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	05/28/2026

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 - Some	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 interview and record review, the facility failed to ensure residents had the right to retain and use personal possessions for 4 (Resident #3, #5, #8 and #9) of 8 reviewed for personal property. The facility failed to allow Resident's #3, #5, #8 and #9 to exercise the right to retain and use personal possessions, including clothing. This failure could place residents at risk emotional distress, embarrassment, and lower self-esteem.Findings included: Record review of Resident #3's face sheet, dated 05/28/26, reflected a [AGE] year-old female that was admitted to the facility on [DATE]. Resident #3 had diagnoses that included: urinary tract infection (a bacterial infection in any part of the urinary system (kidneys, bladder, or urethra), tremor (an involuntary, rhythmic muscle contraction and relaxation that causes shaking or trembling movements), Alzheimer's disease (a progressive, irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to carry out simple tasks), sleep apnea (a common disorder where breathing repeatedly stops and starts during sleep), chronic pain, irritable bowel syndrome (a common, long-term functional gastrointestinal disorder, characterized by recurring abdominal pain, cramping, bloating, and changes in bowel habits like diarrhea, constipation, or both), pain in right shoulder, overactive bladder (a sudden, uncontrollable urge to urinate), abnormal uterine and vaginal bleeding (any bleeding that is heavier, lasts longer, occurs between periods, or happens after menopause). Record review of Resident #3's Quarterly MDS assessment, dated 04/08/26, reflected the resident had BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #3 needed setup or clean-up assistance with eating and was dependent on staff for toileting hygiene. There was no information provided for assistance with showering/bathing. Record review of Resident #3's care plan, initiated 10/13/25, reflected Resident #3 had an ADL self-care performance deficit. The interventions included: bathing: requires staff x1 for assistance, bed Mobility: requires staff x2 for assistance, discuss with resident/family care any concerns related to loss of independence, decline in function, dressing: required staff x1 for assistance, praise all efforts at self-care, PT/OT evaluation and treatment as per MD orders, the resident required a lift for all transfers, the resident used an electric wheelchair, toilet use: required staff x2 for assistance, transfer: the resident required 2 staff participation with transfers via the Hoyer lift, encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function, bathing: check nail length and trim and clean on bath day and as necessary, dressing: assist the resident to choose simple comfortable clothing that maximizes the resident's ability to dress self. Record review of Resident #5's face sheet, dated 05/28/26, reflected an [AGE] year-old female that admitted to the facility on [DATE]. Resident #5's had diagnoses that included: urinary tract infection (infection in any part of the urinary system), difficulty walking, lack of coordination and chronic pain. Record review of Resident #5's MDS assessment dated [DATE], reflected the resident had a BIMS score of 13, which indicated cognitively (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact. The MDS assessment under Section GG-Functional Abilities reflected Resident #5 needed substantial assistancewith toileting hygiene. The MDS assessment did not provide any information for the question regarding assistance with showering/bathing. Record review of Resident #5's care plan, revised on 09/10/25, reflected the resident had an ADL self-care performance deficiency.The interventions were that the resident required staff x1 for assistance with bathing, dressing and toilet use, staff x2 for assistance with bed mobility, supervision with eating, discuss with resident/family care any concerns related to loss of independence, decline in function, Praise all efforts at self-care, PT/OT evaluation and treatment as per MD orders, a lift for all transfers, use a wheelchair, encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, decline in function. Record review of Resident #8's face sheet, dated 05/28/26, reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #8 had diagnoses that included: acute respiratory failure with hypoxia (when the lungs cannot deliver enough oxygen to the blood), type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), chronic venous hypertension with ulcer of left and right lower extremity (a condition in which long-term elevated pressure in the veins of the lower extremities damages valves and vessel walls, leading to blood pooling, tissue damage, and often venous leg ulcers), sepsis due to methicillin resistant staphylococcus aureus (a life-threatening condition where antibiotic-resistant Staphylococcus aureus triggers a systemic inflammatory response, potentially leading to organ failure and death), congestive health failure, acute embolism and thrombosis of right internal jugular vein (he formation of a blood clot within the internal jugular vein, which is a major blood vessel in the neck responsible for draining blood from the brain), gastro-esophageal reflux disease without esophagitis (a common form of acid reflux where symptoms occur without visible esophageal damage), methicillin resistant staphylococcus aureus infection (a type of bacteria that causes skin infections and is resistant to many antibiotics, making it harder to treat), paralysis of vocal cords and larynx (when one or both vocal folds fail to move due to disrupted nerve signals to the larynx, leading to hoarseness, breathing difficulty, and swallowing problems), pleural effusion (abnormal accumulation of fluid in the pleural space around the lungs, which can impair breathing and requires treatment based on its cause), burns involving 50-59% of body surface with 20-29% third degree burns. Record review of Resident #8's MDS, dated [DATE], reflected a BIMS score of 14, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities Section GG-Functional Abilities reflected resident needed setup or clean-up assistance with eating, supervision with toileting hygiene and no other assistance with oral hygiene, showering/bathing, upper and lower body dressing, putting/taking off footwear or personal hygiene. Record review of Resident #9's face sheet, dated 05/28/26, reflected a [AGE] year-old female that was admitted to the facility on [DATE]. Resident #9 had diagnoses that included: multiple sclerosis (a chronic autoimmune disease that affects the central nervous system (brain, spinal cord, and optic nerves), paraplegia (partial or complete paralysis of the lower half of the body, including both legs), functional quadriplegia (the complete inability to move due to severe physical disability or frailty, completely independent of any physical injury or damage to the brain or spinal cord) weakness, difficulty walking, lack of coordination. Record review of Resident #9's Quarterly MDS assessment, dated 04/09/26, reflected the resident had a BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities reflected the resident was dependent on staff for toileting hygiene, sitting to standing, chair/bed-to-chair transfer, toilet transfer, substance assistance with sitting to lying, lying to sitting on side of bed and was independent with eating. The MDS assessment under Section GG-Functional Abilities Section GG-Functional Abilities also reflected oral hygiene, showering/bathing, upper and lower body dressing, personal hygiene, rolling left and right, tub/shower transfer and walking 10 feet were not applicable/not attempted. Record review of (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9's care plan, initiated 03/25/26, reflected the resident had an ADL self-care performance deficit. The interventions included: toilet use: require staff x2 for assistance, two person at all times during ADL care, dressing: the resident require (X2) staff participation to dress. Record review of Grievance Log, reflected Resident #8 filed a grievance on 05/18/26 for missing clothes. The grievance had no resolve date, but that laundry was notified and all items were returned. During an interview on 05/27/26 at 10:43AM, Resident #3 stated some of her clothes were stolen. Resident #3 stated she had also received other residents' clothes. Resident #3 stated her wheelchair was also broken by staff. Resident #3 stated her wheelchair could no longer turn on or move. Resident #3 stated her wheelchair was mishandled when staff were moving her belongings. Resident #3 also stated her TLC Roku television was broken. Resident #3 stated the facility had not replaced her television but put a Samsung tv that was not the same quality in her room. During an interview on 05/27/26 at 11:47 AM, LVN B stated some of the residents' clothes were missing. LVN B stated the residents had the names on the clothes, so she did not understand how laundry lost them. She stated some residents did not have clothes and staff had brought them in clothes. She stated laundry had an issue with losing residents' clothes and stated the names were not on them. LVN B stated she ensured she wrote residents' name on their personal items, so that was not the reason residents' personal items were lost. LVN B also stated residents' personal clothing that had been sent to laundry had gone missing. She stated residents' personal belongings should not be missing because she ensured to write the residents names and room number on them. During an interview on 05/27/26 at12:10 PM, CNA C stated she had a few residents on the memory care unit with clothes that were missing. CNA C stated the clothes went to laundry and did not return. She stated she could not remember if the names of the residents were on the clothes. During an interview on 05/27/26 at 12:42 PM, Housekeeping Supervisor stated the only way residents did not receive their personal items from laundry was if they did not have their name and room number on the clothing. She stated without the information, laundry did not know who it belonged to and put it in in the lost and found. During an interview on 05/27/26 at 3:01 PM, Resident #9 stated a lot of her clothes had gone missing. Resident #9 stated her favorite black shorts went missing approximately one month ago. Resident #9 stated two weeks ago, two pairs of gray shorts that she purchased from Amazon were missing. Resident #9 stated several of her underwear were missing. Resident #9 stated she had some washcloths that were missing. Resident #9 stated her name were on all her clothes that went missing. During an interview on 05/28/26 at 11:59 AM, Resident #5 stated she no longer sent her personal items to laundry because they have lost her items. Resident #5 stated laundry lost her hallmark quilt. Resident #5 stated laundry lost three sets of socks. She stated she had sent her personal items at the beginning of the week and at the end of the week it was not returned due to them losing it. Resident #5 stated as a result her family picked up her laundry and cleaned it. During an interview on 05/28/26 at 12:45 PM, Resident #8 stated several of his personal clothes had gone missing. He stated as of date, he had yet to receive his personal items that he sent to laundry during the week of 05/18/26 prior. Resident #8 stated he ensured to write his name on all his clothing and included a written note of all the items in the bag. Resident #8 stated he had a CNA to bring him to laundry to find his clothes when it was not returned to him. He stated he was about to find his clothes at that time. Review of the facility's policy, titled Resident Rights, no dated, reflected in part the following: Respect and dignity - The resident has a right to be treated with respect and dignity, including:1. The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.2. The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.4. The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the arrangement.5. The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.6. The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.7. The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:a. to relocate a resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, orb. to relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.c. solely for the convenience of staff.d. A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

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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** Based on observations, interviews, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 2 (Resident #1 and Resident #2) of 8 residents reviewed for call lights. The facility failed to ensure Resident #1 and Resident #2 had call lights within reach while in their beds on 05/27/2026. This failure could place residents at risk of being unable to obtain assistance or help when needed and in the event of an emergency. Findings included: Record review of Resident #1's face sheet, dated 05/28/26, reflected a [AGE] year-old female that was originally admitted to the facility on [DATE]. Resident #1 had diagnoses which included: legal blindness, lumbar spondylolysis (stress fracture or structural defect in the small bridge of bone connecting upper and lower joints of the lower back) and osteoarthritis (degenerative joint disease where the protective cartilage cushioning the ends of bones wear down over time). Record review of Resident #1's MDS assessment, dated 02/27/26, reflected the resident had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #1 was dependent on staff for personal hygiene, putting off footwear, lower body dressing, showering/bathing and toileting, sitting to lying, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfer and shower transfer. It further reflected the resident needed supervision with eating and rolling left and right. Resident #1 also used a manual wheelchair to get around. Record review of Resident #1's care plan, revised on 10/11/24, reflected the resident was at risk of falling due to a history of falls, daily use of antianxiety, antipsychotic and antidepressant medications, diuretic medications, blindness, cognitive loss and dementia, weakness from current dialysis treatments and need for staff assistance with ADL tasks. The interventions were to keep call light within reach of resident and tell her the location of the call light due to blindness, cue and encourage resident to use the call light for assistance. The care plan also revealed Resident #1 was at risk for the development of pressure ulcers due to need for staff assistance with toileting, transfers and bed mobility. The interventions were to encourage resident to use call light for assistance with toileting tasks and answer call light promptly. Record review of Resident #2's face sheet, dated 05/28/26, reflected a [AGE] year-old female that was originally admitted to the facility on [DATE]. Resident #2 had diagnoses which included: osteoarthritis (degenerative joint disease where the protective cartilage cushioning the ends of bones wear down over time), seizures, unsteadiness on feet, muscle wasting, difficulty walking, lack of coordination and rheumatoid arthritis (chronic autoimmune disorder when immune systems malfunctions and attacks the lining of the joints). Record review of Resident #2's MDS assessment dated [DATE], reflected the resident had a BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #2 needed supervision or touching assistance with eating, toileting, lying to sitting on side of bed, sitting to standing, chair/bed-to-chair transfer and toilet transfer. Resident #1 also used a manual wheelchair to get around. Record review of Resident #2's care plan, revised on 05/05/22, reflected the resident had the potential for falls related to medications, poor safety awareness, unsteady balance and cognitive deficit. The interventions were to anticipate and meet the resident's needs, place items frequently used by the resident within easy reach when in the room, place the resident's call light within reach and encourage the resident to use it for assistance as needed. The care plan also revealed Resident #2 had an ADL self-care performance deficit related to: activity intolerance, confusion, dementia, fatigue, an impaired balance at risk for decline in ADL function. The interventions also consisted of Resident #2's care plan also revealed the resident had a fall related to deconditioning (decline in physical function of the body). The interventions were to anticipate and meet the resident's needs, be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, call do not fall sign in bathroom. During an observation (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and interview on 05/27/26 at 2:41 PM, Resident #1 was observed lying in bed and her call light was wrapped around bedrail with the call button facing the floor. Resident #1 attempted to reach for the call light but was unsuccessful. Resident #1 stated she could not reach for her call button at the time. Resident #1 stated she needed help with all ADLs. During an observation and interview on 05/27/26 at 2:50 PM, Resident #2 was observed lying in bed and her call light on the floor behind her oxygen tank. Resident #2 stated she could not reach her call light because it was not near her. Resident #2 also stated she needed assistance with most of her ADLs. During an interview on 05/27/26 at 2:55 PM, LVN A was informed of Resident #1's and Resident #2's call lights being out of reach. LVN A checked and observed that the call lights for Resident #1 and Resident #2 were not within reach. He stated the residents' call lights needed to be within reach to call for help. He also stated staff should be checking for call light placement when making rounds. LVN A stated the risk were that the residents could not call for help. During an interview on 05/28/26 at 1:25 PM, CNA E stated she worked 6:00AM-2:00PM with four days on and two days off. CNA E stated she was the CNA working with Resident #1 and Resident #2 on 05/27/26. CNA E stated she forgot to place Resident #1's call light within reach. CNA E stated she had gotten distracted due to Resident #1's family member being in the room. CNA E stated she did not put Resident #2 in bed but was ultimately responsible for ensuring the call light was within reach. CNA E stated the risk with the call light not being within reach was the resident not being able to call for help. A policy on call lights was requested on 05/27/26. The Administrator stated the facility did not have a call light policy. Respect and dignity - The resident has a right to be treated with respect and dignity, including:The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide housekeeping services necessary to maintain a sanitary and comfortable interior for 3 (Resident #3, #7 and #9) of 8 resident's reviewed for environment. The facility failed to ensure there was clean bed linen at the time of residents' showers. The facility failed to change and provide clean bed linen for Resident #3 and Resident #7 on shower/bath days. The facility failed to provide clean bath towels for Resident #9 on shower days. This failure could affect any resident and place them at risk for not having clean linens which could lead to a decreased quality of life. Findings included: Record review of Resident #3's face sheet, dated 05/28/26, reflected a [AGE] year-old female that was admitted to the facility on [DATE]. Resident #3 had diagnoses that included: urinary tract infection (a bacterial infection in any part of the urinary system (kidneys, bladder, or urethra), tremor (an involuntary, rhythmic muscle contraction and relaxation that causes shaking or trembling movements), Alzheimer's disease (a progressive, irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to carry out simple tasks), sleep apnea (a common disorder where breathing repeatedly stops and starts during sleep), chronic pain, irritable bowel syndrome (a common, long-term functional gastrointestinal disorder, characterized by recurring abdominal pain, cramping, bloating, and changes in bowel habits like diarrhea, constipation, or both), pain in right shoulder, overactive bladder (a sudden, uncontrollable urge to urinate), abnormal uterine and vaginal bleeding (any bleeding that is heavier, lasts longer, occurs between periods, or happens after menopause). Record review of Resident #3's Quarterly MDS assessment, dated 04/08/26, reflected the resident had BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #3 needed setup or clean-up assistance with eating and was dependent on staff for toileting hygiene. There was no information provided for assistance with showering/bathing. Record review of Resident #3's care plan, initiated 10/13/25, reflected Resident #3 had an ADL self-care performance deficit. The interventions included: bathing: requires staff x1 for assistance, bed Mobility: requires staff x2 for assistance, discuss with resident/family/POA care any concerns related to loss of independence, decline in function, dressing: required staff x1 for assistance, praise all efforts at self-care, PT/OT evaluation and treatment as per MD orders, the resident required a lift for all transfers, the resident used an electric wheelchair, toilet use: required staff x2 for assistance, transfer: the resident required 2 staff participation with transfers via the mechanical lift, encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function, bathing: check nail length and trim and clean on bath day and as necessary, dressing: assist the resident to choose simple comfortable clothing that maximizes the resident's ability to dress self. Record review of Resident #7's face sheet, dated 05/28/26, reflected a [AGE] year-old male that was admitted to the facility on [DATE].Resident #7 had diagnoses that included: hemiplegia (complete paralysis) and hemiparesis (partial weakness or weakness) following cerebral infarction affecting left non-dominant side (damage occurred in the right hemisphere of the brain), muscle wasting, lack of coordination, restless legs syndrome, chronic pain syndrome, paraplegia (he partial or complete loss of motor and sensory function in the lower half of the body, including both legs, typically caused by spinal cord injury or disease), benign prostatic hyperplasia with lower urinary tract symptoms (non-cancerous enlargement of the prostate gland which lead to weak urine stream, frequent urination, nocturia, and urgency) and contracture of left and right knee. Record review of Resident #7's MDS assessment, dated 03/26/26, reflected the resident had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS assessment under (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section GG-Functional Abilities reflected no information documented for showering/bathing. It further reflected Resident #7 needed setup or clean-up assistance with eating, dependent on staff with toileting hygiene, sitting to lying, lying to sitting on side of bed, chair/bed-to-chair transfer. Resident #7 was not ambulatory and used a manual wheelchair. Record review of Resident #9's face sheet, dated 05/28/26, reflected a [AGE] year-old female that was admitted to the facility on [DATE]. Resident #9 had diagnoses that included: multiple sclerosis (a chronic autoimmune disease that affects the central nervous system (brain, spinal cord, and optic nerves), paraplegia (partial or complete paralysis of the lower half of the body, including both legs), functional quadriplegia (the complete inability to move due to severe physical disability or frailty, completely independent of any physical injury or damage to the brain or spinal cord) weakness, difficulty walking, lack of coordination. Record review of Resident #9's Quarterly MDS assessment, dated 04/09/26, reflected the resident had a BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities reflected the resident was dependent on staff for toileting hygiene, sitting to standing, chair/bed-to-chair transfer, toilet transfer, substance assistance with sitting to lying, lying to sitting on side of bed and was independent with eating. The MDS assessment under Section GG-Functional Abilities Section GG-Functional Abilities also reflected oral hygiene, showering/bathing, upper and lower body dressing, personal hygiene, rolling left and right, tub/shower transfer and walking 10 feet were not applicable/not attempted. Record review of Resident #9's care plan, initiated 03/25/26, reflected the resident had an ADL self-care performance deficit. The interventions included: toilet use: require staff x2 for assistance, two person at all times during ADL care, dressing: the resident required (X2) staff participation to dress. During an interview on 05/27/26 at 10:43 AM, Resident #3 stated her bed linens were not always changed on her shower days. She stated at times there were no clean bed linens available on her shower days. She also stated staff would leave dirty linen in her room. During an interview on 05/27/26 at 11:47 AM, LVN B stated she worked from 6:00AM-6:00PM. LVN B stated she worked the long-term hall (rooms 25-39) and the memory care unit. LVN B stated housekeeping had been slacking with the laundry. LVN B stated at times there were no clean linens from 6:00AM-11:00AM and would come out around 11:00AM-12:00PM. She stated there recently were days that there were no bed linens or bath towels on the halls. She stated at times linens were limited meaning they did not have enough for all residents. LVN B stated not having clean linens affected when residents would shower and caused their showers to be late or delayed. During an interview on 05/27/26 at 12:10 PM, CNA C stated she worked Monday-Friday from 6:00AM-2:00PM. CNA C stated she worked on the memory care unit. She stated sometimes tasks fell behind because there was no clean linen which made her showers/baths late. She stated they did not have clean linens for residents' bed and bath towels. CNA C stated residents' shower days were when bed linens were changed. CNA C stated often they did not receive clean linens by 11:00AM from housekeeping. CNA C stated CNAs were supposed to have residents' beds made by 10:00AM. She stated there had been times when the clean linen came it was at the end of her shift. She stated there had been times when residents did not receive their personal items back from laundry in a timely manner. CNA C stated it was 2-3 days before residents had their personal items returned from laundry. She stated it affected the residents with their baths if there was no clean linen. During an interview on 05/27/26 at 12:42 PM, Housekeeping Supervisor stated there had been issues with having clean linens available. The Housekeeping Supervisor stated the issue was that the CNAs were not returning the dirty linen in timely manner. She stated the nursing staff would drop dirty laundry at the end of their shifts making it hard for her staff to have it completed. The Housekeeping Supervisor also stated nursing staff had thrown away towels. She stated her laundry tech has had to go on the halls to find the barrels because they are not brought to laundry but nursing staff. The Housekeeping Supervisor stated she recently placed an order placed on 05/04/26 for more linens. The Housekeeping Supervisor stated there was no policy for laundry, but her expectations were to have the linen out by 8:00AM, 12:00PM and before leaving at 2:00PM. The Housekeeping (continued on next page)

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	675939	A. Building B. Wing	05/28/2026

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Supervisor stated the residents not having cleaned linens could affect their level of comfort. During an observation on 05/27/26 at 12:55 PM, there were linens in the storage. In the storage, there was one pack of pillowcases, one case of wash clothes, 3 packs of wash clothes, one case of sheets, two cases of flat sheets with a quantity of 10 in each, and two packs of dry towels with a quantity of 12 in each pack. During an interview on 05/27/26 at 1:52 PM, CNA D stated she worked 6:00AM-2:00PM on both north and south hall. CNA D stated at times there were no clean linens. CNA D stated on 05/26/26 she did not have clean linen until she got it 9:30AM. She stated laundry was supposed to bring the linens on the halls. CNA D stated she felt part of the issue was that some nursing staff hid the towels and did not take the barrels with dirty linen as quickly. She stated part of problem was that the CNAs waited until the barrels overfilled to bring them to laundry. CNA D stated the barrels should be brought to laundry prior to it overfilling. She stated not having clean linen caused the residents to wait longer for showers. During an interview on 05/27/26 at 3:01 PM, Resident #9 stated at times there had been no clean linen, and she was unable to take her shower. Resident #9 stated she has had to purchase towels to take her showers. During an interview on 05/28/26 at 12:36 PM, Resident #7 stated his bed sheets were not changed on his bath days. Resident #7 stated he preferred his sheets changed every time he was given a bath. Resident #7 stated if he was lucky, staff would change his linens on his bed once a week. During an interview on 05/28/26 at 1:25 PM, CNA E stated prior to the week of 05/25/26, there had been issues with receiving clean linen. CNA E stated she showered her residents after breakfast between 9:00AM-10:00AM. She stated at times she did not have clean towels when it was time to start her showers. CNA E stated sometimes she had to shower after lunch due to waiting on clean towels. She also stated she ran out of clean linen quickly and had to wait hours to get more. CNA E stated when they had to wait on linens, she would have to stay late to complete her residents' showers. CNA E stated some of the bed linen would be clean but not all. She stated the fitted sheets may have been cleaned but there were no clean flat sheets. CNA E stated her thoughts were nursing staff did not take the barrels down immediately to be cleaned or wait until end of shift to bring them. During an interview on 05/28/26 at 2:21 PM, CNA F stated she worked Monday-Friday on 2:00PM-10:00PM shift. CNA F stated there were times she came in for her shift and there were no clean linens. CNA F stated on 05/14/26 there was no laundry person, and the Housekeeping Supervisor left work, so there was no clean linen available. CNA F stated not having clean linen affected the residents with their showers. CNA F stated she had some residents that were heavy wetters, so she had to remove their linens but there were no clean linens available. During an interview on 05/28/26 at 5:20 PM, LVN A stated there had been issues with laundry. LVN A stated the linens were not always available when needed. LVN A stated there had been no clean towels when it was time for residents to shower. LVN A stated it delayed the residents' showers. During an interview on 05/28/26 at 6:20 PM, the DON stated there was an issue with linens about a month ago. The DON stated residents had delayed showers or bed baths due to waiting on clean linen to return from laundry. She stated the risk was that the residents were not able to be showered without clean linen. Record review of the facility's policy titled, Resident Rights, no date, reflected in part the following: Safe environment - The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide--A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;Clean bed and bath linens that are in good condition;Private closet space in each resident room, as specified Adequate and comfortable lighting levels in all areas;Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 F; andFor the maintenance of comfortable sound levels.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 5 (Resident #3, # 4, #5, #6 and #7) of 8 residents reviewed for ADL care provided to dependent residents. The facility failed to ensure Resident #3, Resident #4, Resident #5, Resident #6, Resident #7 received their scheduled showers. This failure could place residents at risk of not receiving necessary services to maintain good personal hygiene, skin integrity, or decreased self-esteem.Findings included: Record review of Resident #3's face sheet, dated 05/28/26, reflected a [AGE] year-old female that was admitted to the facility on [DATE]. Resident #3 had diagnoses that included: urinary tract infection (a bacterial infection in any part of the urinary system (kidneys, bladder, or urethra), tremor (an involuntary, rhythmic muscle contraction and relaxation that causes shaking or trembling movements), Alzheimer's disease (a progressive, irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to carry out simple tasks), sleep apnea (a common disorder where breathing repeatedly stops and starts during sleep), chronic pain, irritable bowel syndrome (a common, long-term functional gastrointestinal disorder, characterized by recurring abdominal pain, cramping, bloating, and changes in bowel habits like diarrhea, constipation, or both), pain in right shoulder, overactive bladder (a sudden, uncontrollable urge to urinate), abnormal uterine and vaginal bleeding (any bleeding that is heavier, lasts longer, occurs between periods, or happens after menopause). Record review of Resident #3's Quarterly MDS assessment, dated 04/08/26, reflected the resident had BIMS score of 15, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities, reflected Resident #3 needed setup or clean-up assistance with eating and was dependent on staff for toileting hygiene. The MDS assessment under Section GG-Functional Abilities there was no information provided for assistance with showering/bathing. Record review of Resident #3's care plan, initiated 10/13/25, reflected Resident #3 had an ADL self-care performance deficit. The interventions included: bathing: require staff x1 for assistance, bed Mobility: require staff x2 for assistance, discuss with resident/family care any concerns related to loss of independence, decline in function, dressing: require staff x1 for assistance, praise all efforts at self-care, PT/OT evaluation and treatment as per MD orders, the resident require a lift for all transfers, the resident used an electric wheelchair, toilet use: require staff x2 for assistance, transfer: the resident required 2 staff participation with transfers via the mechanical lift, encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, decline in function, bathing: check nail length and trim and clean on bath day and as necessary, dressing: assist the resident to choose simple comfortable clothing that maximizes the resident's ability to dress self. Record review of Resident #3's documented baths in PCC on 05/28/26, reflected the resident showers/baths were Tuesdays, Thursdays and Saturdays during 2:00PM-10:00PM shift. PCC documentation reflected no showers/baths for Resident #3 on 05/05/26 and 05/21/26 with no indication as to why it was not documented. Record review of Resident #4's face sheet, dated 05/28/26, reflected a [AGE] year-old male that was admitted to the facility on [DATE]. Resident #4 had diagnoses that included: orthopedic aftercare (focus on pain management, wound care, and controlled physical rehabilitation) and osteoarthritis (degenerative joint disease where the protective cartilage cushioning the ends of bones wear down over time). Record review of Resident #4's MDS assessment dated [DATE], reflected that the resident had a BIMS score of 05, which indicated severe cognitive impairment. The MDS assessment under Section GG-Functional Abilities, reflected Resident #4 was dependent on staff for personal hygiene, showering/bathing, oral hygiene, toileting, upper and lower body dressing, putting on/taking off (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	footwear. Record review of Resident #4's care plan, date initiated 04/28/26, reflected Resident #4 had an ADL self-care performance deficit. The interventions were that the resident required staff x1 for assistance with bathing, required staff x2 for assistance with bed mobility, required staff x1 for assistance with dressing, required staff x1 for assistance with eating, required staff x2 for assistance with toilet use, discuss with resident/family care any concerns related to loss of independence and decline in function, praise all efforts at self-care, PT/OT evaluation and treatment as per MD orders, encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course and decline in function, check nail length and trim and clean on bath day and as necessary and assist the resident to choose simple comfortable clothing that maximizes the resident's ability to dress self. Record review of Resident #4's documented showers/baths in PCC on 05/28/26, reflected the resident showers/baths were Mondays, Wednesdays and Fridays on 6:00am-2:00pm shift. PCC reflected no documentation of showers/baths on 05/01/26, 05/04/26, 05/11/26 and 05/13/26 no indication as to why it was not documented. Record review of Resident #5's face sheet, dated 05/28/26, reflected an [AGE] year-old female that admitted to the facility on [DATE]. Resident #5 had diagnoses that included: urinary tract infection (infection in any part of the urinary system), difficulty walking, lack of coordination and chronic pain. Record review of Resident #5's MDS assessment dated [DATE], reflected the resident had a BIMS score of 13, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities reflected Resident #5 needed substantial assistancewith toileting hygiene. The MDS assessment did not provide any information for the question regarding assistance with showering/bathing. Record review of Resident #5's care plan, revised on 09/10/25, reflected the resident had an ADL self-care performance deficiency.The interventions were that the resident required staff x1 for assistance with bathing, dressing and toilet use, staff x2 for assistance with bed mobility, supervision with eating, discuss with resident/family care any concerns related to loss of independence, decline in function, praise all efforts at self-care, PT/OT evaluation and treatment as per MD orders, a lift for all transfers, use a wheelchair, encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, decline in function. Record review of Resident #5's documented showers/baths in PCC on 05/28/26, reflected the resident's showers/baths were on Tuesdays, Thursdays and Saturdays during 6:00am-2:00pm shift. PCC documentation reflected no showers/baths for Resident #5 on 05/05/26, 05/19/26 and 05/26/26 no indication as to why it was not documented. Record review of Resident #6 face sheet, dated 05/28/26, reflected a 60-yer-old male that was admitted to the facility on [DATE]. Resident #6 had diagnoses that included: cerebral infraction (blood flow to an area of the brain blocked or significantly reduced), chronic pain and tremors (an involuntary, rhythmic shaking movement in one or more parts of the body). Record review of Resident #6's MDS assessment dated [DATE], reflected the resident had a BIMS score of 14, which indicated cognitively intact. The MDS assessment under Section GG-Functional Abilities reflected showering/bathing not applicable which indicated not attempted. Record review of Resident #6's care plan, revised on 05/27/26, reflected the resident was at risk for falls. The interventions were to anticipate and meet the resident's needs, ensure the resident's call light working and within reach and encourage the resident to use it for assistance as needed. Record review of Resident #6's documented baths in PCC, reflected the resident's shower/bath days were Tuesdays, Thursdays and Saturdays. PCC documentation reflected no showers/baths for Resident #6 on 05/05/26 no indication as to why it was not documented. Record review of Resident #7's face sheet, dated 05/28/26, reflected a [AGE] year-old male that was admitted to the facility on [DATE].Resident #7 had diagnoses that included: hemiplegia (complete (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paralysis) and hemiparesis (partial weakness or weakness) following cerebral infarction affecting left non-dominant side (damage occurred in the right hemisphere of the brain), muscle wasting, lack of coordination, restless