review of Resident 46's PASSR, dated 6/21/23, MDS 2 confirmed she had completed and submitted the document. MDS 2 stated she marked no for the questions regarding regional services. MDS 2 stated RP 1 could not provide the information, and she had not contacted the local regional center to verify if her answers were correct or to refer the Resident 46 for services. MDS 2 stated she should have answered unknown instead of no for Residents 46's PASSR for the questions regarding RC services received as she did not know the answer to the questions. MDS 2 confirmed the preadmission screening letter did not qualify Resident 46 for additional screening or services. MDS 2 acknowledged based on Resident 46's childhood developmental delay there was a high likelihood of him qualifying for additional services had the PASSR been filled out accurately. MDS 2 stated filling out the PASSR accurately ensures residents receive services they qualify for. The MDS 2 stated Resident 46 could benefit from additional therapies or services that help with socialization and activities of daily living. MDS 2 confirmed Resident 46's PASSR completed on 6/16/21 did not reflect his developmental delays and bipolar diagnosis.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/10/25, at 11:14 a.m., the Social Services Director (SSD) stated she helped organize services and new referrals for the local RC. The SSD stated she takes direction from clinical staff of who needs to be referred to the RC and her understanding was those that qualify were intellectually delayed. The SSD explained the RC staff provide services to help meet the resident's various needs and those that qualify can attend offsite day programs. The SSD stated currently there was one resident in the facility who received RC services. The SSD stated she was familiar with Resident 46, and he was a long-term resident. The SSD stated Resident 46's RP 1 was not able to manage Resident 46's behaviors at home. The SSD explained Resident 46 was routine driven, liked to stay in his own room, and did not participate in activities. Through record review the SSD confirmed at the time of Resident 46's initial admission he was diagnosed with lack of expected normal psychological development in childhood. The SSD stated the regional center would be a referral that should have been presented to Resident 46 and the RP 1. The SSD stated the services the RC provided could be beneficial to Resident 46 as they provided specialized therapies, and the SSD acknowledged his behavior could have been better managed with more support.</p> <p>Review of facility Policy & Procedure (P&P) titled ADMISSION, TRANSFER, DISCHARGE, AND BED-HOLDS, dated 2016, indicated, .PURPOSE .To provide uniform guidelines for admission .in compliance with state and federal guidelines. To promote equal access to quality care and facilitate continuity with care transitions .The facility .requires individuals diagnosed with major mental illness .or developmental disabilities to be screened prior to admission and throughout stay in accordance with PASRR requirements .</p> <p>Review of facility P&P titled Behavioral Health Services, dated 2025, indicated, .It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being .The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy[independence], privacy, socialization, independence, choice, and safety .Staff will .Complete PASARR screening .The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrist [doctor specializing in mental health], or neurologists [brain doctor] .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>40583</p> <p>Based on interview, and record review, the facility failed to ensure care plans were developed and implemented for 1 of 27 sampled residents (Resident 79) when, Resident 79's care plan for depression was not developed and implemented.</p> <p>These failures had the potential to negatively affect Resident 79's psycho-social well-being.</p> <p>Findings:</p> <p>A review of Resident 79's clinical record titled, ADMISSION RECORD, indicated Resident 79 was admitted to the facility with diagnoses which did not include depression (a common mental health condition characterized by a persistent low mood, loss of interest in activities, and other symptoms that can significantly interfere with daily life).</p> <p>A review of Resident 79's clinical document titled, Order Details, (contains physician orders), dated 3/26/25, indicated, .Mirtazapine [an antidepressant medication given for depression] Give 1 tablet by mouth at bedtime for Depression .</p> <p>A review of Resident 79's clinical document titled, Care Plan Report, dated 4/8/25, indicated, .[Resident 79] has a mood problem r/t [related to] depression .Date Initiated: 04/08/2025 . Resident 79's depression care plan was initiated 13 days after starting mirtazapine.</p> <p>During a concurrent interview and record review with the Director of Nursing (DON), on 4/11/25, at 11:24 PM, the DON confirmed there was not a care plan in place addressing Resident 79's depression and there should have been. The DON explained the importance of Resident 79 having a care plan for depression was to ensure patient goals and interventions were being met.</p> <p>A review of the facility policy titled, Care Plan, Comprehensive, dated 12/17, indicated, .Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .Resident progress is regularly evaluated, and approaches revised or updated as appropriate . Individualized Care Plans should be accessible to all care givers .</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>52181</p> <p>Based on interview and record review, the facility failed to timely review and revise person-centered comprehensive care plans (a detailed document outlining a person's healthcare needs, goals, and the specific care and support they will receive, including how, when and by whom) for 3 of 27 sampled residents (Residents 25, 28, and 47) when,</p> <ol style="list-style-type: none"> 1. Resident 25's comprehensive care plan for chronic pain lacked personalized non-pharmacological (healthcare approaches that don't primarily rely on medication) interventions that were to be used prior to offering pain medications, 2. Resident 28's comprehensive care plans for Activities of Daily Living (ADLs - refer to the basic self-care tasks essential for independent living, like bathing, dressing, eating and toileting), pressure ulcer (localized damage to the skin and underlying soft tissue, usually over a bony prominence, caused by prolonged or severe pressure) to the left hand, and hospice (provides comfort and support for individuals facing a terminal illness, focusing on improving quality of life during the final stages of life) were not personalized, and 3. Resident 47's comprehensive care plan for smoking was not personalized. <p>These failures had the potential of discomfort, safety risk, poor care coordination for Resident 25, Resident 28 and Resident 47 and had the potential of delay in wound healing and further decline in range of motion for Resident 28.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Resident 25 was admitted to the facility with pertinent diagnosis of malignant neoplasm of prostate (a type of cancer that originates in the prostate gland, a male reproductive organ), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (the right side of the brain has been damaged, leading to one-sided weakness or paralysis on the left side of the body), and secondary malignant neoplasm of bone (also known as secondary bone cancer or bone metastasis, refers to cancer that has spread to the bone from a primary tumor located elsewhere in the body). <p>During a concurrent interview and record review on 4/10/25 at 4:04 PM, Licensed Nurse (LN) 2 confirmed that non-pharmacological pain interventions were not added to Resident 25's care plan for chronic pain. LN 2 further stated that providing non-pharmacological interventions to aide in pain relief should be done before offering any pain medication because if the non-pharmacological intervention worked to relieve pain, then the medication would not be needed. LN 2 then stated that the use of pain medications could cause side effects to the person taking them and that would be avoided if the non-pharmacological interventions provided were affective.</p> <p>During a concurrent interview and record review on 4/10/25 at 4:20 PM, Certified Nursing Assistant (CNA) 1 accessed Resident 25's Kardex (a concise, centralized, and easily accessible record of essential resident information, used by staff to quickly summarize resident care and guide daily actions) and stated there were not any non-pharmacological interventions for pain management listed.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident 28 was admitted to the facility under hospice services with diagnosis of Atrial Fibrillation (an irregular and often rapid heartbeat that originates in the heart's upper chambers) and Sick Sinus Syndrome (a heart rhythm disorder where the heart's natural pacemaker malfunctions, leading to an abnormal heartbeat).</p> <p>During a concurrent interview and record review on 4/9/25 at 12:50 pm, MDS 1 (a nurse who focuses on collecting and assessing patient data for Medicare and Medicaid-certified nursing homes) confirmed that Resident 28's care plan for the left thumb pressure ulcer did not address risk factors or had interventions to prevent further skin breakdown.</p> <p>MDS 1 confirmed that Resident 28's ADL care plan did not address the level of assistance he needed to complete tasks such as bathing, dressing, eating and toileting.</p> <p>MDS 1 confirmed Resident 28's hospice care plan was not personalized with the hospice agency contact information, hospice staff visit schedules or the hospice aide's visit days and times and tasks they were to complete during the facility visit.</p> <p>MDS 1 confirmed that Resident 28s care plan did not address his left-hand contracture.</p> <p>During a concurrent interview and record review on 4/9/25 at 1:41 PM, CNA 2 confirmed that Resident 28's Kardex did not include the information on how to assist him with his ADL care, skin care, contracture management or what hospice services a hospice aide was providing. CNA 2 stated she needed this information in order to properly care for Resident 28.</p> <p>During a concurrent interview and record review on 4/9/25 at 2:26 PM, CNA 1 stated that she relied on the charge nurse or another CNA to provide her resident's care plan information. CNA 1 confirmed that Resident 28's Kardex did not include the information on how to assist him with his ADL care, skin care, contracture management or what hospice services a hospice aide was providing. CNA 1 stated having access to this information on the Kardex would help her provide better care to Resident 28.</p> <p>3. During a record review of Resident 47's Smoking Safety Screen dated 9/26/24, indicated that Resident 47 required supervision and was to wear a smoking apron (a protective non-flammable cover that is worn when smoking to prevent injury) when smoking.</p> <p>During a concurrent interview and record review on 4/10/25 at 11:33 AM, the Activity Director (AD) and the Assistant Activity Director (AA) confirmed that Resident 47 was an active smoker. The AD confirmed that the smoking care plan for Resident 47 did not include the interventions that included Resident 47 was to be supervised and wear a smoking apron while he smoked. The AD and the AA stated that not having this information on the care plan placed Resident 47 at risk for injury when staff taking him out to smoke were unaware of these interventions.</p> <p>During a concurrent interview and record review on 4/10/25 at 11:45 AM, MDS 1 confirmed that Resident 47's smoking care plan did not include interventions for supervision and the use of a smoking apron while he smoked. MDS 1 stated the risk of these interventions not being on the care plan placed Resident 47 at risk for injury during his smoking sessions.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/9/25 at 11:55 AM, the Director of Nurses (DON) stated that her expectation was that Licensed Nurses, and other disciplines should update the care plans with personalized focus statements, goals, and interventions. The DON stated that the failure to personalize the care plans could result in a resident not receiving care at a level they require.</p> <p>Review of the facility policy and procedure titled Care Plan, Comprehensive dated 12/2017 indicates Care Plans should be developed by the Interdisciplinary Team (IDT), which includes activities, dietary, nursing management, social services and therapy and includes input from direct care staff including Licensed Nurses and Nursing Assistants .Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .Care Plans become a comprehensive tool for the IDT to utilize as a reference for identified concerns and approaches to establish guidance for meeting resident individual needs .Individualized Care Plans should be accessible to all caregivers .</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>50977</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of twenty-seven sampled residents (Resident 64) received activities that met their interests and needs when Resident 64 did not attend group activities and in room activities had not been provided since 9/9/24.</p> <p>This failure had the potential to affect Resident 64's psychosocial well-being.</p> <p>Findings:</p> <p>During an interview with Resident 64 on 4/8/25, at 10:31 AM, Resident 64 stated, Activities don't bring me anything to do. The last time was a packet with word search puzzles last year. I prefer activities in my room.</p> <p>During a review of Resident 64's activities care plan dated 8/16/23, the care plan indicates Resident 64 prefers to spend most of her free time resting in the comfort of her room. The care plan also indicated Resident 64 would be empowered to make independent leisure choices daily and would be offered room visit check-ins 4 times weekly.</p> <p>During a record review of Resident 64's, Activities Progress Notes dated 9/9/2, at 1:37 PM, the progress note indicated, .Activity packet received with crayons and pencils for 1:1 .</p> <p>During a concurrent interview and record review on 4/9/25, at 11:43 AM, with the Activities Director (AD), Resident 64's activity documentation was reviewed. The AD confirmed the last one-to-one activity room visit was on 9/9/24. The AD stated, if we do not provide activities that are person centered residents could potentially experience psychosocial decline, depression, and isolation.</p> <p>A review of an undated facility policy and procedure (P&P) titled, ACTIVITY PROGRAM-GENERAL, indicated, .the activity program shall consist of individual .activities which are designed to meet the needs and interests of each resident .activities shall be available on a daily basis .</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50161</p> <p>Based on interview and record review, the facility failed to provide appropriate blood glucose (BG; sugar in the blood) monitoring for a diabetic (blood sugar disease) condition for one of twenty-seven sampled residents (Resident 77) when, Resident 77's blood sugar check order did not contain monitoring parameters (when to notify the provider) related to the blood sugar readings and Resident 77's high blood sugar readings were not reported to the Medical Doctor (MD).</p> <p>This failure could have contributed to unsafe blood glucose monitoring without proper notification of the medical doctor and could have impacted the Resident 77 well-being, including the wound healing process.</p> <p>Findings:</p> <p>Review of Resident 77's ADMISSION RECORD, indicated Resident 77 was admitted to the facility with a diagnosis of diabetes mellitus (DM) and wound care among other diagnosis.