STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345003	A. BUILDING _____ B. WING _____	09/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILAS CREEK MANOR	3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 9/30/2011. Event ID# SERM11.	F 000		

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

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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345003	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 9/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILAS CREEK MANOR	3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences; or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the residents legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, family interview and staff interviews the facility failed to notify the family physical therapy services was discontinued for 1 of 1 resident (Resident #15).

Resident #15 was admitted to the facility on 12/27/10 with cumulative diagnoses of Rehabilitation, Osteoarthrosis (multiple sites) and History of Falls. The Minimum Data Set (MDS) completed on 8/31/11 indicated the resident had short and long term memory loss

A review of the history and physical completed on 12/27/10 indicated Physical Therapy (PT) to evaluate and treat.

A review of the " Notice of Discontinuation of Rehabilitation Services " signed by the facility on 4/11/11 revealed PT was discontinued on 4/18/11, due to minimal functional gains

A review of the PT discharge summary completed on 4/18/11 revealed Resident #15 was discharged form PT due to minimal progress toward goals

A review of the nurses' notes from 4/18/11-9/28/11 revealed no documentation the family was notified PT services was discontinued.

In a family interview on 9/27/11 at 5:02 PM, Resident #15 's family stated the facility failed to notify the resident had been discontinued from PT services several months ago

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345003	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 9/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILAS CREEK MANOR	3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 157	Continued From Page 1

In an Interview on 9/29/11 at 9:22 AM, Staff #1(Physical Therapist) indicated one week prior to discontinuation of PT services, a letter should have been mailed to the family if he/she was not present at the facility to be made verbally aware.

In an Interview on 9/29/11 at 9:40 AM, Staff #2 stated she maintained a copy of the letters mailed to families when PT services were discontinued, after the copy was received from the PT department. Staff #2 elaborated she thought the MDS case manager was responsible for mailing the letters to the family.

In a follow up family interview on9/29/11 at 9:50 AM, Resident #15 ' s family stated the facility should have notified the family PT services was discontinued to allowed the family opportunity for personal encouragement of PT and exercises to the resident. The family member concluded she was annoyed due to not notified.

In an Interview on 9/29/11 at 11:02 AM, the Administrator revealed she talked with the MDS case manager via telephone and he indicated he could not recall if he talked with the family related to PT services being discontinued. The administrator added the MDS case manager stated to review the resident' s medical record. The administrator concluded her expectation was that staff notified families prior to PT services being discontinued.

In an Interview on 9/29/11 at 2:20 PM, the Director of Nursing Services (DNS) stated after review of the medical record the facility was unable to produce documentation of a letter mailed to Resident#15 ' s family, nor verbal notification that PT services was discontinued.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345003	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILAS CREEK MANOR	3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 10/14/11 between 8:00 AM and 12:00 PM the following was noted: 1) The dry storage room to the kitchen was wedged open and did not have latching hardware. 2) The corridor door to the laundry room, clean side did not close, latch and seal. 42 CFR 483.70(a)	K 029	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The kitchen dry storage room door is closed and has latching hardware intact. The laundry room corridor door latch and seal has been replaced and is functioning properly. The facility self closing doors will be audited to ensure proper functioning and latching hardware is intact. The Staff Development Coordinator and/or the Executive Director will re-educate the center staff regarding the policy prohibiting the use of propping self closing doors and the procedure for completing a maintenance request form. The Maintenance Director will audit self-closing doors 3 times weekly for one month and then weekly for two months to ensure proper latching and closure. Data results will be analyzed and reviewed at the centers monthly Performance Improvement Committee monthly for 3 months with a subsequent plan of correction as needed. The Executive Director is responsible for overall compliance.	11-27-2011
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 10/14/11	K 061	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	11-27-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joanne Martin | TITLE: RN/DNS | (X6) DATE: 10-28-11

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345003	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILAS CREEK MANOR	3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 061	Continued From page 1 between 8:00 AM and 12:00 PM the following was noted: 1) The following automatic sprinkler system was observed as non-compliant, specific findings include the accelerator line to the dry side of the sprinkler riser has a valve on both sides of the accelerator that when closed will affect the operation of the system is not equipped with an electronically supervised tamper alarm. 42 CFR 483.70(a)	K 061	An outside agency will install two new supervised tamper switches on the sprinkler system and connected to the fire alarm panel The system will be tested and monitored quarterly as outlined by the facility Preventative Maintenance Program. The results of the monitoring will be reviewed at the centers Performance Improvement Committee Meeting quarterly times three. The Executive Director is responsible for overall compliance.	
K 211 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation on Friday 10/14/11 between 8:00 AM and 12:00 PM the following was noted: 1) Throughout the facility Alcohol Based Hand Rub (ABHR) that were installed within 6 inches of	K 211	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Alcohol Based Hand Rub Dispensers will be relocated and reinstalled greater than 10 inches away from light switches and receptacles. A one time facility room audit will be conducted by the Maintenance Director to ensure that alcohol based hand rub dispensers are located greater than 6 inches from light switches and receptacles. The Maintenance Director will audit alcohol based hand rub dispensers weekly for one month and then monthly for two months to ensure proper placement greater than 6 inches from light switches and receptacles.	11-27-2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345003	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILAS CREEK MANOR	3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 the light switches. 42 CFR 483.70(a)	K 211	Data results will be analyzed and reviewed at the centers monthly Performance Improvement Committee monthly for 3 months with a subsequent plan of correction as needed. The Executive Director is responsible for overall compliance.	