STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Creek Manor	9014 Timber Path San Antonio, TX 78250

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observation, interviews, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 (Resident #2) of 8 residents reviewed for quality of care. 1) The facility failed to ensure LVN C labeled and dated Resident #2's wound treatment dressing after completing wound care on 08/25/24. 2) The facility failed to ensure LVN C followed Resident #2's physician order for wound treatment. These failures could affect residents who receive wound care treatments by placing them at risk for receiving inadequate treatments resulting in the worsening of wounds. The findings were: Review of Resident #2's undated face sheet reflected Resident #2 was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (a chemical imbalance in the blood that causes problems in the brain), type 2 diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar), displaced avulsion fracture of right talus (when a small part of the ankle bone pulls away from the rest of the bone where it is attached to a ligament or tendon), bipolar disorder (a mental illness characterized by alternating periods of elation and depression) and dementia(a general term for impaired ability to remember, think, or make decisions). Review of Resident #2's quarterly MDS assessment, dated 07/17/2024, reflected a BIMS score of 15, indicating no cognitive impairment. Section GG, titled Functional Abilities and Goals, of the MDS reflected Resident #2 required staff assistance for transfers, bathing, toileting, hygiene and dressing. Section M, titled Skin Conditions, indicated Resident #2 had a surgical wound. Review of Resident #2's care plan, initiated date 07/17/2024, reflected Resident #2 had altered skin integrity non-pressure related to surgical wound to right lateral ankle and right medial ankle. The interventions included monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor and notify physician of significant findings and treatments as ordered. (continued on next page)

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: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9014 Timber Path San Antonio, TX 78250	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #2's August 2024 physician orders reflected an order for right lateral leg cleanse with normal saline or wound cleanser, pat dry and apply Medi-honey followed by alginate and cover with a protective dressing every day, start date 08/16/2024. Review of Resident #2's weekly wound review report, dated 08/20/2024 and completed by RN A, revealed Resident #2 had a right lateral ankle surgical incision measuring 6 centimeters. Review of a progress note for Resident #2, dated 08/23/2024, and completed by a wound care nurse practitioner reflected surgical wound continues to improve and healing well with no acute changes. Continue POC. Will continue to monitor wound healing progress. During an observation of a wound treatment for Resident #2, 08/26/2024 at 10:55 a.m., completed by RN A and CNA B, Resident #2's had a right ankle wound dressing that was observed without a date or initial. RN A completed the wound treatment, redressed the wound, and initialed and dated the newly applied dressing. During an interview with RN A, 08/26/2025 at 11:00 a.m., RN A verified Resident #2's wound dressing did not have a date or initial on it prior to RN A initiating wound care. During an interview with Resident #2, 08/26/2024 at 11:11 a.m., Resident #2 stated LVN C performed wound care on 08/24/24 and 08/25/24. Resident #2 stated she was not aware the dressing was not dated but could confirm the treatment was completed by LVN C. In addition, Resident #2 stated her wound care was completed daily and staff had not missed a daily treatment. During an interview with CNA B, 08/26/2024 at 11:16 a.m., CNA B stated she observed Resident #2's treatment dressing was not dated or initialed. During an interview with LVN C, 08/26/2024 at 1:40 p.m., LVN C stated she provided wound care to Resident #2's surgical wound on her right ankle over the weekend on 08/24/2024 and 08/25/24. LVN C said she worked 2pm-10 pm on both days and said she was aware Resident #2 had a daily dressing to her right ankle. LVN C said she did not look at the physician order prior to performing the wound dressing and said she cleaned the wound with normal saline and wrapped it in kerlix. LVN C said she did not date or initial the dressing because she did not have a sharpie on her at the time. LVN C stated it was important to follow physician orders to make sure we don't cause infections or make a wound worse and the importance of labeling the wound dressing was so staff know when the treatment was done. During an interview with the facility DON, 08/27/2024 at 2:50 p.m., the DON stated the facility protocol was to initial and date wound dressings at the time the dressings were administered. The DON said the importance of dating and initialing the wound dressings was because it is the process and it shows that the dressing was done. The DON also said the importance of initiating the TAR and follow the physician orders was it is our job to make sure whatever is ordered by the doctor is done for the wellbeing of the patient. Record review of a facility document titled, RN/LVN Proficiency Audit, reflected the name of LVN C. The document listed skills observed and included dressing changes/staple and suture removal. This skill was marked satisfactory, initialed by an observer, and dated 12/21/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER: Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 9014 Timber Path San Antonio, TX 78250	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled, Wound Care, copyright 2001 Med-Pass and revised October 2010, reflected verify that there is a physician's order for this procedure under the preparation section of the policy. Under the steps in the procedure section, the policy reflected, mark tape with initials, time and date and apply to dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9014 Timber Path San Antonio, TX 78250	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standard and practices that are complete and accurately documented for 7 (#1, #2, #3, #4, #5, #6 #8) of 8 residents reviewed for treatment administration. The facility failed to ensure the treatment administration records (TAR) for Residents #1, #2, #3, #4, #5, #6, and #8 reflected that the administration of the treatment orders were accurately documented. This deficient practice could place residents receiving treatments at risk for not receiving appropriate care. The findings were: 1) Review of Resident #1's undated face sheet revealed Resident #1 was a [AGE] year-old male who originally admitted to the facility 07/28/2023 and readmitted , 01/09/2024 with diagnoses that included Parkinsonism (an umbrella term that refers to brain conditions causing slowing movements, rigidity, tremors), type 2 diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar)and osteomyelitis (bone infection) of vertebra (one of the bones composing of the spinal column), sacral (end of the spine in the pelvic area) and sacrococcygeal region (sacrum and coccyx area). Review of Resident #1's quarterly MDS assessment, dated 06/24/2024, reflected Resident #1 had a BIMS score of 10, indicating moderate cognitive impairment. Section M, titled Skin Conditions, reflected Resident #1 had two Stage 4 pressure ulcers, two stage 2 pressure ulcers and one unstageable pressure ulcer that were present upon admission. Review of Resident # 1's care plan, initiated 07/28/2023, reflected Resident #1 had a pressure ulcer to his sacrum and the intervention included treatments as ordered. Review of Resident #1's August 2024 TAR reflected the following orders: A) cleanse left ischium stage 4 pressure ulcer with wound cleanser, pat dry, apply double antibiotic ointment and cover with protective dressing, every shift, every Tuesday, Thursday, Saturday for wound healing. The order had a start date of 07/20/2024. B) cleanse pressure ulcer to mild upper spine with wound cleanser, pat dry, and apply ordered foam dressing every day shift, every Tuesday, Thursday, Saturday for stage 3 pressure wound with a start date of 06/08/2024. C) cleanse pressure ulcer to right ischium with wound cleanser, pat dry, apply double antibiotic ointment and cover with protective dressing every day shift, every Tuesday, Thursday, Saturday for stage 2 pressure wound with a start date of 07/20/2024. D) cleanse pressure ulcer to sacrum (proximal) with wound cleanser, pat dry and apply bordered foam dressing every day shift on Tuesday, Thursday, Saturday with a start date of 03/14/2024. E) left lateral foot: cleanse with normal saline, pat dry, apply betadine and leave open to air daily every day shift for DTI with a start date of 07/16/2024. The TAR for each order was not initialed off on 08/15/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Creek Manor	9014 Timber Path San Antonio, TX 78250

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's weekly wound review, dated 08/21/2024, indicated Resident #1's wounds were improving and decreasing in size. During an interview with RN A, 08/26/2024 at 1:20 p.m., RN A stated she was the treatment nurse and responsible for administering wound care treatments during the week and the facility Charge Nurses were responsible for administering wound care treatments on the weekend. RN A stated she was the treatment nurse for 8/15/2024 and was confident that she completed wound care and stated she did not know why the TAR was blank and stated I always do my treatments every day for my residents. That is really strange, I don't know. 2) Review of Resident #2's undated face sheet reflected Resident #2 was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (a chemical imbalance in the blood that causes problems in the brain), type 2 diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar), displaced avulsion fracture of right talus (when a small part of the ankle bone pulls away from the rest of the bone where it is attached to a ligament or tendon), bipolar disorder (a mental illness characterized by alternating periods of elation and depression) and dementia(a general term for impaired ability to remember, think, or make decisions). Review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 15, indicating no cognitive impairment. Section M, titled Skin Conditions, indicated Resident #2 had a surgical wound. Review of Resident #2's care plan, initiated date 07/01/2024, reflected Resident #2 had altered skin integrity non pressure related to surgical wound to right lateral ankle and right medial ankle, initiated 07/17/2024. The interventions included treatments as ordered. Review of Resident #2's August 2024 physician orders reflected an order for right lateral leg cleanse with normal saline or wound cleanser, pat dry and apply Medi-honey followed by alginate and cover with a protective dressing every day, start date 08/16/2024. Record review of Resident #2's August 2024 TAR reflected the following order, right lateral leg cleanse with normal saline or wound cleanser, pat dry and apply Medi-honey followed by alginate and cover with protective dressing every day shift for surgical wound, start date 0814/2024. The TAR for each order was not initialed off on 08/18/2024, 08/22/2024, 08/24/2024 and 08/25/2024. Review of a progress note for Resident #2, dated 08/23/2024, and completed by a wound care nurse practitioner reflected surgical wound continues to improve and healing well with no acute changes. Continue POC. Will continue to monitor wound healing progress. During an interview with Resident #2, 08/26/2024 at 11:11 a.m., Resident #2 stated LVN C performed wound care on 08/24/24 and 08/25/24. In addition, Resident #2 stated her wound care was completed daily and staff had not missed a daily treatment. During an interview with LVN C, 08/26/2024 at 1:40 p.m., LVN C stated she provided wound care to Resident #2's surgical wound on her right ankle over the weekend on 08/24/2024 and 08/25/24. LVN C said she worked 2pm-10 pm on both days and said she was aware Resident #2 had a daily dressing to her right ankle. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9014 Timber Path San Antonio, TX 78250	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Record review of Resident #3's undated face sheet revealed Resident #3 was a [AGE] year-old male who admitted to the facility 05/08/2024 with diagnoses that included acute osteomyelitis (bone infection) of multiple sites and paraplegia (paralysis of the legs and lower body). Record review of Resident #3's quarterly MDS, dated [DATE], reflected a BIMS score of 15, indicating no cognitive impairment. Record review of resident #3's care plan, initiated 05/09/2024, reflected Resident #3 had pressure ulcers and the interventions included treatments as ordered. Record review of Resident #3's August 2024 TAR reflected the following orders: A) left hip cleanse with normal saline or wound cleanser, pat dry and pack undermining with 1-inch iodoform strip then apply wet to moist vashe dressing followed by protective dressing every day shift for stage 4 pressure wound, start date 07/20/204. B) right buttock cleanse with normal saline or wound cleanser, pat dry, pack tunneling with 1-inch iodoform strip then apply medi-honey followed by alginate and cover with protective dressing every shift for stage 4 wound, start date 06/20/2024. C) Sacrum cleanse with normal saline or wound cleanser, pat dry and apply Medi honey followed by alginate and cover with Abd pad and secure with tape every day for stage 4 pressure wound, start date 05/25/2024. The TAR for each order was not initialed off on 08/15/2024 and 08/22/2024. Record review of Resident #3's progress notes reflected an entry by a wound care nurse practitioner on 08/23/2024 that stated no wound complaints or concerns reporting by nursing. Chronic pressure injury wounds remain stable with no acute changes. No s/s of acute infection. Continue current treatment and offloading measures. Will continue to monitor wound healing progress. During an interview with Resident #3, 08/27/2024 at 11:50 a.m., Resident #3 stated facility staff performed his wound care daily, have not missed a daily treatment, and his wounds were improving. 4) Record review of Resident #4's undated face sheet reflected Resident #4 was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted , 08/04/2024 with diagnoses that included abscess of epididymis or testis (inflammation of the long coiled tube that attached to the upper part of each testicle), hemiplegia (one sided muscle paralysis or weakness) and type 2 diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar). Record review of Resident #4's annual MDS, dated [DATE], reflected a BIMS score of 04, indicating severe cognitive impairment. Record review of Resident #4's care plan reflected Resident #4 had a surgical wound to the scrotum, initiated 08/12/2024. Interventions included treatments as ordered. Record review of Resident #4's progress notes reflected an entry by a wound care nurse practitioner on 08/23/2024 that stated surgical wound crotal area continues to decrease in size dimension and healing well with no acute changes. Continue POC. Will continue to monitor wound healing progress. Record review of Resident #4's August 2024 TAR reflected an order for scrotum cleanse with normal saline or wound cleanser, pat dry, apply vashe wet to moist dressing every day shift for surgical wound, start date 08/13/2024. The TAR for each order was not initialed off on 08/17/2024, 08/18/2024, 08/22/2024, 08/24/2024 and 08/25/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455652	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Creek Manor	9014 Timber Path San Antonio, TX 78250

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Record review of Resident #5's undated face sheet reflected Resident #5 was a [AGE] year-old male who originally admitted to the facility 02/29/2024 and readmitted [DATE] with diagnoses that included osteomyelitis (bone infection) of vertebra (one of the bones composing of the spinal column), sacral (end of the spine in the pelvic area) and sacrococcygeal region (sacrum and coccyx area), type 2 diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar) , dysphagia (difficulty swallowing) and cerebral infarction (a disruption in the brain's blood flow). Record review of Resident #5's quarterly MDS, dated [DATE], reflected a BIMS score of 6, indicating severe cognitive impairment. Section M, titled Skin Conditions, reflected Resident #5 ad a stage 2 pressure ulcer, stage 3 pressure ulcer, stage 4 pressure ulcer, and two unstageable pressure ulcers. Record review of Resident #5's care plan, initiated 03/01/2024, revealed Resident #5 had an unstageable wound to his sacrum, unstageable wound to right malleolus, left heel dti, dti right medial knee, left lateral ankle stage 2, right ischium dti, left ischium dti, left hallux unstageable, buttock unstageable, left lateral knee unstageable, left lateral leg stage 2. Interventions include treatments as ordered. Record review of Resident #5's August 2024 TAR reflected the following orders: A) Aquaphor ointment 40 oz refills- apply to the feet daily x 3 months in the morning for Xerosis bilat feet, start date 06/15/2024. B) Left buttock cleanse with normal saline and wound cleanser, pat dry and apply Medi-honey followed by alginate and cover with protective dressing every day shift for unstageable, start date 08/06/2024. C) left hallux cleanse with normal saline or wound cleanser, pat dry and apply betadine and LOTA every day shift for unstageable wound, start date 08/06/2024. D) left heel cleanse with normal saline or wound cleanser, pat dry, apply Medi-honey followed b alginate and cover with protective dressing every day shift for stage 3, start date 08/16/2024. E) Left lateral knee cleanse with normal saline or wound cleanser, pat dry and apply betadine and LOTA every day shift for unstageable, start date 08/06/2024. F) Right ischium cleanse with normal saline or wound cleanser, pat dry and apply Medi-honey followed by alginate and cover with protective dressing every day shift for unstageable wound, start date 08/06/2024. G) Right malleolus cleanse with normal saline or wound cleanser, pat dry and apply collagen followed by alginate cut to fit and cover with protective dressing every day shift for stage 3 pressure wound, start date 05/23/2024. The TAR for each order was not initialed off on 08/11/2024, 08/17/2024, 08/18/2024, 08/22/2024, 08/24/2024 and 08/25/24. Record review of Resident #3's progress notes reflected an entry by a wound care nurse practitioner on 08/23/2024 that stated reevaluate multiple pressure injury wounds which remain stable with no acute changes. No s/s of acute infection. 6) Record review of Resident #6's undated face sheet reflected Resident #6 was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted , 05/10/2024 with diagnoses that included metabolic encephalopathy (a chemical imbalance in the blood that causes problems in the brain), pneumonia (a lung infection), sepsis (a condition in which the body's extreme response to an infection becomes life threatening), type 2 diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar) , and acute respiratory failure (gas exchange between the lungs and the blood). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9014 Timber Path San Antonio, TX 78250	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #6's quarterly MDS, dated [DATE], revealed a BIMS score of 12, indicating mild cognitive impairment. Section M, titled Skin Conditions, revealed Resident #6 had a stage 2 pressure ulcer upon admission to the facility. Record review of Resident #6's care plan reflected Resident #6 has altered skin integrity non pressure related to penile shaft, initiated 08/23/2024, and interventions included treatments as ordered. The care plan revealed Resident #6 had a stage 2 pressure wound to his right buttock and left heel, initiated 05/10/2024 and reflected stage 2 pressure to right buttocks resolved 06/04/2024. Record review of Resident #6 August 2024 TAR reflected an order for left heel cleanse with normal saline or wound cleanser, pat dry and apply alginate with silver and cover with protective dressing every day shift for DTI, start date 05/11/2024. The order was not initialed off on 08/22/2024. Order for mupirocin external ointment 2 % apply to scrotum/groin topically every day shift for abrasion, start date 006/28/2024 and d/c date 08/23/2024, was not initialed off on 08/22/2024. Order for sacrum cleanse with normal saline or wound cleanser, pat dry and apply triad and lota every day shift for preventative measures, start date 07/08/2023, was not initialed off on 08/22/2024. Order for right buttock cleanse with normal saline or wound cleanser, pat dry and apply triad and lota every shift for preventative measures, start date 06/04/2024, was not signed off on 6am shift 8/22/2024, 2 pm shift 08/02/2024, 08/23/2024, 10pm shift 08/02/2024, 08/03/2024, 08/04/2024, 08/05/2024, 08/08/2024, 08/09/2024, 08/10/2024,08/14/2024, 08/15/2024, 08/16/2024, 08/17/2024, 08/20/2024, 08/21/2024, 08/22/2024, 08/23/2024. Record review of Resident #6's progress notes reflected an entry by a wound care nurse practitioner on 08/23/2024 that stated abscess groin area was resolved. New MDRI penile shaft noted. Pressure injury left heel remains stable with no acute changes. Record review of weekly wound review, dated 08/23/2024 and completed by RN A, reflected Resident #6's stage 3 coccyx wound measured 0 x 0 x 0 and was healed. During an interview with Resident #6 on 08/27/2024 at 12:04 p.m., Resident #6 said he received wound care daily including the weekends and said his wound had been improving and he said he had been happy with the wound care he was receiving. 7) Record review of Resident #8's undated face sheet reflected Resident #8 was a [AGE] year-old female who originally admitted tot eh facility on 02/12/2022 with a readmitted [DATE] with diagnoses that included multiple sclerosis (autoimmune disease that affects the central nervous system), schizophrenia (mental disorder characterized by significant alterations in perception, thoughts, moods and behavior) and paraplegia (paralysis of the legs and lower body). Record review of Resident #8's quarterly MDS, dated [DATE], reflected a BIMS score of 15 indicating no cognitive impairment. Record review of Resident #8's care plan reflected Resident #8 had a stage 3 pressure wound, date initiated 06/03/2024, altered skin integrity related to right gluteal fold, abscess to right groin, date initiated 04/11/2024. The interventions for both care plans included treatments as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9014 Timber Path San Antonio, TX 78250	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's August 2024 TAR reflected and order for coccyx cleanse with normal saline or wound cleanser, pat dry and [NAME] collagen followed by alginate and cover with protective dressing every day shift for stage 3 pressure wound, start date 06/04/2024 and d/c date 08/23/2024. The order was not initialed off on 08/22/2024. An order for right gluteal fold cleanse with normal saline or wound cleanser, pat dry and apply hydroferablue and cover with protective dressing every day shift for abrasion, start date 07/27/2024 and was not initialed off on 08/22/2024. During an interview with Resident #8, 08/27/2024 at 12:15 p.m., Resident #8 stated she was receiving wound care daily by the facility nurses and stated her wounds are improving with the treatments. During an interview with RN A, 08/26/2024 at 1:20 p.m., RN A said she was responsible for performing wound care on residents with wound care orders Monday through Friday and validated wound care was completed on the weekend when she did wound care on Mondays. RN A stated wound care should have been initialed off on the TAR when wound care was completed. RN A stated if she did not see it initialed off in the TAR, she would have asked the resident if wound care was completed and observe the dressing date. RN A was asked what it meant if the administration record had no initials for a certain day and she said I guess it would mean it was not clicked off on or overlooked but in my case I always do my treatments so I don't know why there are blanks. During an interview with LVN C, 08/26/2024 at 1:40 p.m., LVN C stated Charge Nurses were responsible for completing wound care on the weekends if no one is assigned to wound care. LVN C said she checked the TARs to ensure wound care had been administered and if it was not administered prior to her shift on 2 p.m. to 10 p.m., LVN C would complete the wound care for her residents. LVN C stated she completed wound care over the weekend. During an interview with the DON, 08/27/2024 at 2:50 p.m., the DON stated RN A was responsible for the wound care system and administered wound care Monday - Friday. The DON stated if RN A identified a concern with wound care she would notify the DON and the DON would address the concern immediately. When asked who validated wound care had been completed for the prior day, the DON said every nurse was responsible on their shift to ensure the TAR was completed and said every nurse should not leave their shift without signing off on the TAR. The DON said he believed it was human error that the nurses did not initial off on the administration record and said, there is obviously room for improvement, but no wound is getting worse, and we have not grown any wounds. The DON said the importance of initialing the TAR and following the physician orders was it is our job to make sure whatever is ordered by the doctor is done for the wellbeing of the patient. During an interview with the Administrator, 08/27/2024 at 3:20 p.m., the Administrator said she ensured wound care was being completed timely and as ordered by the physician by monitoring the wound logs and discussing wounds during QA, observing trends with wounds and ensuring wounds were improving. The Administrator stated her expectation was nurses were to initial off on wound care on the TAR when the wound care was administered. The Administrator stated her expectation was the treatment nurse or nurse management would be checking the TARs to ensure treatments were completed the prior day and over the weekend. Record review of the facility's policy titled, Wound Care, dated 2001 Med-pass, Inc. (revised October 2010), under a section related to documentation of wound care, stated the name and title of the individual performing the wound care should be recorded in the resident medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9014 Timber Path San Antonio, TX 78250	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48753 Based on observations, interviews, and record review, the facility failed to maintain an infection control program designed to ensure enhanced barrier precaution procedures were followed by staff in direct care of 1 resident (Resident #2) of 8 reviewed for infection control in that: The facility failed to ensure Resident #2 had a sign on the room door indicating Resident #2 required enhanced barrier precautions per the facility's policy. The deficient practice could place the staff and residents at risk for infection. The findings were: Review of Resident #2's undated face sheet reflected Resident #2 was a [AGE] year old female who originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (a chemical imbalance in the blood that causes problems in the brain), type 2 diabetes (a condition resulting from insufficient production of insulin, causing high blood sugar), displaced avulsion fracture of right talus (when a small part of the ankle bone pulls away from the rest of the bone where it is attached to a ligament or tendon), bipolar disorder (a mental illness characterized by alternating periods of elation and depression) and dementia(a general term for impaired ability to remember, think, or make decisions). Review of Resident #2's quarterly MDS, dated [DATE], reflected a BIMS score of 15, indicating no cognitive impairment. Section GG, titled Functional Abilities and Goals, of the MDS reflected Resident #2 requires staff assistance for transfers, bathing, toileting, hygiene and dressing. Section H of the MDS revealed Resident #2 was always incontinent of bladder and frequently incontinent of bowels. Section M, titled Skin Conditions, indicated Resident #2 had a surgical wound. Review of Resident #2's care plan, initiated date 07/01/2024, reflected Resident #2 was on enhanced barrier precautions related to infection or colonization of urine. The interventions in place were listed as: don gown and gloves during high contact resident care activities, enhanced barrier precautions and monitor/document/report bodily excretions or sections that cannot be contained. The care plan also reflected Resident #2 had altered skin integrity non pressure related to surgical wound to right lateral ankle and right medial ankle, initiated 07/17/2024. The interventions included monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor and notify physician of significant findings and treatments as ordered. Review of Resident #2's August 2024 physician orders reflected an order for enhanced barrier precautions related to colonized urine every shift, initiated 05/15/2024. Review of Resident #2's August 2024 physician orders reflected an order for right lateral leg cleanse with normal saline or wound cleanser, pat dry and apply Medi-honey followed by alginate and cover with a protective dressing every day, start date 08/16/2024. Review of Resident #2's weekly wound review report, dated 08/20/2024 and completed by RN A reflected Resident #2 had a right lateral ankle surgical incision measuring 6 centimeters. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9014 Timber Path San Antonio, TX 78250	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on initial rounds, 08/26/2024 at 10:20 a.m., enhanced barrier precaution signs were observed on multiple resident room doors throughout the facility. The signs included two stop signs in the top corners of the legal sized orange paper and read, ENHANCED BARRIER PRECAUTIONS EVERY MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and gown for the following high-contact resident care activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. The sign had a CDC, U.S. Department of Health and Human Services Center for Disease Control and Prevention logo in the bottom right corner. During an observation, 08/26/2024 at 10:47 a.m., RN A and CNA B were observed donning PPE prior to entering Resident #2's room. Resident #2 did not have an enhanced barrier precaution sign on her door. When asked why RN A and CNA B were donning PPE, RN A stated because [Resident #2] was on enhanced barrier precautions and she had a wound. When asked if Resident #2 should have had a sign on her door indicating enhanced barrier precautions, RN A stated yes. Upon entering Resident #2's room, Resident #2 was heard stating to RN A and CNA B, oh, you all are going to gown up today, you all are doing the works today. During an interview with RN A, 08/26/2024 at 11:00 a.m., RN A stated residents on enhanced barrier precautions were identified by a sign on their door that says enhanced barrier precautions. RN A said the importance of enhanced barrier precautions was to prevent the spread of infection and should have been used for any resident with a wound or any opening to the body like a feeding tube. RN A stated she did not know who was responsible for placing the signs on resident doors. During an interview with CNA B, 08/26/2024 at 11:16 a.m., CNA B stated residents on enhanced barrier precautions had a sign on their door and said it was important to identify those residents so the staff knew before entering the room that staff were to use PPE to protect the resident and themselves from infection. CNA B said she had received training on enhanced barrier precautions. During an interview with RN B, 08/27/24 at 12:55 p.m., RN B stated she was the facility's Infection Preventionist. RN B stated any resident with an indwelling device, artificial portal to the body, or wounds was placed on enhanced barrier precautions and the staff were able to identify these residents by a sign placed on their door stating enhanced barrier precautions. RN B stated the Charge Nurses or management was responsible for placing the signs on the doors and said it was important to identify those residents in order to protect staff and resident from transferring infections to other residents or staff members. RN B revealed, not following enhanced barrier precautions, could cause a person to contract a bacteria or infection and spread it to other people. During an interview with the facility's DON, 08/27/2024 at 2:50 p.m., the DON stated the facility rolled out the CMS guidance on enhanced barrier precautions on 04/02/2024 and all direct care staff were educated on the precautions and the use of a sign on the door to identify the residents on enhanced barrier precautions. The DON stated, the facility completed an audit the prior day after the missing sign was observed for Resident #2 and observed a total of three residents without the sign on their door. The DON revealed the importance of identifying residents on enhanced barrier precautions was to prevent further infections or complication for the residents or others. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Silver Creek Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9014 Timber Path San Antonio, TX 78250	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Enhanced Barrier Precautions, dated August 2022, reflected EBP's were indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. The policy also reflected, signs were posted in the door or wall outside the resident room indicating the type of precautions and PPE required.