</p> <p>During a concurrent observation and interview on 4/8/25, at 1:05 p.m., Resident 77 was observed eating her lunch and stated she was diabetic and was not receiving a diabetic meal. Resident 77 stated she did not have any insulin coverage for her high blood sugars. Resident 77 stated she was concerned because about a week ago she had a blood sugar level of 300 (normal blood sugar level is between 80mg/dL and 120mg/dL; milligram per deciliter is a unit of measure) and never received insulin (medication to treat blood sugar disease). Resident 77 explained she asked the licensed nurse (LN) for insulin to bring the number down the same as she had received it at home and in the hospital, as she was not getting any insulin in the facility. Resident 77 stated she was concerned because having high blood sugar was not good for her body and explained she had multiple wounds, and they had been difficult to heal. Resident 77 stated prior to coming to the facility she had lived independently and had been giving herself insulin at home.</p> <p>Review of Resident 77's facility communication document, with the MD, dated 2/17/25, the written fax (a method of transmitting by scanning and transmitting over telephone lines) document indicated patient and family were requesting to do lab tests since the patient used to take insulin at home. Further review indicated the MD ordered to check BG for one week.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/9/25, at 12:39 PM, LN 9 stated Resident 77's family member had asked why she was not on insulin. LN 9 stated most of her diabetic residents were on some sort of diabetic medication or insulin. LN 9 stated Resident 77's BG had been spiking into the high number in the afternoons. Through clinical record review, LN 9 confirmed Resident 77 had orders for BG checks four times a day, but there were no diabetic medications ordered. LN 9 confirmed there were no nursing notes or interventions performed regarding Resident 77's high BG readings. Through record review of Resident 77's progress notes, LN 9 confirmed there was no communication or notification to the MD for Resident 77's high BG's. LN 9 stated the nurse should have notified the MD if the BG was high with no treatment orders. LN 9 confirmed on 4/6/25, at 8:39 p.m. Resident 77 had a BG of 390 mg/dL and there was no notification made to the MD. LN 9 confirmed on 4/4/25, at 4:22 p.m., Resident 77 had a BG of 314 mg/dL and there were no notification made to the MD. LN 9 stated if a residents BG was above 200 md/dL she would have notified the MD. LN 9 stated the risk for a resident who had a high BG was hyperglycemic coma (when blood sugar high enough to cause severe symptoms such as mental status change) and the resident could become lethargic (drowsiness), and/or confused. LN 9 stated the high BG could slow Resident 77's wound healing.</p> <p>Review of Resident 77's Medication Administration Record [record of the doctors order and nursing documentations], dated 4/2025, the record indicated, .FSBG [Fasting (before eating) blood glucose] AC/HS before meals and at bedtime for DM .order date 3/13/24 . Review of the document indicated there were no parameters listed for blood sugar monitoring, including when to notify the doctor. Further review of the document indicated the following BG readings for Resident 77 were as follows:</p> <p>4/4: 139, 183, 314, 291</p> <p>4/5: 87, 194, 190, 215</p> <p>4/6: 175,180, 185, 390</p> <p>4/7: 113, 138, 290, 215</p> <p>4/8: 101, 159,167, 200</p> <p>4/9: 107,133, 148, 153</p> <p>4/10: 114, 135, 230, 200</p> <p>The MAR record did not indicate any nursing interventions, documentation, or physician notification for BG changes outside of the standard range.</p> <p>During a phone interview on 4/10/25, at 7:38 p.m., LN 13 stated Resident 77 had multiple wounds and was receiving antibiotics (medicines that fight bacterial infections). LN 13 stated she recalled taking Resident 77's FSBG's and having high BG readings. LN 13 stated she reached out to another nurse at the facility regarding Resident 77's high blood sugars of 390 mg/dL but the other nurse told her she did not think it was necessary to call the doctor because Resident 77's BG was not normally high. LN 13 stated she did not notify Resident 77's doctor of the high blood sugar. LN 13 stated the risk factor for residents having high blood sugars that were not managed were medical complications from high blood sugar and delayed wound healing.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/25, at 2:05 p.m., the MD stated Resident 77 was on antibiotics for a wound infection and was placed on orders for FSBG (finger stick blood glucose, same as using blood from finger to measure blood sugar) just in case she had high blood sugars. The MD stated he was not aware of Resident 77's high FSBG and the nurses should have informed him of high readings. The MD stated he should have put in place orders including parameters for when to notify him and an insulin order for treatment of high blood sugars. The MD stated he was not aware Resident 77 was previously on insulin or diabetic medication at home or in hospital.</p> <p>During a phone interview on 4/11/25, at 12:22 p.m., the wound care Medical Doctor (MD) 2 stated Resident 77 was admitted into the facility for a severe wound infection. The MD 2 stated Resident 77's DM diagnosis could delay the wound healing process. The MD 2 stated Resident 77's wounds were rarely seen in non-diabetics.</p> <p>During a concurrent interview and record review on 4/11/25, at 1:29 p.m., with the Director of Nursing (DON) and the Director of Nursing Consultant (DONC), the DON stated for Resident 77 the nurses should have communicated high blood sugar trends to the MD. The DON stated BG measurements should have had monitoring parameters for resident safety as the blood sugar was taken four times a day. The DON stated with a diabetes diagnosis the resident was at risk for delayed wound healing.</p> <p>Review of facility Policy & Procedure (P&P) titled Blood Sugar Monitoring, dated 2006, indicated, .check physician's order for blood sugar testing frequency .If blood glucose level is above or below normal range, document the time the physician was notified .</p> <p>Review of facility P&P titled Change of Condition, dated 2016, indicated, .Basic Responsibilities Licensed Nurse .to appropriately assess, document and communicate changes of condition including diagnostic results to the primary care provider. To provide treatment and services to address changes in accordance with resident needs .Document assessment findings and communications as soon as practical .Notify the physician and responsible party for assessment findings .Notify the Patient and/or responsible party of current status and subsequent actions/orders .</p> <p>Review of facility P & P titled Resident Rights, dated 10/2022, indicated, .The resident has the right to be informed of, participate in, his or her treatment, including: The right to be fully informed .of his or her total health status, including but not limited to .The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, duration of care, and other factors related to the effectiveness of the plan of care .</p> <p>Review of undated facility provided job description titled DUTIES OF MEDICAL DIRECTOR, indicated, . Coordination of medical care in the Facility to ensure that adequate and appropriate medical services are provided to the patients in the Facility .participating in the development of a system providing a medical care plan for each patient, which covers medications, nursing care .</p> <p>Review of facility provided job description titled LVN/LPN [Licensed Vocational Nurse/Licensed Practical Nurse], dated 11/13/17, indicated, .Provides accurate assessment, over-sight, and monitoring of Patients for quality medical management and early detection of changes in condition .Recognizes AND appropriately responds to emergent [new] and significant change in condition; completes documentation as required .</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>52181</p> <p>Based on observation, interview, and record review the facility failed to ensure that one of twenty-seven sampled residents (Resident 28) received the necessary treatment and services consistent with professional standard of practices to prevent a pressure ulcer (PU - localized damage to the skin and underlying soft tissue, usually over a bony prominence, caused by prolonged or severe pressure) from developing and to promote healing when:</p> <ol style="list-style-type: none"> 1. Interventions were not developed to prevent a PU from occurring to Resident 28's left contracted (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) hand; and 2. A wound evaluation was not completed when a PU was identified to Resident 28's left hand; and 3. Treatment interventions such as splinting (a medical technique used to immobilize a limb or body part, typically to support healing from injuries like fracture, sprains or dislocations) and range of motion exercises (designed to move a joint through its full available movement, helping to maintain or improve flexibility and reduce stiffness) were not included in Resident 28's PU care plan (specific actions nurses take to address a patient's health needs and work towards achieving desired outcomes) interventions, consistent with professional standards, to promote healing and/or minimizing the risk of the development of a new PU from occurring to Resident 28's left hand. <p>These failures resulted in the development of a PU to Resident 28's left thumb with the potential to prolong healing of the PU.</p> <p>Findings:</p> <p>Review of Resident 28's ADMISSION RECORD indicated Resident 28 admitted to the facility with a diagnosis of HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINATE SIDE (the right side of the brain has been damaged, leading to one-sided weakness or paralysis on the left side of the body) , CONTRACTURE (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) OF MUSCLE, RIGHT LOWER LEG, CONTRACTURE OF MUSCLE LEFT LOWER LEG, AND CONTRACTURE OF MUSCLE, LEFT UPPER ARM</p> <ol style="list-style-type: none"> 1. Review of Resident 28's nurse progress dated 3/29/25 noted that .Patient has a pressure ulcer (localized damage to the skin and underlying soft tissue, usually over a bony prominence, caused by prolonged or severe pressure) on his left hand. It is located between the left thumb and index finger. Appears to be moisture associated due to his contraction (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Pt [patient] unable to give statement. No complaints of pain at this time. Nurse cleansed with NS (normal saline is a mixture of sodium chloride and water. It has several uses in medicine including cleaning wounds), pat dry with gauze and dry gauze placed between fingers to reduce further injury/moisture . There is no mention of an intervention to treat the contraction of the left hand. <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 28's nurses progress note dated 4/3/25, indicated that Hospice Nurse (HN) 2 from the hospice agency was in house and was made aware that Resident 28 had developed a pressure ulcer to his left thumb and that Resident 28's left hand was contracted. LN 5 wrote that she received an order from the hospice physician to apply silver alginate and cover with gauze, and that LN 5 sent a message to HN 1 regarding the new pressure ulcer and new treatment orders. There is no mention of a discussion regarding the left-hand contraction.</p> <p>During wound care observation with LN 5 on 4/10/25 at 10:18 am, Resident 28's left thumb was noted to have an unstageable wound to the top of the left thumb that was covered in dry, black eschar.</p> <p>A review of the care plans (a detailed document outlining a person's healthcare needs, goals, and the specific care and support they will receive, including how, when and by whom) for Resident 28 found no care plan for at risk for skin breakdown or pressure ulcer development based on Braden Scale evaluation and diagnosis risk factors. On 3/29/25 a LN initiated a care plan for Acute Physical injury (specify) Pressure Ulcer location: left thumb and index finger. On 4/9/25 LN 5 cancelled the care plan that was initiated on 3/29/25 and activated a care plan titled Actual pressure ulcer: unstageable to left thumb. Intervention included perform hand hygiene to contracted left hand an apply dry cloth every shift. This information was not on the CNA (Certified Nursing Assistant) Kardex (a concise, centralized, and easily accessible record of essential resident information, used by staff to quickly summarize resident care and guide daily actions)</p> <p>2. During a concurrent interview and record review on 4/10/25 at 10:02 AM, LN 5 confirmed that the Skin & Wound Evaluation was not completed on 3/29/25 by the facility nurse that first identified the wound, nor did LN 5 complete it on 4/3/25. LN 5 stated that the facility procedure was for this evaluation to be completed by the LN that first assesses the wound and then it is to be completed weekly by the treatment nurse until the wound has resolved. LN 5 confirmed that this procedure had not been followed and that not completing this evaluation meant the interdisciplinary team (IDT - group of professionals from different disciplines or fields who work together on a project or task, leveraging their unique expertise to achieve a common goal) would be at risk for not being aware of a new wound as this evaluation then crosses over to the wound report that the DON (Director of Nursing) runs for their IDT meeting.</p> <p>During an interview with the DON on 4/10/25 at 10:28 AM the DON confirmed that there was no Skin & Wound Evaluation completed for the pressure ulcer on Resident 28's left thumb on 3/29/25 or on 4/3/25. The DON stated that if that evaluation was not completed when she runs the skin and wound report, the wound would not be listed. The DON also stated that they were not doing IDT meetings on residents with wounds unless that resident also had weight loss. The DON stated that they had not met for an IDT review of Resident 28's wound. The DON stated that the expectation going forward was that all pressure ulcers would have the Skin & Wound Evaluation completed by a LN when the wound was first noted and then weekly until resolved and that the IDT would start reviewing all residents with pressure ulcers weekly. The DON stated that not having the IDT review residents with pressure ulcers places the resident at risk for not having a full assessment of medical and nutritional needs that could impact wound healing.</p> <p>Review of facility provided undated policy and procedure titled Documentation of Wound Treatments .1. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. A review of Resident 28's Braden Scale (a tool used in healthcare to assess a patient's risk for developing pressure injuries) evaluations completed on the following dates with adjacent scoring and risk category were noted as follows: (scoring breakdown: 9 or less very high risk, 10-12 High Risk, 13-14 Moderate Risk, 15-18 Mild Risk, and 19-23 No risk)</p> <p>9/11/24 - 11 - Category: High Risk</p> <p>9/18/24 - 13 - Category: Moderate Risk</p> <p>11/26/24 - 12- Category: High Risk</p> <p>2/18/25 - 13 - Category: Moderate Risk</p> <p>During a record review for Resident 28's Skin and Wound Evaluation dated 4/10/25 noted as an intervention for care to offload wound, reposition, rolled wash cloth to hand. This information was not on Resident 28's care plan for the pressure ulcer of the left hand or for the care plan for the left-hand contracture or the Kardex.