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	07/02/2025

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 4 residents (Resident #13) reviewed for pressure ulcers. The facility failed to implement the repositioning schedule indicated in Resident #13's comprehensive care plan. This failure could place residents at risk of hindered healing of the residents with existing pressure ulcers or lead to the development of additional skin injuries.Findings included:Record review of Resident #13's face sheet, date printed 7/2/2025, revealed resident was a [AGE] year-old female originally admitted on [DATE]. Record review of the quarterly MDS submitted on 6/1/2025 reflected a BIMS score of 02. Section M of the MDS indicated Resident #13 had 2 unstageable pressure ulcers and 1 unstageable pressure ulcer presenting as a deep tissue injury. Record review of Resident #13's comprehensive care plan, date printed 6/30/2025, revealed the following intervention: [Resident #13] requires extensive assistance by 1-2 staff to turn and reposition in bed Q2hrs and as necessary. Record review of Resident #13's scheduled tasks and treatment record for June 2025 did not reveal documentation of resident repositioning.Observations of Resident #13 on 7/1/2025 revealed the following:a) 8:13: AM: the resident was lying flat on her back with a neck pillow in place and additional pillow positioned under right elbow, the head of the bed was elevated to approximately 45 degrees. b) 10:15 AM the resident was lying flat on her back with a neck pillow in place and additional pillow positioned under right elbow, the head of the bed was elevated to approximately 45 degrees, which indicated no change in position.c) 12:20 PM the resident was lying flat on her back with a neck pillow in place and additional pillow positioned under right elbow, the head of the bed was elevated to approximately 45 degrees, which indicated no change in position. An attempt was made on 7/1/2025 at 8:13 AM to interview Resident #13, but she was unable to participate due to cognitive decline.In an interview with CNA E on 7/1/2025 at 8:00 AM, she stated Resident #13 required repositioning every 2 hours. She stated she was unsure where to document this intervention in the medical record. In an interview with RN G on 7/1/2025 at 8:20 AM, she stated CNAs were responsible for repositioning the residents. She also stated she had conversations with the CNAs to ensure this task was being completed. In an interview with the DON on 7/1/2025 at 3:30 PM, she stated her expectation was for staff to adhere to the Q2hrs turning schedule, as tolerated by the resident. She stated the medical record does not contain a place for documentation, but the nurse should be overseeing the task and ensuring it is being performed. She reported the potential harm of residents not being repositioned was skin breakdown. Record review of the facility policy titled Pressure Injury Prevention and Management (revised 6/1/2025) revealed interventions will be documented in the care plan and communicated to all relevant staff. Compliance with interventions will be documented in the weekly summary charting.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment for 1 of 4 residents (Resident #39) reviewed for nutrition. The facility failed to assess and document the restricted fluid intake for Resident #39, as ordered by the physician.This failure could place residents at risk of impaired cardiovascular function, impaired breathing, and decreased quality of life. Findings included: Record review of Resident #39's face sheet, date printed 6/29/2025, revealed a [AGE] year-old male who was originally admitted to the facility on [DATE]. A relevant diagnosis included chronic diastolic (congestive) heart failure (weakening of the heart muscle leading to impaired function and fluid overload). Record review of the annual MDS submitted 6/19/2025 revealed a BIMS score of 15, which indicated intact cognition. Additional record review of Resident #39's comprehensive care plan, date of completion 5/16/2025, revealed an intervention as follows: 1500mL fluid restriction: total nursing = 780mL per day, total dietary = 720mL per day. Please document in PN if resident in non-compliant with fluid restriction and notify MD [sic]Record review of Resident #39's active physician orders revealed the following associated order: 1500ml Fluid RESTRICTION: Total Nursing = 780ml per day, Total Dietary = 720ml per day. Please document in PN if resident in non-compliant with fluid restriction and notify MD. every shift related to HEART FAILURE, UNSPECIFIED [sic] (order start date 8/23/2024)Record review of Resident #39's progress notes for April-June 2025 did not reveal any documentation regarding the resident's fluid intake. A record review of Resident #39's lunch dining ticket on 7/1/2025 reflected instruction to provide the resident with 8 ounces (240mL) due to the fluid restriction. In an observation and interview on 7/1/2025 at 12:20 PM, CNA F was observed serving Resident #39 two glasses of water with his lunch tray, totaling 16 ounces (480mL). CNA F stated she was aware of the fluid restriction for Resident #39. She stated she monitored his fluid intake by answering his call light promptly and conversing with the other nursing staff. She was not sure if the two cups of water were within the limits of his ordered fluid restriction. She also stated Resident #39 had never exceeded the 1500mL fluid restriction when she was on shift. In an interview with CNA E on 7/1/2025 at 8:00 AM, she reported she was not aware of any residents on the hall which Resident #39 resided who were on fluid restrictions. In an interview with RN G on 7/1/2025 at 8:54 AM, she stated she tracked Resident #39's fluid intake by documenting progress notes and monitoring the documentation entered by the CNAs. Resident #39 was interviewed on 7/1/2025 at 8:39 AM. He stated the staff never went into his room to ask him how much fluid he had to drink. He reported they would frequently remind him to limit his intake, but they do not ask specifically how many beverages he consumed. CNA H was interviewed on 7/1/2025 at 3:01 PM. She stated she was not told during shift report how much fluid Resident #39 consumed during the prior shift, but she was aware of the restriction. She stated she tracked his fluid intake by communicating with the nurse. LVN I was interviewed on 7/1/2025 at 2:58 PM. She stated she was not told during shift report how much fluid Resident #39 had consumed during the prior shift. She stated she monitored the fluid intake by communicating with the CNAs. She was unsure how she would know if he exceeded 1500mL of fluid for the day. ADON J was interviewed on 7/1/2025 at 3:30 PM. He stated the staff were made aware of Resident #39's fluid restriction via the care plan. He reported Resident #39 is frequently non-compliant and consumes beverages without notifying the staff, but the staff should notify the provider if he displayed symptoms of fluid overload, like shortness of breath, or abnormal laboratory results. He stated the staff should be communicating his intake across shifts and recording it on paper. He reported the potential harm of not monitoring the fluid intake for Resident #39 was fluid retention and shortness of breath. Record review of the facility's policy titled Provision of Quality of Care (implemented 6/10/2025) revealed the following: Qualified persons will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices.

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 facility reviewed for food and nutrition services.1.-The facility failed to ensure an overhead ceiling vent in the main kitchen area was cleaned2. The facility failed to ensure a side wall vent in the main kitchen area was cleaned3. The facility failed to ensure overhead lighting in the main kitchen area was repaired.4. The facility failed to ensure overhead lighting in the dish room area was repaired5. The facility failed to repair broken side wall tiles in the main kitchen area.6-The facility failed to ensure two ceiling vents in the dry storage room were repaired. 7-The facility failed to ensure two ceiling vents in the employee bathroom were repaired8-The facility failed to ensure broken floor molding in the main kitchen area was repaired.9-The facility failed to ensure broken floor molding in the dietary manager's office was repaired.10-The facility failed to ensure a side wall crack in the main kitchen area was repaired.These failures could place residents at risk for food borne illness.The findings include:Observation on 06/29/2025 from 9:05am until 9:15am with Cook-A revealed the following: a. There was a overhead ceiling vent which measured approximately 3x4 ft in the main kitchen area that was covered with dust and dirt.b. There was a side wall vent which measured approximately 4x2 ft in the main kitchen area that was covered with dust and dirt.c. There were 4 overhead ceiling lights which measured approximately 5x2 ft in the main kitchen area that had non-working light bulbs.d. There was 1 overhead ceiling light which measured approximately 5x2 ft in the dish room area that had non-working light bulbs.e. There were missing side wall tiles under the two basin sink which measured approximately 4x2 ft in length and height in the main kitchen area. f- There were two ceiling vents in the dry storage room which measured approximately 8x8 inches in diameter. One of the vents was not attached to the ceiling. The other vent was covered with rust.g. There were two ceiling vents in the employee bathroom which measured approximately 4x8 inches in diameter and 6x6 inches in diameter. The ceiling vent which measured approximately 4x8 inches in diameter was covered with rust. The ceiling vent which measured approximately 6x6 inches in diameter was covered with dirt and dust.h. There was area under the walk-in refrigerator which measured approximately 1.5 ft by 3 inches in the main kitchen area where a section of floor molding was missing.i. There was an area on a side wall which measured approximately 1 ft by 3 inches in the dietary manager's office where the floor molding was not attached to the side wall.j. There was an area which measured approximately 1x4 inches on a side wall next to the kitchen entrance in which the wall was cracked. Observation on 06/29/2025 from 9:05am until 9:15am with the Food Service Director revealed the following: a. There was a overhead ceiling vent which measured approximately 3x4 ft in the main kitchen area that was covered with dust and dirt.b. There was a side wall vent which measured approximately 4x2 ft in the main kitchen area that was covered with dust and dirt.c. There were 4 overhead ceiling lights which measured approximately 5x2 ft in the main kitchen area that had non-working light bulbs.d. There was 1 overhead ceiling light which measured approximately 5x2 ft in the dish room area that had non-working light bulbs.e. There were missing side wall tiles under the two basin sink which measured approximately 4x2 ft in length and height in the main kitchen area. f- There were two ceiling vents in the dry storage room which measured approximately 8x8 inches in diameter. One of the vents was not attached to the ceiling. The other vent was covered with rust.g. There were two ceiling vents in the employee bathroom which measured approximately 4x8 inches in diameter and 6x6 inches in diameter. The ceiling vent which measured approximately 4x8 inches in diameter was covered with rust. The ceiling vent which measured approximately 6x6 inches in diameter was covered with dirt and dust.h. There was an area under the walk-in refrigerator which measured approximately 1.5 ft by 3 inches in the main kitchen area where a section of floor molding was missing.i. There was an area on a side wall which measured approximately 1 ft by 3 inches in the dietary manager's office where the floor molding was not attached to the side wall.j. There was an area which measured approximately 1x4 inches on a side wall next to the kitchen entrance in which the wall was cracked.During an interview with the Food Service Director on 6/29/25 at 1:20pm she stated she was responsible for notifying the Maintenance Director if any repairs were needed in the kitchen. The Food Service Director stated all of the identified areas in the kitchen needing repair could affect kitchen cleanliness for food preparation as well as impact employee safety.During an interview with the Administrator on 6/29/25 at 1:30pm she stated she observed all of the areas needing repair in the kitchen. The Administrator stated all of the identified areas needing repair could affect maintaining a clean kitchen for food preparation. The Administrator stated she

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to enact a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption, for 1 (Resident # 33) of 3 residents reviewed, in that:Resident # 33's personal refrigerator located in her room observed on 06/29/2025, revealed food items, with no date and no label. This failure could place residents at risk of foodborne illness due to consuming foods which might be spoiled. The findings included: Record review of Resident #33's face sheet, dated 06/29/2025, reflected the resident was an [AGE] year old female and was initially admitted to the facility on [DATE] with diagnoses that included: dementia (loss memory or problem solving and other thinking abilities), muscle wasting and atrophy (loss of muscle tissue and strength), and Type 2 Diabetes Mellitus(not control blood sugar in the body). Record review of Resident #33's quarterly MDS assessment, dated 04/18/2025, reflected the resident's BIMS score was 13 out of 15 which indicated the resident cognitive function is intact. The resident needs Supervision with eating and was Maximal assistance (helper does more than half the effort) for dressing and transfers.Observation on 06/29/2025 at 10:07 a.m. revealed Resident #33 was not in her room. There was a personal refrigerator in the room, and inside the refrigerator was ham in an unlabeled and undated clear plastic bag. Also inside the refrigerator was green salsa in 3 small clear plastic round containers with a lid, but it was unlabeled and undated. Observation on the temperature log on the outside of the refrigerator revealed the log was last filled out on 06/26/2025.Interview on 07/01/2025 at 11:00 a.m. the DON stated that food in resident refrigerators should be dated and labeled. She also confirmed the temperature log should be filled out daily. When asked who is responsible for checking the refrigerator on the hallway, she told me she was responsible for checking the refrigerator and updating the temperature log. Record review of the facility policy titled Foods Brought by Family/Visitors, revised October 2017, revealed . 6. Food brought by family/visitors that is left with the resident to consume later will labeled and stored in a manner that is clearly distinguishable from facility-prepped food. 7. The nursing staff will discard perishable foods on or before the se by or expiration date. Record review of the facility policy titled Food Receiving and Storage, revised October 2017, revealed .8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date).This failure could place residents at risk of consuming spoiled foods which could cause food borne illness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 laundry areas, 1 of 5 facility hallways (300 hall), and 3 of 6 residents (Residents #37, #191, and #78) reviewed for infection control. 1. The facility failed to ensure clean linen in the laundry area was stored in a method to reduce the risk of contamination.2. The facility failed to ensure PPE was readily available to staff caring for residents identified as requiring EBP in the 300 hallway.3. The facility failed to ensure staff members were following TBP procedures and donning PPE when providing high contact care for Residents #37, #191, and #78. These failures could place residents at risk for the transmission of infection, infection, or illness. Findings included:1. In an observation of the facility's only laundry area on 6/30/2025 at 1:00 PM with Laundry Aide C it was revealed clean bath towels were being stored in a lint trap of a non-working clothes dryer. The lint trap was observed to contain debris and dust. The Laundry Aide stated the dryer being used for storage had not been functional for a while, but he was unsure of the exact length of time. He also stated he stored the towels here in order to hide them and prevent staff from taking all of the clean towels during a single shift. The Laundry Aide reported no concerns with possible contamination of the towels. In an interview with the Admin and Maintenance Director on 6/30/2025 at 3:00 PM, both staff stated Laundry Aide C should not be storing linen in the lint trap of the dryer due to potential for contamination. Observations on 6/29/2025 at 11:16 AM revealed four resident rooms in the 300 hallway had signage posted which indicated EBP. There was no PPE cart present in the hallway. In an interview with the DON on 7/1/2025 at 3:30 PM, she reported awareness that the PPE cart was not present on 6/29/2025 She speculated staff had been utilizing PPE from a neighboring hallway when providing high contact care for residents and that the cart had been mistakenly moved. She stated every hall should have at least one PPE cart and not having a cart could be a barrier to staff utilizing PPE. Record review of the facility's policy titled Transmission-Based (Isolation) Precautions (implemented 4/18/2025, revised 4/18/2025) reflected the followingF. The facility will have PPE readily available near the entrance of the resident's room and will don appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions. 2. Record review of Resident #37's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #37 had a relevant diagnosis which included gastrostomy status (a surgical opening to the stomach to allow the intake of food/medications).Record review of Resident #37's physician orders reflected the following: Enhanced barrier precautions r/t G-tube status, chronic-wound-coccyx (start date 3/28/2025)In an observation on 7/1/2025 at 8:46 AM, CNA E and CNA F were observed entering Resident #37's room to perform incontinent care without PPE. In an interview with CNA E and CNA F on 7/1/2025 at 8:50 AM, they stated they did not wear PPE while providing incontinent care to Resident #37. They stated they were aware she required EBP precautions, but they were in a hurry. They reported the potential harm of not using PPE for residents requiring EBP was the spread of infection. 3. Record review of Resident #78's face sheet, dated 6/29/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #78 had relevant diagnoses which included encounter for gastrostomy and non-pressure chronic ulcer of unspecified ankle with unspecified severity. In an observation on 06/29/25 at 12:00 PM, revealed CNA D entered Resident #78's room without donning PPE. She was then observed exiting the room with bagged linen.CNA D was interviewed on 6/29/2025 at 12:03 PM, she reported she assisted Resident #78 with incontinence care. She stated neither resident in Resident #78's room required EBP precautions, despite the signage posted on the door. She stated the signage indicated a resident had an indwelling foley catheter, which neither resident had. She then stated the proper PPE when providing care for residents on EBP was to wear gloves. She reported she was a new hire and had received infection control training and TBP training during orientation. 4. Record review of Resident #191's face sheet, dated 7/2/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #191 had relevant diagnoses which included retention of urine and gastrostomy status.Record review of Resident #191's physician orders reflected the following:Enhanced barrier precautions r/t gastrostomy status, indwelling foley catheter (start date 5/19/2025)Observation on 07/01/2025 at 2:42 PM revealed CNA K and LVN L performed catheter care for Resident #191. Neither staff members donned gowns prior to performing care.In an interview on 7/1/2025 at 2:50 PM, CNA K and LVN L

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 of 5 resident hallways (100 and 500 hallways) and 2 of 2 shower room (West and East Wing shower rooms) reviewed for environmental concerns in that:1-The facility failed to clean a bathroom ceiling vent in room [ROOM NUMBER].2-The facility failed to replace a bathroom light bulb and repair a piece of bathroom floor molding in room [ROOM NUMBER].3-The facility failed to clean a bathroom vent in room [ROOM NUMBER].4-The facility failed to replace a bedroom side wall light in room [ROOM NUMBER].5-The facility failed to clean a ceiling vent and and sprinkler head on the [NAME] Wing shower room.6-The facility failed to clean the ceiling vents and replace light bulbs in the East Wing shower room.These failures could place residents at risk of not residing in a safe, comfortable, and homelike environment.The findings included:Observation on 7/1/25 from 8:05am until 8:20am with the Administrator and Maintenance Director revealed the following:a-There was a bathroom ceiling vent which measured approximately 2x2 ft that was covered with dust in room [ROOM NUMBER].b-There was a bathroom light bulb not working and a missing piece of floor molding which measured approximately 1 ft by 1 inch near the bathroom entrance in room [ROOM NUMBER].c-There was a bathroom ceiling vent which measured approximately 2x2 ft that was covered with dust in room [ROOM NUMBER].d-There was a light on the B-side of the bedroom adjacent to the bed that would not turn on in room [ROOM NUMBER].Observation on 7/1/25 from 1040am until 10:55am with the Administrator and Maintenance Director revealed the following:e-There was a ceiling vent which measured approximately 2x2 ft that was covered with dust and a sprinkler head that measured 2 inches in diameter that had a rusted base cover in the [NAME] Wing shower room.f-There were a two ceiling vents which each measured approximately 2x2 ft that were covered with dust/dirt and two of three bathroom sink light bulbs out on the East Wing shower room.During an interview on 7/2/25 at 11:00 with the Administrator and Maintenance Director, the Maintenance Director stated he was responsible for repairs in the Resident room and the facility shower rooms. He stated he had not received any work order requested for any repairs on the resident rooms on the 100 and 500 hallways and the shower rooms. The Maintenance Director and Administrator both stated completing the repairs would provide a more homelike environment for the residents.Record review of the facility's policy for Maintenance Service dated 2009 reflected Maintenance service shall be provided to all areas of the building, grounds, and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all time.