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	04/22/2026

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident had the right to be treated with respect and dignity for 2 of 4 residents (Resident #3 and #6) reviewed for dignity.Med Aide G was observed standing over Resident #1 feeding her while the resident was sitting in his wheelchair and not at eye level.The facility failed to ensure Resident #6's indwelling urinary catheter bag had a dignity/privacy bag/screen on 04/22/26.These failure could place residents at risk of not feeling not treated with dignity, privacy, and respect.Findings include:Record review of Resident #3's Face Sheet, dated 04/22/26, reflected a [AGE] year-old male admitted [DATE], diagnosis included difficulty swallowing.Record review of Resident #3's Quarterly MDS assessment, dated 04/19/26, reflected a BIMS score of 00 (severe cognitive impairment). The resident had an active diagnosis of difficulty swallowing. Record review of Resident #3's Comprehensive Care Plan, dated 04/17/26, reflected the resident had a nutritional problem; however, there was no intervention indicating the resident required assisted feeding. During an observation on 04/22/26 at 12:50 p.m., Medication Aide G was observed in the dining room feeding Resident #3 while he was sitting in his wheelchair. Medication Aide G was standing over him while feeding him and not sitting down at eye level of the resident.During an interview and observation on 04/22/26 at 12:51 p.m., LVN S and LVN E were observed watching Medication Aide G standing over Resident #3 while feeding him. They stated the medication aide was new and still in training. They stated the Med Aide should be sitting down at eye level feeding the resident. They stated it was a dignity issue and to ensure the residents did not choke. LVN S went over to Med Aide G and instructed her to sit down and feed the resident. During an interview on 04/22/26 at 1:00 p.m., the DON and ADON J were informed by the Investigator of Medication Aide G standing over Resident #3 while she was feeding him. They stated staff were to sit at eye level with the resident when feeding the resident. They stated it was for the residents' dignity and to ensure they did not choke.During an interview on 04/22/26 at 1:50 p.m., Medication Tech G stated she knew she should be sitting down when feeding Resident #3, but she was trying to monitor the entire dining area to ensure other residents did not choke. She stated they were to sit down at eye level to feed the resident but thought it was okay to stand.Record review of Resident #6's Face Sheet, dated 04/22/26, revealed she was an [AGE] year-old female admitted [DATE]. Diagnoses included Acute Kidney Failure (a sudden, temporary loss of kidney function, often occurring within hours or days), Fracture of left Femur (a broken or cracked bone in the left thighbone).Record review of Resident #6's active physician order, dated 04/16/26, revealed orders for Indwelling urinary catheter (a soft, flexible, hollow tube that is inserted into the bladder through the urethra to drain urine into a collection bag) 16 French (size of Foley catheter) with 5 ml bulb - change for occlusion, leaking, closed system was compromised Change foley catheter on the 15th of each month as Needed and Ensure foley bag is in privacy bag while in bed or wheelchair every shift.Record review of Resident #6's active care plan revealed no care plan problem goals, or intervention related to the resident's Indwelling urinary care. Record review of Resident #6's Quarterly MDS assessment, dated 04/03/26, reflected a BIMS score of 00 (severe cognitive impairment). Resident #6's diagnoses (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included Acute Kidney Failure (a sudden, temporary loss of kidney function, often occurring within hours or days), Fracture of left Femur (a broken or cracked bone in the left thighbone).During an observation on 04/22/26 at 9:05 a.m., Resident #6 was observed lying in bed, her catheter bag could be observed from the hallway hanging from her bed, and no privacy bag was covering it.During an interview and on 04/22/26 at 1:00 p.m,. LVN E stated the resident should have a privacy bag to always cover the catheter drainage bag as ordered by the physician. She stated it was the nursing staff's responsibility to ensure the resident had a privacy bag. She stated that the purpose of the privacy bag was to maintain the resident's dignity and privacy. She stated the risk of not having the drainage bag covered was a loss of dignity and self-respect for the residents. During an interview on 04/22/26 at 1:13 p.m., ADON K stated the resident should always have a privacy bag for her Foley catheter drainage bag, he stated they usually provide 2 privacy covers, one for when the resident was in bed and one for when they were out of bed. He stated that the purpose of the privacy covers were to maintain privacy of treatment and dignity. He stated that the risk of not having a privacy bag could result in a loss of dignity.During an interview on 04/22/26 at 1:23 p.m., h CNA U stated the foley catheter privacy bag should always be on. CNA U stated, I would be embarrassed if someone is looking at my urine. She stated that not having a privacy cover could result in a loss of dignity for the residents. During an interview on 04/22/26 at 1:45 p.m., the DON stated that the foley catheter drainage bag should be in place at all times, she stated it was the responsibility of all nursing staff to make sure that they are always in place. She stated that not having the privacy cover on will result in a loss of dignity and privacy violation. Record review of the facility's policy titled, Resident Rights, dated 07/13/2017, revealed, As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States. As a resident of this nursing facility, you have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. You have the right to exercise your rights without interference, coercion, discrimination, or reprisal from the facility as a resident of the facility and as a citizen or resident of the United States. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. Privacy and confidentiality - The resident has a right to personal privacy and confidentiality of his or her personal and medicalrecords.1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.2. The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is,spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and otherletters, packages and other materials delivered to the facility for the resident, including those delivered through a means otherthan a postal service.3. The resident has a right to secure and confidential personal and medical records.a. The resident has the right to refuse the release of personal and medical records except as provided at S483.70(i)(2)or other applicable federal or state laws.b. The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine aresident's medical, social, and administrative records in accordance with State law.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right for residents to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for four (Resident #4, #7, #9, and #10) of ten residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #4, #7, #9, and #10's room were in a position that was accessible to the resident on 04/22/2026.This failure could place the residents at risk of not obtaining assistance when needed and help in the event of an emergency.Findings include: Record review of Resident #4's Face Sheet, dated 04/22/26, reflected an [AGE] year-old female, admitted [DATE]. Resident #2 was diagnosed with fractures of the ribs, neck, and femur. Record review of Resident #4's MDS Assessment, dated 3/27/26, reflected the resident had a BIMS of 7, indicating severe cognitive impairment. The resident had an active diagnosis of fractures of the neck, and femur. The resident's ADL indicated she received maximum assistance with toileting and showering care. Record review of Resident #4's Comprehensive Care Plan, dated 10/01/25, reflected the resident was a fall risk and an intervention was to ensure call light was within reach.During an observation and interview on 04/22/26 at 11:30 a.m., Resident #4 was observed lying in bed and her call light was on the floor near the nightstand. Resident #4 stated she needed help with repositioning herself but did not know where her call light was. During an observation and interview on 04/22/26 at 11:33 a.m., CNA T observed Resident #4's call light lying on the floor and out of the resident's reach. She stated the resident needed the call light to be within her reach so she could call for help. During an interview on 04/22/26 at 12:06 a.m., LVN E was informed by the Investigator of Resident #4's call light being out of reach and her fall mat not placed alongside her bed. She stated the resident's call light needed to be within reach to contact someone for help and the resident should have a fall mat placed alongside her bed because she was a fall risk. She stated staff should be checking for this when making rounds. Record review of Resident #7's Face Sheet, dated 04/22/26, revealed a [AGE] year-old female who was admitted [DATE]. Diagnoses included Vascular Dementia (a decline in thinking, memory, and behavior caused by conditions that block or reduce blood flow to the brain, depriving brain cells of oxygen and nutrients) and repeated falls.Record review of Resident #7's active care plan, dated 03/05/26, revealed the resident was at risk for falls with intervention to 1) Be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, 2) the resident needs a safe environment with: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach).Record review of Resident #7's Quarterly MDS assessment, dated 03/09/26, revealed the resident had repeated falls prior to admission in the last month. Record review of Resident #9's Face Sheet, dated 04/22/26, revealed a [AGE] year-old female admitted [DATE]. Diagnoses included legal blindness, as defined in the USA and Generalized Anxiety Disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry or fear that interferes with daily life).Record review of Resident #9's care plan dated 04/08/26 revealed the resident was a risk for falls with intervention to 1) Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, 2) the resident needs a safe environment with: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach).Record review of Resident #9's Quarterly MDS assessment, dated 04/02/26, revealed no fall diagnosis nor did the resident have an application for fall intervention.Record review of Resident #10's Face Sheet, dated 04/22/26, revealed a [AGE] year-old female, admitted [DATE]. Diagnosis included Lack of coordination (The inability of different parts of a system or body to work together effectively), difficulty walking, anxiety disorder.Record review of Resident #10's active care plan dated 03/10/26 revealed the resident is a risk for falls with (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intervention to 1) Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, 2) the resident needs a safe environment with: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach).Record review of Resident #10's Quarterly MDS assessment, dated 03/04/26, revealed the resident has had no falls prior to admission to the facility.During an observation on 04/22/26 at 9:07 a.m., Resident #7 was observed lying in her bed. The resident call light was observed on the floor lying on the left side of her nightstand and out of her