legs syndrome, chronic pain syndrome, paraplegia (he partial or complete loss of motor and sensory function in the lower half of the body, including both legs, typically caused by spinal cord injury or disease), benign prostatic hyperplasia with lower urinary tract symptoms (non-cancerous enlargement of the prostate gland which lead to weak urine stream, frequent urination, nocturia, and urgency) and contracture of left and right knee. Record review of Resident #7's MDS assessment dated [DATE], reflected that resident had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS assessment under Section GG-Functional Abilities reflected no information documented for showering/bathing. It further reflected Resident #7 needed setup or clean-up assistance with eating, dependent on staff with toileting hygiene, sitting to lying, lying to sitting on side of bed, chair/bed-to-chair transfer. Resident #7 was not ambulatory and used a manual wheelchair. Record review of Resident #7's documented baths in PCC on 05/28/26, reflected the resident's shower/bath days were Mondays, Wednesdays and Fridays during 2:00pm-10:00pm shift. PCC reflected no documented shower/bath for Resident #7 on 05/04/26 no indication as to why it was not documented. During an interview on 05/27/26 at 10:43 AM, Resident #3 stated she did not get a bath on 05/23/26. Resident #3 stated her shower/bath days were Tuesdays, Thursdays and Saturdays. Resident #3 stated she did not know why she did not receive her shower. She stated she knew the reason was not because the facility was short staffed. Resident #3 stated the staff would lie saying that she refused her shower, but she never refused her showers. During an interview on 05/28/26 at 11:20 AM, Resident #6 stated he only showered about two times the entire time he had been at the facility. Resident #6 stated he spoke with someone regarding the shower issue, and they were supposed to talk to the nurse or aide about ensuring he received his showers. He stated he did not remember who or when he spoke to someone about it. Resident #6 stated he required supervision for his showers. Resident #6 also stated staff was supposed to inform him of his time to shower and provide supervision but did not. During an interview on 05/28/26 at 11:59 AM, Resident #5 stated there have been many times that she did not receive her showers. She stated staff did not show up to shower her. Resident #5 stated staff have told her that they would do it later but have not done it by 2:00 PM. Resident #5 stated her shower days were Tuesdays, Thursdays and Saturdays. Resident #5 stated she had missed her Saturday showers numerous times. Resident #5 stated some weeks she received one shower, other times two showers but not her three showers. Resident #5 stated she did not refuse her showers and wanted her three showers a week. During an interview on 05/28/26 at 12:36 PM, Resident #7 stated he was supposed to receive his bed baths on Mondays, Wednesdays and Fridays on the 2:00pm-10:00pm shift. Resident #7 stated he did not always receive his three baths during the week. He stated it depended on what staff were on shift that determined if he would get his baths. Resident #7 stated he was unaware of exactly which staff it was that did not bathe him. Resident #6 stated he did not receive his bath on 05/20/26 or 05/22/26 but did not say anything to staff. During an interview on 05/28/26 at 2:22 PM, Resident #4's family stated the facility promised to shower Resident #4 on 04/28/26 but did not happen. Resident #4's family member stated the resident had not had a shower on 04/27/26-04/28/26. She stated Resident #4 received his first bath on 04/29/26 in which his family went to the facility and gave him a bed bath. Resident #4's family member stated on 05/02/26, both her and Resident #4's family gave him a bed bath. Resident #4's family member stated Resident #4 received his first bath from facility staff on 05/03/26. She stated the family was told that the resident's baths were Mondays, Wednesday and Fridays. She stated once they complained about the bath issue, the family was informed that Resident #4's baths were Tuesdays, Thursdays and Saturdays. During an interview on 05/28/26 at 5:20 PM, LVN A stated mostly CNAs provided residents with their showers. LVN A stated residents had complained about not being showered. LVN A stated one reason a resident would have not received a shower was due to being short staffed. LVN A stated another reason the resident may not have been showered was due (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to refusal and wanting to take it at another time. During an interview on 05/28/26 at 6:20 PM, the DON stated some residents refused and then said they did not get showered. The DON stated there was an option of PRN showers. The DON stated some residents would say they wanted their showers later. The DON stated she had not received any complaints from any residents about not being showered or bathed. The DON stated the expectations were for staff to give residents showers on their shower days. The DON stated if a resident refused, it should have been documented and reported to the nurse so the nurse could speak with the resident. The DON stated showers and baths were documented on skin sheets and signed off by the nurse. She also stated it was also documented in PCC. Record review of the facility's policy on Bath, Tub/Shower, no date, revealed the following in part: Bathing by tub or shower is done to remove soil, dead epithelial cells, microorganisms from the skin, and body odor to 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 depend on resident preference, skin condition, tolerance, and energy level. Although a daily bath or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed.