STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675939	A. Building B. Wing	04/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Health Care Center	205 N Bonnie Brae Denton, TX 76201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at S483.10(c)(2) and S483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 resident (Resident#1) of 3 residents reviewed for Care Plans. The facility failed to ensure Resident #1 was care planned for indwelling foley catheter. This failure could place residents at risk of needs not being met. Findings include: Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected that Resident #1 was a [AGE] year-old female initially admitted to facility on 10/23/24 and readmitted [DATE]. Relevant diagnoses included Cancer, Cerebrovascular accident (CVA), metabolic encephalopathy (a condition where brain dysfunction occurs due to underlying metabolic disturbances, not primary brain damage or infection), and anxiety. Resident#1 had a BIMS score of 05/15 indicating severe cognitive impairment. Resident #1 was readmitted with indwelling foley catheter after hospitalization . Review of Resident #1's Physician's Order on 04/24/25 at 12:17 PM revealed Foley Catheter: _16_F (French Scale, a unit of diameter) change . every month AND as needed for occlusion or dislodgment. Provide catheter care every shift. Empty drainage bag every shift. Monitor f/c q shift for) leakage, blockage, sediment buildup, or low output every shift. Ensure catheter strap in place and holding. Review of Resident #1's Comprehensive Care Plan dated 03/10/25 reflected no care plan for indwelling foley catheter care. Review of Resident #1's Nurses Progress Notes dated 04/23/25 at 19:03 PM indicated, Urine Control: Catheter . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation/Interview on 04/27/25 at 11:20 AM revealed Resident #1 was lying in bed with eyes open, confused unable to respond to question , and did not know where she was. It was also observed that Resident #1's foley catheter drainage bag was hanging at the left side of the bed frame, with privacy bag, and sitting on the floor. Further observation revealed the catheter strap had come off and was draped over the catheter. Interview with DON on 04/27/25 at 2:52 PM, the DON stated that care planning was a team approach. The DON said that the MDS nurse, and herself were the one responsible in making the care plans for the residents and updating it accordingly. The DON added that without a care plan, the current health issues would not be addressed and managed accordingly. The DON further stated that the care plan should be accurate and up to date. It should be done upon, resident admission, and resident change of condition. Interview with the Administrator on 04/27/25 at 3:18 PM, the Administrator stated that without a care plan, the resident would not have care needed. The Administrator concluded that the expectation is that the staff will ensure that every issue of the residents are care planned. Record review of facility's policy, Catheter Care, Nursing Policy & Procedure Manual 2003, revealed General Guidelines .9. Review the resident's plan of care daily for changes . Record review of facility's policy, Comprehensive Care Planning, Nursing Policy & Procedure Manual, The facility will develop and implement a comprehensive person-centered care plan for each resident . the resident's goals for admission and desired outcome . the resident's care plan will be reviewed after Admission, Quarterly, Annual, and/or Significant Change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #2, and Resident#3) of 8 residents reviewed for ADLs. The facility failed to ensure Resident#2 had his fingernail cleaned and trimmed. The facility failed to ensure Resident#3 had his toenails trimmed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings include: A record review of Resident #2's admission MDS assessment dated [DATE] reflected Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of: cerebrovascular accident, muscle weakness, and personal history of other mental and behavioral disorders. Resident#2's has a BIMS score of 08/15 indicating moderate cognitive impairment. The review further reflected the resident was substantial to maximal assist with ADL's (activity of daily living). A record review of Resident #2's Comprehensive Care Plan dated 03/20/25 reflected Focus. The [Resident #2] has, and ADL self-Care Performance Deficit. Goal: The [Resident#2] will maintain or improve current level of function in (.and Personal hygiene; ADL Score) through the review date. Interventions o BATHING: Check nail length and trim and clean on bath day and as necessary . An observation and interview on 04/27/25 at 10:30 AM revealed Resident #2 was up in wheelchair in the dining. Resident#2 had a long fingernail approximately 0.6 cm on both hands, with a brown matter underneath. Resident#2 was asked if he want his fingernail trimmed and cleaned, he replied asked the staff to clean and trim them and they did not do it. A record review of Resident#3 quarterly MDS assessment dated [DATE] reveled Resident#3 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of: type 2 diabetes mellitus (elevated blood sugar), anxiety, bipolar (a mental health condition characterized by significant mood swings, including emotional highs and lows), and schizophrenia (a serious mental health condition that affects how people think, feel, and behave). Resident#3 has a BIMS score of 13/15 indicating that he is cognitively intact. Further review revealed Resident#3 was total dependent on the staff for his ADLs. Review of Resident #3's Care Plan dated 03/07/25 reflected Focus. The [Resident #3] has, and ADL self-Care Performance Deficit. Goal: The [Resident#3] will maintain or improve current level of function in (. and Personal hygiene; ADL Score) through the review date. Interventions o BATHING: Check nail length and trim and clean on bath day and as necessary. If diabetic, the nurse will provide toenail care . Review of Resident #3's Doctor order summary dated 03/07/25 revealed May have Podiatry Consult PRN. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 04/27/25 at 11:05 AM revealed Resident#3 was lying in bed with his bare feet uncovered. Resident#3' toenails were long approximately 0.5 centimeter in length extending from the tip of his toes and cracked. Resident#3 stated he was uncertain who could safely trim his toenails given his diagnosis of diabetic. In an observation and interview on 04/27/25 at 11:53 AM GVN B physically assessed Resident#2's fingernails and stated needed trimming and cleaning due to fecal contamination beneath the nails. GVN B stated that nail care for the resident is performed by CNAs on shower days and emphasized that it is the responsibility of the nurses and CNAs to ensure resident's nails kept clean and trimmed to prevent infection, and skin injury through scratching. GVN B looked at Resident#3 toenail and stated they are cracked and long. GVN B stated Resident#3 needed a referral to the podiatric service. She stated CNAs and charge nurses on the floor were supposed to let the ADON and SW know so they could do the referral. GVN B stated the risk to Resident#3 could be infection development, and foot ulcer related to cuts or pressure point from long and cracked toenail. Interview and observation on 04/27/25 at 2:52 PM the DON stated, she expected resident nails care to be provided during the shower days, and if the resident is diabetic the nurses had to trim the nails. The DON looked at Resident#3 toenail and stated they were long and chipped. The DON stated the nurses should notify the SW. The DON stated it looks like it was not reported to the SW. She stated it is also her responsibility to make sure residents' toenail were referred to the SW. The DON stated the facility social worker scheduled residents for podiatric care Monthly. She stated she would look to the last referral to see if Resident#3 was on it. The DON stated that residents were at risk of infection and skin break down if they scratch themselves, and diabetic resident can develop foot ulcer from toenail cut or pressure point. Record review of facility's policy, Nail Care, Nursing Policy & Procedure Manual 2003, revealed Nail management is the regular care of the toenails and fingernails to promote integrity of tissue, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenail. It includes cleaning, trimming, smoothing, and cuticle are and is usually done during the bath. NAIL CARE, ESPECIALLY TIMMING, IS PERFORMED BY A PODIATRIST IN THOSE WITH DIABETES AND PERFERAL VASCULAR DISEASE .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47690 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 resident (Resident #1) of 1 reviewed for catheter and incontinence care. The facility failed to ensure Resident#1 urine catheter bag was off the floor when she was lying in bed, and the tubing was properly strapped to her leg. These failures could place residents at risk for not receiving care appropriate to address their incontinence and could increase the risk of urinary tract infections. Findings included: Review of Resident #1's Quarterly MDS assessment dated [DATE] reflected that Resident #1 was a [AGE] year-old female initially admitted to facility on 10/23/24 and readmitted [DATE]. Relevant diagnoses included Cancer, Cerebrovascular accident (CVA), metabolic encephalopathy (a condition where brain dysfunction occurs due to underlying metabolic disturbances, not primary brain damage or infection) and anxiety. Resident#1 had a BIMS score of 05/15 indicating severe cognitive impairment. Resident #1 was readmitted with indwelling foley catheter after hospitalization . Review of Resident #1's Physician's Order on 04/24/25 at 12:17 PM revealed Foley Catheter: _16_F (French Scale, a unit of diameter) change . every month AND as needed for occlusion or dislodgment. Provide catheter care every shift. Empty drainage bag every shift. Monitor f/c q shift for leakage, blockage, sediment buildup, or low output every shift. Ensure catheter strap in place and holding. Review of Resident #1's Comprehensive Care Plan dated 03/10/25 reflected no care plan for indwelling foley catheter care. Review of Resident #1's Nurses Progress Notes dated 04/23/25 at 7:03 PM indicated, Urine Control: Catheter. Observation/Interview on 04/27/25 at 11:20 AM revealed Resident #1 was lying in bed with eyes open and confused unable to respond to question , and did not know where she was. It was also observed that Resident #1's foley catheter drainage bag was placed on the floor and inadequately secured to the resident's leg; the catheter strap had come off and was draped over the catheter. RN A entered resident#1 room to check her blood pressure; when asked to check the foley catheter drainage bag; she looked and ascertained that the F/c drainage bag was positioned on the floor and was not properly secured to the resident#1's leg. RN A stated the presence of the drainage bag on the floor can cross-contamination, and development of infection to the resident. She further explained that if the catheter tubing is not properly secured, it can become dislodge. RN A stated nurses and CNAs were responsible for ensuring the bag was not sitting on the floor and that the tubing was property secured. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON on 04/27/25 at 2:52 PM, the DON stated any resident with a foley catheter, the drainage bag should never be touching the floor, and the tubing should be properly secured. She stated having the drainage bag on the floor would place residents at risk of a urinary tract infection and cross contamination. She further stated if the foley catheter tubing is not adequately secured, it could cause dislodgment, placing the resident at risk of pain and bleeding. Record review of facility's policy, Catheter Care, Nursing Policy & Procedure Manual 2003, revealed General Guidelines .5. Check the resident frequently to be sure he or she is not lying on the catheter and keep the catheter and tubing free of kinks. Keep tubing off floor and minimize friction or movement at insertion site. 10. be sure the catheter tubing and drainage bag are kept off the floor .