</p> <p>LN 5 reviewed the care plan and confirmed there was no at risk care plan for skin breakdown and the care plan for the wound to the left thumb did not have intervention for pressure relief. LN 5 confirmed that the active care plan for the pressure ulcer to the left thumb did not include the interventions that were listed on the Skin & Wound evaluation that she completed on 4/10/25. LN 5 confirmed that there was no documentation in Resident 28's electronic health record that the left-hand contracture had been discussed with the hospice nurse and this put Resident 28 at risk for further contracture development and continued skin breakdown or delay in wound healing.</p> <p>During a concurrent interview and record review on 4/9/25 at 12:50 PM, MDS (Minimum Data Set - a nurse who focuses on collecting and assessing patient data for Medicare and Medicaid-certified nursing homes) 1 confirmed that the care plan for the pressure ulcer of the left thumb and index finger did not include care plan interventions to maintain clean skin or prevent further breakdown.</p> <p>MDS 1 confirmed that the care plan for the left-hand contracture did not contain interventions for range of motion exercises or splinting of the hand. MDS 1 stated that the risk for a resident's care plan not reflecting personalized interventions for skin care and range of motion would impact the Certified Nursing Assistant (CNAs) ability to provide personalized care to the residents they were assigned too and could impact the resident's overall welfare.</p> <p>During a concurrent observation and interview on 4/9/25 at 2:40 PM, the DON and the ADON (Assistant Director of Nursing), checked Resident 28's skin. The DON and ADON assessed Resident 28's left hand and noted that the palm was dry and clean and there was a dry, clean gauze pad placed in the palm of the hand. The DON attempted passive range of motion (PROM - involves moving a joint through its full range of motion by an external force, like a therapist or another person, without the individual's active muscle contraction) to the hand. The DON stated that Resident 28's left hand contracture was not a fixed (a permanent shortening or tightening of muscles, tendons, ligaments, or skin, resulting in a limited range of motion at a joint) contracture but she did note some pain with the PROM attempt. The DON further stated that use of a carrot (a device used to position severely contracted hands) would be better used to help prevent the contracture from getting worse than the pad of dry gauze that was in place.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/10/25 at 8:48 AM, HN 1 stated that she had not personally looked at Resident 28's skin during her last visit but used prior records for review and the verbal report received by the facility nurses. HN 1stated that the Hospice IDT (a group of professionals from different disciplines or fields who work together on a project or task, leveraging their unique expertise to achieve a common goal) note completed by the hospice staff on 4/2/25 should have reflected interventions for the prevention of skin breakdown and contracture prevention or management. HN1 confirmed that the Hospice IDT note dated 4/2/25 did not contain any such interventions.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>40911</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services were provided in a timely manner to three of twenty-seven sampled residents (Resident 3, Resident 25, and Resident 28) when:</p> <ol style="list-style-type: none"> 1. Resident 3's physician order for therapy to evaluate for possible use of a brace to both contracted hands/fingers was not carried out in a timely manner; 2. Resident 25's physician order for therapy to evaluate for possible use of a brace for left hand contracture was not carried out in a timely manner; and, 3. Resident 28's contracted left hand was not assessed of the need for contracture management after developing a pressure ulcer from the contracture on 3/29/25. <p>These failures placed Resident 3, Resident 25, and Resident 28 at risk for contracted hands/fingers to worsen and a pressure ulcer to develop or worsen.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 3's ADMISSION RECORD indicated, Resident 3 was admitted to the facility in the mid 2021 with diagnoses that included contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to right shoulder and pain. <p>During a concurrent observation and interview on 4/8/25, at 12:50 p.m. with Resident 3 in Resident 3's room, Resident 3 was noted to have contractures to left hand and fingers. Resident 3 stated she did not receive exercises from restorative (focuses on maintaining ability to perform activities of daily living and to prevent contractures) program and required assistance with daily activities.</p> <p>During a record review of Resident 3's Minimum Data Set, (MDS-an assessment and care planning tool) dated 3/6/25, under the section Functional Abilities indicated, impairment to both upper and lower extremities and dependent on most of the activities of daily living.</p> <p>During a record review of Resident 3's Care Plan Report, dated 6/24/21, indicated, Resident 3 needed assistance with activities of daily living related to contractures.</p> <p>During a concurrent interview and record review on 4/10/25, at 4:17 p.m. with the Regional Director of Therapy (RDT), Resident 3's physician Order Summary, dated 3/29/25 was reviewed. The order indicated, . therapy to eval [evaluate] for possible brace for her both contracted hands/fingers . The RDT confirmed there was an order for therapy evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a subsequent interview with the Physical Therapy Assistant (PTA), he stated he was not aware of an order for therapy evaluation for a brace to contracted hands and fingers for Resident 3 was ordered by the physician. The PTA further stated, he usually received notification from the nursing staff or he was usually alerted of a new therapy order during the morning meetings.</p> <p>During a concurrent interview and record review on 4/10/25, at 4:28 p.m. with the MDS nurse, Resident 3's Order Summary revealed there was no order for restorative program and a new therapy order was in place. The MDS nurse also stated there was no documentation the therapy department was alerted to the new order. The MDS nurse explained the best practice was staff who received the order would let the therapy department know the same day the order was received. The MDS nurse further explained the order was not communicated because there was no documentation noted.</p> <p>During a concurrent interview and record review on 4/11/25, at 9:13 a.m. with the Interim Director of Nursing (IDON), Resident 3's Order Summary, dated 3/29/25 was reviewed. The IDON stated she was not aware there was a therapy order for Resident 3. The IDON further stated the order was missed and Resident 3 did not receive the services as ordered and therefore there was a delay in implementing the therapy treatment and services.</p> <p>A review of the facility's policy and procedure titled, Restorative Nursing Programs, dated 12/2021, indicated, .The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities .</p> <p>A review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), Supporting, revised 1/2025, indicated, .Residents will be provided with care, treatment and services to ensure their ADLs do not diminish .</p> <p>A review of the facility's Registered Nurse JOB DESCRIPTION, revised 11/13/17, indicated, .Completes appropriate referrals to other departments and ancillary providers when needed to address patient needs . Takes .carries out orders in accordance with professional standards .</p> <p>52181</p> <p>2. A review of Resident 25's ADMISSION RECORD indicated Resident 25 was admitted to the facility with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side (the right side of the brain has been damaged, leading to one-sided weakness or paralysis on the left side of the body).</p> <p>A review of Resident 25's evaluation titled N Adv - Restorative Nursing Screener/GG Evaluation dated 3/23/25, indicated that the upper extremity and lower extremity range of motion was impaired on one side.</p> <p>A review of Resident 25's physician's order dated 4/7/25 indicated that therapy was to evaluate Resident 25's left-hand contracture for possible brace use.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 25's nurses progress noted dated 4/8/25 indicated that an order for therapy to evaluate Resident 25 for brace need for the left upper extremity due to contracture had been received. Further review of Resident 25's progress notes found no evidence that the order had been carried out by the therapy department.</p> <p>During a concurrent interview and record review on 4/10/25 at 4:42 PM, the Regional Director of Therapy (RDT) stated that therapy had been not notified of the order for Resident 25 and as a result, the evaluation had not been completed. The RDT stated that when Resident 25 did not receive therapy evaluation or treatment as ordered it placed Resident 25 at risk for delay in treatment that would have benefited Resident 25's hand mobility.</p> <p>During an interview 4/11/25 at 10:01 AM, the Director of Nursing (DON) stated that the order given on 4/7/25 for therapy to complete a screen for contracture of Resident 25's left upper extremity was not discussed during the morning clinical meeting on 4/8/25. The DON stated that when a physician ordered therapy for a resident, it should be communicated to the therapy department. The DON stated the failure to communicate the therapy evaluation order for Resident 25 delayed the completion of the evaluation and as such delayed the start of treatment.</p> <p>3. A review of Resident 28's ADMISSION RECORD indicated Resident 28 was admitted with multiple diagnosis including Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side, Contracture of muscle, right lower leg, Contracture of muscle, left lower leg, and Contracture of muscle, left upper arm.</p> <p>A review of Resident 28's nurses progress note dated 3/29/25 indicated Patient has pressure ulcer on his left hand. It is located between the left thumb and index finger. Appears to be moisture associated due to his contraction .'</p> <p>A review of Resident 28's nurses progress note dated 4/3/25 indicated the pressure ulcer and left-hand contracture had been discussed with Hospice Nurse (HN) 2.</p> <p>During a concurrent interview and record review on 4/9/25 at 12:50 PM, MDS 1 confirmed that Resident 28 was noted to have a left-hand contracture on 3/29/25. MDS 1 confirmed that there had not been any follow up with Resident 28's physician or a discussion with therapy regarding Resident 28's the left-hand contracture.</p> <p>During a concurrent interview and record review on 4/10/25 at 8:48 AM, HN 1 confirmed that Resident 28 was noted with a left-hand contracture on 3/29/25. HN 1 confirmed there were no follow up for Resident 28's left-hand contracture.</p> <p>During concurrent interview and record review on 4/9/25 at 2:26 PM, Certified Nursing Assistant (CNA) 1 stated she was not aware that Resident 28 had a contracture of the left-hand. CNA 1 confirmed that it would be helpful to her to provide better resident care if that information had been communicated to her.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and observation on 4/9/25 at 2:40 pm of Resident 28's hands, the DON confirmed Resident 28's left hand contracture and left thumb pressure ulcer. The DON confirmed that there was some dry gauze placed in the palm area of Resident 28's left hand. The DON stated that staff should have used a carrot (a device used to position severely contracted hands) to prevent the contracture from getting worse. The DON stated a therapy referral should have been requested to evaluate Resident 28's hands to provide recommendations for contracture care.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50778</p> <p>Based on observation, interview, and record review, the facility failed to ensure a census of 89 residents were safe from accidental hazards when:</p> <ol style="list-style-type: none"> 1. Resident 63 kept cigarettes and a lighter in her purse, unsecured in her room, and received oxygen (O2) via nasal canula (NC- tubing that delivers oxygen into resident's nose); 2. Smoking paraphernalia (items used to smoke which may include cigarette wrapper or cigarette paper, and tobacco) items were observed to be unsecured and on top of Resident 65's bed and Resident 65 did not have a lock box in the room; and <p>These failures exposed residents, staff, and visitors to be at risk of burns, fire, and/or explosion while in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 63's Smoking Safety Screen, dated 3/13/25, indicated, Resident 63, .Has expressed continued desire to smoke despite explained health and safety risks .Expresses an understanding that smoking is not allowed near oxygen delivery systems (devices used to provide oxygen to a patient who is unable to obtain enough oxygen from their own breathing) even if the delivery system is turned off and complies with this practice .Had a signed Smoking Rules & Safety Agreement .Smoking Care Plan .Focus: High risk for accidental injury .Goal: Resident will exhibit safe smoking practices .Intervention: Observe/report unsafe smoking practices . <p>During a concurrent observation and interview on 4/8/25 at 11:45 a.m. with Resident 63 in the center courtyard, Resident 63 was sitting on her walker (a device designed to assist individuals with support and stability while walking) seat and was smoking a cigarette. Resident 63 stated, she was a smoker, kept cigarettes in her purse, and kept her purse in her room. Resident 63 stated she had the right to smoke when she wanted.</p> <p>During a concurrent observation and interview on 4/10/25 at 8:50 a.m. with Resident 63 and the Administrator (ADM), Resident 63 was on her bed and wore a NC which was connected to an oxygen delivery system. The ADM asked Resident 63 where her cigarettes and lighter were located. Resident 63 stated her cigarettes and lighter were in her room inside her purse, she did not have a lock box, and did not want one. The ADM stated the risk to Resident 63 and her roommate was getting hurt caused by explosion and/or fire, and the building was at risk (for fire) too.</p> <p>A review of Resident 63's Release and Disclosure of Smoking Risk, signed 5/16/24, indicated, .By initialing and signing below .Consent and agree to abide by facility smoking policy .I understand I must relinquish my cigarettes and ignition devices to the facility .I understand that I must keep these items secured in a locked container .</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 63's Care Plan Report (Care Plan), initiated on 12/30/23, indicated, .Focus . Resident has hx [history] of noncompliance with smoking policy and smoking contract e/b [evidenced by] . Smoking in room and has denial of risk factors .Resident will verbalize understanding of consequences of non-compliance .</p> <p>2. During a concurrent observation and interview on 4/10/25 at 8:20 a.m. in Resident 65's room, with Certified Nursing Assistant (CNA) 2, there was unsecured smoking paraphernalia on top of Resident 65's bed in a food plate cover and included loose tobacco, an unfilled cigarette wrapper, and a plastic bag of loose tobacco. Resident 65 was not in the room and the items were left unattended. CNA 2 stated Resident 65 was not in the facility, and she did not know what the items were on the bed and thought it might be nicotine or tobacco.</p> <p>During an interview on 4/10/25 at 8:24 a.m. with Licensed Nurse (LN) 4, LN 4 confirmed the items on Resident 65's bed were cigarettes and Resident 65 rolled his own (cigarettes).