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	05/20/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #2) of five residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #2's room was in a position that was accessible to the resident on 05/20/2025. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency. Findings included: Record review of Resident #2's Face Sheet, dated 05/20/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with spondylosis (degeneration of the spine that could cause pain and stiffness) and legal blindness (a person's vision that could not be corrected beyond a certain level even with glasses or contact lenses). Record review of Resident #2's Quarterly MDS Assessment, dated 05/08/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03 (requires significant assistance and support in daily life). The Quarterly MDS Assessment indicated the resident had limited vision and was dependent to staff for bed mobility, transfer, and personal hygiene. Record review of Resident #2's Comprehensive Care Plan, dated 03/25/2025, reflected the resident was at risk for injuries from falling and one of the interventions was to keep call light within reach of the resident and tell the resident the location of the call light due to blindness. In an interview and observation on 05/20/2025 at 9:47 AM revealed Resident #2 was in her bed, awake. It was observed that the resident's call light was on the shelf at the left side of her bed. When asked where her call light was, the resident said she did not know where her call light was because her sight was not that good. She said sometimes the staff would put the call light beside her where she could easily search for it. The resident started to search the call light but did not find it. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 05/20/2025 at 9:52 AM, LVN B stated call lights should be with the residents so they could call the staff if they needed something. He said the call lights were for the independent and dependent residents. He said Resident #2 was legally blind and the staff usually put her call light on the same place so the resident could remember where her call light was. LVN B went inside the resident's room and saw the call light was not within the reach of the resident. He said a staff went inside to change the resident and might have forgotten to put the call light near the resident when she was done. He took the call light from the shelf and placed it beside the resident. LVN B also told the resident where her call light was. He said staff should make sure the call lights were within reach of the residents before they leave the room so that the residents could let the staff know that they needed assistance or some help. He said if the call lights were not with the residents, they won't be able to call the staff and their needs and wants would not be addressed. LVN B then called CNA C and asked if she changed the resident. In an interview and observation on 05/20/25 at 9:58 AM, CNA C stated she went inside Resident #2's room earlier to clean and change the resident. She said after she was done changing the resident, she went out of the room to attend to another resident. She said she was not aware that she did not put the call light near the resident. She said the resident's call light should always be within the reach of the resident so the resident could notify the staff if she needed something or was not feeling good. She said the resident might have a fall if she tried to do things by herself. She went inside the room to check if the call light was with the resident. She then went to the rooms of other residents and checked if the call lights were with the residents. She said she was responsible in ensuring the call lights were with the residents. In an interview on 05/20/2025 at 11:08 AM, the DON stated call lights should always be within reach of the residents so they can call the staff for assistance, for pain medication, or because they wanted to get up. The DON said if the call lights were not within reach, their needs would not be met, and the residents might get upset because there was no way to call the staff. The DON said all the staff were responsible for the call lights, whether CNAs, nurses, therapists, housekeeping, and management. The DON said the expectation was for the staff to ensure the call lights were within reach of the residents before they leave the room. The DON said she would start an in-service about call lights as soon as the interview was over. In an interview on 05/20/2025 at 12:16 PM, the Administrator stated call lights should be with the residents all the time so the residents could call for help if needed. He said the call lights were for all the residents whether dependent or independent and that everybody was responsible in making sure the call lights were with the residents, even the administrator. He said without the call lights, the residents would not be able to communicate their needs to the staff. He said an in-service about call lights was already going around. In an interview on 05/20/2025 at 12:38 PM, ADON A stated the call lights should always be with the residents in case they needed assistance with something like a refill of water or the resident needed a pain medication. He said the staff should make sure that the call lights were with the residents before they left the room because without the call lights the residents might get upset or might fall. He said an in-service about call light was being done. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy Resident Rights undated, revealed The resident has a right to a dignified existence, self -determination, and communication with and access to persons and services inside and outside the facility . 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two (Resident #1 and Resident #2) of four residents reviewed for respiratory care. 1. The facility failed to ensure Resident #1's humidifier bottle (a medical device designed to increase the moisture level in supplemental oxygen) had water in it on 05/20/2025. 2. The facility failed to ensure Resident #2's nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) were properly stored when not in use on 05/20/2025. These failures could place residents at risk for respiratory infection and not having their respiratory needs met. Findings included: 1. Record review of Resident #1's Face Sheet, dated 05/20/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #1's Comprehensive MDS Assessment, dated 02/02/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 10 (resident may need additional support and monitoring). The Comprehensive MDS Assessment indicated the resident had oxygen therapy. Record review of Resident #1's Comprehensive Care Plan, dated 02/26/2025, reflected the resident had COPD and one of the interventions was to give oxygen therapy as ordered by the physician. Record review of Resident #1's Physician Orders, dated 11/20/2024, reflected OXYGEN 2 LITERS PER NASAL CANNULA. every shift for Shortness of Breath related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE. Record review of Resident #1's Physician Orders, dated 12/25/2024, reflected Change oxygen humidifier and tubing every week on Sunday night every night shift every Sun. Observation and interview on 05/20/2025 at 8:57 AM, Resident #1 was in his bed, awake. It was observed that the resident was using oxygen at 2 liters per minute via nasal cannula that was connected to an empty humidifier bottle. The resident said he had been using oxygen for months and thought his oxygen bottle was already empty because his nose was a bit dry. He said he could not remember when the oxygen bottle run out of water. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 05/20/2025 at 9:15 AM, LVN B stated the purpose of a humidifier was to keep the nasal passageway moist to prevent dryness and irritation. He said he did his morning round but did not notice if the water in Resident #1's humidifier bottle was running low or if the bottle was already empty. He disconnected the humidifier bottle from the oxygen concentrator and said he would put some water in it and would put it back. 2. Record review of Resident #2's Face Sheet, dated 05/20/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease. Record review of Resident #2's Quarterly MDS Assessment, dated 05/08/2025, reflected the resident had a severe impairment in cognition with a BIMS score of 03 (requires significant assistance and support in daily life). The Quarterly MDS Assessment indicated the resident was on oxygen therapy. Record review of Resident #2's Comprehensive Care Plan, dated 03/25/2025, reflected the resident needed oxygen constantly or intermittently and one of the interventions was O2 at 2 liters per minute via nasal cannula. Record review of Resident #2's Physician Order, dated 11/07/2024, revealed Oxygen Maintenance: Continuous O2 Therapy @2 - 4LPM via Mask/Nasal Cannula at night at bedtime for (Routine Oxygen Maintenance). In an interview and observation on 05/20/2025 at 9:47 AM revealed Resident #2 was in her bed, awake. It was observed that the resident's nasal cannula was inside the drawer and was not bagged. There was no bag in the drawer or on the table. The resident said she usually used her oxygen at night and the staff would usually take it off. In an interview and observation on 05/20/2025 at 9:52 AM, LVN B stated Resident #2 was using oxygen at night. He said during daytime, the nasal cannula should be stored in a plastic bag to keep it clean for the next use. He went inside the room and saw the unbagged nasal cannula inside the drawer with the prongs of the nasal cannula touching the things inside the drawer. LVN B disconnected the nasal cannula, threw it, and said he will get a new nasal cannula and a plastic bag for the nasal cannula. He said if the nasal cannula was just laying around and touching something not clean, the resident might have respiratory infections. He said he did not notice during his morning rounds that the nasal cannula was not bagged. In an interview on 05/20/2025 at 11:08 AM, the DON stated the nasal cannulas were supposed to be in a bag when the residents were not using them to prevent cross contamination and worsening of respiratory issues. She said the oxygen concentrator should always have water in it to prevent dryness and irritation of the nasal passageway. She said the expectation was for the staff to be mindful and make sure the nasal cannulas were bagged and that there was water in the humidifier bottle. She said she would conduct an in-service about respiratory care as soon as the interview was over. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/20/2025 at 12:16 PM, the Administrator stated the nasal cannulas should be bagged when the residents were not using them to prevent introduction of opportunities for infection. He said if there was a humidifier connected to the oxygen concentrator, then the humidifier should have water in it. He said an in-service about respiratory care was already going around and he said the expectation was for the staff to be mindful and follow the policy and procedure of respiratory care. The Administrator said they do not have a policy specific for bagging the nasal cannula but it was a given that the nasal cannula should be in a bag when not in use. In an interview on 05/20/2025 at 12:38 PM, ADON A stated the nasal cannulas should be stored properly inside a plastic bag if the residents were not using them. He said the staff were responsible for ensuring the nasal cannulas were clean every time the residents would use them. He said the expectation was for all nasal cannulas be stored properly. He said another expectation was for the staff to check if the humidifier bottle was running low or was empty to prevent dryness and irritation of the nose and throat. He said a humidifier was used regardless of how many liters per minute flow of oxygen was ordered. He said an in-service about respiratory care was being done. Record review of the facility policy Oxygen Administration Nursing Policy & Procedure revised February 13, 2007 revealed Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask . Common oxygen sources for long-term administration include cylinder (portable or stationary) . or concentrator. All sources require humidification to prevent drying of mucous membranes and thickening of respiratory secretions if used routinely.