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	02/12/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations and interviews, the facility failed to ensure the resident environment remained free of accident hazards as was possible for 1 of 1 doorway to the Clean Linen Storage on the secure unit reviewed for accidents and hazards. The facility failed to ensure residents who resided on the secure unit were safe from hazardous items when the door to the Clean Linen storage room was observed open on 2/10/2026. This failure could place residents in the secure unit at risk of harm from exposure to hazardous materials, injury from freestanding shelves and linens, or entrapment in a confined space.Findings included: Observation on 02/10/2026 at 1:15 PM in the facility's secure unit revealed the clean linen closet door that had a numerical combination locking handle was left open approximately 1 inch and the closet light left on. There was no staff visible in hall however two secure unit residents were seen walking in the hallway nearby. The door to the clean linen closet had a sign stating Please make sure the door is completely closed behind you. At 1:19 PM a secure unit staff member walked by the open clean linen door and exited secure unit without noticing. No staff member was observed at the nurse's station next to the clean linen closet. Observation of items in the clean linen closet included a shelving unit with 5 shelves to the right of the doorway holding clean sheets, gowns, and blankets; a 5 shelf unit along the back wall of the closet with towels, blankets, and pillow cases, and a wall mounted 5 shelf unit that contained incontinent supplies of adult diapers, 2 stacks of bed pads, a pack of premoistened premium adult washcloths, as well as a purple topped container of Sani-Cloth Germicidal Disposable Wipes, and opened case of large powder free stretch vinyl exam gloves. Interview and observation on 02/10/2026 at 1:29 PM with MA C revealed that any door with combination lock should remain closed when not in use; when an employee is exiting a room, they were responsible for making sure the door was closed and locked. MA C went and closed the clean linen closet door and checked twice it was secure. MA C stated this was so that a resident did not wander into the closet and get locked in. MA C stated that there was a potential for items unsafe for residents to be in the room and the residents could get hurt. MA C agreed that residents on the secure unit were particularly vulnerable as they all had a dementia diagnosis and may not be aware of the dangers as everything in the closet might be hazardous particularly the disinfectant wipes and washcloths from the chemicals in them as well as the sheets and blankets being a risk of tripping and falls. Interview on 02/10/2026 at 1:33 PM with CNA E revealed that any combination locking door should always to be closed for safety. CNA E stated that she did not recall formal training on doors with combination locking handles but keeping non-resident room or area doors closed and locked had been emphasized on the first 3 days working at the facility. CNA E stated that the open door could be dangerous because a resident or unauthorized person could go into the closet and become trapped or be exposed to dangerous items; the linens that were stored inside could be a trip hazard. CNA E stated that the wipes and washcloths could be extremely dangerous if ingested or put on the eyes. CNA E stated when a staff member saw an open storage door, they should check inside for anyone and if no one then close the door and check it was securely locked. Interview on 02/10/2026 at 2:01 PM with GVN D revealed that areas that had doors with combination locked doors should be left closed and always locked and not be left slightly open. GVN D stated that storage room (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doors, particularly in the secure unit, should not be left open as it presented a risk of someone getting hurt, a resident getting items not meant for them or that may be specific to another room. GVN D stated the hazards of items that were in the clean linen closet could include ingestion of toxins, items being placed in body areas that were inappropriate, sheets and blankets posed a risk of falls or tripping, choking, and items could be used as a suicidal ideation aid. Interview on 02/12/2026 at 12:55 PM with Adm revealed the purpose of storage areas with combination lock doors was to ensure the room and items within remained secured. The Adm stated the risk of these areas not being secured ranged from a resident having ability to enter and have access to hazardous items. The Adm stated that training covering doors with combination locks was conducted when the codes changed and when a new employee began work. A policy was requested from the Administrator and DON on 02/12/2026 at 9:32 AM and again on 02/12/2026 at 1:37 PM, but not provided, that addressed doors with combination locks or an environmental safety procedures policy.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 7 (Resident #10, Resident #12, Resident #49, Resident #56, Resident #63, Resident #64, and Resident #80) of 8 resident rooms observed and reviewed for grab/assist bars. The facility failed to have evidence of informed consent for Resident #12, Resident #49, Resident #56, Resident #63, Resident #64, and Resident #80, for grab/enabler bars (smaller bars used by the person in bed to reposition themselves) to be placed on the bed. The facility failed to have evidence of assessment for Resident #10, Resident #12, Resident #49, Resident #56, Resident #64, and Resident #80, for risk of entrapment and ability to safely use the grab/enabler bars. The facility failed to follow assessment recommendations for Resident#10 and Resident #62 which indicated the residents were not appropriate for grab/assist bars. These failures could affect residents who used grab/assist bars at risk of the resident/responsible party not being aware of the risks, informed consent not being obtained from the resident or responsible party, and assessments not being completed for appropriateness. Findings include:Record Review of Resident #10's admission Record dated 02/11/2026 revealed a [AGE] year-old female who had originally admitted to the facility on [DATE] with most recent admission on [DATE]. Resident #10 was noted to have diagnoses including Difficulty in Walking, Unsteadiness on Feet, Other Lack of Coordination, Major Depressive Disorder (mental health disorder characterized by persistent, intense sadness or loss of interest), Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), Alzheimer's Disease (progressive, irreversible disorder that causes brain cells to degenerate, shrink, and die, resulting in memory loss, cognitive decline, and behavioral changes), and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris (plaque buildup in the heart's natural arteries, reducing blood flow, without chest pain). Record review of Resident #10's Quarterly MDS, dated [DATE], revealed Resident #10 was usually able to make self understood and to understand others. Resident #10 was noted to utilize a wheelchair for mobility. Resident #10 was noted to be dependent for toileting hygiene and needed substantial/maximal assistance for putting on/taking off footwear. Resident #10 required partial/moderate assistance for oral hygiene and lower body dressing, and required supervision or touching assistance with upper body dressing, personal hygiene, and eating. Resident #10 was noted to be dependent with tub/shower transfers and needed substantial/maximal assistance with roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/chair-to-bed transfer, and toilet transfer. Resident #10 was noted to require partial/moderate assistance with walking. Record review of Resident #10's BIMS revealed a score was not able to be obtained. Resident #10 was noted to continually have had have difficulty focusing attention, being easily distractible or having difficulty keeping track of what was said, having had disorganized or incoherent thinking, and an altered level of consciousness. Record review of Resident #10's Care Plan, last updated on 12/15/2025, revealed a focus area of The resident uses a bed rail to assist themselves with ADL's with interventions of Grab/Assist bar to be used, 1/4 rail to be used, The resident uses a rail on the right side of the bed, and Perform a Bed Rail Assessment at least every quarter. Record review of Resident #10's Bed Rail Consent, dated 07/24/2024, revealed verbal consent from the RP by telephone call. Record review of Resident #10 ?s Bed Rail Assessment - V 2, dated 05/08/2025, indicated: 1. Do any of the items below apply to this resident? Answered as 5. None OF The Above 2. Does the resident have a diagnosis of seizures or involuntary movements? Answered as 2. No 3. Will or does the resident utilize the bed rail or grab/assist bar to assist themselves with activities of daily living? Answered as 2. Nob. Based on the response(s) above, the (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident is not a candidate for a bed rail or grab/assist bar at this time Observation on 02/10/2026 at 9:14 AM of resident beds revealed grab bars were attached to the bedframe and raised on the bed of Resident #10. The bed of Resident #10 was observed with a grab bar on the left-hand side of the bed; the resident was not in the room. Record review of Resident #12's admission Record dated 02/11/2026 revealed a [AGE] year-old male who had original admission date of 08/23/2024. Resident #12 was noted to have diagnoses including Chronic Venous Hypertension (Idiopathic) with Ulcer of Right Lower Extremity (condition caused by long term-high pressure in the veins, causing skin break downs), Major Depressive Disorder (mental health disorder characterized by persistent, intense sadness or loss of interest), Post-Traumatic Stress Disorder, Chronic Obstructive Pulmonary Disease (progressive, incurable lung disease that makes breathing difficult by damaging airways and air sacs), Type 2 Diabetes Mellitus (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, but has not yet caused organ damage), Cerebral Infarction (blocked blood flow to the brain leading to tissue death), and Bradycardia (abnormally slow resting heart rate). Record review of Resident #12's Quarterly MDS, dated 11/05.2025, revealed a BIMS score of 11 indicating moderate cognitive impairment. Resident #12 was noted to have functional abilities requiring partial/moderate assistance with shower/bathe self and lower body dressing and substantial/maximal assistance with putting on/taking off footwear. Record review of Resident #12's Care Plan, last updated on 07/15/2025, revealed no focus or intervention related to the use of bed rails or grab/assist bars. Record review of Resident #12's Assessment List and Miscellaneous Document List, both dated 02/11/2026, in the EHR revealed no assessment for bed rail or grab bar safety or bed rail consent form. Observation on 02/10/2026 at 9:14 AM of resident beds revealed grab bars were attached to the bedframe and raised on the bed of Resident #12. The bed of Resident #12 was observed with a grab bar on the right-hand side of the bed; the left-hand side of the bed was against the wall; the resident was asleep in the bed. Record review of Resident #49's admission Record dated 02/11/2026 revealed a [AGE] year-old female who had original admission date of 08/29/2025. Resident #49 was noted to have diagnoses including Alzheimer's Disease With Early Onset (progressive, irreversible disorder that causes brain cells to degenerate, shrink, and die, resulting in memory loss, cognitive decline, and behavioral changes developing in individuals before [AGE] years old), Major Depressive Disorder (mental health disorder characterized by persistent, intense sadness or loss of interest), Delusional Disorders (type of serious mental illness (psychosis) characterized by fixed, false beliefs (delusions) that persist even with evidence that contradicts them), Auditory Hallucinations (perception of sounds, most commonly voices, without any external stimulus), Dementia (diagnosis used when symptoms of cognitive decline- severe memory loss, impaired thinking, and reduced social abilities- are present but underlying cause has not been determined), Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), and Psychotic Disorder With Delusions (psychotic condition characterized by the presence of one or more fixed, false beliefs without severe functional impairment). Record review of Resident #49's Quarterly MDS, dated [DATE], revealed a BIMS score of 3 indicating severe cognitive impairment. Resident #49 was indicated to have functional abilities requiring partial/moderate assistance of oral hygiene, lower body dressing, putting on/taking off footwear, personal hygiene, and supervision or touching assistance for upper body dressing. Resident #49 was noted to be independent with mobility with the need for supervision or touching assistance for tub/shower transfers. Record review of Resident #49's Care plan, last updated on 10/08/2025, revealed no focus or intervention related to the use of bed rails or grab/assist bars. Record review of Resident #49's Assessment List and Miscellaneous Document List, both dated 02/11/2026, in the EHR revealed no assessment for bed rail or grab bar safety or bed rail consent form. Observation on 02/10/2026 at 9:14 AM of resident beds revealed grab bars were attached to the bedframe and raised on the bed of Resident #49. The bed of Resident #49 was observed with grab bars raised on both sides of the bed; the resident was not in the room. Record review of Resident #56's admission Record (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 02/11/2026 revealed a [AGE] year-old female who originally admitted on [DATE]. Resident #56 was noted to have diagnoses including Obsessive-Compulsive Disorder (chronic mental health condition characterized by uncontrollable, recurring thoughts or behaviors that an individual feels compelled to repeat), Generalized Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), Major Depressive Disorder (mental health disorder characterized by persistent, intense sadness or loss of interest), Unsteadiness On Feet, Alzheimer's Disease (progressive, irreversible disorder that causes brain cells to degenerate, shrink, and