

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675939	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2025
NAME OF PROVIDER OR SUPPLIER Vintage Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the comprehensive care plan described the services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for four (Residents #1, #2, #3, and #5) of nine residents reviewed for Comprehensive Care Plans. Based on interview and record review, the facility failed to ensure the comprehensive care plan described the services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 (Residents #1, #2, #3 and #5) of nine residents reviewed for Comprehensive Care Plans.1.A. The facility failed to implement and modify interventions to ensure Resident #1 did not experience 7 falls after admitting to the facility on [DATE], and as a result of the last fall on 06/22/2025, sustain a head injury which resulted in the resident's death in the hospital on [DATE]. B. The facility failed to implement and modify interventions to ensure Resident #2 did not experience 5 falls after admitting to the facility on [DATE] with a right hip fracture resulting from a fall at home. C. The facility failed to implement and modify interventions to ensure Resident #3 did not experience 5 falls after admitting to the facility on [DATE]. The facility failed to create , implement and revise care plans to meet the medical , nursing, mental and psychosocial needs identified in the comprehensive assessment related to falls with appropriate and effective interventions . These failures placed residents at risk of serious injury and death. 2.The facility failed to devise and implement any Comprehensive Care Plan goals and/or interventions for Resident #5's documented wandering, exit seeking, and/or elopement behavior on 07/08/2025 to prevent an incident of elopement by Resident #1 on 07/12/2025. The care plan showed no elopement intervention until 07/13/2025. The first non-compliance was identified, and an Immediate Jeopardy (IJ) situation was identified on 07/02/2025. The IJ was removed on 07/16/2025. The facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. The second non-compliance was identified, and an Immediate Jeopardy (IJ) Template was presented to facility Administrator and DON on 07/15/2025 at 5:37 PM. The IJ was removed on 07/16/2025. The facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. Findings Included: 1.1. Record review of Resident #1's Face Sheet, dated 06/26/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1 had diagnoses which included Parkinson's disease (movement disorder of the nervous system that worsens over time), unspecified abnormalities of gait (walking pattern) and mobility, and a history of falls. Record review of Resident #1's admission MDS (tool used to assess health status) Assessment, dated 04/19/2025, reflected moderately impaired cognition with a BIMS (screening tool to assess cognitive status) score of 10. Section J (Health Conditions) reflected Resident #1 had 2 or more falls since admission with no injury. Record review of Resident #1's Comprehensive Care Plan, dated 04/28/2025, reflected the focus resident at risk for falls was initiated on 05/25/2025. Interventions included staff x 1 to assist resident with transfers, ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed, and ensure the resident was wearing appropriate footwear when ambulating or mobilizing in his wheelchair. The care plan did not reflect each fall or a new intervention after each fall. Record review of Resident #1's Fall Risk Assessments, dated 06/12/2025, 06/20/2025, and 06/22/2025, reflected Resident #1 was in the high-risk category for falls. Record review of the facility's incident reports reflected Resident #1 fell on [DATE], 04/11/2025, 04/15/2025, 04/20/2025, 05/25/2025, 06/10/2025, 6/20/2025 which did not result in a serious injury. Resident #1 was sent to the hospital after he fell on [DATE]. Record review of Resident #1's progress notes, dated 06/13/2025, reflected RN C documented This client is somewhat confused. He does not abide by the nurses' instructions about his safety and constantly gets out of the recliner and makes movements that could severely hurt him. He slid out of the recliner at 2145. Once we put him in bed, 30 minutes later, we found him by the door in his chair, naked.We need a baby monitor so that the nurse can see him from the nurse's station. Record review of Resident #1's progress notes, dated 06/20/2025, reflected RN X documented This nurse was called by an Aide that resident was on the floor. Resident was lying next to his recliner and bed. Resident said he was trying to use the bathroom. Resident was lifted off the floor with a Hoyer lift. Resident sustained a skin tear on his right elbow. Site was cleaned and covered with border dressing. Resident assessed and his vital signs were normal. DON family and NP were notified. Record review of Resident #1's progress notes dated</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision to prevent accidents for 4 (Residents #1, #2, #3 and #5) of 9 residents reviewed for accidents and hazards. Based on observations, interviews, and record review the facility failed to ensure the resident environment remained as free of accident hazards as is possible and each resident received adequate supervision to prevent accidents for 4 (Residents #1, #2, #3 and #5) of 9 residents reviewed for accidents and hazards. 1. A. The facility failed to implement and modify interventions to ensure Resident #1 did not experience 7 falls after admitting to the facility on [DATE], and as a result of the last fall on 06/22/2025, sustain a head injury which resulted in the resident's death in the hospital on [DATE]. B. The facility failed to implement and modify interventions to ensure Resident #2 did not experience 5 falls after admitting to the facility on [DATE] with a right hip fracture resulting from a fall at home. C. The facility failed to implement and modify interventions to ensure Resident #3 did not experience 5 falls after admitting to the facility on [DATE]. 2. A. The facility failed to adequately assess, devise, and implement appropriate interventions to prevent Resident #5's elopement from the facility for approximately 5 minutes on 07/12/2025. The first non-compliance was identified, and an Immediate Jeopardy (IJ) situation was identified on 07/02/2025. The IJ was removed on 07/16/2025. The facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. The second non-compliance was identified, and an Immediate Jeopardy (IJ) Template was presented to facility Administrator and DON on 07/15/2025 at 5:37 PM. The IJ was removed on 07/16/2025. The facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. The failures could place residents at risk of harm and injuries, hospitalization, and death. Findings include: 1. 1. Record review of Resident #1's Face Sheet, dated 06/26/2025, reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1 had diagnoses which included Parkinson's disease (movement disorder of the nervous system that worsens over time), unspecified abnormalities of gait (walking pattern) and mobility, and a history of falls. Record review of Resident #1's admission MDS (tool used to assess health status) Assessment, dated 04/19/2025, reflected moderately impaired cognition with a BIMS (screening tool to assess cognitive status) score of 10. Section J (Health Conditions) reflected Resident #1 had 2 or more falls since admission with no injury. Record review of Resident #1's Comprehensive Care Plan, dated 04/28/2025, reflected the focus resident at risk for falls was initiated on 05/25/2025. Interventions included staff x 1 to assist resident with transfers, ensure the resident's call light was within reach and encourage the resident to use it for assistance as needed, and ensure the resident was wearing appropriate footwear when ambulating or mobilizing in his wheelchair. The care plan did not reflect each fall or a new intervention after each fall. Record review of Resident #1's Fall Risk Assessments, dated 06/12/2025, 06/20/2025, and 06/22/2025, reflected Resident #1 was in the high-risk category for falls. Record review of the facility's incident reports reflected Resident #1 fell on [DATE], 04/11/2025, 04/15/2025, 04/20/2025, 05/25/2025, 06/10/2025, 6/20/2025 which did not result in a serious injury. Resident #1 was sent to the hospital after he fell on [DATE]. Record review of Resident #1's progress notes, dated 06/13/2025, reflected RN C documented This client is somewhat confused. He does not abide by the nurses' instructions about his safety and constantly gets out of the recliner and makes movements that could severely hurt him. He slid out of the recliner at 2145. Once we put him in bed, 30 minutes later, we found him by the door in his chair, naked. We need a baby monitor so that the nurse can see him from the nurse's station. Record review of Resident #1's progress notes, dated 06/20/2025, reflected RN X documented This nurse was called by an Aide that resident was on the floor. Resident was lying next to his recliner and bed. Resident said he was trying to use the bathroom. Resident was lifted off the floor with a Hoyer lift. Resident sustained a skin tear on his right elbow. Site was cleaned and covered with border dressing. Resident assessed and his vital signs were normal. DON, family, and NP were notified. Record review of Resident #1's progress notes, dated 06/22/2025, reflected RN C documented nurse was called to resident room and observed resident on the floor next to the bed, resident is alert and able to response to verbal commands, disorientation also noted, head to toe assessment done at this time, laceration of about 1 cm x 0.5 cm noted right side of the head, extensive bruising from his right shoulder to right lower back vital</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #4) of eight residents observed for infection control. Based on observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #4) of eight residents observed for infection control. The facility failed to ensure that CNA E changed gloves and performed hand hygiene while providing incontinent care to Resident #4. These failures could place the residents at risk of cross-contamination and development of infections. Findings included: Review of Resident #4's Face Sheet, dated 06/27/2025, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #4 had diagnoses which included dependence on renal dialysis (medical treatment required when kidneys no longer function), unspecified dementia (decline in cognitive function that interferes with daily life), and type 2 diabetes (body does not use insulin effectively causing blood sugar levels to rise). Review of Resident #4's Quarterly MDS Assessment, dated 05/19/2025, reflected severely impaired cognition with a BIMS score of 03. The MDS Assessment indicated Resident #4 was incontinent of bowel and bladder and dependent on staff for self-care needs. Review of Resident #4's Comprehensive Care Plan, dated 08/28/2024, reflected Resident #4 was at risk for altered skin integrity related to end stage kidney disease and diabetes. One of the interventions was to ensure appropriate incontinent care was provided after each episode of incontinence. An observation and interview on 06/26/2025 at 2:45 PM, revealed CNA E and the Hospitality Aide were preparing to provide incontinent care for Resident #4. Incontinence care items were placed on a drape on Resident #4's bedside table. CNA E and the Hospitality Aide used hand sanitizer and put on gloves. CNA E pulled down the front of Resident #4's brief. The Hospitality Aide handed CNA E wipes and CNA E used a single wipe with each pass while cleaning Resident #4 and dropped the wipes into a trash bag. CNA E removed her gloves, used hand sanitizer, and put on clean gloves. The Hospitality Aide assisted CNA E to turn Resident #4 on her right side. The Hospitality Aide provided wipes to CNA E and she cleaned Resident #4's bottom. CNA E dropped the soiled brief in the trash bag. CNA E placed a clean brief under Resident #4. The Hospitality Aide squeezed barrier cream from a tube on CNA E's gloved right hand. CNA E placed her left hand on Resident #4's hip and used her right hand to apply cream to the resident's bottom. CNA E used her left hand to remove the glove from her right hand. The Hospitality Aide put hand sanitizer on CNA E's right hand from a bottle on the bedside table. CNA E rubbed her hands together to clean the ungloved right hand and gloved left hand and the Hospitality Aide put barrier cream on CNA E's right hand. She placed her left hand on Resident #4's hip and used her right hand to apply barrier cream to other side of the resident's bottom. The Hospitality Aide assisted the Resident #4 to roll on her back. CNA E removed both gloves and used hand sanitizer before putting on clean gloves. The Hospitality Aide put barrier cream on CNA E's right hand. CNA E pulled down the brief in the front and applied barrier cream on one side. She removed the right glove and the Hospitality Aide put hand sanitizer on CNA E's right hand. She rubbed her hands together to clean the ungloved right hand and gloved left hand. The Hospitality Aide put barrier cream on CNA E's right hand and she applied it to the other side. CNA E removed her gloves, used hand sanitizer, and applied clean gloves. She secured Resident #4's brief in the front and pulled up the sheet to cover the resident. The Hospitality Aide and CNA E washed their hands in the resident's restroom before exiting the room. CNA E stated she had been a CNA for 18 years. She stated maybe she could have put a second glove on her right hand and removed it before applying more barrier cream. CNA E then stated she should have removed both gloves and used hand sanitizer before putting on clean gloves. She stated the facility provided in-services on incontinence care and they had one the previous week. CNA E stated it was important to hand wash or use hand sanitizer after removing gloves to prevent the spread of germs. CNA E stated not doing that could cause the resident to get an infection. During an interview on 06/26/2025 at 3:15 PM, ADON A stated it was not appropriate for CNA E to use hand sanitizer to clean her gloved hand. She stated that broke the infection control chain. ADON A stated staff must remove the gloves and clean their hands. ADON A stated she would talk to CNA E about it. During an interview on 06/26/2025 at 4:01 PM, UN V F stated CNA E should not have used hand sanitizer to</p>		