PRINTED: 02/20/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345003	B. WING			1	C 05/2015
	ROVIDER OR SUPPLIER	ENTER		335	EET ADDRESS, CITY, STATE, ZIP CODE D SILAS CREEK PARKWAY ISTON-SALEM, NC 27103	, v	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157 SS=D	A facility must immed consult with the resid-known, notify the resid-known, notify the resid-or an interested family accident involving the injury and has the pointervention; a significantly and in health status in either life throlical complications significantly (i.e., a nexisting form of treatmonsequences, or to treatment); or a decising resident from the §483.12(a).  The facility must also and, if known, the resident rights under regulations as specified in §483.15(resident rights under regulations as specificating section.  The facility must reconsequences and phorned in representative of the address and phorned in regulations.  This REQUIREMENT by:  Based on record review the physician interview the physician of resident.	istely inform the resident; ent's physician; and if dent's legal representative y member when there is an resident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a the mental, or psychosocial eatening conditions or to a need to alter treatment the dot discontinue and the mental due to adverse commence a new form of ion to transfer or discharge facility as specified in the promptly notify the resident ident's legal representative tember when there is a commate assignment as the end of the resident's red in paragraph (b)(1) of the end of the resident's the number of the resident's the interested family member.		157	Resident #3 no longer resident the facility.  The nurses utilize the 24 hor report from Point Click Care (PCC) during shift to shift report to ensure any resident change have been documented and reported to the physician and responsible party. The nursing management team also review the 24 hour report and new physicians order listing report each morning during Clinical rounds to ensure the residents physicians, and family membhave been notified of any incidents, falls, or other significant changes.	ur port es ng ws	3   5   15 (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.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	
							;
1511		345003	B. WING			02/0	5/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
SILAS CR	EEK REHABILITATION (	CENTER		1	50 SILAS CREEK PARKWAY		
				l w	INSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	e 1	F	157	TI 1' 1 ' (61	T-CASTAGO AND	!
	residents (Resident#	<i>‡</i> 3)			The licensed nursing staff h		
	Planetta and to alread a de				been re-educated on the nee		
	Findings included:				inform the resident, the resi		
	Resident #3 was adm	nitted to the facility on			physician and responsible p	•	
	1/8/2015. Her diagno	ses included Cerebral Artery			immediately, when there is		
		t (stroke); late effects of			injury, significant change in		
	Cerebrovascular Dise	ease; Tracheostomy strostomy (feeding tube);			resident's condition or treatr	nent	
	Dysphagia (difficulty:				plan, a decision has been ma	ide to	
		ease; Speech and Language		ł	transfer the resident from th	e	
		ovascular Disease; Lack of			facility and if there is a char	ige in	
	(paralysis of one side	Weakness; Hemiplegia of the body) Affect due to ease; and Acute Respiratory			the resident's room or room	nate.	
	Failure.	ease, and Acute Nespiratory			Newly hired Licensed Nurse	es will	į
					be educated during their		
		summary dated 1/8/2015			orientation period, on the ne	ed to	!
		s experienced acute onset of e to the right and weakness			inform the resident, the resident		;
		and lower extremities on			physician and responsible p		ļ
		t #3 received thrombolytic			immediately when there is a		i
		Labetalol (used to treat high			The state of the s		
	blood pressure) and medication) for mana	required Ativan (antianxiety		ì	injury, significant change in		-
	1 *	lology exam) confirmed a			resident's condition or treatr		1
-		t (stroke). A Tracheostomy			plan, a decision has been ma		i
	was placed on 12/23/	/2014 with oxygen therapy			transfer the resident from th	-	
		as placed on 12/24/2014.			facility and if there is a char	ige in	1
	discontinued at disch	opin (antianxiety) was arge.					Ì
		_		ļ			
		num Data Set (MDS) dated		ļ	•		
		sident #3 as no speech for times able to make self	***				
		erstand others. Her vision			•	***************************************	1
	was coded highly imp	paired. A staff assessment			~# *		
	for mental status reve				•		
	memory was intact ai	nd she was independent in	1			ĺ	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345003	B. WING		02/	05/2015
	ROVIDER OR SUPPLIER	CENTER	3	TREET ADDRESS, CITY, STATE, ZIP CODE 350 SILAS CREEK PARKWAY VINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	MDS did not code an restlessness) or beha kicking). Resident #3 extensive assistance for activities of daily if An Admission nurse PM revealed (in part) for large right CVA wi placement of Trached and moves around in Nurse Note dated 1/1 [Resident #3] is very Nurse Note dated 1/1 [Resident #3] is non vintervals. "  Nurse Note dated 1/1 She (Resident #3) is Nurse Note dated 1/1she (Resident #3) she (Resident #3) has epi Nurse Note dated 1/1 [Resident #3] has epi Nurse Note dated 1/1 Resident #3 was hittings out of bed and she was on Klonopin (before the CVA and [communication book needed something for	ally decision making. The y mood (e.g. fidgety or aviors (e.g. hitting and 's functional status was to total dependent on staff iving.  Inote dated 1/8/2015 at 9:30 hospitalized on 12/16/2014 th left side paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized on 12/16/2014 th left side paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized on 12/16/2014 th left side paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized paralysisNew betomy 12/23/2015 at 9:30 hospitalized paralysisNew betomy 12/23/2015 at 4:27 hospitalized paralysisNew betomy 12/23/2015 at 4:27 hospitalized paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized paralysisNew betomy 12/23/2014. Restless bed a lot.  Inote dated 1/8/2015 at 9:30 hospitalized paralysisNew betomy 12/2014 at 9:30 hospitalized paralysisNew betomy 12/2015 at 9:30 hospitalized paralysisNew beto	F 157	The Director or Nursing will a the nursing documentation of resident charts a week for thre (3) months. The results of the weekly audits will be presente the Quality Assurance (QA) committee for a minimum of t months. The Quality Assurance and Performance Improvement Committee will review the audit and make recommendations to ensure compliance is sustained ongoing; and determine the nefor further auditing beyond the three (3) months.	hree ce t dits	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345003	B. WING			02/0	05/2015
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
SILAS CR	EEK REHABILITATION C	ENTER		l .	3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	iχ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Continued From page	e 3	F	157	7		
		Vellbutrin (antidepressant)					:
	Agitation noted this P	8/2015 at 10:36 PM read, " M. Hitting at [family] and of the bed. Very restless bed. "					
	Resident (Resident #: hitting bed crying resi replaced by this write	r " and included the nurse e bedside and orders were					
	#3 's family reported	/20/2015 included Resident Resident #3 stated she fell / night 3rd shift and put bed.					
	Thrashing around and headboard. Pulled [or Pulled trach out. Staff Bed lowered to lowes	21/2015 at 2:48 PM " d throughout early AM hours. d banging bed rails and xygen] off over and over. f unable to calm resident. st position. At 4 AM, while e rolled out of bed into the					
	1	21/2015 at 2:52 PM included If her oxygen supply during anding the trial.					
	Agitation noted this P	21/2015 9:03 PM read, " PM hitting at family and of bed. Very restless kicking					
	Nurse Note dated 1/2	24/2015 at 4:12 AM noted					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`'		CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		345003	B. WING_			I .	05/2015
	ROVIDER OR SUPPLIER EEK REHABILITATION	CENTER		33	TREET ADDRESS, CITY, STATE, ZIP CODE 550 SILAS CREEK PARKWAY FINSTON-SALEM, NC 27103	1 02:	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	Resident #3 's [fam bed with the entire out. Unsuccessful at the tube. Resident # hospital and the cur replaced and was real and the cur replaced and was real and traced and was real and traced [Reside over the place." Not of times e.g. wou and traced dressing.  An interview on 2/4/#6 revealed Reside grabbing at stuff, the hitting family, and the hitting family, and the traced Reside frustrated, and had #1 reported Reside she coughed and when traced the traced that was agont to the traced the finiterview on 2/5/20' Resident #3 was agont the traced that the families of	Id trach collar.  Id 1/24/2014 at 8:25 AM revealed fily] found the resident lying in Fracheostomy [tube] pulled fitempts were made to replace fig was transported to the rent size 6 tube could not be eplaced with a smaller size 4.  Id 1/2015 at 2:37 PM with Nurse fint fig 1/2015 at 9. The pulled at everything a find dressing, gtube, trach,  Id 1/2015 at 4:24 PM with Nurse fint fig 1/2015 at 4:24 PM with Nurse fint fig 1/2015 at 4:24 PM with Nurse fint fig 1/2015 at 4:25 PM with Nurse fint fig 1/2015 at 4:26 PM with Nurse fint fig 1/2015 at 4:26 PM with Nurse fint fig 1/2015 at 4:27 PM with Nurse fint fig 1/2015 at 4:28 PM with Nurse fint fig 1/2015 at 4:29 PM with Nurse fint fig 1/2015 at 4:29 PM with Nurse fint fig 1/2015 at 4:20 PM with Nurse	F	157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		345003	B. WING_		0:	C 2/05/2015
	ROVIDER OR SUPPLIER EEK REHABILITATION C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF 6 X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE
F 157	side, her left arm was was resting on her left bed. An additional int Nurse #9 was aware (documented as restinotes) and when she the first shift nurse (N Resident #3 did it all the first shift nurse (N Resident #3 did it a	e was positioned on her left bent back, and her head fi arm. Staff put her back in erview at 2:00 PM revealed of Resident #3 's behaviors ess and agitated in nurse mentioned the behaviors to lurse #6) the nurse said the time.  O15 at 2:06 PM with the Unit esident #3 kept her legs out and tugged at everything. Forted when she went in to the time was as aware of things as got she was or she was the Unit Manager reported with was as aware of things as got she was or she was the Unit Manager reported with was more anxiety than anxiety. "  with Nurse #8 said, " If a go increased are able to get an emergent consult. At the very least offity the doctor. "  O15 at 3:20 PM with the aled the facility had a mental ed for the residents at the was how to manage skilled nursing facilities was	F	157		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		345003	B. WING				05/2015
	ROVIDER OR SUPPLIER	ENTER .		33	TREET ADDRESS, CITY, STATE, ZIP CODE 350 SILAS CREEK PARKWAY /INSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 157 F 241 SS=D	behaviors and reporte her. She would have Resident #3 based or 483.15(a) DIGNITY A INDIVIDUALITY  The facility must prommanner and in an envenhances each reside full recognition of his full recognit	ency of Resident #3 's and the staff did not inform expected a consult for a nurse notes.  ND RESPECT OF  Interpretation of the interpretation of the individuality.  It is not met as evidenced  we and interviews with mily member and staff, the per resident call bells in a poide assistance, for sistance, to maintain dignity desidents #2 and #1)  Individuality and  Interpretation of the individuality and  Interpretation of the interpretat		241	Resident concerns regarding the timeliness of staff answering colights were addressed individually with resident #1 and resident #1 on February 27, 2015 by the Resident Care Coordinator. The Resident Care Coordinator shat the facility's plan of action to ensure that call lights are answering a timely manner.  All residents in the facility have Department Manager assigned their "Guardian Angel." Residente are asked during the week day Guardian Angel rounds if their needs are being met and if the clights are answered in a timely manner. Resident care and call light concerns are immediately addressed and documented as a grievance to ensure appropriate follow up.	all ally 2 ne red rered re a as ents	3/5/15

V -3111 - 11	to r ortingpiorate a	MEDIONID OFICAIOFO				CIND M	<u>, 0900-0091</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345003	B. WING				05/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHASCE	EEK REHABILITATION O	ENTED		3:	350 SILAS CREEK PARKWAY		
JILAJ CK	CER REPABLITATION C	ENIER		W	VINSTON-SALEM, NC 27103		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	GI		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
F 241	Continued From page	. 7		241			
		ner with dignity and respect,	F	2 <del>4</del> (			
		I had a fall when I was					
		I slid down the side of the					
	bed. The only thing						
		because I was trying to get			Facility staff have been re-		1
		to help me. I rang the call			educated on the expectation	fo	1
		minutes that I was waiting. I			energies cell lights in a time t	.O	1
	spoke to someone ye	sterday about having to wait			answer call lights in a timely		
		metimes for the call light to			manner to ensure the resident		į
		a clock in my room that I can			needs are being met and that	heir	
	1 -	me that works. When i			dignity is maintained. Newly	J	
		use I need something like			hired facility staff will be	•	
		s me to have to wait so long				• .	
		ey don ' t want to help me. hings like ' You are a big			educated during their orientat	ion	
		g to have to lose some			on the expectation to answer	call	i
		. ' It is very disrespectful			lights in a timely manner to en	isure	1
		t my size. They are so			their needs are being met and	that	
		ies. There is one [aide] on			their dignity is maintained.		
		to shut up. I was asking			is maintained.		
	for them to change m	e and told them I had been					
		es waiting. She said 'shut			~		
		at was about 3 weeks ago.			Call light response times will	be	
		Coordinator] just about			monitored by utilizing a call li	ght	
		but it doesn't change. I			audit. The audit form will be	0	,
		ant a grievance form filled		1	completed by the Resident Ca	eo :	
	ł	m and no one ever has ne about it at all. That night		ļ	! Coordinator to a server 11 11 1		
		ess. I have told staff that I		,	Coordinator to ensure call ligh	its	
		and was told 'No one can			are being answered in a timely	,	
	do anything to me. ' I	have had to holler out to			manner. The audit will be		
		to stop hollering. They also			randomly performed during al	1	
		light off without asking what			, , ,	~	
		nt this week I turned on the					
		o one came until 5:30 am. 1					
	needed to be change	d. I have told many staff					
		Resident #2 indicated			-, (		
	during her interview th				, ·		
	disrespected and has	been so frustrated, due to					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMPI	
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		345003	B. WING	······································		02/	05/2015
	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 350 SILAS CREEK PARKWAY		
SILAS CR	EEK REHABILITATION C	ENTER	WINSTON-SALEM, NC 27103		/INSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	times when she push- has not been nice to [ the level of her frustra indicated that staff res not improved " at all ' mentioned her concer Coordinator " months During an interview of Resident Care Coord #2 's call bell concern remember [Resident is on 3rd shift primarily. been within the past re concerns from her. Of council meeting and of Resident Care Coord like the concerns had 2. Resident #1 was of facility on 12/8/09 and on 12/18/14. Her dial and depression. The MDS dated 12/23 cognitively intact, rejet did not have behavior dependent with toilet required extensive as hygiene. She was all and bladder. She had vision, clear speech, a understood and unde During an interview of asked if staff treated if Resident #1 stated, " me with respect. Som takes 30 minutes to 1 here to change me or clock and have my was	If and very lengthy wait es her call bell, that she " staff] at times " because of ation. Resident #2 further sponse to call bell lights has ' since the first time she rns to the Resident Care ago." 12/5/15 at 4:30 pm with the inator, regarding Resident ns, she stated, " I #2] speaking of wait times I did an in-service. It has nonth. I have only taken 2 ne was during a resident one was this week. " The inator indicated that she felt been resolved. riginally admitted to the I most recently readmitted gnoses included paraplegia  3/14 indicated she was ceted care 1-3 of 7 days and rs. She was totally use and bathing and sistance with personal ways incontinent of bowel d adequate hearing and and was able to be	F	241	three shifts and at different tinduring the shifts. The audit will completed daily for 2 weeks, weekly for 10 weeks and then monthly x 3 months.  Any concerns identified when completing the audit will be addressed immediately. The clight audit results will be review monthly for a minimum of thr (3) months in the facility's QA meeting. Any identified issue will be discussed and recommendations followed to ensure ongoing compliance are determine the need for further audits beyond three (3) months.	all ee	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345003	B. WING				C 05/2015
	ROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103		350 SILAS CREEK PARKWAY	<u> </u>	03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 241	wall, which indicated it resident also was weathe correct time, on he The resident's family in her room during the 2/5/15 at 10:15 am the regularly and has "m resident push her call and provide care for "	aled a working clock on the he correct time. The aring a working watch, with er right wrist.  I member, who was present a interview, indicated on at she visited Resident #1 ore than once " seen the bell and staff not respond '30 minutes to an hour."	The state of the s	319			
\$S=D	MENTAL/PSYCHOSO Based on the compre- resident, the facility m	OCIAL DIFFICULTIES  nensive assessment of a  ust ensure that a resident or psychosocial adjustment ropriate treatment and			Resident #3 no longer resides a facility.  A review of all resident records be completed by the Social Ser	will	3 5115
	by: Based on record review of facility falled to recogn symptoms of psychos nursing home and to 1 of 1 resident (Resident)	is not met as evidenced  ew, staff interview, nurse and physician interview the nize or identify the signs or ocial adjustment to the ner medical condition for 1 t #3).			Director/designee to identify the psychosocial needs. Careplans also be reviewed and revised accordingly. The physician with notified and a consult made for facility's contracted mental her group for any resident found to	eir will  Il be the alth	
The second secon	Occlusion with infarct Cerebrovascular Dise	es included Cerebral Artery (stroke); late effects of ase; Tracheostomy rostomy (feeding tube);	Total designation of the second of the secon		have unaddressed needs.		

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	
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		345003	B, WING			02/	)5/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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SILMS CR	CEN REMABLITATION C	CNIER		٧	VINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 319	deficit due to Cerebro Coordination; Muscle (paralysis of one side (paralysis of one side Cerebrovascular Disc Failure.  A hospital discharge revealed Resident #3 speech difficulty, gaz to the left face, upper 12/16/2014. Resident therapy, intravenous blood pressure) and medication) for mana agitation. A MRI (radi large ischemic infarct was placed on 12/23, and a Gastrostomy w. The medication Kloned discontinued at disch An Order for resident Refer to Mental Health An Admission nurse in PM included (in part) for large right CVA will placement of Trached and moves around in Nurse Note dated 1/2 [Resident #3] is very	ease; Speech and Language ovascular Disease; Lack of Weakness; Hemiplegia of the body) Affect due to ease; and Acute Respiratory summary dated 1/8/2015 experienced acute onset of e to the right and weakness and lower extremities on the 4/3 received thrombolytic Labetalol (used to treat high required Ativan (antianxiety gement of extreme ology exam) confirmed a confirmed a confirmed and the example of the experienced on 12/24/2014. Spin (antianxiety) was arge.  #3 dated 1/8/2015 read, the as needed.  #4 dated 1/8/2015 at 9:30 hospitalized on 12/16/2014 the left side paralysis New postomy 12/23/2014. Restless bed a lot.	F	319	Licensed nursing staff member have been re-educated on the correct procedure to notify the mental health group in an emerication should a resident's condition warrant.  Newly hired Licensed Nurses be educated during their orient period on the correct procedur notify the mental health group emergent situation should a resident's condition warrant.  Prior to, or upon admission, the Director of Nurses or designed review available records to enthe facility is able to meet the of each potential admission. The Interdisciplinary Team (IDT) review new admissions record each morning in the daily stant meeting to determine the residenceds to be addressed on the inplan of care.  The Social Service Director we complete chart audits on the radmitted residents each week weeks, then every 2 weeks x and weeks to ensure their mental and the stant and the residents and the residents each weeks are weeks to ensure their mental and the stant and the residents and the residents are their mental and the residents are the residents are the residents and the residents are the residents and the residents are	will ation e to in an eee, will sure needs he will lent's nitial	
	Nurse Note dated 1/1	11/2015 at 4:27 AM read, "			]		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345003	B. WING			1	05/2015
NAME OF P	ROVIDER OR SUPPLIER	0.0000		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 021	05/2015
SILAS CR	EEK REHABILITATION C	ENTER		3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 319	she (Resident #3) s during trach care. "  Resident #3 was care dependent on staff for stimulation, and social physical limitations ar  The admission Minim 1/15/2015 coded Res speech clarity; someth understood and sile for mental status reversities of daily lips continued as a status of daily lipsychosocial well-being were not triggered for care.  Nurse Note dated 1/1 [Resident #3] has epical nurse Note dated 1/1 Resident #3 was hitting legs out of bed and silestimated and	still fearful. "  2/2015 at 8:18 AM read, " till gets anxious especially  planned on 1/12/2015 for activities, cognitive all interaction related to addimmobility.  um Data Set (MDS) dated ident #3 as no speech for imes able to make self arstand others. Her vision aired. A staff assessment alled Resident #3 's and she was independent in ally decision making. The y mood (e.g. fidgety or viors (e.g. hitting and 's functional status was to total dependent on staff ving. The care areas for ang, mood, and behaviors Resident #3 's plan of  6/2015 at 4:13 AM read, "  7/2015 at 9:55 PM included ang at [family], throwing her apping hand away. Resident antianxiety medication) written] in doctor to see if Resident #3 rewithdraw. [Welbutrin	F	ļ	psychosocial needs have been addressed and met. The results the audits will be presented at monthly QA meeting for mining of three (3) months. The Quality Assurance and Performance Committee will review the audity make recommendations to ensure compliance is sustained ongoing and determine the need for furth auditing beyond the three (3) months.	the num ity its to ire	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA UND PLAN OF CORRECTION UMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
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	ROVIDER OR SUPPLIER EEK REHABILITATION	CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 350 SILAS CREEK PARKWAY VINSTON-SALEM, NC 27103	- " <u>-</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 319	impaired cognitive for processes related to (stroke). Approache needed supervision making. Monitor/dod any changes in (in particular for the following stress of the following	re planned on 1/18/2015 for unction or impaired thought of late effects of the CVA as included: Resident #3 /assistance with all decision cument/report to the physician part) difficulty expressing self.  The planned on 1/18/2015 for estion related to legal blindness.  The planned on 1/18/2015 for estions related to the reaches included monitor for indicators of discomfort or indicators or in	F	319			
	Resident #3 was ca limited physical mol Weakness, Lack of effects of CVA, CAE and Respiratory Fal potential for falls du	are planned on 1/18/2015 for billty related to Muscle Coordination related to late O (coronary artery disease) illure. Resident #3 had a le to the above.					