</p> <p>During a concurrent observation and interview on 4/10/25 at 8:29 a.m. with the Activity Director (AD), the AD identified the following items on Resident 65's bed: a bag of loose tobacco, a white circular item that was an unfilled cigarette wrapper, and loose tobacco poured onto a plate cover. The AD stated the items should not be in Resident 65's room and should be at the nurse's station or in the locked medication cart (portable cart which contains medication). The AD verified that normally cigarettes were labeled and kept in the medication cart for all residents. The AD removed the items on Resident 65's bed to label and placed the items in a locked medication cart. The AD stated Resident 65 was not in the building.</p> <p>During an interview on 4/10/25 at 8:37 a.m., the ADM stated Resident 65 had cigarette making material and a lighter in his room on 4/9/25 and Resident 65 was not in the building. The ADM stated some residents were allowed to have cigarettes with them (no lighters) or locked in the medication cart. The ADM further stated residents were also encouraged to keep cigarettes at a nurse's station. The ADM stated the residents could also store cigarettes in drawers in their room. The ADM confirmed the facility bought locking containers or lock boxes to be kept in residents' rooms and Resident 65 did not have one.</p> <p>A review of the facility's policy titled, Appendix D: Smoking Policy, dated 1/23, indicated, .Residents who smoke will be assessed by Interdisciplinary Team (IDT [a group of healthcare professionals]) .and annually . to determine safe smoking ability and provide individualized intervention to address .Non-compliance or behavioral issues .Those assessed and deemed independent may be provided with a way to secure their own smoking materials (locked drawer or container) .Failure to abide by smoking policy (or care plan) may result in revised safety measures, behavior contracts, and considering alternate placement if non-compliance compromised the safety of resident and/or others .</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>50977</p> <p>Based on observation, interview, and record review, the facility failed to ensure 2 of 27 sampled residents' (Resident 30 and Resident 79) nutrition and hydration requirements were met when:</p> <ol style="list-style-type: none"> 1. Nutritional recommendations of the Registered Dietitian (RD) to address Resident 30's significant weight loss were not followed. 2. Resident 79's significant weight loss was not addressed and monitored. <p>These failures had the potential to result in Resident 30 not to receive the necessary intervention to prevent further weight loss and Resident 79's continued weight loss, negatively affecting Resident 30 and Resident 79's health and well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 30's ADMISSION RECORD, indicated Resident 30 was admitted to the facility with a diagnosis of gastrostomy status (Gastrostomy Tube (GT); a soft tube surgically placed into the stomach to provide nutrition and medications). <p>During a concurrent interview and record review on 4/9/25, at 2:22 PM, with Licensed Nurse (LN) 11, Resident 30's Medical Director (MD) progress note, dated 3/17/25, and Resident 30's enteral tube feeding orders were reviewed. LN 11 confirmed the Resident 30's MD progress note indicated, .Diet adjusted per Registered Dietitian (RD) recommendation due to weight loss . LN 11 confirmed Resident 30's enteral tube feeding orders indicated the following: meal replacement formula (a special nutrition drink for people with diabetes, directly into the body through a tube) that provided 1.2 Calories per milliliters (ML; a unit of measurement) and 100 ML of water through the GT every 6 hours. LN 11 was not sure if Resident 30's meal replacement formula had been adjusted per the RD recommendations.</p> <p>During a concurrent interview and record review on 4/9/25, at 2:50 PM, with the RD, Resident 30's, Nutritional Risk Assessment/Full, dated 2/25/25 was reviewed. The RD confirmed the risk assessment indicated, an RD recommendation to adjust Resident 30's meal replacement formula from 1.2 calories per ML to 1.5 calories per ML. The RD stated, if recommendations made by the RD were not followed Resident 30 was at risk of further weight loss.</p> <p>During a concurrent interview and record review on 4/9/25, at 3:22 PM, with the Director of Nursing (DON), Resident 30's, Nutritional Risk Assessment/Full, dated 2/25/25 and Resident 30's enteral tube feeding orders were reviewed. The DON confirmed Resident 30's enteral tube feeding orders indicated the following: meal replacement formula that provided 1.2 Calories per ML and 100 ML of water through the GT every 6 hours. The DON also confirmed Resident 30's, Nutritional Risk Assessment/Full indicated recommendations made by the RD to changed Resident 30's meal replacement formula from 1.2 calories per ML to 1.5 calories per ML. The DON confirmed the recommendations were not carried out and stated, it was her expectation that RD recommendations be carried out as soon as possible. The DON further stated Resident 30 was at risk for continued weight loss because of RD recommendations not being followed.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>40583</p> <p>2. a. A review of Resident 79's clinical record titled, ADMISSION RECORD, indicated Resident 79 was admitted to the facility with diagnoses which included a need for assistance with personal care and a primary diagnosis of hypo-osmolality (a low concentration of solutes (like sodium) in a fluid) and hyponatremia (a condition where there's a low concentration of sodium in the blood).</p> <p>A review of Resident 79's clinical record titled, Weights and Vitals Summary, dated 2/6/25 through 3/27/25, indicated, on the following dates, Resident 79's weight:</p> <p>2/6/25 129.3 lbs. (pounds a unit of measure)</p> <p>2/16/25 121 lbs.</p> <p>3/1/25 118 lbs.</p> <p>3/3/25 119 lbs.</p> <p>3/9/25 118 lbs. noted in the record as an 8.7% weight loss since admit.</p> <p>3/16/25 116 lbs. noted in the record as a 10.3% weight loss since admit.</p> <p>3/27/25 115 lbs. noted in the record as an 11.1% weight loss since admit.</p> <p>A review of Resident 79's clinical document titled, . Progress Notes . did not indicate any refusals for weights from date of admission on 2/3/25 until 2/6/25, when the facility weighed Resident 79 for the first time. Resident 79 was not weighed weekly, as indicated above. Progress notes do not indicate any attempts to weigh Resident 79, and/or refusals for weights, from 2/6/25 through 2/16/25, 2/16/25 through 3/1/25, and 3/16/25 through 3/27/25.</p> <p>During a concurrent interview and record review of Resident 79's clinical record, with the Assistant Director of Nursing (ADON), on 4/10/25, at 12:24 PM, the ADON stated Resident 79's initial weight should have been done on admission. The ADON explained, after reviewing Resident's 79's weights, Resident 79's weights should have been done weekly due to her weight loss and they were not. The ADON further explained the registered dietitian should have noted Resident 79's weight loss and put Resident 79 on a weekly weight schedule, and did not.</p> <p>b. A review of Resident 79's clinical record titled, Medication Administration Record, (MAR contains physician orders with dates and times of administration) dated 2/1/25 through 2/28/25, indicated, .[brand name dietary supplement containing vitamins, minerals, protein, and fats] one time a day in the afternoon for variable PO [my mouth] intake. Encourage >75% intake .Order Date .02/07/2025 . To be administered at 4:30 PM. The supplement was not administered on 2/8/25 and 2/9/25. The supplement was signed off as administered 2/10/25 through 2/28/25 and did not indicate how much of the supplement Resident 79 consumed.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 79's MAR, dated 3/1/25 through 3/31/25, indicated, [brand name dietary supplement] one time a day in the afternoon for variable PO intake. Encourage >75% intake .Order Date .02/07/2025 . To be administered at 4:30 PM. The supplement was refused on 3/4/25, 3/5/25, and administered the rest of the month and did not indicate how much of the supplement Resident 79 consumed.</p> <p>A review of Resident 79's MAR, dated 4/1/25 through 4/30/25, indicated, [brand name dietary supplement] one time a day in the afternoon for variable PO intake. Encourage >75% intake .Order Date .02/07/2025 . To be administered at 4:30 PM. Resident 79 refused the supplement on 4/3/25, and was administered the supplement through 4/11/25. The amount of the supplement consumed was not indicated.</p> <p>A review of Resident 79's clinical record titled, MINI NUTRITIONAL ASSESSMENT, dated 2/5/25, and Nutritional Risk Assessment / Full, dated 2/7/25, were the only nutritional assessments completed from 2/3/25, date of admission, through 4/11/25.</p> <p>During a concurrent interview and record review of Resident 79's clinical record, with the Assistant Director of Nursing (ADON), on 4/10/25, at 12:24 PM, the ADON confirmed Resident 79's clinical document titled, MINI NUTRITIONAL ASSESSMENT, dated, 2/5/25, did not have accurate information. The ADON explained Resident 79's weight was not indicated on the assessment to determine Resident 79's Body Mass Index (BMI - is a measure that calculates a person's weight relative to their height), and the clinical document indicated a BMI of 23 or greater.</p> <p>During an interview with the Registered Dietitian (RD), on 4/11/25, at 3:14 PM, the RD stated residents are weighed weekly for the first four weeks of admission. The RD further stated he recently started at the facility. The RD explained to determine a resident's weight loss, a weekly weight report is done. The RD further explained the report indicates if anyone was triggered for weight loss and how much they had lost. The RD explained his process was to run the weekly weight report. The RD stated Resident 79's weight loss had gone past the threshold for weight loss and would have been caught on the report. The RD further explained he would do a weight review to see what her intake was and what her medications were. The RD stated if Resident 79 was refusing meals he would expect to be notified. The RD explained the importance of being notified was to figure out if it was Resident 79's preference or if something else was going on. The RD stated he would have initiated weekly weights. The RD further stated when a resident is on [brand name supplement] he would want to know the milliliters consumed to determine how much nutrition she received from the [brand name supplement]. The RD stated the importance of know how many milliliters are consumed would show if she was consuming the [brand name supplement], stating just putting a check mark that the [brand name supplement] was given to Resident 79 does not give him any valuable information. The RD stated he would think a weight committee should have been triggered for Resident 79.</p> <p>A review of the facility policy titled, .Nutrition Assessment , dated 2/2009, indicated, .Each resident receives a comprehensive nutritional assessment upon admission .and whenever a resident is identified as having a significant change in status .At a minimum, a new nutritional assessment is completed .In conjunction with Significant Change in Status .Nutritional Screening and Assessment includes .Height and weight, including recent weight changes .Food and fluid intake in measurable terms .Calculation of energy protein and fluid needs for resident .Appropriateness of and rationale for diet .</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy titled, .WEIGHT MANAGEMENT STANDARD, effective 10/2011, indicated, . Licensed nurse to review electronic weight reports and schedule re-weights within 24 hours for significant weight variance .A 5% weight variance (loss/gain) in one month, 7.5% in three months, or 10% in six months . Weekly weight monitoring may be appropriate for .New admissions for one month .Significant unplanned weight loss .Licensed nurse, IDT [interdisciplinary team consisting of nurses, registered dietitian (RD), physician etc.] and/or RD complete an assessment which may include a review of meal intake records, medication changes, physical assessment for declines, special equipment needs .pain, psych-social issues . IDT may coordinate Walking Rounds in order to better assess contributing factors to significant weight variance .Review to identify potential causal factors of loss .need for significant change in condition assessment and referral for continued assessment and intervention. Assess impact which may include . Medication that alters taste or appetite .Medication that causes fluid loss/gain .Vision problems .</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>50161</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of twenty-seven sampled residents (Resident 77) who received parenteral fluids (delivery of fluid or medication through a vein) was provided services consistent with professional standards of practices when:</p> <ol style="list-style-type: none"> 1. Resident 77's PICC (Peripherally Inserted Central Catheter; a thin, soft, long catheter (tube) that is inserted into a vein in the arm with the tip of the catheter positioned in a large vein that carries blood into the heart to provide medications) clear dressing was not changed within seven days according to the physician order; and, 2. There was no care plan created in relation to Resident 77's PICC line. <p>These failures had the potential to result in a PICC line malfunction and/or infection for Resident 77.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 77's ADMISSION RECORD, indicated Resident 77 was initially admitted to the facility with a diagnosis of diabetes (a chronic condition that affects the way the body processes blood sugar), wound care, management of vascular access (a medical device used to gain access to the blood vessels for various purposes, such as administering medications, drawing blood, or delivering fluids), and urinary device (urinary catheter, flexible tube used empty bladder and collect urine in a drainage bag) among other diagnosis. <p>During an observation on 4/8/25, at 1:10 p.m., Resident 77 had a PICC on her upper right arm and the clear dressing had a handwritten date of 3/30/25 along with the initial's cc. The clear dressing covering the PICC site was noted to be ten days old from the date of observation (4/8/25).</p> <p>During a review of Resident 77's Order Summary Report, indicated an active order, dated 3/13/25, as follows .IV PICC .</p> <p>During a review of Resident 77's Order Summary Report, indicated an active order, dated 3/27/25, as follows .Change Catheter Site RUA [right upper arm] Dressing with transparent dressing .Q [once] week, and prn [as needed] .</p> <p>During a review of Resident 77's Order Audit Report, indicated Resident 77's PICC dressing was changed on 4/6/25 by LN 11 and 3/30/25 by LN 14.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation, interview, and record review on 4/9/25, at 3 p.m., LN 11 confirmed Resident 77's PICC clear dressing was dated 4/8/25 and did not have written initials of the LN who changed the dressing. Through review of Resident 77's clinical record, LN 11 acknowledged he had documented a PICC line dressing change on 4/6/25. LN 11 explained his 4/6/25 dressing change documentation was an error on his part, and he had not changed the PICC line dressing on 4/6/25 when it was due. LN 11 confirmed the clear dressing observed on Resident 77's arm with a date of 4/8/25 was not documented in Resident 77's electronic chart. LN 11 stated it should have been documented in Resident 77's electronic chart. LN 11 stated the PICC line dressings should be changed every 7 days or as needed if the dressing was soiled to maintain sterility and to prevent infection and includes measurement of the arm circumference to make there was no DVT (Deep Vein Thrombosis; refers to the formation of a blood clot in a deep vein). LN 11 stated it was important for the LN to initial the dressing change as it identifies who last changed it and for accountability.