reach.During an observation on 04/22/26 at 9:07 a.m., Resident #9 was observed lying in her bed. The resident call light was observed on the floor lying behind the headboard and out of her reach.During an observation on 04/22/26 at 9:07 a.m., Resident #10's resident call light was observed on the floor next to her bed and out of her reach.During an interview on 04/22/26 at 1:00 p.m., LVN E stated the call light should be within reach of every resident and readily available for them to call for help. She stated that the risk of not having the call bell within reach was falls. LVN E stated the resident may not be able to call for hydration and help to the restroom when neededDuring an interview on 04/22/26 at 1:13 p.m., ADON K stated the call bell should be within reach whether the resident was in bed or in the wheelchair. He stated that all staff were responsible for making sure the call bell was within reach of all residents. He stated that since the residents were dependent on staff it could place them at risk of not receiving needed care.During an interview on 04/22/26 at 1:23 p.m., CNA U stated that the call bell should always be within reach for all residents and should be responded as soon as possible when the resident calls. She stated that the risk of not having the call bell within reach is possible falls and the residents need not being met in a timely manner. During an interview on 04/22/26 at 1:45 p.m., CNA V stated that the call bell should always be within reach, and that all staff should make sure it is within reach before leaving residents' room. She stated that the risk of not having the call bell within reach could result in falls, and inability to get to the in a timely manner. She also stated that if the residents are unable to reach the call bell, they could get upset and start yelling leading to behaviors that could also upset other residents. During an interview on 04/22/26 at 3:42 p.m., the DON stated the call bell should be withing reach of every resident per the facility policy. She stated that all staff was responsible for making sure that the call bells are within reach of every resident. She stated that the risk of not having the call bell within reach of the resident could result in a fall and possible injury. Review of the facility's policy on Call Light/Bell (08/03/21) revealed It is the policy of this facility to provide the resident a means of communication with nursing staff. 5. Leave the resident comfortable. Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor.

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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** Based on interviews, and record reviews the facility failed to ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 8 residents (Resident #5) reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #5 received her scheduled showers since admission on [DATE]. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self- esteem.Findings include: Record review of Resident #5's Face Sheet, dated 04/22/26, reflected a [AGE] year-old female admitted [DATE]. Resident #5 had a diagnosis of morbid obesity. Record review of Resident #5's MDS Assessment, dated 3/28/26, reflected the resident had a BIMS score of 13, which was an intact cognitive response. The MDS Assessment reflected the resident had active diagnosis of morbid obesity. The resident required maximum assistance for ADL care. Record review of Resident #5's Comprehensive Care Plan, dated 3/27/26, reflected the resident had an ADL self-care deficit and the resident was totally dependent on staff to provide ADL care. There was no mentioning of the resident refusing showers.Record review of Resident #5's Progress notes from 03/26/26 to 04/22/26 reflected no documentation of resident refusing showers.Record review of Residents' shower sheets for March 2026 to April 2026 revealed no shower sheets on file for Resident #5.During an interview on 04/22/26 at 12:21 p.m., Resident #5 stated she had been at the facility for a month and had only had one shower and one bed bath. She stated she had never refused a shower and would prefer a shower rather than a bed bath. Resident #5 stated staff always told her there was an issue with the Hoyer lift. She stated she could not recall when she received a shower and she stated she received a bed bath this past weekend. She stated she really wanted her hair washed. During an interview on 04/22/26 at 12:30 p.m., LVN B stated Resident #5 had just moved to the south hall last week. He stated he was not familiar with the resident. He was informed by the Investigator that the resident stated she had only received one shower and one bath since being at the facility. He stated the resident should have a shower sheet completed each time she received a shower and if she refused, the floor nurse should attempt to persuade the resident to shower.During an interview on 04/22/26 at 1:00 p.m., the DON and ADON J were informed by the Investigator of Resident #5 stating she had only received one shower and one bed bath since being admitted to the facility on [DATE]. They stated the resident was scheduled to receive her showers on Tuesday, Thursday, and Saturdays by the evening CNA. They stated the CNAs were to complete shower sheets for each resident and the sheets were to be signed off by the charge nurse. The DON stated if the resident refused a shower, the nurse was to attempt to persuade the resident to take a shower, and if they still refused, they were to contact the RP and attempt to encourage them to take a shower. They stated if the resident did not receive their shower it could cause skin breakdown.During an interview on 04/22/26 at 2:00 p.m., CNA S stated he provided the resident with a bed bath on 04/18/24. He stated he completed