die, resulting in memory loss, cognitive decline, and behavioral changes), and Bipolar Disorder (chronic mental health condition causing extreme, debilitating shifts in mood, energy, and functioning). Record review of Resident #56's Quarterly MDS, dated [DATE], revealed a BIMS score of 14 indicating cognition was intact. Resident #56 had functional abilities requiring supervision or touching assistance were toileting, shower/bathing, and personal hygiene. Resident #56 was noted to require supervision or touching assistance with chair/bed-to-chair transfer, tub/shower transfer and toilet transfer. Record review of Resident #56's Care Plan, last updated on 09/10/2025, revealed a focus of Patient to have assist bar on bed for functional mobility and repositioning in bed with no intervention or indication of alternatives tried related to the use of bed rails or grab/assist bars. Record review of Resident #56's Assessment List and Miscellaneous Document List, both dated 02/11/2026,in the EHR revealed no assessment for bed rail or grab bar safety or bed rail consent form. Observation on 02/10/2026 at 9:14 AM of resident beds revealed grab bars were attached to the bedframe and raised on the bed Resident #56. The bed of Resident #56 was observed with grab bars raised on both sides of the bed; the resident was not in the room. Record review of Resident #63's admission Record dated 02/11/2026 revealed an [AGE] year-old female who had original admission date of 10/17/2022 and most recent admission date of 1/14/2026. Resident #63 was noted to have diagnoses including Acute Respiratory Failure with Hypoxia (critical condition where the lungs cannot adequately oxygenate the blood), Muscle Wasting and Atrophy, Unsteadiness on Feet, Difficulty in Walking, Generalized Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), Chronic Obstructive Pulmonary Disease (progressive, incurable, yet treatable lung disease that causes chronic airflow constriction leading to severe breathing difficulties), Alzheimer's Disease with Late Onset (progressive, irreversible disorder that causes brain cells to degenerate, shrink, and die, resulting in memory loss, cognitive decline, and behavioral changes developing in individuals aged 65 or older, with risks increasing significantly with age), Chronic Systolic (Congestive) Heart Failure (condition where the heart's left ventricle weakens, becomes enlarged, and cannot contract properly to pump enough blood), Unspecified Dementia (diagnosis used when symptoms of cognitive decline- severe memory loss, impaired thinking, and reduced social abilities- are present but underlying cause has not been determined), and Type 2 Diabetes Mellitus without Complications (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, but has not yet caused organ damage). Record review of Resident #63's quarterly MDS, dated [DATE], revealed resident was noted to have been able to make self understood and had the ability to understand others some of the time. Resident #63 had a BIMS (standardized assessment tool to evaluate cognitive function, specifically memory and orientation) score of 0 (zero) indicating severe impairment. Resident #63 was noted to need substantial/maximal assistance for toileting hygiene, lower body dressing, putting on/taking off footwear; partial/moderate assistance for oral hygiene, upper body dressing, and personal hygiene. Resident #63 was noted to need supervision or touching assistance for functional abilities of roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair, bed-to-chair transfer, and sit to stand, Resident was noted to need partial/moderate assistance for toilet transfer and walking. Record review of Resident #63's Care Plan, last updated on 01/23/2026, revealed a focus of The resident uses 1/4 assist rails to assist themselves with ADL's and interventions of Grab/Assist bar to be used, 1/4 rail to be used, The resident uses rails on the left and right side of the bed, and Perform a (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bed Rail Assessment at least every quarter. Record review of Resident #63's Bed Rail Assessment - V 2, dated 05/08/2025, indicated: 1. Do any of the items below apply to this resident? Answered as 5. None OF The Above 2. Does the resident have a diagnosis of seizures or involuntary movements? Answered as 2. No 3. Will or does the resident utilize the bed rail or grab/assist bar to assist themselves with activities of daily living? Answered as 2. Nob. Based on the response(s) above, the resident is not a candidate for a bed rail or grab/assist bar at this time Observation on 02/10/2026 at 9:14 AM of resident beds revealed grab bars were attached to the bedframe and raised on the bed of Resident #63, Resident #64, and Resident #80. The bed of Resident #63 was observed with a grab bar on the right-hand side of the bed; the resident was asleep in the bed. Record review of Resident #64's admission Record dated 02/11/2026 revealed a [AGE] year-old female who originally admitted to the facility on [DATE]. Resident #64 was noted to have diagnoses including Type 2 Diabetes Mellitus (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, but has not yet caused organ damage), Pulmonary Embolism (condition where a blood clot travels to the lungs blocking blood flow), Acute Embolism And Thrombosis Of Unspecified Deep Veins (when blood clots form in deep veins and block flow), Unspecified Hearing Loss, Generalized Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), Cognitive Communication Deficit, Major Depressive Disorder (mental health disorder characterized by persistent, intense sadness or loss of interest), and Unspecified Dementia (diagnosis used when symptoms of cognitive decline- severe memory loss, impaired thinking, and reduced social abilities- are present but underlying cause has not been determined). Record review of Resident #64's Annual MDS, dated [DATE], revealed a BIMS score of 12 indicating moderate impairment. Resident #64 was assessed as having been independent with all functional abilities. Record review of Resident #64's Care Plan, last updated on 06/30/2025, revealed focus of Patient to have assist bar on bed to help with functional transfers and repositioning in bed and no intervention of previously attempted alternatives. Record review of Resident #64's Assessment List and Miscellaneous Document List, both dated 02/11/2026, in the EHR revealed no assessment for bed rail or grab bar safety or bed rail consent form. Observation on 02/10/2026 at 9:14 AM of resident beds revealed grab bars were attached to the bedframe and raised on the bed of Resident #64. The bed of Resident #64 was observed with a grab bar on the left-hand side of the bed; the resident was not in the room. Record review of Resident #80's admission Record dated 02/11/2026 revealed a [AGE] year-old male with initial admission date of 12/15/2023 and most recent re-admission date of 01/26/2026. Resident #80 was noted to have diagnoses including Unsteadiness On Feet, Cognitive Communication Deficit, Type 2 Diabetes Mellitus (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, but has not yet caused organ damage), Other Seizures, Cerebral Infarction (blocked blood flow to the brain leading to tissue death), and Bipolar Disorder (chronic mental health condition causing extreme, debilitating shifts in mood, energy, and functioning). Record review of Resident #80's BIMS, dated 01/29/2026, revealed a score of 15 indicating intact cognition. Record review of Resident #80's Care Plan, last updated on 01/27/2026, revealed no focus or intervention related to the use of bed rails or grab/assist bars. Record review for Resident #80 revealed no completed MDS. Record review of Resident #80's Assessment List and Miscellaneous Document List, both dated 02/11/2026, in the EHR revealed no assessment for bed rail or grab bar safety or bed rail consent form. Observation on 02/10/2026 at 9:14 AM of resident beds revealed grab bars were attached to the bedframe and raised on the bed of Resident #80. The bed of Resident #80 was observed with grab bars raised on both sides of the bed; the resident was not in the room. Interview on 02/12/2026 at 11:29 AM with GVN D revealed they were unsure about the facility requirements for grab bars or bed rails to be placed or remain on a resident bed; they would speak with the DON for clarification. GVN D stated that possibly a resident would need an assessment before going into new bed that had grab bars on it. GVN D agreed that grab bars or any change to a resident's bed should be included in their (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan as each resident would have individualized requirements that would be linked to their mobility function or therapy needs. GVN D also agreed that a resident or RP should provide consent for grab bars or bed rails to be placed on a resident bed as the items could be perceived as a type of restraint depending on type or size and be considered a danger. Interview on 02/12/2026 at 11:48 AM with LVN F revealed that a resident should have had an assessment, signed a consent form, and be care planned for any type of grab bar or bed rail. LVN F stated that grab bars or bed rails could be a danger to a patient if that patient were not assessed to be able to use the grab bar or bed rail in a safe manner. LVN F stated that consent from the resident or RP was needed so they knew the purpose of the grab are or bed rail and it was not for a restraint. LVN F stated that grab bars or bed rails could pose a risk to a resident who may potentially hurt themselves up to and including strangulation, skin tears, injuries, falls, or death. Interview on 02/12/2026 at 12:02 with CNA G revealed they were unsure of the requirements for grab bars or bed rails to be on a residents bed. CNA G stated the risks of grab bars or bed rails to a resident could be the bars or rails being seen as restraint or the resident could be injured. CNA G agreed that the resident or their RP should sign consent for the grab bars/bed rails, have an assessment to ensure they could safely utilize the grab bars or bed rails. Interview on 02/12/2026 at 12:21 PM with the DON revealed for grab bars or bed rails the facility required the resident to have an assessment to ensure they were able to use the grab bars or bed rails safely, a signed consent from the resident or RP, and for documentation in the resident's EHR notes. The DON agreed that the need for and ability to safely use the grab bars or bed rails would also be entered in the resident's care plan. The DON thought the version of the EHR the facility utilized the consent form was triggered by the completion of the assessment showing the resident was appropriate for grab bars or bed rails. The DON stated that the care plan and consents for acute needs or conditions was the responsibility of the DON or a RN, comprehensive care plan updates were the responsibility of the MDS nurse, and ultimately the DON was responsible for oversight of all care plan entries. The DON stated that assessments were the responsibility of the admitting nurse, the MDS nurse would conduct assessments periodically, and the ultimate responsibility was on the DON. The risks to a resident of grab bars or bed rails according to the DON were potentially being restrained or incurring an injury. Interview on 02/12/2026 at 12:55 PM with Adm revealed they expected residents to be referred to therapy for an assessment for appropriateness to utilize grab bars or bed rails and therapy should then be coordinated with nursing with the results of the assessment or evaluation. The Adm agreed that consent and care planning was needed for bed rails or grab bars to be placed or remain on a resident bed. The Adm stated that consents and care plans were the responsibility of the interdisciplinary team. Record review of the facility's provided Bed Rail policy, dated 11/08/2016, revealed a statement of This facility will utilize bed rails for those residents that use them for bed mobility. The policy further states The facility will attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements: Assess the resident for risk of entrapment from bed rails prior to installation. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. Ensure that the bed's dimensions are appropriate for the resident's size and weight.a. Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.Assessment: Prior to use of a bed rail the resident will be assessed to ensure the proper rail is utilized for the resident's need. The facility will re-evaluate the use of the rail on a periodic basis Based on the resident assessment, the interdisciplinary team (IDT) will make the determination for the plan of care as it relates to bed rails.Consent - The resident and/or resident representative will provide consent for the use of rails prior to installation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services in accordance with currently accepted professional principles for three (Residents #44, #48, and #62) of twelve residents reviewed for pharmaceutical services. The facility failed to ensure MA C documented in the controlled medication logbook immediately after administering Hydrocodone to Resident #44 on 02/11/2026.The facility failed to ensure MA C documented in the controlled medication logbook immediately after administering Clonazepam to Resident #48 on 02/11/2026.The facility failed to ensure MA C documented in the controlled medication logbook immediately after administering Pregabalin to Resident #62 on 02/11/2026.This failure could place residents at risk of not receiving their medications as ordered by their physician. Findings include:Resident #44Record review of Resident #44's Face Sheet, dated 02/12/2026, reflected a [AGE] year-old male who admitted on [DATE]. He was diagnosed with unspecified pain. Record review of Resident #44's Comprehensive MDS Assessment, dated 11/25/2025, reflected moderately impaired cognition with a BIMS score of 08. Section N (Medications) indicated the resident received opioid medication. Record review of Resident #44's Comprehensive Care Plan, dated 11/19/2025, reflected the resident had the potential for uncontrolled pain. An intervention was to administer medication as ordered and evaluate the effectiveness.Record review of Resident #44's Physician's Order, dated 03/11/2025, reflected Hydrocodone-Acetaminophen oral tablet 10-325 