</p> <p>During a phone interview on 4/10/25, at 7:19 p.m., LN 12 stated she was asked by the Director of Nurses (DON) to change the dressing for all residents who had IVs on Tuesday night (4/8/25). LN 11 stated she performed Resident 77's dressing change on the evening of 4/8/25. LN 11 stated she thought she documented the dressing change in the Resident 77's electronic chart.</p> <p>During a concurrent interview and record review on 4/11/25, at 11:35 a.m., the Infection Preventionist (IP) stated Resident 77 had chronic wound infections and a bone infection. The IP stated the expectation was Resident 77 should have had her PICC line dressing changed within seven days to prevent infection. The IP confirmed this was the facility's policy. The IP confirmed Resident 77's PICC dressing was changed at ten days and stated it was out of the acceptable range. The IP stated it was important to change the PICC line dressing every seven days because the LN also checked for infiltration (fluid leaking to surrounding tissue) and infection. The IP stated her expectation was for the LN to initial and date the dressing change, and document the details accurately in the resident's electronic health record.</p> <p>During a concurrent interview and record review on 4/11/25, at 1:29 p.m., with the DON and the DON Consultant (DONC), the DON stated her expectation was the PICC line dressing be changed within seven days for infection control.</p> <p>Review of a facility policy titled Dressing Change, Clean, dated 2006, indicated, .PURPOSE .To prevent infection and spread of infection .DOCUMENTATION GUIDELINES .Date, time, dressing change .Signature and title of nurse changing dressing .CARE PLANS DOUCUMENTATION GUIDELINES .List instructions unique to the resident .List necessary monitoring and observations of the underlying condition .List preventative measures if any .</p> <p>Review of an online article created by the Joint Commission titled, CVC [central venous catheter] Maintenance Bundles, dated 11/20/13, indicated, Central venous catheters (CVCs) can be in place from hours to weeks or longer and are manipulated by a multitude of staff members. CVCs are accessed many times while in place, to deliver fluids and medications and to collect blood specimens. Because each entry into access points in the delivery system is an opportunity to introduce microorganisms [germs], the post-CVC insertion period presents multiple opportunities for risk of infection . In the section titled Proper procedures for catheter site dressing monitoring/changes, indicated, . Proper procedures for catheter site dressing monitoring/changes ? Change gauze dressing every 2 days, clear dressings every 7 days (and more frequently if soiled, damp, or loose).5 (or according to the manufacturer's recommendations and whenever the administration set is changed) .</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(https://www.jointcommission.org/-/media/tjc/documents/resources/health-services-research/clabsi-toolkit/clabsi_toolkit_tool_3-22_cvc_maintenance_bundlespdf.pdf)</p> <p>2. During a concurrent interview and record review on 4/10/25, at 4:02 p.m., Resident 77's medical record was reviewed with LN 11. LN 11 confirmed Resident 77 did not have a care plan in place for her PICC line. LN 11 stated care plans guide staff on the proper and safe care of the PICC line.</p> <p>During a concurrent interview and record review on 4/11/25, at 1:29 p.m., with the DON and the DONC, the DON acknowledged there was no PICC line care plan for Resident 77. The DON stated her expectation was a PICC line care plan be in place for Resident 77. The DON explained the care plan provides the care team direction to give the best maximum care for the resident. The DON stated the care plan directs staff to the resident's goal, interventions, and outcome for the care of the residents PICC line.</p> <p>Review of a facility policy titled Care Plan, Comprehensive, dated 2017, indicated, .it is the policy of this facility to develop .the Comprehensive Resident Care Plan. The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life .Care Plans are individualized through the identification of resident concerns, unique characteristics .Each plan should include measurable foals and associated time-frames and responsibility .</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>52181</p> <p>Based on observation, interview, and record review, the facility failed to identify, assess and treat pain to the extent possible for one of twenty-seven sampled residents (Resident 25), when</p> <ol style="list-style-type: none"> 1. Resident 25 did not receive a pain medication as ordered when he had rated his pain level between 4-6 (on a pain scale of 0- 10 (0 = no pain and 10 = severe pain), and 2. Resident 25 did not have a pain regimen for pain level of 7 to 10. <p>These failures resulted in the potential for inadequate pain relief and emotional distress for Resident 25.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 4/8/25 at 10:03 AM Resident 25 was observed to have nonverbal signs of pain which included facial expression of grimacing, wincing, and moaning as he attempted to reposition himself in his bed. Resident 25 stated that when he got pain medication it sometimes helped the pain in his back. <p>Review of ADMISSION RECORD indicated Resident 25 was admitted to the facility with multiple diagnoses including malignant neoplasm of prostate, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, and secondary malignant neoplasm of bone.</p> <p>Review of Resident 25's Minimum Data Set (MDS - a standardized assessment tool used in nursing homes and swing bed facilities to assess residents' functional status, health needs, and preferences) dated of 3/11/25 indicated Resident 25 had a Brief interview for Mental Status (BIMs - a brief cognitive screening measure that focuses on orientation and short-term member recall) of a score of 9 out of a possible 15 indicating moderate cognitive impairment.</p> <p>Review of Resident 25's Medication Administration Record (MAR) dated for April 2025 indicated physician order for pain management for Norco Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6 on pain scale), was ordered on 3/23/25.</p> <p>Review of Resident 25's Medication Administration Record (MAR) for the month of April 2025 indicated Pain - Record Highest level Of Pain Every Shift . Resident 25's pain level was recorded at 4 on 4/8/25. Further review of MAR failed to show Resident was offered or given the Norco as prescribed for his recorded pain level of 4 on 4/8/25.</p> <p>During a concurrent interview and record review on 4/10/25 at 4:04 PM, LN (Licensed Nurse) 2 confirmed that Resident 25 was able to verbally communicate and rate his pain level. LN 2 confirmed the pain level parameter that accompanied Resident 25's Norco order was for moderate pain (4-6 on pain scale). LN 2 confirmed that Resident 25 did not receive Norco as ordered on 4/8/25 for a pain level of 4.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Review of Resident 25's MAR for the months of March 2025 and April 2025 indicated Pain - Record Highest level Of Pain Every Shift . Staff documented the following pain scores from 3/25/25 through 3/30/25 and from 4/1/25 through 4/6/25 for the day, evening, and night shifts:</p> <p>3/25/25 4.4.0</p> <p>3/26/25 7.0.0</p> <p>3/27/35 7.0.0</p> <p>3/28/25 6.0.0</p> <p>3/29/25 7.0.0</p> <p>3/30/25 0.0.0</p> <p>4/1/25 0.5.7</p> <p>4/2/25 0.5.0</p> <p>4/3/35 0.0.0</p> <p>4/4/25 0.7.7</p> <p>4/5/25 7.7.0</p> <p>4/6/25 7.0.0</p> <p>4/7/25 0.0.0</p> <p>4/8/25 4.0.0</p> <p>4/9/25 0.0.0</p> <p>4/10/25 0</p> <p>There were no orders for pain management when Resident 25 rated his pain at or above a 7.</p> <p>During a concurrent interview and record review on 4/10/25 at 4:04 PM, LN 2 confirmed that there was no pain regimen order in place for a pain rating at or above 7 for Resident 25. LN 2 stated they should have reached out to Resident 25's physician to request a review of Resident 25's pain medication orders and/or parameters for possible order changes. LN 2 confirmed that there was no documentation found in Resident 25's medical record that there had been communication from nursing to the physician with this request. LN 2 stated the risk of not assessing pain correctly or communicating pain levels with the physician puts residents at risk for poorly management pain which may affect their ability to sleep, eat, complete activities of daily living (ADLs) and/or cause depression.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/25 at 4:27 PM, the Director of Nursing (DON) stated that her expectation was that the nursing staff would offer prn pain medication as ordered for the pain level being reported and document if the resident refused to take the medication. The DON further stated nursing staff should have contacted Resident 25's physician to review medication regimen for pain level being report at a level of 7 or higher. The DON stated the risk of not having an adequate regimen placed Resident 25 at risk for inadequate pain control, psychosocial health as well as his ability to complete ADL tasks.</p> <p>Review of an undated facility policy and procedure titled Pain Management indicated The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain . Recognition: 1. In order to help a resident attain or maintaining his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: .b. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments . 1. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. 7 .The following are general principles the facility will utilize for prescribing analgesics: j. Facility staff will notify the practitioner, if the resident's pain is not controlled by the current treatment regimen.</p>

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161</p> <p>Based on observation, interview, and record review, the Attending Physician/Medical Doctor/Medical Director (MD) failed to provide blood glucose (sugar, BG) monitoring parameters for diabetic (blood sugar disease) condition, and physician oversight for one of twenty-seven sampled residents (Resident 77) when, Resident 77's blood sugar monitoring orders from February 2025 and March 2025 did not provide parameters for management of blood sugar.</p> <p>This failure could have contributed to unsafe blood sugar monitoring with high or low blood sugar levels.</p> <p>Findings:</p> <p>Review of Resident 77's ADMISSION RECORD, indicated Resident 77 was initially admitted to the facility in 12/2024 and a readmitted ,d+[DATE], with a diagnosis of diabetes and wound care among other diagnosis.</p> <p>Review of Resident 77's admission history and physical, dated 12/18/24, written by the MD, indicated diabetic diagnosis and under recommendation included .DON'T SEE DM (diabetes, same as blood sugar disease) diet MED (medications) AC/HS (before meals and at bedtime) FS (fingerstick) on DM .</p> <p>During a concurrent observation and interview on 4/8/25, at 1:05 p.m., Resident 77 was observed eating her lunch and stated she was diabetic and was not receiving a diabetic meal. Resident 77 stated she did not have any insulin coverage for her high blood sugars. Resident 77 stated she was concerned because about a week ago she had blood sugars of over 300 (normal blood sugar is between 80mg/dL and 120mg/dL; milligram per deciliter is a unit of measure to express is a measure of unit used for blood sugar test) and never received insulin (medication to treat blood sugar disease). Resident 77 explained she asked the licensed nurse (LN) for use of insulin to bring the number down the way she received it at home and in the hospital, as she was not getting it in the facility. Resident 77 stated she was concerned because having high blood sugar was not good for her body and explained she had multiple wounds, and they had been difficult to heal. Resident 77 stated prior to coming to the facility she had lived independently and had been giving herself insulin at home.</p> <p>Review of Resident 77's facility communication document, with the MD, dated 2/17/25, the written fax (a method of transmitting by scanning and transmitting over telephone lines) document indicated patient and family were requesting to do lab tests since the patient used to take insulin at home. Further review indicated the MD ordered to check BG for one week.</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/9/25, at 12:39 PM, LN 9 stated Resident 77's family member had asked why she was not on insulin. LN 9 stated most of her diabetic residents were on some sort of diabetic medication or insulin. LN 9 stated Resident 77's BG had been spiking in high number in the afternoons. Through clinical record review, LN 9 confirmed Resident 77 had orders for BG checks four times a day while there were no diabetic medications ordered. LN 9 confirmed there were no nursing notes or interventions performed regarding Resident 77's high BG. Through record review of Resident 77's progress notes LN 9 confirmed there was no communication or notification of AP for high BG's. LN 9 stated the nurse should have notified the AP if BG was high with no parameters. LN 9 confirmed on 4/6/25, at 8:39 p.m. Resident 77 had a BS of 390 mg/dL and there was no notification of AP. LN 9 confirmed on 4/4/25, at 4:22 p. m., Resident 77 had a BG of 314 mg/dL and there were no notification of the AP. LN 9 stated if a residents BG was above 200 md/dL she would have notified the AP. LN 9 stated the risk for a resident who had high BG was hyperglycemic coma (when blood sugar high enough to cause severe symptoms such as mental status change), become lethargic (drowsiness), and/or confused. LN 9 stated BG could slow Resident 77's wound healing.</p> <p>During the review of Resident 77's Medication Administration Record (record of the doctors order and nursing documentation), dated 4/2025, the record indicated, .FSBG AC/HS before meals and at bedtime for DM .order date 3/13/24 . Review of the document indicated no parameters for blood sugar including when to notify the doctor. Further review of the document indicated the following BG readings (in milligram per deciliter (mg/dl) a measure of blood sugar, normal target range 80-120 ml/dL) for Resident 77 taken four times a day were as follows:</p> <p>4/4: 139, 183, 314, 291</p> <p>4/5: 87, 194, 190, 215</p> <p>4/6: 175,180, 185, 390</p> <p>4/7: 113, 138, 290, 215</p> <p>4/8: 101, 159,167, 200</p> <p>4/9: 107,133, 148, 153</p> <p>4/10: 114, 135, 230, 200</p> <p>The MAR record did not indicate any nursing interventions, documentation, or physician notification for BG changes outside of the standard range.</p> <p>Review of the MD's progress notes for Resident 77 with date range of 12/24 through 4/25, the notes did not address FSBG measurements or plan of care for diabetic management as follows:</p> <p>12/26/24 Lab REVIEWED: .glu [glucose] 244 [assessment noted as diabetes without complications]</p> <p>1/16/25 FSBG: [no result and no assessment]</p> <p>1/23/25 FSBG: [no result and no assessment]</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Vintage Faire Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3620 B Dale Rd. Modesto, CA 95356	
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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1/30/25 FSBG: [no result and no assessment]</p> <p>2/10/25 FSBG: [no result and no assessment]</p> <p>2/13/25 FSBG: [no result and no assessment]</p> <p>2/17/25 FSBG: [no result and no assessment]</p> <p>3/20/25 FSBG: 146 mg/dL [no assessment of FSBG readings]</p> <p>4/3/25 FSBG: 142 mg/dL [no assessment of FSBG readings]</p> <p>During an interview on 4/10/25, at 2:05 p.m., the MD stated Resident 77 was on antibiotics for wound infection and was placed on orders for FSBG (finger stick blood glucose, same as using blood from finger to measure blood sugar) just in case she had high blood sugars. The MD stated he was not aware of Resident 77's high FSBG, and the nurses should have informed him of high readings. The MD stated he should have put in place orders including parameters for when to notify him and an insulin order for treatment of high blood sugars. The MD stated he was not aware Resident 77 was previously on insulin or diabetic medication at home or hospital.</p> <p>During a phone interview on 4/11/25, at 12:22 p.m., with the wound care doctor, MD 2, stated Resident 77 was admitted into the facility for a severe wound infection. The MD 2 stated Resident 77 was readmitted to the hospital in 3/2025 for increased drainage and worsening wound condition. The MD 2 stated Resident 77's DM diagnosis could delay the wound healing process. The MD 2 stated Resident 77's wounds were rarely seen in non-diabetics.</p> <p>During a concurrent interview and record review on 4/11/25, at 1:29 p.m., with the Director of Nursing (DON) and the Director of Nursing Consultant (DONC), the DON stated for Resident 77 the nurses should have communicated high blood sugar trends to the MD. The DON stated BG measurements should have had monitoring parameters for resident safety as the blood sugar was taken four times a day. The DON stated with diabetes diagnosis the resident was at risk for delayed wound healing.</p> <p>During a phone interview on 4/11/25, 3:02 p.m., the MD stated he ordered an A1C blood test (hemoglobin A1C, blood test that measures average blood sugar level over the past three months) for Resident 77 and he did not address it in his progress notes. The MD stated he only had received the results for one week in 2/2025 which were not worrying. The MD stated Resident 77's A1C was in the normal range and for daily FSBG above 200 mg/dL he would have expected the nursing staff to notify him.</p> <p>Review of facility Policy & Procedure titled Blood Sugar Monitoring, dated 2006, indicated, .check physician's order for blood sugar testing frequency .If blood glucose level is above or below normal range, document the time the physician was notified .</p> <p>Review of facility P & P titled Resident Rights, dated 10/2022, indicated, .The resident has the right to be informed of, participate in, his or her treatment, including: The right to be fully informed .of his or her total health status, including but not limited to .The right to participate in establishing the expected foals and outcomes of care, the type, amount, frequency, duration of care, and other factors related to the effectiveness of the plan of care .</p> <p>(continued on next page)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of undated facility P & P titled DUTIES OF MEDICAL DIRECTOR, indicated, .Coordination of medical care in the Facility to ensure that adequate and appropriate medical services are provided to the patients in the Facility .participating in the development of a system providing a medical care plan for each patient, which covers medications, nursing care .</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>52181</p> <p>Based on observation, interview, and record review, the facility failed to ensure that two of three certified nursing assistants (CNA 1 and CNA 2) had the appropriate competency to provide individualized resident care for a census of 89 residents when, CNA 1 and CNA 2 were not aware of how to access the resident Kardex (a concise, centralized, and easily accessible record of essential resident information, used by staff to quickly summarize resident care and guide daily actions) in the residents medical record.</p> <p>This failure had the potential for resident centered interventions not to be implemented with the risk for residents not to meet their identified goals or suffer declines in their Activities of Daily Living.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/9/25, at 2:26 PM, CNA 1 stated she had worked at the facility for about one month. CNA 1 confirmed she was assigned to care for Resident 28 for her shift. CNA 1 stated she was not aware that Resident 28 had a pressure injury (PI; localized damage to the skin and underlying soft tissue, usually over a bony prominence, caused by prolonged or severe pressure). When asked to show Resident 28's Kardex, CNA 1 logged into the wall mounted tablet located in the hallway to access a resident's plan of care information (system used to document care provided to a resident and to view a resident's person-centered plan of care tasks assigned to the CNA). CNA 1 was unable to locate Resident 28's Kardex. CNA 1 stated to her knowledge there was no Kardex to review, and she relied on the charge nurse (CN) to inform her of any resident care plan issues. CNA 1 stated she did not receive report from the off going CNA or the CN that Resident 28 had a PI.</p> <p>During a concurrent observation and interview on 4/9/25 at 2:46 PM, CNA 2 stated she had worked at the facility for a month. CNA 2 logged into the wall mounted tablet located in the hallway. CNA 2 was unable to confirm how to access a resident Kardex in the residents' plan of care system. CNA 2 stated not having access to a resident's information from the Kardex would affect her ability to properly care for the residents she was assigned to.</p> <p>During an interview on 4/9/25, at 2:59 PM, the Director of Staff Development (DSD) stated CNAs were made aware of resident care needs through shift report, beginning of shift huddle (when information is shared between staff regarding resident care needs), and by viewing the residents Kardex. The DSD stated the expectation was for CNAs to review a resident Kardex every day. The DSD stated the risk to a resident if the CNA did not review the Kardex could result in a patient care not to be completed and could make a resident's condition, like a pressure ulcer, worse.</p> <p>Review of a facility policy and procedure titled Care Plan, Comprehensive, dated 12/17, .Care Plans are individualized through the identification of resident concerns, unique characteristics, strengths and individual needs .Individualized Care Plans should be accessible to all caregivers .</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility provided document titled New Hire Clinical Orientation Standards - Day 2 Clinical Staff, dated 12/17, indicated, .CLINICAL ORIENTATION Training .[Name of electronic medical record, EMR] VIDEOS .Kardex in POC [plan of care] .</p> <p>Review of a facility provided document titled JOB DESCRIPTION / PERFORMANCE EVALUATION, revised 11/13/17, indicated, .JOB TITLE: CERTIFIED NURSING ASSISTANT .DOCUMENTATION .Utilizes facility time of care documentation system as directed .</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>50161</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate behavioral health treatment and services to meet the psychosocial needs for one of twenty-seven sampled residents (Resident 46), when</p> <ol style="list-style-type: none"> 1. Resident 46's mental health consult notes and therapy recommendations via telehealth care (use of technology, video, or phone to provide long distance mental health care) dated 9/19/24 were not communicated to the Medical Doctor (MD) and the licensed nursing (LN) staff; and, 2. Resident 46 displayed episodes of anger and was refusing his treatments and medications, including his medication, and the resident's psychological evaluation (a comprehensive evaluation focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders) and/or consultation was not provided as ordered by the physician on 2/13/25. <p>This deficient practice had the potential to negatively affect the Resident 46's psychosocial (the mental, emotional, social, and spiritual effects of a disease) well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 46's ADMISSION RECORD, indicated Resident 46 was originally admitted to the facility in summer of 2021, with a diagnosis including but not limited to lack of expected normal physiological development in childhood (refers to a developmental delay in one or more areas such as a way a person thinks, interacts with and communicates with others and persists into adulthood), screening for other developmental delays, bipolar disorder (a mental disorder characterized by periods of extreme mood swings, and causes shifts in mood, energy, activity levels, and concentration), hypertension (high blood pressure), and protein-calorie malnutrition. <p>During a concurrent interview and observation on 4/8/25 at 10:49 a.m., Resident 46 was observed in a private room with the door shut, sitting on the edge of his bed. Resident 46 stated his food was not served to him correctly on the food tray and as he was speaking it was observed Resident 46 was getting agitated. It was observed Resident 46's voice was raising and stated the sugar packets were being placed in the dirt and served to him dirty and contaminated.</p> <p>(continued on next page)</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 4/9/25, at 9:18 a.m., Responsible Party (RP) 1 stated he was Resident 46's health care decision maker and family member and prior to coming to the facility four years ago, he had lived at home but was not independent and had a caretaker. The RP 1 stated Resident 46 was bipolar and had grown up as a child with a developmental delay. The RP 1 stated a nurse had called him from the facility 2 days ago regarding Resident 46 refusal of taking his medications and was not allowing staff to address the swelling in his feet. The RP 1 stated Resident 46 was refusing care and had become aggressive with staff in the last few months because the facility had changed his psychiatric medications. The RP 1 stated in the last two years there had been issues regarding Resident 46's mental health and was exhibiting escalating behaviors. The RP 1 explained he was concerned regarding Resident 46's refusal of medications and nursing care. The RP 1 stated staff have told him they cannot control Resident 46. The RP 1 stated Resident 46 was angry, easily agitated and was verbally lashing out at people. The RP 1 stated Resident 46 initially was able to tolerate a roommate but due to his behaviors he was not able to be housed with other residents. The RP 1 stated he was not aware Resident 46 had been referred for a mental health consult or had been seen by a psychiatrist.</p> <p>During a record request, with the Medical Records Assistant (MRA) on 04/10/25, at 12:44 p.m., a request for Resident 46's mental health records to include all psychiatric progress notes and consultation reports. The MRA provided Resident 46's name redacted, Psychiatric Visit Progress Report, dated 9/19/24.</p> <p>Review of Resident 46's name redacted, Visit Progress Report, dated 9/19/24, written by the psychiatrist (MD) 3 (psychiatrist, medical doctor who specializes in mental health), indicated a Plan as follows:</p> <p>.Can refer to neuropsychology [medical doctor that specializes in the way a person thinks and behavior] for further evaluation and then adjust meds [medications] as appropriate on further discussion .Psychiatry team will continue to assess resident's behavior in future visits and appropriateness of current psychotropic medication /s .</p> <p>Further review of the document indicated a Medication Order as follows:</p> <p>.#Refer to neuropsychology when available</p> <p>#Continue current medication/s and nonpharmacologic measures</p> <p>#Psychiatric MD [Medical Doctor] or NP [Nurse Practitioner] while in the facility .</p> <p>Review of the Resident 46's electronic medical records and notes did not reflect the recommendations were communicated with the medical doctor or the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/25, at 1:53 p.m., the MD stated Resident 46 had behavioral and psychiatric issues and was aggressive to staff members. The MD stated Resident 46 was refusing to take his medications. The MD stated it would be beneficial if Resident 46 was cooperative and therapy could help support his behaviors. The MD stated he was not aware of Resident 46's orders for neuropsychology from the mental health telehealth psychiatrist dated 9/19/24 and had not seen the report. The MD stated his expectation was the facility follow-up and communicate with him regarding residents' psychiatry consults so that he may review recommendations and new orders. The MD stated Resident 46 behavior was getting worse. The MD stated his expectation was the order he placed a psychiatric consult on 2/13/25 for Resident 46 be carried out.</p> <p>During a concurrent interview and record review on 4/11/25, at 1:29 p.m., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON reviewed Resident 46's clinical record and stated the orders from his psychiatry consult should have been shared with the MD so new orders could have been placed for him. The DON stated the expectation would have been for the new orders to be transcribed for MD to approve. The DON stated the telehealth psychiatrist's order for neurotherapy should have been referred out from the social services department. The DON stated the therapies might have been beneficial to Resident 46 to address his behaviors. The DON explained Resident 46 refusal of medical care and medication could have been improved with the neuropsychology consult and additional therapies.</p> <p>2. Review of Resident 46's Order Details, dated 2/23/25, written by MD, indicated, .Psych [psychiatric] eval [evaluation] and adjust as needed .</p> <p>Review of MD's progress notes for Resident 46, dated 1/22/25, indicated, .Patient continues to refuse care off and on. Legs still quite swollen, not sure if he is taking diuretic daily or not .PLAN Patient not compliant and still having behavior issue .</p> <p>Review of MD's progress notes for Resident 46, dated 2/19/25, indicated, .Patient still noted with leg edema [swelling] Per staff patient not allow them to look whether took med [medication] or not, also refuse to take meds crushed. Psych [Psychiatrist] eval [evaluation] ordered, will continue to monitor .PLAN .Watch PB [blood pressure] HR [heart rate] .Monitor behavior. Refer [referral] psych, doubt will be helpful either .</p> <p>Review of MD's progress notes for Resident 46, dated 3/19/25, indicated, .Patient still refusing meds off and on. PLAN .Monitor behavior, encourage compliance .</p> <p>Review of Resident 46's Social Services Note, dated 2/11/25, indicated, .Per nursing staff, the patient was refusing to have the echocardiogram [a test that measures and takes images of the heart] done with which was scheduled on 2/18. Due to the patient refusing the exam, I contacted RP [name redacted, RP 1] to confirm they wanted to cancel the appointment .</p> <p>Review of Resident 46's Nursing Note, dated 2/13/25, written by the DON 2, indicated, . [name redacted, mental health telehealth provider] informed and will next schedule for follow up psychiatric call .</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 46's Nursing Note, dated 2/21/25, written by the DON 2, indicated, .Resident has psychiatric telehealth follow up visit with [name redacted, mental health telehealth provider] mental health . Further review of Resident 46's clinical record did not include details of a date and time Resident 46 met with the telehealth mental health provider.</p> <p>During a concurrent interview and record review on 4/10/25, at 12:33 p.m., the Administrator (ADM) stated the facility uses a telehealth psychiatric service for residents who have orders for mental health services. The ADM stated the mental health telehealth employee will come to the facility on ce a month or as needed. The ADM stated when they come out there was a list of patients for them to see and a nurse will accompany them in the residents' rooms. The ADM stated the telehealth company communicates mainly with the DON 2 and stated she was currently on leave. During a record review of email communication with the mental health telehealth company and the DON 2, the ADM stated the DON 2 had emailed the company on 2/21/25 regarding Resident 46 needing to be seen. The ADM stated there was no other communication regarding an appointment for Resident 46 and he could not locate a record Resident 46 was seen for the psychiatric consultation ordered 2/13/25. The ADM confirmed the only psychiatric consultation progress notes for Resident 46 was from 9/19/24. The ADM was not aware of any neuropsychology appointments made for Resident 46.</p> <p>Review of Resident 46's Nursing Note, dated 3/13/25, indicated, Pt refused all his morning medications, except the white pills .</p> <p>Review of Resident 46's Nursing Note, dated 3/25/25, indicated, Endorsed from AM nurse that [name redacted, MD] gave new order for nursing to crush patient's medication to ensure patient not hiding/throwing way pills. Writer attempted to administer due medication crushed in applesauce. Pt refused x 3[times] attempts. Patient stated I am not taking medication in pudding or crushed, I need to see what I'm taking . Patient came close to writer with his hands up and very agitated from his meds being crushed .[name redacted, MD] notified of via fax of patients refusals and behavior .</p> <p>Review of Resident 46's Nursing Note, dated 3/25/25, indicated, Pt [patient] only took his Small white pill in PM shift, Pt refused the rest of his medications .</p> <p>During an interview on 4/9/25, at 11:53 a.m., Certified Nursing Assistant (CNA) 4 stated Resident 46 used have a roommate, but they had to isolate him because he was talking about the roommate having the devil in him. CNA 4 stated Resident 46 now stayed mostly in his room and does not want to participate in activities.</p> <p>During an interview on 4/9/25, at 12:39 p.m., LN 9 stated Resident 46 was verbally aggressive towards staff and was kind of scary. LN 9 stated he had a lot of odd behaviors. LN 9 stated Resident 46 had a psychiatrist see him one time via telehealth. LN 9 stated Resident 46 used to take all the medications but about a month ago he stopped taking his medications and he now only wanted to take the white pills. LN 9 stated he sometimes refused to take those too. LN 9 stated he would also refuse the water staff offer him because he thought staff was poisoning him.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/25, at 3:00 p.m., LN 11 stated Resident 46 was sharing a room with another resident and but had to be moved to a private room. LN 11 stated Resident 46 refuses his medication and only wants to take specific medications. LN 11 stated Resident 46 does not want to talk to anyone and wants his room door shut. LN 11 stated he did not believe Resident 46 was currently receiving mental health therapies. LN 11 stated he thought Resident 46 would benefit from mental health interventions including counseling.</p> <p>During an interview on 4/9/25, at 3:59 p.m., LN 8 stated Resident 46 refuses a lot of medications and will have outbursts where he gets upset and yells at people. LN 8 stated Resident 46 often thinks things are missing and get very upset about the missing items.</p> <p>During an interview on 4/10/25, 10:11 a.m., LN 6 stated when residents have new orders for psychiatrist consult the nurse will voice it over to the Director of Nursing (DON) who will then take over from there.</p> <p>During an interview on 4/10/25, at 10:19 a.m., the Social Services Director (SSD) stated nurses take care of psychiatrist consults and her department does not help with the scheduling of psychiatrist appointments. The SSD stated she was not aware Resident 46 had a psychiatric consult ordered.</p> <p>During a concurrent interview and record review on 4/10/25, at 11:14 a.m., the SSD stated she was familiar with Resident 46, and stated he was a long-term resident. The SSD stated the RP 1 was not able to manage Resident 46's behaviors at home and he was routine driven, likes to stay in his own room, and does not participate in activities.</p> <p>During an interview on 4/10/25, 11:29 a.m., with the DON and ADON, the DON stated she was the interim DON and had worked in the facility for the last two months since the DON (DON 2) had been off work. The ADON stated she was new and started the week before. The DON stated to her knowledge when a resident had an order for a psychiatrist consult, staff will inform the ADON and the SSD will schedule the appointment. The DON stated the facility used a telehealth company for mental health consults and services. The DON stated the psychiatrist assistant from the company came in last week and introduced herself but did not see any residents. The DON stated she was not aware Resident 46 had a psychiatrist consult ordered. The DON stated her expectation was Resident 46 should be seen as soon as possible and within the month. The DON stated if the resident was not seen timely, it could affect their psychosocial health, and their needs would not be met.</p> <p>During a concurrent interview and record review on 4/11/25, at 1:29 p.m., with the DON and Assistant Director of Nursing (ADON), the DON reviewed Resident 46's clinical record and the psychiatric consult ordered 2/13/25 and stated her expectation for scheduling would depend on the severity of the residents behaviors. The DON stated she would have wanted the appointment to be made within 24 hours for severe behaviors or if less behaviors then scheduled for him to be seen within 48-72 hours. The DON stated her expectation was social services should help with contacting mental health providers and carry out scheduling and ensuring the residents visit with the provider. The DON stated the risk to the resident were continuing or worsening behaviors and delays to the patient experiencing a benefit from the mental health treatment.</p> <p>(continued on next page)</p>		

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

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility Policy & Procedure titled Social Services, dated 2025, indicated, .The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include .Providing or arranging for needed mental and psychosocial counseling .The facility should provide social services or obtain needed services from outside entities during situations that include .Expressions or indications of distress that affect the resident's mental and psychosocial well-being .difficulty with personal interaction and socialization skills, and resident to resident altercations .</p> <p>Review of facility P & P titled Behavioral Health Services,, dated 2025, indicated, .It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being .The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy [self-determination], privacy, socialization, independence, choice, and safety .The Social Services Director shall serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside sources such as physician, psychiatrist [doctor specializing in mental health], or neurologists [brain doctor].</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40583</p> <p>Based on interview and record review the facility failed to ensure the psychosocial well-being of one resident (Resident 79), in a sample of 27, when there was no documented evidence of Social Services following up with Resident 79 following initiation of three separate psychotropic (drugs that affect the mind and brain to treat mental health conditions) medication.</p> <p>These failures, due to lack of documented follow-up from social services, had the potential to negatively effect Resident 79's mental health and psychosocial well-being.</p> <p>Findings:</p> <p>A review of Resident 79's clinical record titled, ADMISSION RECORD, indicated Resident 79 was admitted to the facility on [DATE], with diagnoses which included a need for assistance with personal care and a primary diagnosis of hypo-osmolality (a low concentration of solutes (like sodium) in a fluid) and hyponatremia (a condition where there's a low concentration of sodium in the blood). Further review of Resident 79's ADMISSION RECORD, did not include any psychiatric diagnoses.</p> <p>A review of Resident 79's clinical record titled, Order Details, dated 2/20/24, indicated the following orders on the following dates:</p> <p>. [brexpiprazole] (medications used to treat mental health conditions) 1 MG (milligrams a unit of measure) . for Psychosis (a mental health condition characterized by a loss of touch with reality) m/b [manifested by] banging on side rails .Start Date: 02/20/2025 .</p> <p>. [brexpiprazole] 2 MG . for Psychosis m/b [manifested by] banging on side rails .Start Date: 02/24/2025 . indicating a dosage increase.</p> <p>.[aripiprazole] (medication used to treat mental health conditions) 10 MG . for psychosis . Start Date: 03/08/2025 .</p> <p>.[aripiprazole 15 MG . for antipsychotic . Start Date: 03/20/2025 . indicating a dosage increase.</p> <p>.Mirtazapine 15 MG . for Depression (a common mental health condition characterized by a persistent low mood, loss of interest in activities, and other symptoms that can significantly interfere with daily life) . Start Date: 03/25/2025 .</p> <p>During a concurrent interview and record review with Social Services Director (SSD), on 4/11/25, at 9:35 AM, the SSD stated she visits residents in the facility daily, but does not document her visits.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nurses (DON), on 4/11/25, at 10:22 AM, (INT) DON, the DON stated when psychotropic medications are initiated for social services needs to be informed and social services would need to do an assessment on the resident. The DON explained it was important for Social Services to go and see Resident 79. The DON further explained Social Services would be part of the team that would help determine the source of Resident 79's behavior. The DON stated Social Services should be documenting their resident visits to be able to discuss how residents were doing in facility meetings.</p> <p>A review of the facility policy titled, Social Worker's Role With Psychotropics at Admission, dated 11/2016, indicated, . It is the social worker's responsibility to obtain the history psychotropic use . If a resident has a mental illness . our efforts in due diligence are even more important . A social service assessment is not complete unless we have interviewed the resident's family or responsible party and have obtained a comprehensive picture of the resident . A supporting diagnosis must be found in the H&P [history and physical], Psychiatric evaluation, or physician progress notes to justify the use of the psychotropic . Psychotropics/Behavior Management . Champion the psychotropic committee meeting . Lead the IDT [interdisciplinary team consists of the DON, nurses, social services etc.] to identify possible medical, environmental and psychosocial causal factors of behaviors .</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50778</p> <p>Based on observation, interview, and record review the facility failed to follow safe disposition and destruction of controlled prescription medications (a drug with the potential for misuse and abuse) based on facility's policy with a census of 89 when controlled medication disposal bins or containers (where unused prescribed medications were held for ultimate safe disposal) were not secured, sealed, and rendered unusable (medication that has been altered in a way that it was no longer available for use) to prevent unauthorized access and risk of drug diversion (unsafe drug acquisition and unauthorized use by someone other than for whom it is prescribed) when stored in the shared Interim Director of Nursing (DON) and Assistant Director of Nursing (ADON) office.</p> <p>These failures had the potential to contribute to unsafe medication handling and risk of drug diversion.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE] at 3:52 p.m., accompanied by the DON and Pharmacist Consultant (PC), in the shared DON and ADON office, two controlled medication disposal containers were located on top of a file cabinet. Further observation indicated the two disposal containers were not secured, not sealed, and the contents were easily accessible by hand. The medications inside the disposal containers were not rendered unusable and medications could be seen and/or identified easily. The PC stated the facility had 90 days to send disposal containers for destruction to a contracted disposal company and acknowledged the disposal bins were not securely sealed. The DON confirmed the pills in the disposal containers located on top of the file cabinet were not rendered unusable and the disposed pills could have been poured or accessed from the top of the unsecured and unsealed containers. The DON stated there was a risk of unauthorized access to controlled medications with unsecured and unsealed containers that were not rendered unusable was diversion. The DON stated the facility's policy was not followed for controlled medication disposition and rendering it unusable.</p> <p>During a review of facility's undated policy titled, Destruction of Unused Drugs, the policy indicated, .drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements .upon verification of the dangerous drugs and controlled substances to be destroyed, the consultant pharmacist must seal the container .the sealed container must be maintained in a secure area in the pharmacy or in a locked cabinet in the medication room until transferred to the waste disposal service .</p> <p>During a review of facility's policy titled, Disposal/Destruction of Expired or Discontinued Medication, revised on [DATE], indicated, .facility staff should destroy and dispose of medications in accordance with facility policy and applicable law .An authorized facility staff member should remove medications, including pills, capsules, liquids, creams, etc., from their dispensing containers and pour the medications into a container or plastic bag. An authorized facility staff member may add a substance that renders the medications unusable to the plastic container or bag .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50778</p> <p>Based on observation, interview, and record review, the facility failed to ensure accurate medication labeling practices were followed when a blood pressure (BP-the force of blood pushing against the walls of arteries as heart pumps blood throughout the body) medication label was not updated with a new hold parameter (a number reflecting a change in the order for direction of use) for one resident (Resident 440) with a census of 89.</p> <p>This failure had the potential for Resident 440 to not receive blood pressure medication as prescribed to manage fluctuations in blood pressure.</p> <p>Findings:</p> <p>During a medication administration observation on 4/9/25 at 7:40 a.m. with Licensed Nurse (LN) 6 at medication cart 4, Resident 440's medication label on the bubble pack (a card that packages dosed of medication inside clear or light-colored bubbles or blisters) for amlodipine (a medication to treat high blood pressure; high blood pressure-when the force of blood pushing against artery walls is consistently too high) was not consistent with the Medication Administration Record (MAR-a legal record of the drugs administered to a patient at a facility by a health care professional) for use as follows:</p> <p>The mislabeled direction on the bubble pack indicated to hold the amlodipine when Systolic Blood Pressure (SBP-a numerical value for the pressure in the arteries when the heart contracts and pumps blood throughout the body) was greater than 110mm Hg (millimeters of mercury-a unit of measurement for blood pressure reading) when the MAR direction indicated to hold amlodipine for SBP less than 110mm Hg.</p> <p>During a concurrent interview and record review on 4/9/25 at 2:24 PM with LN 7 and LN 8, the bubble pack label and the MAR for amlodipine were reviewed. LN 7 and LN 8 also reviewed the active and discontinued orders for amlodipine. LN 8 stated the original label on the bubble pack should have been updated with the new and accurate hold parameters as prescribed by the doctor. LN 8 stated for problem with medication label the nursing staff should have called the pharmacy for clarification and/or requested a new medication label. LN 7 stated the wrong BP medication parameters could result in unsafe BP level and subsequent risk to Resident 440's well-being.</p> <p>During a concurrent interview and record review on 4/10/25 at 12:40 p.m. with the Consultant Pharmacist (CP) and accompanied by the Interim Director of Nursing (DON), the amlodipine orders, and the picture of the medication label on the bubble pack were reviewed. The CP stated the label should have been changed to reflect the current order and was not.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/10/25 at 12:50 p.m. with the the CP and the Pharmacy Representative (PR), the PR stated the labeled amlodipine bubble pack for Resident 440 was sent to the facility on [DATE] and the hold parameters on the label was not accurate. The PR stated the pharmacy sent a fax to the facility on the morning of 4/3/25 to clarify the order and received the clarification from the facility on 4/3/25 at 4 PM with the corrected hold parameter. The PR stated once the pharmacy processed the clarified order, the insurance would not cover the cost of a new bubble pack to send to the facility until 4/9/25. The PR stated the process should have been to place a change in direction sticker (a sticker that alerts nursing staff of a change on the label of the bubble pack) on the original bubble pack. The PR confirmed the process for using the change in directions sticker was not followed.</p> <p>During a telephone interview on 4/10/25 at 1:01 p.m., the Pharmacist Supervisor (PS) stated the pharmacy had a policy that the facility should have placed a Directions Changed label on the bubble pack if there was a change in medication use directions. The PS stated a medication error could have resulted if the nurse followed the mislabeled medication directions. The PS stated it was a breakdown in the process of clarifying the order at the facility and not putting a Directions Changed sticker on the label while waiting for the new bubble pack to arrive (with the corrected label). The PS stated the risk was it could cause harm to the resident, and they could have high blood pressure if medications were held incorrectly.</p> <p>A review of the facility's policy titled, Physician/Prescriber Authorization and Communication of Orders to Pharmacy, revised 1/1/12, indicated, .Facility should contact Physician/Prescriber when staff is notified by Pharmacy of an order requiring clarification .Facility should explain the issue to the Physician/Prescriber, document the clarification and document any new orders received .Facility should then communicate the result and any new orders or directions to the Pharmacy .</p> <p>A review of the facility's policy titled, Reordering, Changing, and Discontinuing Orders, revised 1/1/13, indicated, Change orders: Any request to change an existing order should be treated by Facility as a new order .Pharmacy should receive a discontinuation order BEFORE a new order (that reflects a change) is filled .If Pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand .Pharmacy should discontinue the original order .Prescriber should write the new order with new directions and Facility should enter the new order on the appropriate Medication Record Forms .Facility should notify Pharmacy not to send the medication by attaching a 'Change in Directions' sticker to the existing quantity of medications until Pharmacy permanently affixed the new label to the medication package or container .</p> <p>A review of the facility's policy titled, Authorization and Communication of Orders, revised 7/1/24, indicated, . This policy 4.0 sets forth procedures relating to physician/prescriber authorization and communication of orders .Upon receipt of medications from the pharmacy .facility staff should reconcile the medications received to the orders entered in the resident's medical record .Pharmacy may contact facility staff .when the pharmacist believes that there is a need to clarify the medication order .Facility staff should regularly monitor approved channels for pharmacy communication .Facility should explain the issue to the physician/prescriber, document the clarification .Facility staff should then communicate the result and any new orders or directions to the pharmacy .Facility should closely monitor communications from the pharmacy regarding significant medication-related issues .to assure the issue has been resolved in a timely manner, per regulation .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>40583</p> <p>Based on interview and record review, the facility failed to ensure one of twenty-seven residents' (Resident 17) medical records were complete and accurate when Resident 17's dialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidneys are not functioning properly) medical record was in another resident's (Resident 21) clinical records.</p> <p>This failure had the potential to result in Resident 17's private health care information and personal information being disclosed to the unauthorized person.</p> <p>Findings:</p> <p>A record review of Resident 21's clinical record titled, ADMISSION RECORD, indicated Resident 21 was admitted to the facility with diagnoses that did not include dialysis.</p> <p>A record review of Resident 17's clinical record titled, ADMISSION RECORD, indicated Resident 17 was admitted to the facility with diagnoses that included a dependence on dialysis.</p> <p>A review of Resident 21's electronic health record (EHR) revealed Resident 17's clinical document titled, DIALYSIS CARE COMMUNICATION COORDINATION, dated 3/8/24, was contained in Resident 21's EHR.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 4/10/25, at 1 PM, the ADON confirmed Resident 17's above clinical document was in Resident 21's EHR. The ADON explained Resident 17's clinical document should not be in Resident 21's EHR. The ADON further explained the importance of keeping resident's clinical document in the right place for privacy.</p>

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>52181</p> <p>Based on interview and record review the facility failed to develop and implement a coordinated plan of care with Hospice (provides comfort and support for individuals facing a terminal illness, focusing on improving quality of life during the final stages of life) for two of two sampled residents (Resident 28 and Resident 47), when</p> <ol style="list-style-type: none"> 1. The facility did not invite or include Resident 28's and Resident 47's hospice staff in the facility's interdisciplinary team (IDT - group of professionals from different disciplines or fields who work together to assess, coordinate, and plan resident care) meetings for care coordination, 2. The facility did not ensure that the hospice agencies nurses progress notes, IDT notes, and plan of care updates were available to the facility staff for Resident 28 and Resident 47. <p>These failures had the potential for Resident 28 and Resident 47 to not receive proper, appropriate, and coordinated care and services from the facility and the hospice agency; and had the potential for Resident 28's and Resident 47's medical record to have insufficient information to reflect the condition, care and services provided.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1a. A review for Resident 28's ADMISSION RECORD indicated that Resident 28 was admitted to the facility under hospice services with a diagnosis of Hypertensive heart disease (heart problems that arise from prolonged high blood pressure (hypertension) with heart failure (a condition where the heart can't pump enough blood to meet the body's needs). <p>A review of Resident 28's physician orders for March 2025 and April 2025 indicated there were no orders placed for hospice services.</p> <p>A review of Resident 28's IDT Assessment & Progress note - V4 dated 2/18/25, did not indicate that hospice staff involved in the care of Resident 28 attended or were invited to the IDT meeting. Further review of the IDT assessment and progress note did not specify what hospice services were being provided or the name of the hospice agency.</p> <ol style="list-style-type: none"> 1b. A review for Resident 47's ADMISSION RECORD indicated that Resident 47 was admitted to the facility under hospice services with a diagnosis of vascular dementia (a type of dementia caused by impaired blood flow to the brain, leading to damage and eventual loss of brain cells). <p>A review of Resident 47's physician orders for March 2025 and April 2025 indicated there were no order placed for hospice services.</p> <p>A review of Resident 47's IDT Assessment & Progress note - V4 dated 3/17/25 did not indicate that hospice staff involved in the care of Resident 47 attended or were invited to the IDT meeting. Further review of the IDT assessment and progress note did not specify what hospice services were being provided or the name of the hospice agency.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/9/25 at 12:17 PM, MDS (a nurse who focuses on collecting and assessing patient data for Medicare and Medicaid-certified nursing homes) 1 and the Social Service Director (SSD) stated that hospice staff had not attended any facility IDT meetings for Resident 28 or Resident 47. The SSD verified there was no record indicating hospice staff were invited to attend Resident 28 and Resident 47's IDT meetings. The SSD stated that an email or letter was not sent to hospice staff to inform them of the meeting date and time for Resident 28 or Resident 47. MDS 1 and SSD stated the invitation should have been sent out and that it was important for the IDT meetings to include facility and hospice team members so there was coordination of care.</p> <p>During a concurrent interview and record review on 4/10/25 at 8:48 AM, Hospice Nurse (HN) 1 stated that she had never received a phone call, email or verbal invitation to attend a facility care conference for Resident 28. HN 1 stated she had been the RN Case manager for the facility since February and was not sure what the process was for a combined team meeting. HN 1 stated she had not spoken to anyone at the facility about what the facilities process was for the IDT meetings. HN 1 stated the risk of not having a combined IDT meeting could lead to poor care coordination between the hospice agency and the facility and could put the resident at risk for neglect from the lack of communication regarding care needs.</p> <p>During a concurrent staff interview and record review on 4/9/25 at 11:55 AM, the Director of Nursing (DON) stated that if there was no documented care coordination between facility and hospice staff it could affect resident care delivery. The DON stated that the expectation was for the IDT to review and update hospice care plans with personalized interventions that showed care coordination for different disciplines visits and task assignments during a joint IDT meeting.</p> <p>2a. During a concurrent interview and record review on 4/9/25 at 12:33 PM, MDS 1 confirmed that Resident 28's hospice nurse progress notes, IDT meeting notes and care plan updates from November 2024 through April 2025 were not available in Resident 28's facility medical record.</p> <p>During a concurrent interview and record review on 4/9/25 12:33 PM, MDS 1 confirmed that in the electronic health record for Resident 28, there was a document from the hospice agency titled Plan of Care dated 8/28/24 had the following interventions: Patient to be totally fed in upright position Turn Patent every 2 hours if unable to turn self . MDS 1 stated that these orders listed on the document had not been transferred to Resident 28's facility physician orders or facility care plan. MDS 1 stated that the facility expectation is that the nurse who received this document would have reviewed it and transferred all orders and interventions into the resident's physician order orders section or the care plan.</p> <p>2b. During a concurrent interview and record review on 4/9/25 at 12:33 PM, MDS 1 confirmed that Resident 47's hospice nurse progress notes, IDT meeting notes and care plan updates from January 2025 through April 2025 were not available in Resident 47's facility medical record.</p> <p>During an interview with the Medical Records Assistant (MRA) on 4/10/25 at 2:00 PM, the MRA stated that hospice usually emailed the most recent notes to the Medical Records Director (MRD). The MRA stated she was not sure why there were no current hospice records for Residents 28 or 47 facility medical record.</p> <p>(continued on next page)</p>		

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 04/11/2025
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.

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent staff interview and record review on 4/9/25 at 11:55 AM, the DON stated that she expected that Resident 28 and Resident 47 would have the most current hospice records uploaded into their medical records or paper copies be placed in their hospice binders.</p> <p>A review of the facility provided document titled End of Life dated 11/2016, indicated .the goal is for the hospice and facility staff to provide joint care. Communication is key .Careplans must be combined and illustrate that the two groups are working together on each careplan need identified .</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>50977</p> <p>Based on interview, and record review the facility failed to ensure one of five sampled residents (Resident 23) received vaccine (a process whereby a person is made resistant to a disease by the administration of vaccines) education prior to administration of Pneumococcal (vaccine to prevent pneumonia) and Influenza (a contagious respiratory illness cause by influenza viruses) vaccines.</p> <p>These failures resulted in Resident 23 to not be aware or informed of the benefits, risks, and potential side effects of the immunizations, prior to receiving the vaccines.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 4/11/25, at 10:00 AM, the Infection Preventionist (IP) stated Resident 23 received the influenza vaccine on 9/23/24, and Resident 23 received the pneumococcal vaccine on 9/26/24. During record review the IP was unable to find documented evidence where Resident 23 was educated on the risk and benefits of the influenza or pneumococcal vaccines.</p> <p>During an interview on 4/11/25, at 10:15 AM, the IP stated the importance of giving the education and benefits of the vaccines to Resident 23; was so that they may be aware of the side effects, benefits of vaccines they chose to receive, or not receive. The IP further stated if no education was provided Resident 23 may not understand the side effects and benefits of influenza and pneumococcal vaccines.</p> <p>During a review of the facility's policy and procedure titled, IMMUNIZATIONS: INFLUENZA (FLU VACCINATION OF RESIDENTS, STAFF, AND VOLUNTEERS dated 2012, indicated, .Informed consent in the form of a discussion regarding risks and benefits of vaccination will occur prior to vaccination .</p>		