a shower sheet but did not give it to the charge nurse. He stated he had just placed it in a basket. He stated he and his co-worker had trouble using the Hoyer lift because the shower chair was too small, and the resident was not comfortable with the transfer. He stated this was the first time he provided a bed bath or shower to the resident and did not know why she had not received her showers. He stated the risk of the resident not getting her showers could result in an infection. Record review of the facility's policy on Bath, Tub/Shower, undated , revealed, Bathing by tub or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body order promote comfort, cleanliness, circulation, and relaxation. A medicated tub bath can also be provided to treat skin conditions. The aging skin becomes dry, wrinkled, thinner, and blemished with various aging spots over time and is easily affected by environmental temperature and humidity, sun exposure, soaps, and clothing fabrics. The frequency and type of bathing depends on resident preference, ski condition , tolerance, and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	energy level. Although the daily bath or shower is preferred nd necessary for some , the aging skin can be maintained by bathing every wo days or with partial bathing as needed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents' environment remained as free of hazards as was possible for one of six residents (Resident #4) reviewed for accident hazards. The facility failed to ensure Resident #4 had fall mat placed alongside her bed for fall prevention. This failure could place residents at risk for potential injury. Findings included: Record review of Resident #4's Face Sheet, dated 04/22/26, reflected an [AGE] year-old female, admitted [DATE]. Resident #2 was diagnosed with fractures of the ribs, neck, and femur. Record review of Resident #4's MDS Assessment, dated 3/27/26, reflected the resident had a BIMS of 7, indicating severe cognitive impairment. The resident had an active diagnosis of fractures of the neck, and femur. The resident's ADL indicated she received maximum assistance with toileting and showering care. Record review of Resident #4's Comprehensive Care Plan, dated 10/01/25, reflected the resident was a fall risk and an intervention was to utilize the fall mat to provide cushion to landing area. During an observation on 04/22/26 at 11:30 a.m., Resident #4 was observed lying in bed and the resident's fall mat was leaning against a wall and not placed alongside the resident's bed.During an observation and interview on 04/22/26 at 11:33 a.m., CNA T observed Resident #4's fall mat leaning against the wall and not placed alongside the resident's bed. She stated the resident was a fall risk and should have her bed in a low position with the fall mat placed alongside her bed. She stated if the resident fell out of bed, the low bed and fall mat would limit her injuring herself. During an interview on 04/22/26 at 12:06 a.m., LVN E was informed by the Investigator of Resident #4's fall mat not placed alongside her bed. She stated the resident should have a fall mat placed alongside her bed because she was a fall risk. She stated the resident's bed was to be in a low position and fall mat in place to prevent the resident from having a severe injury if she fell out of bed. She stated staff should be checking for this when making rounds.During an interview on 04/22/26 at 1:00 p.m., the DON and ADON J was informed by the Investigator of Resident #4's fall mat not placed alongside her bed. They stated the resident was a fall risk and an intervention was to have a fall mat placed alongside her bed. They stated staff were responsible for checking to ensure the resident area was setup for fall prevention when she is in bed. Record review of the facility's policy titled, Resident Rights, dated 02/21, reflected Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existence;b. be treated with respect, kindness, and dignity;c. be free from abuse, neglect, misappropriation of property, and exploitation;d. be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, 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 three of twelve (Resident #1, #2, and #6) reviewed for respiratory care. The facility failed to ensure Resident #1 had his nebulizer mask bagged when not in use on 04/22/26. The facility failed to ensure Resident #2's nasal cannula was bagged when not in use on 04/22/26.The facility failed to ensure Resident #2 had physician orders for use of the oxygen concentrator. The facility failed to ensure Resident #6's nasal canula was properly stored in a bag when not in use on 04/22/26 These failures could place residents at risk of respiratory infection, respiratory complications, and not having their respiratory needs met.Findings include: Record review of Resident #1's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old male admitted [DATE]. The resident was diagnosed with congestive heart failure.Record review of Resident #1's Comprehensive MDS Assessment, dated 4/17/26, reflected Resident #1 had a BIMS score of 14 indicating intact cognition. The Comprehensive MDS Assessment indicated the resident had an active diagnosis of acute respiratory failure (lack of oxygen).Record review of Resident #1's Physician Order, dated 04/22/26, reflected no physician orders for the use of the nebulizer device. During an interview and observation on 04/22/26 at 8:59 a.m., Resident #1 was lying in bed, and his nebulizer mask was on top of the nightstand unbagged. He stated he had not used the nebulizer since last night.Record review of Resident #2's Face Sheet, dated 04/22/2026, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with congestive heart failure and COPD (difficulty breathing).Record review of Resident #2's Comprehensive MDS Assessment, dated 4/13/26, reflected Resident #2 had a BIMS score of 15, indicating intact cognition. The Comprehensive MDS Assessment indicated Resident #2 had an active diagnosis of acute respiratory failure and COPD.Record review of Resident #2's Physician Order, dated 04/22/26, reflected no physician orders for the use of the oxygen device. During an interview and observation on 04/22/26 at 9:00 a.m., Resident #2 was lying in bed with the nasal cannula for the oxygen concentrator on the floor and unbagged. Resident #2 stated she had complications with the nasal cannula a few days ago because it had gotten fluid on it and it was hurting her nose Resident #2 stated she was trying to get the nasal cannula replaced but staff had not responded to her yet. Resident #2 stated she had not used it for a few days and really needed it to help with breathing.During an interview and observation on 04/22/26 at 9:05 a.m., LVN E went to Resident #1's and Resident #2's room and observed the breathing devices unbagged. LVN E stated they needed to be bagged to avoid the residents getting an infection.During an interview on 04/22/26 at 1:00 p.m., the DON and ADON J were informed by the Investigator of Resident #1 and Resident #2 breathing devices being unbagged. They stated it was everyone's responsibility to ensure the breathing devices were bagged when not in use. They stated not bagging the devices could result in the residents getting an infection. During an interview on 04/22/26 at 2:05 p.m., ADON J was informed by the Investigator of Resident #2 not having an active physician order for use of an oxygen concentrator until after LVN [NAME] was interviewed about the resident's nasal cannula being unbagged. She stated the resident should have had physician orders because it was a form of medication provided to the resident.During an interview on 04/22/26 at 2:10 p.m., the DON was informed by the Investigator of Resident #2 not having physician orders for oxygen use until 04/22/26. She stated the resident should have had physician orders for the use of oxygen because it was medication being administered to the resident. She stated the admitting charge nurse should check for orders.During an interview on 04/22/26 at 2:30 p.m., LVN E was informed by the Investigator of Resident #2 not having physician orders for the use of the Oxygen concentrator until 04/22/26. She stated she checked the resident's physician orders and realized the resident did not have orders. She stated she was able to contact the physician (continued on next page)

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	04/22/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and get orders for the resident. She stated orders were needed for the resident because it was needed to treat the resident.Record review of Resident #6's Face Sheet, dated 04/22/26, revealed she was an [AGE] year-old female admitted [DATE]. Resident #6 diagnoses included Acute Kidney Failure (a sudden, temporary loss of kidney function, often occurring within hours or days) and Fracture of left Femur (a broken or cracked bone in the left thighbone).Record review of Resident #6's active physician order, dated 04/16/26, did not reveal an order for oxygen use or care.Record review of Resident #6's active care plan, dated 03/05/26, revealed a diagnosis of COPD with intervention to give oxygen therapy as ordered by the physician.Record review of Resident #6's Quarterly MDS assessment, dated 04/03/26, reflected a BIMS score of 00 (severe cognitive impairment). Resident #6's diagnosis included COPD. During an observation on 04/22/26 at 9:05 a.m., Resident #6's nasal cannula was lying on the floor unbagged.During an interview on 04/22/26 at 1:00 p.m., LVN E stated all oxygen nasal cannulas should be bagged when not in use. She stated all staff were responsible for making sure the nasal cannulas were bagged when not in use. She stated not bagging the nasal cannulas could result in respiratory infection and possible respiratory distress.During an interview on 04/22/26 at 1:13 p.m., ADON K stated oxygen nasal cannulas should be always bagged when not in use. He stated the resident could develop a respiratory infection if the nasal cannulas were exposed and collects germs. During an interview on 04/22/26 at 1:23 p.m., CNA U stated oxygen nasal cannulas should always be bagged when not in use and every staff member was responsible for making sure it was bagged or reported to the charge nurse to bag it. She stated that if not bagged the resident could develop an infection if the nasal cannula was contaminated and used on the resident, bugs could possibly crawl into the nasal cannula, which would not be good for the resident. During an interview on 04/22/26 at 1:45 p.m., CNA V stated the nasal cannulas should be bagged when not in use. She stated not bagging the nasal cannula could result in cross contamination, infection, and possibly the resident tripping over the tubing.During an interview on 04/22/26 at 3:42 p.m., the DON stated the nasal cannula should be bagged when not in use per the facility policy. She stated the risk of not having the nasal cannula bagged was bacteria getting on it that could cause an infection. Record review of the facility's policy titled, Oxygen Administration, dated 02/13/07, reflected Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse. The nasal cannula delivers 22-40 % oxygen and is the most common, inexpensive, and easiest device to use. Common oxygen sources for long-term administration include cylinder (portable or stationary) or wall system near the resident=s bed or concentrator. All sources require humidification to prevent drying of mucous membranes and thickening of respiratory secretions if used routinely.