mg. Give 1 tablet by mouth every 4 hours for severe pain.Record review of Resident #44's Medication Administration Record revealed MA C documented administration of the 7:00 AM dose of Hydrocodone-Acetaminophen on 02/11/2026.Record review of the controlled medication logbook on MA C's medication cart, on 02/11/2026, did not reflect Resident #44's 7:00 AM dose of Hydrocodone-Acetaminophen was given on 02/11/2026.Resident #48Record review of Resident #48's Face Sheet, dated 02/12/2026, reflected a [AGE] year-old male who admitted on [DATE]. The resident was diagnosed with anxiety disorder. Record review of Resident #48's Comprehensive MDS Assessment, dated 01/05/2026, reflected the resident intact cognition with a BIMS score of 15. Section N (Medications) indicated the resident received anti-anxiety medication. Record review of Resident #48's Comprehensive Care Plan, dated 12/04/2025, reflected the resident received anti-anxiety medication. An intervention was to give the medication as ordered by the physician and monitor/document side effects and effectiveness. Record review of Resident #48's Physician Order, dated 03/06/2025, reflected Clonazepam) oral tablet 0.5 mg. Give 1 tablet by mouth two times a day for anxiety.Record review of Resident #48's Medication Administration Record revealed MA C documented administration of the morning dose of Clonazepam on 02/11/2026.Record review of the controlled medication logbook on MA C's medication cart, on 02/11/2026, did not reflect Resident #48's morning dose of Clonazepam was given on 02/11/2026.Resident #62Record review of Resident #62's Face Sheet, dated 02/12/2026, reflected a [AGE] year-old female who admitted on [DATE]. The resident was diagnosed with neuropathy (a condition that affects nerve signals and causes pain or numbness). Record review of Resident #62's Comprehensive MDS Assessment, dated 12/11/2025, reflected the resident had intact cognition with a BIMS score of 13. Section N (Medications) indicated the resident received an anti-convulsant medication (used to treat neuropathy). Record review of Resident #62's Comprehensive Care Plan, dated 12/08/2025, reflected the resident had the potential for uncontrolled pain. An intervention was to administer medication, monitor for side effects, and evaluate the effectiveness of the pain intervention. Record review of Resident #62's Physician Order, dated 04/10/2024, reflected Pregabalin oral capsule 100 mg. Give 1 capsule by mouth three times a day for neuropathy. Record review of Resident #62's Medication Administration Record revealed MA C documented administration of the 8:00 AM dose of Pregabalin on 02/11/2026.Record review of the controlled medication logbook on MA C's medication, on (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	02/12/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/11/2026, cart did not reflect Resident #62's 8:00 AM dose of Pregabalin was given on 02/11/2026.During an observation and interview on 02/11/2026 at 8:03 AM, ADON B observed the surveyor review MA C's medication cart for medication storage and labeling. ADON B stated MA C had gone to the dining room to help with breakfast. The controlled medications were in a separate locked box inside the medication cart. When comparing the medication count on the card of pills to the logbook, it showed the pill count was off by 1 when reviewing medication for Residents #44, #48, and #62. ADON A called MA C to the medication cart. MA C verified that she had given the medication but was called to the dining room before she could document the medication in the logbook. She opened the laptop on her medication cart to show she had documented giving the medications as ordered. MA C stated she was supposed to sign the book when she pulled medication from the locked box and gave it to the residents. She stated it was important to do it immediately to avoid a discrepancy. She stated it was also a way to verify what she actually gave and the time she gave it. ADON B stated it was important to document the dose when you pulled the medicine to ensure the medication count was accurate and reflected the correct time the resident received the medication. During an interview on 02/12/2026 at 10:17 AM, the DON stated it was important to document controlled medication in the logbook so everyone knew what was given. She stated even if the medication was documented on the residents' medication administration record, the best practice was to sign out the medication when you pulled it and gave it to the resident. She stated they had begun in-service training. Record review of the facility's policy Controlled Medications - Administration, undated, reflected Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulation.When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record:ˆ Date and time of administrationˆ Amount Administeredˆ Signature of the nurse administering the dose, completed after the medication is actually administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed. The facility failed to ensure all food items in the facility kitchen were dated and discarded prior to their use-by date.The facility failed to ensure all canned items in the dry storage area were dated and discarded prior to their use-by date. These failures could place residents at risk for food contamination and food-borne illness.Finding included: During observation(s) on 02/10/2026 and 02/11/2026 between 9:15 AM and 9:50 AM in the facility's kitchen revealed: One Gallon size freezer bag containing several small plastic cups of ketchup, located in the refrigerator with a preparation date of 02/02/2026 and a use-by date of 02/09/2026. One Gallon size freezer bag containing several small plastic cups of orange colored sauce located in the refrigerator with a preparation date of 02/02/2026 and a use-by date of 02/09/2026. One Gallon size freezer bag containing several small plastic cups of shredded cheese, located in the refrigerator with a date of 02/03/2026 and a use-by date of 02/10/2026 Eight loaves of bread in the bread pantry with a best by date of 01/26/2026.Eight cans of peppers in the bread pantry dated 10/08/2024 with a best by date of December 2025. During an interview on 02/12/2026 at 1:00 PM the FSS stated she has been the FSS for about 5 months. The FSS stated she was the person overall responsible for ensuring the kitchen was meeting guidelines for food storage and kitchen sanitization. The FSS stated she confirmed the surveyor observations. The FSS confirmed she was responsible for kitchen sanitation and proper storage of food products and that these ere oversights. She stated the risk of all these concerns observed in the kitchen could result in residents getting sick. The FSS stated the risk of the concerns not being addressed could result in food-borne illnesses. The labeling and dating were done by any of the staff who gets it in from the delivery, further it was their responsibility to label it and place it properly. During an interview on 02/12/2026 at 1:15 PM, the ADMIN stated he oversaw all departments, and ensured residents were taken care of. The ADMIN said the policy or procedure for storing food was, everything needed to be dated, and if opened it needed to have an open date and an expiration date. He said the risk to residents if policy were not followed was, they could get sick from food borne illnesses. The ADMIN stated he expected staff to ensure they were following policies and procedures of the facility kitchen policy, to protect residents and to deliver good care. The ADMIN stated the risk of these concerns not being addressed could result in food contamination and residents becoming ill. The Administrator stated if foods were not discarded properly, sanitized properly, or heated properly, there was the potential for foodborne illness.Record review of the facility's Dietary Services Policy & Procedure Manual, dated 2012, indicated 6 When items are received from the vendor, they should be first examined for expiration date, and if an expiration date is present, it is beneficial to mark it by circling it, so it is readily visible and noticeable. As the quality may deteriorate after the date passes, the dietary manager should closely inspect any products that are past the best by date to determine if they are still good quality. If in doubt, discard the product. If any stamped date is unclear, contact the food vendor for clarification. If an item does not have a date designated by the manufacturer as an expiration date, then the item should be dated as to when it is received, and shelf-stable items will be stored in a first in, first out manner, to be used within one year. Any product with a stamped expiration date will be discarded once that date passes. 8. On perishable foods, microorganisms such as molds, yeasts, and bacteria can multiply and cause food to spoil. Spoiled foods will develop an off odor, flavor, or texture due to naturally occurring spoilage bacteria. If a food has developed such spoilage characteristics, it should not be eaten food spoilage is observed prior to the best by date, the product will be discarded.Record review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, Packaged Food shall be labeled as specified in law, including 21 CFR 101 Food Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR (continued on next page)

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	675939	A. Building B. Wing	02/12/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	381 Subpart N Labeling and Containers, and as specified under S 3-202.18. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

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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 the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #14) of sixteen residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #14's room was in a position that was accessible to the resident on 02/10/2026.This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings include: Record review of Resident #14's Face Sheet, dated 02/10/2026, reflected a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. She was diagnosed with dementia and hearing loss.Record review of Resident #14's Comprehensive MDS Assessment (tool used to measure health status), dated 12/24/2025, reflected severely impaired cognition with a BIMS (tool used to measure cognitive status) score of 04. The Quarterly MDS Assessment indicated the resident required staff assistance with mobility and self-care needs. Record review of Resident #14's Comprehensive Care Plan, dated 12/04/2025, reflected the resident was at risk for falls. An intervention was to ensure the call light was within reach. During an observation and interview on 02/10/2026 at 9:14 AM, Resident #14 was sitting in her wheelchair near the foot of her bed. Her call light was observed on the floor between the wall and the head of the bed. When asked about her call light, she asked my car light? The Staffing Coordinator entered the room and stated the call light should have been within arm's reach. She picked up the call light from the floor and placed it on the bedside rail near the resident's wheelchair. She stated Resident #14 could not hear well. She spoke in a loud voice and reminded Resident #14 to push the button if she needed help. She stated the resident called staff to assist her with transferring to the toilet and it was important to ensure the call light was in reach. During an interview on 02/10/2026 at 9:28 AM, LVN B stated the call light should have been on the side of the bed so Resident #14 could reach it from her wheelchair. He stated maybe the resident had used it and dropped it. He stated the nurse, CNA, or any staff member in her room should ensure the call light was in reach before leaving. He stated it was important for Resident #14 to be able to call with any needs she had. During an interview on 02/10/2026 at 2:13 PM, ADON B stated everyone in the building monitored to ensure residents' call lights were in reach. She stated at the end of the day, everyone was an advocate. She stated if a resident had a need, the call light was the way to communicate it. During an interview on 02/12/2026 at 10:17 AM, the DON stated nurse and aides monitored the call lights during rounds to ensure residents' call lights were in reach. She stated all staff were expected to ensure the residents had their call light in reach before leaving the room. She stated it was important for the safety of the residents. She stated they had begun in-service training. During an interview on 02/12/2026 at 12:40 PM, the administrator stated the nursing staff monitored call lights during rounds. He stated the expectation was for every staff member to ensure the call light was in reach before leaving a resident's room. He stated it was important for call lights to be within the resident's reach and answered timely to ensure their needs were met.On 02/19/2026 at 1:34 PM, an email was sent to the Administrator requesting a policy related to the placement of call lights. A policy was not provided.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the residents had the right to personal privacy and confidentiality of his or her personal space for 1 of 4 residents (Resident #63) reviewed for privacy. The facility failed to ensure that the roommates of residents with AEM had signed consents in the active section of the EHR from the roommate or their RP acknowledging the AEM in the shared room since 01/28/2026. This failure could place residents at risk of having medical or personal information or conversations recorded or exposed to others, and cause residents to feel a loss of privacy, dignity, and decreased self-worth and self-esteem.Findings included: Observation on 02/10/2026 at 9:20 AM of the shared room door for Resident #10 and Resident #63 revealed a sign stating This room is being electronically monitored. Observation on 02/11/2026 at 1:45 PM of the shared room door for Resident #10 and Resident #63 revealed a sign stating This room is being electronically monitored. Record Review of Resident #10's admission Record dated 02/11/2026 revealed a [AGE] year-old female who had originally admitted to the facility on [DATE] with most recent admission on [DATE]. Resident #10 was noted to have diagnosis including Difficulty in Walking, Unsteadiness on Feet, Other Lack of Coordination, Major Depressive Disorder (mental health disorder characterized by persistent, intense sadness or loss of interest), Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), Alzheimer's Disease (progressive, irreversible disorder that causes brain cells to degenerate, shrink, and die, resulting in memory loss, cognitive decline, and behavioral changes), and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris (plaque buildup in the heart's natural arteries , reducing blood flow, without chest pain). Record Review of Resident #10's Care Plan, last updated on 12/15/2025, revealed focus area of Resident/Resident's responsible party has requested electronic monitoring with date of 12/15/2025. Intervention included Obtain consent from resident's (sp) roommate/Responsible party (if applicable) for electronic monitoring. Record review of Resident #63's admission Record dated 02/11/2026 revealed an [AGE] year-old female who had original admission date of 10/17/2022 and most recent admission date of 1/14/2026. Resident #63 was noted to have diagnosis including Acute Respiratory Failure with Hypoxia (critical condition where the lungs cannot adequately oxygenate the blood), Muscle Wasting and Atrophy, Unsteadiness on Feet, Difficulty in Walking, Generalized Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), Chronic Obstructive Pulmonary Disease (progressive, incurable, yet treatable lung disease that causes chronic airflow constriction leading to severe breathing difficulties), Alzheimer's Disease with Late Onset (progressive, irreversible disorder that causes brain cells to degenerate, shrink, and die, resulting in memory loss, cognitive decline, and behavioral changes developing in individuals aged 65 or older, with risks increasing significantly with age), Chronic Systolic (Congestive) Heart Failure (condition where the heart's left ventricle weakens, becomes enlarged, and cannot contract properly to pump enough blood), Unspecified Dementia (diagnosis used when symptoms of cognitive decline-severe memory loss, impaired thinking, and reduced social abilities- are present but underlying cause has not been determined), and Type 2 Diabetes Mellitus without Complications (chronic metabolic condition where the body develops insulin resistance, causing high blood sugar levels because cells fail to respond to insulin properly, but has not yet caused organ damage). Record Review of Resident #63's Care Plan, last updated 1/23/2026, revealed no indication of resident being in a room that currently had ongoing AEM. Record review of Resident #63's quarterly MDS, dated [DATE], revealed resident was noted to have been able to make self understood and had the ability to understand others some of the time. Resident #63 had a BIMS (standardized assessment tool to evaluate cognitive function, specifically memory and orientation) score of 0 (zero) indicating severe impairment. Resident #63 was noted to need substantial/maximal assistance for toileting hygiene, lower body dressing, putting on/taking off footwear; partial/moderate assistance for oral hygiene, (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upper body dressing, and personal hygiene. Resident #63 was noted to need supervision or touching assistance for functional abilities of roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair, bed-to-chair transfer, and sit to stand, Resident was noted to need partial/moderate assistance for toilet transfer and walking. Record review for Resident #63 revealed no consent from resident/RP to be moved into a room with ongoing AEM for roommate.Interview on 02/12/2026 at 11:29 AM with GVN D revealed that AEM in shared resident rooms required both parties to have signed consent forms. These forms showed the resident or RP had been informed of the monitoring by video and/or audio and that if the resident or families were not in agreement and preferred a room without AEM the resident could have been moved elsewhere. Interview on 02/12/2026 at 11:48 AM with LVN F revealed that in resident rooms with AEM, the roommate or their RP, needs to sign a form to consent to the monitoring. This was needed because the camera should only be pointed at intended monitored resident but could still end up recording the non-monitored roommate on camera too; if the camera has sound recording that could pick up private conversations the roommate may not want heard. LVN F stated that obtaining consents were the responsibility of all nursing staff, whoever was speaking with the resident or RP about a specific room for the resident should inform of the AEM and request the consent or the room will need to be changed to one without AEM. Interview on 02/12/2026 at 12:02 with CNA G revealed that when a resident was being prepared for a room change the staff member was to notify the resident or RP of the AEM in the room and be sure the curtain was pulled for privacy of the resident not being monitored. CNA G agreed that consent should be needed from a resident or RP being moved into a room with AEM, that way if the resident or family were not wanting to possibly be on camera or overheard the facility would offer a different room. CNA G also stated that the RP should be notified with any room change of a resident. Interview on 02/12/2026 at 12:21 PM with the DON revealed that for AEM to be approved by the facility, consent from the resident or RP, any roommate or their RP was required to be obtained. In addition, the facility would post a sign on the room door. The DON stated that AEM consent was obtained by the admitting nurse when monitoring was requested on admission to the facility from the family or resident, or by the DON or ADON when a room change was made after admission. The DON stated the signed consent form should be in miscellaneous or documents tab of the EHR. The DON stated that the risks of not having the signed consent was that there was no evidence the resident or RP was made aware they could possibly be filmed, and that there may be audio recording capabilities as well; this would be a privacy violation and that ultimately the DON was responsible to ensure all consents were obtained and in the EHR. Record review of the facility provided policy, dated 02/15/2005, revealed the statement A resident or the resident's guardian or legal representative is entitled to conduct authorized electronic monitoring (AEM) under Subchapter R, Chapter 242, Health and Safety Code. To request AEM, you, your guardian or your legal representative must:1) complete the Request for Authorized Electronic Monitoring form2) obtain the consent of other residents, if any, in your room, using the Consent to Authorized Electronic Monitoring form and3) give the form(s) to the facility administrator or designee.Who may consent to AEM?1) The other resident(s) in the room.2) The guardian of the other resident if the resident has been judicially declared to lack the required capacity.3) The legal representative of the other resident, if the resident does not have capacity to sign the form, but has not been judicially declared to lack the required capacity.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #38) of six residents reviewed for respiratory care.The facility failed to ensure Resident #38's nasal cannula was stored properly when not in use on 02/10/2026.This failure could place residents at risk for respiratory infection and not having their respiratory needs met.Findings include: Record review of Resident #38's Face Sheet, dated 02/10/2026, reflected a [AGE] year-old male who initially admitted on [DATE] and readmitted on [DATE]. A related diagnosis was shortness of breath on exertion. Record review of Resident #38's Comprehensive MDS Assessment, dated 11/11/2025, reflected intact cognition with a BIMS score of 15. Section O (Special Treatments, Procedures, and Programs) did not reflect the resident received oxygen therapy during the fourteen days prior to the MDS Assessment. Record review of Resident #38's Comprehensive Care Plan, dated 12/04/2025, reflected the resident had oxygen therapy related to ineffective gas exchange. An intervention was to administered oxygen via nasal cannula at 2-4 liters per minute. Record review of Resident #38's Physician Order, dated 09/12/2025, reflected oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath.During an observation on 02/10/2026 at 9:22 AM, Resident #38 was not in his room. A nasal cannula was connected to the oxygen concentrator. The nasal cannula was on his bed unbagged. During an observation and interview on 02/10/2026 at 9:28 AM, LVN B stated the nasal cannula should have been in a bag. He stated when Resident #38 left his room, he used the portable oxygen tank on his wheelchair. He stated staff reminded the resident to put the oxygen tubing in the bag or tell staff when he takes off oxygen so staff can place it in a bag. He stated Resident #38 had respiratory issues and it was important to keep the nasal cannula bagged for infection control. During an observation and interview on 02/11/2026 at 12:27 PM, Resident #38 was lying on his bed. He stated in the beginning he did not use oxygen, then he started using it just when he was in his room. He stated if he needed to use it when he left the room, he used the portable tank on his wheelchair. He stated he usually put the oxygen tubing in the bag himself so he did not have to wait for staff to come and do it. During an observation and interview on 02/10/2026 at 1:13 PM, ADON B stated the nasal cannula should have been in a bag. She stated the nurses and CNAs were responsible for monitoring to ensure the oxygen tubing was stored in a bag when the resident was not using it. She stated all staff were trained to report to nursing staff if they observed oxygen unbagged or on the floor. She stated it was important for infection control. During an observation and interview on 02/12/2026 at 10:17 AM, the DON stated the resident took off the nasal cannula in the room and switched to the oxygen on his wheelchair. She stated he had been educated to place the nasal cannula in the bag or call staff to put in the bag before leaving the room. She stated staff were responsible for rounding to ensure it was bagged appropriately for infection control. She stated they had begun in-service training for staff. During an observation and interview on 02/12/2026 at 12:40 PM, the Administrator stated the nasal cannula should be bagged to avoid cross contamination and infection. He stated the nursing staff and CNAs monitored during rounds to ensure those items were bagged when not in use. Record review of the facility's policy Oxygen Administration, revised February 13th, 2007, did not reflect storage of respiratory items when not in use. On 02/19/2026 at 1:34 PM, an email was sent to the Administrator requesting a policy for the storage of respiratory items when not in use. A policy was not provided.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for one (Resident #31) of twelve residents reviewed for medication storage. The facility failed to ensure Resident #31 did not have a topical analgesic ointment on her bedside table on 02/10/2026.This failure could place residents at risk of not receiving the full benefit of the medications or misuse of medications that could lead to adverse reactions or overdose.Findings include: Record review of Resident #31's Face Sheet, dated 02/10/2026, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with osteoarthritis and blindness in one eye with low vision in the other eye. Record review of Resident #31's Comprehensive MDS Assessment, dated 11/17/2025, reflected intact cognition with a BIMS score of 15. She required assistance with mobility and self-care needs. Record review of Resident #31's Comprehensive Care Plan, dated 12/04/2025, reflected the resident had impaired visual function. Interventions included to encourage the resident to use her glasses and ensure appropriate visual aides were available to support her participation in activities. Record review of Resident #31's Physician Order reflected the resident did not have an order for topical analgesic ointment or to self-administer medication. An observation on 02/10/2026 at 9:14 AM revealed Resident #31 was not in her room. A container of topical analgesic ointment was on her bedside table.During an observation and interview on 02/10/2026 at 9:17 AM, the Staffing Coordinator was in Resident #31's room. She removed the topical analgesic ointment from Resident #31's bedside table and stated it should not be in the room. She stated a resident might get it and swallow it, put it in their eyes, or may use too much of it. During an interview on 02/10/2026 at 9:28 AM, LVN B stated he did not notice the ointment in the room. He stated it could be harmful if resident used it the wrong way. He stated there should not be any medication in residents' rooms. He stated that was a facility policy and everyone knew it. He stated another resident might get it and have side effects. He stated someone might use too much or not use it properly. He stated any medication should be locked in the nurse's or medication aide's cart. During an interview on 02/10/2026 2:13 PM, ADON A stated no one should have medication at the bedside. She stated staff try their best to look for issues and correct them. She stated she did not know if it belonged to the resident. She stated sometimes families brought in things the facility was unaware of. She stated when they see something like that, the facility addresses it. She stated it was for the safety of all the residents. During an interview on 02/12/2026 at 10:17 AM, the DON stated there should not be medication at any resident's bedside for safety. She stated some residents had dementia. She stated a resident might get the topical analgesic ointment and ingest it. She stated they had begun in-service training. During an interview on 02/12/2026 at 12:40 PM, the Administrator stated medications should not be at the bedside. He stated medications should be secured to ensure the right resident gets the right amount of medicine. Record review of the facility's policy Bedside Storage of Medications, dated 2003, reflected bedside medication storage is permitted for sublingual and emergency medications and for residents who are able to self-administer medications upon the written order of the prescriber and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of this procedure and related policy when necessary.