	On 1/18/2015 a nur	se practitioner (NP) progress					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			SURVEY .ETED	
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	ROVIDER OR SUPPLIER			3:	TREET ADDRESS, CITY, STATE, ZIP CODE 350 SILAS CREEK PARKWAY VINSTON-SALEM, NC 27103	1 0210	7.07.2010
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F 319	Nurse Note dated 1/1 Received orders for 1/1 Received orders for 1/1 An Order dated 1/18 (milligrams) two time days. [Welbutrin cau.] Nurse Note dated 1/1 Agitation noted this F throwing her legs out kicking legs out of the Nurse Note dated 1/1 Resident (Resident # hitting bed crying reseived by this write was at the bedside a one time dose of Ativ.  An Order dated 1/19 (antianxiety medicationly, Klonopin (antiatwice a day as needed A record review of Readministered on 1/18 time only dose.  Nurse Notes dated 1/18 s family reported Record bed on Sunday nigback into the bed.	ression/plan for to start a low dose Welbutrin.  18/2015 at 3:48 PM read, Welbutrin for anxiety.  /2015 Welbutrin 75 mg s a day for anxiety, for 4 sed nightmares]  18/2015 at 10:36 PM read, "PM. Hitting at [family] and to f the bed. Very restless e bed."  19/2015 at 10:38 PM read, "PM	L.	319			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER EEK REHABILITATION C	ENTER		STREET ADDRESS, CITY, STATE, ZIP C 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 319	same side effect prior attempted. Welbutrin (anticonvulsant medic and Namenda (deme The NP noted that Recourse of Ativan.  An Order dated 1/20/mg twice a day; Nam discontinue Welbutrin Nurse Note dated 1/2 Restless and agitated Thrashing around an headboard. Pulled for Pulled trach out. Staf Bed lowered to lowes thrashing around, she floor. "  Nurse Note dated 1/2 Resident #3 pulled of an oral therapy trial end or oral therapy trial end of the pulled of the pu	ting Welbutrin. She had the to admission when discontinued and Depakote cation used for behaviors) intia medication) started. It is	F	319			

NAME OF PROVIDER OR SUPPLIER  SILAS CREEK REHABILITATION CENTER  SILAS CREEK REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SILAS CREEK REHABILITATION CENTER  SILAS CREEK REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			345003	B. WING				1
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
Nurse Note dated 1/24/2015 at 4:12 AM noted Resident #3 removed trach collar.  Nurse Note dated 1/24/2014 at 8:25 AM included Resident #3 's [family] found the resident lying in bed with the entire Tracheostomy [lube] pulled out. Unsuccessful attempts were made to replace the tube. Resident #3 was transported to the hospital and the current size 6 tube could not be replaced and was replaced with a smaller size 4.  A review of hospital records dated 1/24/2015 revealed frach stoma was intact and trach was absent. Resident #3 pulled trach out sometime during the night and it was replaced with a size 4.  Nurse Note 1/25/2015 at 12:27 AM included pain medication was given to Resident #3 for a complaint of left hip pain. Resident #3 for a complaint of left hip pain. Resident #3 for a complaint of left hip pain. Resident #3 framily insisted the physician be called due to pain in Resident #3 's left hip and agitation. Medications and radiology exams were ordered. The lamily requested to have Resident #3 taken to the hospital for further evaluation.  A Nurse Note dated 1/25/2015 at 2:47 PM revealed the family of Resident #3 requested she go to the hospital for a neurological evaluation. Resident #3 transported.  An interview on 2/4/2015 at 2:37 PM with Nurse #7 revealed Resident#3's behavior was "all over the place." Nurse #7 pulled at everything a tot of times e.g. wound dressing, gtube, trach, and trach dressing.  An interview on 2/4/2015 at 4:24 PM with Nurse #6 revealed Resident #3 was anxious and always	F 319	Nurse Note dated 1/2 Resident #3 removed Nurse Note dated 1/2 Resident #3 's [familibed with the entire Trout. Unsuccessful att the tube. Resident #3 hospital and the curreplaced and was replaced and was replaced and was replaced and was replaced trach stoma absent. Resident #3 during the night and Nurse Note 1/25/201 medication was giver complaint of left hip pinsisted the physician Resident #3 's left his and radiology exams requested to have Rehospital for further example of the hospital for Resident #3 transport An interview on 2/4/2 #7 revealed Resident over the place. "Nullot of times e.g. wour and trach dressing.  An interview on 2/4/2 An interview on 2/4/2	24/2015 at 4:12 AM noted di trach collar.  24/2014 at 8:25 AM included by found the resident lying in racheostomy [tube] pulled tempts were made to replace 3 was transported to the ent size 6 tube could not be placed with a smaller size 4.  Pecords dated 1/24/2015 a was intact and trach was pulled trach out sometime it was replaced with a size 4.  5 at 12:27 AM included pain in to Resident #3 for a pain. Resident #3 for a pain. Resident #3 is family in be called due to pain in the pain and agitation. Medications a were ordered. The family esident #3 taken to the valuation.  1/25/2015 at 2:47 PM if Resident #3 requested she a neurological evaluation.  2015 at 2:37 PM with Nurse that is behavior was "all urse #7 pulled at everything a ned dressing, gtube, trach,	F	319			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
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F 319	hitting family, and the Resident #3 pulled revealed Resident #4 to the hospital for a something was not.  An interview on 2/4, #1 revealed Reside frustrated, and had #1 reported Reside she coughed and with trach. The familidaily. Resident #3 vand would hang heinterview on 2/5/20 Resident #3 was agthrow her leg out of reported she talked informed her she withdrawals from Ki conversation with thumbs up (indicating Klonopin. Nurse #1 to be on Klonopin. With the provided intervention/evaluating med a physician on Nurse #1 reported in	rowing her legs off the bed, hrashing. On 1/25/2015 at her trach. Nurse #6 #3 's family suggested she go in evaluation because right.  //2015 at 4:58 PM with Nurse in #3 was young, restless, trouble communicating. Nurse in #3 was anxious every time when Nurse #1 was suctioning your was very nervous and here would turn from side to side in leg out. An additional it is at 3:19 PM revealed	F	319				
	about her behaviors #3 would have ben An interview on 2/5 #4 revealed Reside irritable at times, gr	discussed with family in depth s. Nurse #1 reported Resident efited from a medication.  /2015 at 10:35 AM with Nurse ent #3 's behaviors were abbing at rails and trach. She g uncomfortable. Nurse #1 did						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 319	repositioned her or pand she was fine.  An interview on 2/5// #9 revealed at 4:00 assistant informed N was on the floor. She side, her left arm wa was resting on her lebed. An additional in Nurse #9 was aware (documented as resonotes) and when she the first shift nurse (Resident #3 did it all An interview on 2/5// occupational therapy Resident #3 reveale fidget and wiggle in An interview on 2/5// Resident #3 could not back in the bed from Resident #3 was cap of the bed. The physical was up in the changer revealed from the bed and pulle the Unit Manager reprovide care Reside her arm still. The Unit Manager reprovide care Reside her arm still.	r was consistent and reported provide her pain medication  2015 at 11:42 AM with Nurse AM Sunday/Monday a nurse lurse #9 that Resident #3 he was positioned on her left is bent back, and her head eft arm. Staff put her back in atterview at 2:00 PM revealed to of Resident #3 's behaviors at less and agitated in nurse is mentioned the behaviors to Nurse #6) the nurse said the time.  2015 at 8:00 AM with the repossistant who worked with a Resident #3 would always the bed.  2015 at 11:20 AM with dical therapist revealed of use the left side of her possible for her to get herself in the floor. She reported pable of throwing herself out sical therapist reported she sident #3 unattended when	F	319			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION		E SURVEY MPLETED
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F 319	doing it intentionally. Resident #3 's behave twitching. "It was an Manager reported the the emergency room reason for her to go.  An interview on 2/5/2 facility Nurse Practitic #3 had decannulated a concern if her beha stabilization. The NP Ativan because Resid Depakote was the first stabilization of a resid Benzodiazepine (Ative) disorders were a last Resident #3 had wea Benzodiazepines [Klothe facility.  An interview on 2/5/1: If a resident was exhi anxiety/behaviors we psych [mental health] we should call and not a stabilization of a resident was exhi anxiety/behaviors we psych [mental health] we should call and not a stabilization of a resident was exhi anxiety/behaviors we psych [mental health]	ght she was or she was The Unit Manager reported vior was more anxiety than anxiety. " The Unit e day Resident #3 went to there was no apparent  015 at 2:41 PM with the oner (NP) revealed Resident herself twice and there was viors were stroke v/s mood revealed she did order the dent #3 was really agitated. et line medication for mood dent who had a stroke. an) used to treat anxiety result. The NP reported ned herself off onopin] prior to her arrival to  5 at 3:45pm with Nurse #8 " bitting increased are able to get an emergent consult. At the very least	F 31	,		
	health group contract facility. The question of because the trend in a to avoid psychotropic medications. The phy mental health consult was an automatic [state behaviors and the con-	ed for the residents at the was how to manage skilled nursing facilities was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER EEK REHABILITATION C			33	TREET ADDRESS, CITY, STATE, ZIP CODE 150 SILAS CREEK PARKWAY TINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
F 319 F 329 SS=D	behaviors and reporte her. She would have Resident #3 based or An Interview on 2/5/1. Director of Nursing in made to psychiatric s stated, "She was a r felt like we were just to before we addressed 483.25(I) DRUG REGUNNECESSARY DRUGNECESSARY DRUGNECESSAR	requency of Resident #3 's ed the staff did not inform expected a consult for n nurse notes.  5 at 3:20 PM with the dicated there was no referral ervices [mental health] and esident [Resident #3] that I trying to get settled medically the behaviors. " BIMEN IS FREE FROM UGS  regimen must be free from An unnecessary drug is any accessive dose (including for excessive duration; or nitoring; or without adequate c; or in the presence of es which indicate the dose discontinued; or any easons above.  ensive assessment of a nust ensure that residents intipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic Il dose reductions, and		319	Resident #3 no longer resides this facility.  A facility wide audit will be completed to identify resident receiving psychotropic medic and ensure those residents has appropriate psychosocial assessments and intervention implemented prior to the administration of psychotropic medications. Resident carepla will be reviewed and updated reflect the interventions to be used.	ation ve s	315/15
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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SILAS CR	EEK REHABILITATION (	CENTER	;	350 SILAS CREEK PARKWAY		
			] .'	VINSTON-SALEM, NC 27103		
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F 329	by: Based on record rev practitioner interview, facility failed to imple interventions to addre with 1 of 1 resident (I the nursing home and prior to the administra	is not met as evidenced iew, staff interview, nurse , and physician interview the ment psychosocial ess behaviors associated Resident #3) adjustment to d a new médical condition	F 329	Nursing staff will be re-educe on the process of implement and documenting these interventions prior to the usate psychotropic medications.  Newly hired Licensed Nurse be educated during their orientation period on the proof implementing and document these interventions prior to administering psychotropic medications.	ge of s will cess	
	Occlusion with infarci Cerebrovascular Disa (breathing tube); Gas Dysphagia (difficulty Cerebrovascular Disa deficit due to Cerebro Coordination; Muscle (paralysis of one side Cerebrovascular Disa Failure.  A hospital discharge revealed Resident #3 speech difficulty, gaz to the left face, upper 12/16/2014. Residen therapy, intravenous blood pressure) and medication) for mana	ses included Cerebral Artery t (stroke); late effects of ease; Tracheostomy strostomy (feeding tube); swallowing) due to ease; Speech and Language evascular Disease; Lack of tweakness; Hemiplegia of the body) Affect due to ease; and Acute Respiratory  summary dated 1/8/2015 to experienced acute onset of the to the right and weakness and lower extremities on t #3 received thrombolytic Labetalol (used to treat high required Ativan (antianxiety tigement of extreme		The Interdisciplinary team vassess and monitor the appropriateness of the psychotropic medications are effectiveness of the psychos interventions for each reside the Minimum Data Set (MD process.  Monthly, the Consultant Pharmacist reviews both the psychotropic medications are interventions as part of each regimen review.  If, at anytime during the assessment or monitoring prothe psychosocial interventions.	nd the ocial and via S)	
		iology exam) confirmed a t (stroke). A Tracheostomy				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 329	and a Gastrostomy w The medication Klond discontinued at disch	/2014 with oxygen therapy /as placed on 12/24/2014. opin (antianxiety) was arge. resident #3 dated 1/8/2015	F3	329	found to be lacking or inappropriate, the Director of Nurses will be notified and the Interdisciplinary Team (IDT) make the needed changes and update the resident's careplan	will		
	An Admission nurse note dated 1/8/2015 at 9:30 PM revealed (in part) hospitalized on 12/16/2014 for large right CVA with left side paralysisNew placement of Tracheostomy 12/23/2014. Restless and moves around in bed a lot.  Nurse Note dated 1/10/2015 at 8:30 AM read, " [Resident #3] is very fearful."  Nurse Note dated 1/11/2015 at 12:15 AM read, " [Resident #3] is non verbal this PM -tearful at intervals."  Nurse Note dated 1/11/2015 at 4:27 AM read, " She (Resident #3) is still fearful."			THE PARTY OF THE P	The Director of Nurses or designee will complete audits resident records receiving psychotropic medications to ensure non-pharmacological interventions are utilized prior administering the medications. Audits will be conducted week for one month, then monthly fininimum of three (3) months. The Director of Nurses will rethe results of the audits to the Quality Assurance and Performance Improvement	to kly or a		
	during trach care. "  Resident #3 was car dependent on staff for stimulation, and soci physical limitations at the admission Minir 1/15/2015 coded Respeech clarity; some understood and und was coded highly im	e planned on 1/12/2015 for or activities, cognitive al interaction related to and immobility.  num Data Set (MDS) dated sident #3 as no speech for estimes able to make self erstand others. Her vision paired. A staff assessment realed Resident #3 's			Committee. The Quality Assurance and Performance Improvement Committee will review the audits and make recommendations to ensure compliance will be sustained ongoing; and determine the ne for further auditing beyond the three (3) months.	eed		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		INSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345003	B. WING				C 2/05/2015
	ROVIDER OR SUPPLIER EEK REHABILITATION	CENTER		3350	ET ADDRESS, CITY, STATE, ZIP CODE SILAS CREEK PARKWAY STON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 329	cognitive skills for d MDS did not code a restlessness) or bel kicking). Resident # extensive assistant for activities of daily psychosocial well-b were not triggered for care.  Nurse Note dated 1 [Resident #3] has element #3 was hillegs out of bed and #3 was on Klonopir before the CVA and communication body needed something antidepressant star Resident #3 was calimpaired cognitive processes related to (stroke). Approached the communication body needed supervision making. Monitor/do any changes in (in the communication on 1/18/2015 a Nurse Note dated in Anxiety/Depression Nurse Note dated in Received orders for the code in	and she was independent in ally decision making. The my mood (e.g. fidgety or naviors (e.g. hitting and 3's functional status was e to total dependent on staff living. The care areas for eing, mood, and behaviors or Resident #3's plan of  /16/2015 at 4:13 AM read, "pisodes of restlessness."  /17/2015 at 9:55 PM included ting at [family], throwing her slapping hand away. Resident a (antianxiety medication)  [written] in doctor k to see if Resident #3 for withdraw. [Welbutrin ted]  are planned on 1/18/2015 for function or impaired thought to late effects of the CVA es included: Resident #3 h/assistance with all decision cument/report to the physician part) difficulty expressing self.  rse Practitioner (NP) progress	F	329			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION  NG	1 COM	
		345003	B. WING			C 02/05/2015
	ROVIDER OR SUPPLIER	ON CENTER		STREET ADDRESS, CITY, STATE, ZIP 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 329	Nurse Note dated Agitation noted the throwing her legs kicking legs out of Nurse Note dated Resident (Resider hitting bed crying replaced by this was practitioner was a received for one to the An Order dated 1 medication) 0.5 m (antianxiety medication) 0.5 m (antianxiety medication) o.5 m (antianxiety medicat	mes a day for anxiety, for 4 raused nightmares]  1/18/2015 at 10:36 PM read, " is PM. Hitting at [family] and out of the bed. Very restless if the bed. "  1/19/2015 at 10:38 PM read, " int #3) agitation level increased resident pulled out trach riter " and included the nurse it the bedside and orders were ime dose of Alivan.  1/19/2015 Ativan (antianxiety ing now x1 dose only, Klonopin ation) 0.25mg twice a day as on for 5 days.  If Resident #3 's Medication realed Ativan for agitation was in/19/2015 at 8:38 PM as a one  1/19/2015 at 8:38 PM as a one  1/19/2015 read, Resident #3 ' Resident #3 stated she fell out r night 3rd shift and put herself  IP progress note included an Resident #3 was having starting Welbutrin. She had the prior to admission when utrin discontinued and Depakote nedication used for behaviors) ementia medication) started. at Resident #3 had a short	F	329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
345003			B. WING			02/0	05/2015
NAME OF PROVIDER OR SUPPLIER  SILAS CREEK REHABILITATION CENTER				33	TREET ADDRESS, CITY, STATE, ZIP CODE 150 SILAS CREEK PARKWAY INSTON-SALEM, NC 27103		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 329	Continued From pa	age 24	F	329			
	An Order dated 1/20/2015 included Depakote 250 mg twice a day; Namenda 5 mg daily and discontinue Welbutrin.						
	Restless and agital Thrashing around a headboard. Pulled Pulled trach out. So Bed lowered to low	I/21/2015 at 2:48 PM read, " ied throughout early AM hours. and banging bed rails and [oxygen] off over and over. itaff unable to calm resident. iest position. At 4 AM, while ishe rolled out of bed into the					
		1/21/2015 at 2:52 PM included off her oxygen supply during I ending the trial.					
	Agitation noted this	1/21/2015 9:03 PM read, " PM hitting at family and out of bed. Very restless kicking		:			
		cation administration record 15 at 11:23 PM noted					
	Administration Reconly dose of Klono day period, was ad 11:23 PM. Welbutr between 1/18/2015 behaviors and Narias daily medication on 1/21/2015 through	Resident #3 's Medication ford revealed one dose and the pin, ordered as needed for a 6 iministered on 1/21/2015 at in was administered 4 times 5 and 1/20/2015. Depakote for needa for anxiety were ordered as administration was started 1/24/2015 at 4:12 AM noted					
	Nurse Note dated   Resident #3 remov	1/24/2015 at 4:12 AM noted red trach collar.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					<del> </del>	c	
345003		B. WING			02/05/2015		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
SILAS CREEK REHABILITATION CENTER				3350 SI	LAS CREEK PARKWAY		
OILHO OIL	LEN NEIMOREIMION C	, ENTER		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 PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION DATE
F 329	Continued From page	<b>⇒</b> 25	F3	29			
		4/2014 at 8:25 AM included y] found the resident lying in		4			
		acheostomy [tube] pulled					
		empts were made to replace					
		was transported to the					
		ent size 6 tube could not be		1		ĺ	
		placed with a smaller size 4.					
	An interview on 2/4/2	015 at 4:58 PM with Nurse					
	#1 revealed Resident	#3 was young, restless,					
		ouble communicating. Nurse					
	#1 reported Resident	#3 was anxious every time					
	she coughed and who	en Nurse #1 was suctioning					
	the trach. The family	was very nervous and here					
	daily. Resident #3 wo	ould turn from side to side		ļ			
	and would hang her l	<del>-</del>					
	interview on 2/5/2015			ļ			
		ated, situational, and would		-			
	_	ed forcefully. Nurse #1		ļ			
	reported she talked to						
		on an antidepressant,	***************************************				
		prior to admission. Nurse		1			
		ght Resident #3 was having	İ				
	withdrawals from Klo	nopin. During the family Resident #3 put her					
		yes) when talking about					
		elt like Resident #3 wanted					
	•	hen asked about her (Nurse					
	#1) ability to provide			-			
		on she replied she would					
		er for a psychiatric consult.					
		esident #3 was all over the					
		scussed with family in depth					1
	about her behaviors.	Nurse #1 reported Resident		1			-
	#3 would have benef	ited from a medication.	ŀ				
		015 at 10:35 AM with Nurse					
	#4 revealed Resideni	t #3 ' s behaviors were	1	1			1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OATION AUTHORO.		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345003	B. WING			C 02/05/2015		
NAME OF PROVIDER OR SUPPLIER SILAS CREEK REHABILITATION CENTER				335	REET ADDRESS, CITY, STATE, ZIP CODE 50 SILAS CREEK PARKWAY NSTON-SALEM, NC 27103	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
F 329	complained of being not feel the behavior repositioned her or p and she was fine.  An interview on 2/5/2 #9 revealed at 4:00 / assistant informed N was on the floor. Sh side, her left arm was was resting on her lebed. An additional in Nurse #9 was aware (documented as rest notes) and when she the first shift nurse (N Resident #3 did it all An interview on 2/5/2 Manager revealed R of the bed and pulled The Unit Manager re provide care Residen her arm still. The Urnot feel Resident #3 they [the family] thou doing it intentionally. Resident #3 's beha twitching. "It was ar An interview on 2/5/2 facility NP revealed if decannulated herself concern if her behav stabilization. The NP Ativan because Resi	bbing at rails and trach. She uncomfortable. Nurse #1 did was consistent and reported rovide her pain medication  2015 at 11:42 AM with Nurse AM Sunday/Monday a nurse urse #9 that Resident #3 e was positioned on her left is bent back, and her head of terview at 2:00 PM revealed of Resident #3 's behaviors less and agitated in nurse in mentioned the behaviors to durse #6) the nurse said the time.  2015 at 2:06 PM with the Unit tesident #3 kept her legs out if and tugged at everything, ported when she went in to not #3 's family had to hold was as aware of things as 19th she was or she was 17the Unit Manager reported wior was more anxiety than in anxiety. "  2015 at 2:41 PM with the Resident #3 had if twice and there was a liors were stroke v/s mood if revealed she did order the dent #3 was really agitated.	F	329				
	Depakote was the fir	st line medication for mood dent who had a stroke.						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED C 02/05/2015	
		345003 B. WING			0:		
NAME OF PROVIDER OR SUPPLIER  SILAS CREEK REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	LD BE COMPLETION	
F 329	disorders were a last Resident #3 had wea Benzodiazepines [Klothe facility.  On 2/5/15 at 3:45 PM resident was exhibiting anxiety/behaviors were psych [mental health] we should call and not a should call and not a should call and not be a should call and not a should psychotropic altering). The physicial health consult had not a should have a should	an) used to treat anxiety result. The NP reported ned herself off proping prior to her arrival to a line of the proping prior to her arrival to a line of the proping prior to her arrival to a line of the proping prior to her arrival to a line of the proping prior to her arrival to a line of the proping prior to her arrival to a line of the residents at the line of the proping prior to have an arrival consult for behaviors and the staff did not inform the proping prior to have proping prior to have proping prior to have a line of the	F 32				