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	06/06/2024

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 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. 49305 Based on and biologicals were stored properly for 2 of 6 medication carts (400 hall medication cart, 100 hall nurse medication cart). 1. An expired bottle of medication was stored in the drawer of the 400-hall medication cart . 2. The medication cart assigned to hall 100 had a loose pill. This failure could place residents at risk of not receiving prescribed medications as ordered, receiving medications that were less effective or have altered composition, and drug diversions. The findings included : 1. During an observation on 06/05/24 at 9:37 AM of the medication cart for hall 400 with CMA A, an expired bottle of Healthy Eyes Mineral Supplement with Lutein and Antioxidants was found in the cart drawer. The expiration date on the bottle was observed to be 2/2024. CMA A removed the expired medication bottle from the cart and stated it would be given to the DON for destruction. During an interview on 06/05/24 at 02:48 PM with CMA A, he stated there should not be expired medications on the cart. He stated he put the expired bottle of medication in the bottom cart drawer with the intention to remove it from the cart but failed to do so. He stated it was the responsibility of the nursing staff and CMA's to ensure medications on the cart were within date and removed when out of date. He stated he has been trained by the facility DON to monitor the expiration dates for medications on the cart. He stated a potential negative outcome of expired medications on the cart was that the medications could be administered and cause harm to a resident. During an interview on 06/06/24 at 10:30 AM, the DON stated it was the responsibility of the CMA's and nursing staff to ensure expired medications were removed from the medication cart. He stated the staff were trained annually and as needed on proper storage of medications. He stated his expectation of staff was to stay on top of cart checks and monitor for expired medications daily. The DON stated the nurse auditor, pharmacy consultant, and the weekend supervisor each conduct cart audits monthly. He stated a potential negative outcome of expired medications on the cart was that an expired medication could be administered to a resident. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/06/24 at 11:20 AM, the ADM stated there should not be any expired medications stored on the cart. She stated staff were trained on proper medication storage by the DON. The ADM stated her expectation of staff was that all medications were properly labeled and expired medications were removed from the cart. She stated a potential negative outcome of expired medications on the cart would be residents being administered expired medications and having an adverse reaction. 2. During an observation on 06/05/24 at 10:06 AM of the medication cart for hall 100 with RN A, one loose pill was found in the medication cart drawer. RN A placed the loose pill in a dispensing cup and the DON identified the medication as Gabapentin. The DON took the medication to be destroyed. During an interview on 06/05/24 at 10:10 AM with RN A, she stated she wasn't sure why there was a loose pill on the cart. She stated it was her responsibility to check the medication cart for loose medications. She stated she had been trained by the DON to check the cart for proper medication storage daily. She stated a potential negative outcome of loose medications on the cart would be that a resident may not have enough medication, or the medication may be given to the wrong resident. During an interview on 06/06/24 at 10:30 AM, the DON stated there should not be loose medications on the cart. He stated staff were trained annually and as needed on proper storage of the medications. He stated his expectation of staff was to stay on top of cart checks and monitor for proper storage of medications daily. The DON stated the nurse auditor, pharmacy consultant, and the weekend supervisor each conduct cart audits monthly. He stated a potential negative outcome of loose medications on the cart was that a resident could miss a dose. During an interview on 06/06/24 at 11:20 AM, the ADM stated there should not be any loose medications on the cart. She stated staff were trained on proper medication storage by the DON. The ADM stated her expectation of staff was that all medications were properly labeled and stored on the cart. She stated a potential negative outcome of loose medications on the cart would be that the medication was not administered to the resident. Record review of the facility provided policy labeled, Medication Labeling and Storage, date revised, February 2023, revealed: Policy Interpretation and Implementation: 1. Medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medication between containers. 2. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 5. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medication of several residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observations, interviews, and record review, the facility failed to ensure all drugs

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41480 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure foods were processed and pureed under sanitary conditions. These failures could place residents at risk for food contamination and foodborne illness. The findings included: The following observations were made on 06/04/24 at 11:15 AM during observation of puree meal preparation: After pureeing garlic bread sticks, Cook A took processor bowl, lid, and blade to 3-compartment sink and cleaned all 3 parts. Cook A took all there parts back to processor base and assembled. Observed liquid in bottom of bowl, lid and blade was dripping liquid on floor and countertop. Cook A removed processor bowl and lid and poured liquid into sink. Cook A placed processor bowl and blade back on the processor base. Cook A prepared puree spaghetti then took processor bowl, lid, and blade to 3 compartments sink and cleaned all 3 parts. She then took bowl, lid, and blade to processor base and assembled. Observed bowl, lid, and blade had liquid dripping off onto floor and countertop. Cook A prepared puree veggies then took processor bowl, lid, and blade to 3 compartments sink and cleaned all 3 parts. She then took bowl, lid, and blade to processor base and assembled. Observed bowl, lid, and blade had liquid dripping off onto floor and countertop. During an interview on 06/06/24 at 09:15 AM with the Cook A, she stated all puree processor parts should be air dried before using. She stated she has only worked in the kitchen a couple of weeks and had not been trained on allowing puree processor parts to air dry before use until yesterday (6/5/24). She stated she was not sure why the processor needs to air dry before use. She stated she did complete her safe serve certificate. She stated the potential negative outcome could be chemical in water mixing with the food. During an interview on 06/06/24 at 09:20 AM with the DM, she stated any items washed in the 3-compartment sink needed to air dry before using. She stated they currently only have one bowl, lid, and blade for puree processor. She stated the reason the cook did not allow the bowl, lid, and blade to dry was because she was pressed on time. She stated all staff have been trained during orientation. She stated the potential negative outcome could be bacteria and sanitation on bowl, lid, and blade mixing with the puree food. During an interview on 06/06/24 at 09:30 with the ADM, she stated she was not sure if items washed in the 3-compartment sink needed to be air dried before use. She stated the DM was responsible for training all staff. She stated new staff were trained in orientation. She stated the potential negative outcome could be chemical mixing with the puree causing the resident to become ill. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Sanitization, revised November 2022, revealed the following: Policy Statement: The food service area is maintained in a clean and sanitary manner . 7. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination.