| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675939 | A. Building<br>B. Wing | 11/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Vintage Health Care Center | 205 N Bonnie Brae<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>(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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #2) of eight residents reviewed for respiratory care. The facility failed to ensure Resident #2's breathing mask (medical device used to deliver medication in a form of mist) was stored properly when not in use on 10/08/2025. This failure could place residents at risk for respiratory infection and not having their respiratory needs met.Findings included: Record review of Resident #2's Face Sheet, dated 10/08/2025, reflected a [AGE] year-old male 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 #2's Quarterly MDS Assessment (assessment used to determine functional capabilities and health needs), dated 09/24/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 15. The Quarterly MDS Assessment indicated the resident had chronic obstructive pulmonary disease. Record review of Resident #2's Comprehensive Care Plan, dated 10/08/2025, reflected the resident had chronic obstructive pulmonary disease and one of the interventions was give aerosol (substance released in fine mist) or bronchodilators (medication that caused widening of the air passages) as ordered. Record review of Resident #2's Physician's Order, dated 06/13/2025, reflected Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 milliliter inhale orally every 6 hours as needed for SOB or Wheezing via nebulizer. During an observation and interview on 10/08/2025 at 8:47 AM revealed Resident #2 was in his bed, awake. It was observed that a nebulizer was on top of the resident's shelf with a breathing mask connected to it. The breathing mask was not bagged. The resident said he would have the breathing treatment if he was having shortness of breath. He said nurses would give it to him and would come back to take it off. When asked when was the last time he had the breathing treatment, the resident said he could not remember. During an observation and interview on 10/08/2025 at 9:17 AM, LVN D stated if the resident was not using the breathing mask, it should be inside a clean plastic bag to ensure cleanliness for the next use. She said she did not notice that Resident #2's breathing mask was not bagged when she did her morning round. She said did not know when was the last time the resident used the breathing mask and said, if she was not mistaken, the order for his breathing treatment was if needed. She went inside the resident's room and disconnected the breathing mask and said she would get another breathing mask and would put it in a bag. She said she was one of the responsible in ensuring the breathing mask was bagged. In an interview on 10/08/2025 at 11:35 AM, ADON A stated the breathing mask should be stored properly to prevent cross contamination and respiratory infections. He said whoever administered the breathing treatment was responsible for cleaning it and storing it in a plastic bag. He said the expectation was for the staff to bag the breathing mask to when not in use. He said she would coordinate with the DON to do an in-service about bagging the breathing mask. In an interview on 10/08/2025 at 12:18 PM, the DON stated the breathing mask should be bagged when not in use to prevent any respiratory infection. She said the staff that administer the breathing treatment should have place it inside a bag after the breathing treatment. she said the expectation was for the breathing mask be bagged when not in use and for the staff to scan the rooms to see a breathing mask was not bagged so they could change it. She said it was her responsibility to check if the staff were compliant in bagging the breathing mask. She said she would start an in-service about bagging the breathing mask when not in use. In an interview on 10/08/2025 at 1:01 PM, the Administrator stated the expectation was for the staff to bag the breathing mask when not in use to prevent respiratory issues. He said he would coordinate with the DON to re-educate the staff about bagging the breathing mask when not in use. Policy specific to bagging the breathing mask requested verbally to the Administrator on 10/08/2025 at 1:01 PM but was not provided prior to exit. Record review of the facility's policy entitled Oxygen Administration Nursing Policy & Procedure Manual 2003, undated, reflected Goals . 1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen . 3. The resident will be free from infection |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to, in accordance with State and Federal laws, store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for four (Resident #1, #2, #3, and #4) of ten residents reviewed for medication storage. 1. The facility failed to ensure zinc oxide (medicated cream used to prevent skin irritation) was not left inside the Resident #1's room on 10/08/2025. 2. The facility failed to ensure zinc oxide was not left inside the Resident #4's room on 10/08/2025. 3. The facility failed to ensure a vial of solution used for breathing treatment was not left inside Resident #2's room on 10/08/2025. 4. The facility failed to ensure a tube of topical pain reliever was not inside Resident #3's room on 10/08/2025. These failures could place residents at risk of misuse of medications that could lead to overdosing or underdosing. Findings included: 1. Record review of Resident #1's Face Sheet, dated 10/08/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body). Record review of Resident #1's Comprehensive MDS Assessment, dated 09/15/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated the resident had dementia and was incontinent for bladder and bowel. Record review of Resident #1's Comprehensive Care Plan, dated 08/25/2025, reflected the resident had incontinence and one of the interventions was to apply barrier cream after each incontinent episode. Record review of Resident #1' Physician Order, dated 10/09/2024, reflected May apply barrier cream as needed every shift. During an observation and interview on 10/08/2025 at 8:44 AM revealed Resident #1 was in his bed, awake. It was observed that there was a cup of cream on top of the resident's drawer. The cup of cream was visible from the hallway. The resident said the cream was applied to his bottom. He said the staff would usually leave it on top of his drawer or sometimes on top of his side table. 2. Record review of Resident #4's Face Sheet, dated 10/08/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with obesity (excessive accumulation of body fats). Record review of Resident #4's Quarterly MDS Assessment, dated 08/08/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Quarterly MDS Assessment indicated the resident was incontinent for bladder and bowel. Record review of Resident #4's Care Plan, dated 09/10/2025, reflected the resident reflected the resident was incontinent and one of the interventions was to apply barrier cream after every incontinent episode. Record review of Resident #4's Physician Order, dated 01/07/2024, reflected Barrier Cream of facility choice QID and PRN to prevent skin breakdown . four times a day for preventive care. During an observation and interview on 10/08/2025 at 8:56 AM revealed Resident #4 was in her bed awake. It was observed that a cup of cream was on top of her side table. the resident said the cream was used after incontinent care. She said she did not know who left the cream on her side table. During an observation and interview on 10/08/2025 at 9:07 AM, CNA B stated the cream inside the cups were zinc oxide used during incontinent care. She said it should not be left inside the rooms of the residents because they were medicated creams and confused residents might get hold of them and eat them. She said the resident might be allergic to the cream or might give them stomach issue. She went inside the Resident #1's room and took the cup of cream from the top of the drawer. She said Resident #4 was not assigned to her but she would also get the cup of zinc oxide from her room. She went inside Resident #4's room and took the cup of zinc oxide from the Resident #4's side table. She said she the cups of zinc oxide should be thrown away after incontinent care was done or should not be left inside the residents' rooms for use later. She said she did not know who left the cups of zinc oxide inside the residents' rooms and she did not notice it when she did her round. She said she would check the rooms of the residents and would also tell CNA C to check also the rooms assigned to her for any zinc oxides inside the room so the residents. In an interview on 10/08/2025 at 9:12 AM, CNA C stated CNA B already told her about the zinc oxide on Resident #4's side table. She said zinc oxide should not be left inside the rooms of the residents because the residents might though it was lotion and apply it to their face. She said it might cause irritation of the eyes. She said she would just finish cleaning a resident and then she would check the rooms assigned to her for any zinc oxide. She said she did not notice it when she did her round. 3. Record review of Resident #2's Face Sheet, dated 10/08/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed |